Application for Review of the Scope of Practice of Dietetics in Ontario

Submitted to the Health Professions Regulatory Advisory Council

June 30, 2008

by

The College of Dietitians of Ontario

and

Dietitians of Canada
Executive Summary

Registered Dietitians (RDs) are the health professionals who are uniquely trained to provide expertise on food and nutrition. Registered Dietitians provide nutrition services in a variety of settings in Ontario including Community Health Centres, Family Health Teams, home care, hospitals, long-term care homes, Diabetes Education Centres, public health, sports and recreation facilities, food industry, academic and research settings, and private practice. In disease prevention and treatment, RDs’ expertise in food, nutrition, counselling and education encompasses the complex interactions between nutrients, medications, and metabolic processes. In diabetes care, for example, the effect of insulin and other medications must be integrated with nutrient intake, activity patterns, and changes in nutrient metabolism that occur with diabetes, while at the same time managing nutrition therapy for co-morbidities such as hypertension and dyslipidemia. All of these considerations must be translated into a therapeutic diet that fits the patient’s lifestyle and preferences.

Collaboration with clients, caregivers, and other health professionals is central to dietetic practice; RDs are valued members of interprofessional teams in health care settings, using their expertise to integrate nutrition care into health promotion and disease prevention and management for patients.

The dietetic profession’s code of ethics, professional misconduct regulation, competency statements and standards of practice establish a level of practice that ensures patient safety and prohibits RDs from undertaking activities for which they are not personally competent.

Registered Dietitians’ expertise in managing nutrition for health promotion, disease prevention, and treatment of acute and chronic diseases is not fully recognized or utilized under the current scope of practice and the current system of controlled acts limits the RD’s ability to provide effective care. Furthermore, health human resources issues compounded by the increasing prevalence of chronic disease have created serious shortages of many health professionals across the province. Changes to the dietetic scope of practice would improve the quality of patient care and improve patient access to necessary care by qualified RDs.

The College of Dietitians of Ontario (CDO) and Dietitians of Canada (DC) collaborated to develop a revised scope of practice statement based on a review of other jurisdictions, in addition to member input. In the process of creating this submission, DC and CDO discussed issues with professional associations, regulatory bodies, and practitioners from the professions most closely involved in working with RDs in health care and health promotion.
roles (medicine, nursing, pharmacy, medical laboratory technology). The changes being sought are primarily to enable initiation of activities related to nutrition care by RDs, where they are already competently performing through medical directives, delegations, or protocols.

The following proposed changes to the Regulated Health Professions Act (RHPA) and Dietetics Act are supported by RDs’ current professional activities and are founded in existing dietetic knowledge, competencies and standards. While not all dietitians currently perform all the proposed changes in legislated scope of practice, many currently do depending on the setting and on medical directives and delegation.

Changes to support dietetic practice in Ontario involve: rewording the scope of practice statement, authorizing RDs to perform identified controlled acts within their scope of practice, creating two new controlled acts and recommending changes to the Public Hospitals Act and other regulations to authorize RDs to effectively manage nutrition therapy.

**New proposed scope of practice statement:**

*Dietetics is the assessment of nutrition related to health status and conditions for individuals and populations, the management and delivery of nutrition therapy to treat disease, the management of food systems, and building the capacity of individuals and populations to promote or restore health and prevent disease through nutrition and related means.*

The proposed scope of practice statement is more reflective of the extent of dietitians’ involvement in population health, nutrition therapy, food systems management, and health promotion.

Registered Dietitians’ diverse roles and competencies are not recognized under the current system of controlled acts, and this limits the RD’s ability to provide safe and effective care. **It is proposed that RDs be authorized to perform the following controlled acts within their scope of practice.**

**Controlled Act #1 – Communicating a Diagnosis**

*It is proposed that RDs be authorized to communicate a diagnosis that relates to nutrition therapy, only when the diagnosis has been confirmed by a physician, nurse practitioner or other authorized healthcare practitioner.*

Communicating a diagnosis that has already been made provides much more streamlined and efficient care. A barrier to effective counselling is created if the client does not know their diagnosis. In contrast, by communicating a diagnosis that has been made, the RD is able to discuss the nutritional implications of the diagnosis and ensure the client understands the rationale for lifestyle changes and nutrition therapy.
Obtaining informed consent based on a diagnosis is very important to the quality and effectiveness of nutrition therapy.

**Controlled Act #2 – Procedure below the dermis**

*It is proposed that RDs be authorized to perform skin pricks for the purpose of monitoring capillary blood levels.*

Diabetes is currently the only common condition for which capillary readings are well accepted, however the technology is also used to determine blood lipid levels and it is expected that this will expand to other areas as technology develops. Registered Dietitians need blood glucose readings in order to accurately evaluate the patient’s response to prescribed diet therapy, to assess the need to implement treatment for hypoglycemia, and to develop appropriate meal plans and nutrition interventions. Limiting access to this information restricts the ability of the dietitian to provide high quality care. For the patient, authorizing the RD to perform skin prick testing supports a seamless approach to providing services, which can reduce stress for the patient and their family.

**Controlled Act #8 – Prescribing or dispensing, specifically for the adjustment of insulin and oral hypoglycemic regimens**

*It is proposed that RDs be authorized to make adjustments to the dose of existing insulin or oral hypoglycemic medications that have been prescribed by a physician or authorized healthcare practitioner.*

Enabling RDs to make insulin adjustments for individuals with diabetes on existing insulin regimens supports effective interprofessional team-based care and contributes to patient self-management and safety by preventing hypoglycemia and reducing the risk of long term vascular complications.

**Controlled Act #14 – Psychotherapy**

*It is proposed that RDs be involved in the definition of psychotherapy as it relates to dietetic scope of practice.*

Psychosocial counselling, including cognitive behavioural therapy and solution-focused therapy, are used in nutrition therapy on a regular basis and form part of the competencies underpinning RDs’ professional education and training. If the controlled act of psychotherapy impacts on the use of psychotherapy techniques by RDs in psychosocial counselling, they must be authorized to perform it within their scope of practice.

Registered Dietitians also work in specialized mental health, addictions and eating disorders programs. These dietitians self-identify as using psychotherapeutic techniques in their practices and employers attest to the appropriateness and competence of the dietitians in these settings. Client care will be seriously compromised if the definition of psychotherapy restricts the ability of dietitians to provide these services as part of the interprofessional team.
New Controlled Acts

The evidence of risk associated with enteral and parenteral nutrition and therapeutic diets is clear. This, combined with the increased recognition and demand for therapeutic diets to treat and manage disease and the changing use of providers in the health care system, aims to ensure that only qualified people prescribe/recommend and manage nutrition therapy. Two new controlled acts are proposed.

Prescribing and managing enteral and parenteral nutrition

It is proposed that a new controlled act be created and that RDs be authorized to prescribe and manage enteral and parenteral nutrition.

Patient safety is the impetus behind our application for a new controlled act for the prescription and management of enteral and parenteral nutrition (EN/PN). Both EN and PN are complex nutrition interventions that include significant risks to patients if not prescribed and managed with the appropriate knowledge and skills.

The College and DC considered how EN and PN could be more effectively restricted to only qualified professionals and with the assistance of legal counsel explored the options:

- Modifying an existing controlled act by amending “administering a substance by injection or inhalation” to “prescribing or administering a substance by injection or inhalation”, leaves ambiguity as to whether adding nutrition through a feeding tube or IV tube constitutes an injection.
- Force-fit existing controlled acts:
  - 1) interpret “injection” to include adding EN or PN into an existing port into the body. Giving authority to RDs for administering a substance by injection or inhalation however, does not capture the formulation or designing of the content of the supposed injection. Further, RDs do not typically do the actual administration.
  - 2) interpret the controlled act of prescribing or dispensing drugs to include prescribing EN and PN. This creates issues in relation to the definition of “drug” with reference to the drug schedules established by the National Association of Pharmacy Regulatory Authorities’ (NAPRA)

The purposes of a controlled act is not to enable performance of high risk health care activities, but instead to restrict their performance to qualified people. This necessitates clarity in the law and its interpretation. Our
concern is that force-fitting prescribing and managing EN and PN into the existing controlled acts would not achieve the important public protection objective.

**Prescribing and managing therapeutic diets**

*It is proposed that a new controlled act be created and that RDs be authorized to prescribe and manage therapeutic diets.*

Therapeutic diets are formulated and managed to treat disease or a nutrition-related disorder and are contrasted with nutrition guidance or advice for healthy eating. Therapeutic diets may be the sole treatment for a disease or condition, or an adjunct to other medical treatment. In some cases, therapeutic diets may be needed for a subset of patients with a specific condition but not all. Therapeutic diets are individualized to a person based on a comprehensive nutrition and health assessment and include recommended intake of food or recommended intake of food in combination with vitamins and minerals, and food supplements.

Examples of the most common RD interventions for associated medical conditions are described in Appendix 1. The risks of inappropriate prescription or design of therapeutic diets may be exacerbation of symptoms (Crohn’s disease, allergies), disease progression (cancer or arthritis), irreversible damage (diabetes or inborn errors of metabolism like phenylketonuria), or loss of life (end-stage renal disease). Therapeutic recommendations involving supplements or exclusion of food groups may carry a significant risk of harm when they are used inappropriately in the context of treatment for a medical condition. Our goal is to ensure public safety and support interprofessional collaboration by delineating the situations of highest risk.

The following changes to other legislation and regulations are proposed to authorize RDs to effectively manage nutrition therapy:

**Public Hospitals Act**

*For the Public Hospitals Act, it is proposed to add the RD to the list of professionals authorized to order specified treatment and/or diagnostic procedures within the dietetic scope of practice.* Examples include: diet orders, enteral and parenteral nutrition, vitamin and mineral supplements, laboratory tests of particular relevance to managing nutrition therapy, body weight, and assessments by other health professionals.

Although the increasing use of medical directives demonstrates the interprofessional team’s reliance on the RD to assess, treat and manage nutrition therapy, the complicated and cumbersome process of creating these does not represent the best use of limited resources in the health care
system and compromises optimal patient care. Authorizing the RD to order diagnostic and treatment procedures in consultation with the interdisciplinary team supports optimal patient care.

**Laboratory Specimens and Collection Centre Licensing Act**

*It is proposed that RD be added to the list of professionals authorized to order specified tests as prescribed in the regulation, within their scope of practice and limited to those of particular relevance to managing nutrition therapy.* Examples include: hemoglobin, albumin, glycolysated hemoglobin.

Timely access to lab values expedites and improves patient care by enabling the RD to tailor nutrition therapy to the individual. Authorizing the RD to order specific laboratory tests in a judicious manner and in coordination with the entire healthcare team will optimize care while ensuring that patients are not subject to excessive blood draws and that costs are contained.

**Health Care Consent Act**

*It is proposed that RD be added to the list of professionals that may act as an “evaluator” for the purpose of determining capacity for admission to a LTC home.*

The current regulation prevents RDs from becoming Case Managers in Community Care Access Centres. Registered Dietitians possess the competencies needed to act as evaluators in this circumstance. Employers and RDs have expressed the need to include RDs on the list of professionals (along with psychologists, nurses, physicians, occupational therapists and social workers) in order to facilitate case management in the homecare setting.

**The Long Term Care Act**

*As regulations are developed, it is proposed that it be specified that nutritional care is ordered and managed by the RD, including therapeutic diet orders and enteral and parenteral nutrition*

It is important that the regulations currently being developed clearly indicate the RD’s responsibility and authority to prescribe and manage nutrition therapy to support optimal patient care.

**Anticipated Benefits**

The proposed changes to dietetic scope of practice will provide better patient care by enhancing the ability of RDs to initiate and monitor nutrition therapy. Patient safety will be improved by the proposed changes to the scope of practice and other legislation by ensuring that comprehensive care can be provided by RDs and that procedures with significant risk, such as
enteral and parenteral nutrition and therapeutic diets, are prescribed and managed by competent professionals.

The changes proposed to RD’s scope of practice are built upon a solid foundation of assessment skills and evidence-based practice, and supported by the education and training requirements already in place for RDs in Ontario and Canada.

Interprofessional care and collaborative scopes of practice are emphasized in Ontario’s healthcare transformation. Registered Dietitians are strongly supportive of interprofessional care, and believe that the patient’s best interests are served when healthcare teams work collaboratively and maximize the expertise of all professions. Increased efficiency and more effective utilization of health practitioners’ time will result from the proposed changes by streamlining the care that is already being competently performed by RDs through medical directives or other authority mechanisms.

The recommended changes to RD’s scope of practice support the need for coordinated and collaborative change. Public access to care and collaboration with other health professionals will be enhanced, allowing more effective management of chronic diseases and improved treatment of acute conditions.
Introduction – Registered Dietitians in Ontario

Registered Dietitians (RDs) are the health professionals who are uniquely trained to provide expertise on food and nutrition. Registered Dietitians help people meet their nutritional needs in health and disease at all stages of the life cycle, from pregnancy, infancy and childhood, to adults and geriatrics. They translate the complex science of nutrition into practical advice on food choices and use their expertise in the prevention and treatment of a broad range of medical disorders for individuals. As public health professionals, this knowledge is used to design programs and policies that will promote health in communities and specific sub-groups of the population.

Registered Dietitians provide nutrition services in a variety of settings in Ontario including Community Health Centres, Family Health Teams, home care, hospitals, long-term care homes, Diabetes Education Centres, public health, sports and recreation facilities, food industry, academic and research settings, and private practice. Registered Dietitians use a range of approaches to address nutrition needs, ranging from social marketing and health promotion for the population to individualized food provision for individuals at risk or who already have health issues. Discussion in this document is primarily focused on dietetics practice in the health care system.

![Work Settings for RDs in Ontario](chart)

An important aspect of the RDs expertise in the care of individuals is the ability to synthesize objective components of the nutrition assessment, such
as anthropometrics and laboratory evaluations, with the lifestyle and psychosocial aspects of the patient/client.

Collaboration with clients, caregivers, and other health professionals is central to dietetic practice; RDs are valued members of interprofessional teams in healthcare settings, using their expertise to integrate nutrition care into health promotion and disease management for patients and clients.

Registered Dietitians’ expertise in food and nutrition encompasses the complex interactions between nutrients, medications, and metabolic processes. In diabetes care, for example, the effect of insulin and other medications must be integrated with nutrient intake, activity patterns, and changes in nutrient metabolism that occur with diabetes, while at the same time managing nutrition therapy for co-morbidities such as hypertension and dyslipidemia. Nutrition therapy for patients on hemodialysis involves a comprehensive assessment of macro- and micro-nutrient intake, the effect of medications, and the effect of the dialysis process, and planning interventions to optimize nutrition status. Further information on the RD’s role in treatment of various conditions is included in Appendix 1. The complexities of nutrition therapy in a paediatric intensive care unit are illustrated by the case of Baby G:

Baby G was born at 24 weeks gestation weighing 680 grams. She was immediately intubated as her lungs were not mature enough to sustain breathing on their own. Intravenous tubes were put in her veins and arteries to supply necessary fluids and drugs to minimize the metabolic stress of being born so early. Intravenous nutrition was started within the first 18 hours of life. The RD calculated the initial amount of amino acids necessary to prevent catabolism, carbohydrate necessary to prevent hypoglycemia/hyperglycemia and possible irreversible brain damage, and electrolytes. From day 2 of life, careful progression and advancement of nutrients were made daily based on medical status and fluid intake. Baby G then developed further medical complications requiring fluid restriction. A concentrated parenteral nutrition solution was designed to meet nutrient requirements in a very minimal volume of fluid, until she could undergo surgery. After surgery, her feedings resumed and the RD again adjusted the parenteral nutrition to meet increased fluid tolerance; further adjustments were needed when blood values indicated that the kidneys were not functioning properly. The RD continued monitoring Baby G’s progress, adjusting protein, carbohydrate, sodium, and calcium levels to support growth and development as enteral feedings were started. The RD adjusted these feedings according to Baby G’s assessed needs and eventual transition to oral feeding.
1. Does your current scope of practice accurately reflect your profession’s current activities, functions, roles and responsibilities?

No. The roles and responsibilities of the RD in healthcare settings across Ontario are not fully reflected in the scope of practice statement or the authority mechanisms imposed by current legislation. Registered Dietitians’ expertise in managing nutrition for health promotion, disease prevention, and treatment of acute and chronic diseases is not fully recognized or utilized under the current scope of practice. The legislative changes proposed are not truly an expansion of dietetic practice; rather they enable and legally permit the practices that are currently happening through a variety of authority mechanisms and protocols. We support the use of medical directives and delegations where appropriate, and concur with the opinion of the Federation of Health Regulatory Colleges of Ontario which states that:

“Directives and delegation can address evolving health care needs by extending authority to perform procedures within existing legislative frameworks. However, they are not always a viable solution for addressing evolving needs in part due to the administrative load incurred when using them. Therefore, as health care professionals evolve in their competence to perform procedures that address evolving needs, consideration must also be given to updating their legislative authority.” (An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario; 2007)

2. Name the profession for which a change in scope of practice is being sought, and the professional Act that would require amendment

Dietetics; The Dietetics Act, 1991

3. Describe the change in scope of practice being sought

Changes to support dietetic practice in Ontario involve

- rewording the scope of practice statement,
- authorizing RDs to perform, within their scope of practice,
  - Controlled act #1 – communicating a diagnosis, limited to a diagnosis that has been confirmed by an MD or NP
  - Controlled act #2 – a procedure below the dermis, for the purposes of skin pricking to obtain a blood sample
  - Controlled Act #8 – prescribing a drug, limited to adjustments of insulin and oral hypoglycemics in an existing regimen
- creation of a new controlled act, authorized to RDs, for prescription and management of enteral and parenteral nutrition
- creation of a new controlled act, authorized to RDs, for prescription and management of therapeutic diets
• changes to regulations under The Public Hospitals Act, Laboratory Specimens and Collection Centres Act, Health Care Consent Act, and Long Term Care Act to authorize RDs to effectively manage nutrition therapy

Full details on the proposed changes are found in response to question #12.

4. Name of the College/association/group making the request, or sponsoring the proposal for change, if applicable

The College of Dietitians of Ontario (CDO) and Dietitians of Canada (DC) have prepared this submission together; relevant information for CDO is provided in questions 5 –8, and for DC in questions 9 – 11.

5. Address/website/e-mail (CDO)

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6. Telephone and fax numbers

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7. Contact person (including day telephone numbers)

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416-598-1725, Extension 228

8. List other professions, organizations or individuals who could provide relevant information applicable to the proposed change in scope of practice of your profession. Please provide contact names, addresses and contact numbers where possible.

These contacts are provided as resources; if there is a need for additional sources of information please contact Linda Dietrich, Dietitians of Canada or Mary Lou Gignac, College of Dietitians of Ontario.

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Chair, Board of Directors
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10. Length of time the association has existed as a representative organization for the profession
Dietitians of Canada has existed in its present form since 1997; previously the national association was known as the Canadian Dietetic Association (formed in 1935), and the Ontario Dietetic Association was the provincial counterpart.

11. List name(s) of any provincial, national or international association(s) for this profession with which your association is affiliated or who have an interest in this application. Please provide contact names, addresses, and

None. Please see response to question 8.
DETAILS OF THE PROPOSAL

Legislative Changes

12. What are the exact changes that you propose to the profession’s scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply to the profession, standards of practice, guidelines, policies and by-laws developed by the College, other legislation that may apply to the profession, and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?

Scope of Practice Statement

The scope of practice of dietetics as defined in the Dietetics Act, 1991, is “the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition related disorders by nutritional means”.

Proposed Change:

Dietetics is the assessment of nutrition related to health status and conditions for individuals and populations, the management and delivery of nutrition therapy to treat disease, the management of food systems, and building the capacity of individuals and populations to promote or restore health and prevent disease through nutrition and related means.

Rationale

The unique body of knowledge and competencies are used by RDs in a broad range of practice areas. The current scope of practice statement does not adequately capture the breadth of the functions and contributions made by RDs to nutrition and health. The diverse roles and abilities of RDs are not captured in the current scope of practice statement, nor is the extent to which nutrition therapy affects clients and patients. In May 2008, CDO members were asked to rate the current scope of practice statement for its ability to reflect their individual role, as well as the essential activities performed by RDs in Ontario. Forty percent of respondents felt that their professional role was not well reflected in the current statement; an even greater proportion (45% of respondents) indicated that the current scope of practice statement does not describe the essential activities and focus of dietetic practice.

Dietitians of Canada and CDO collaborated to develop a proposed scope of practice statement based on a review of other jurisdictions, in addition to member input. The national scope of practice statement for dietetics was also used: *The practice of dietetics and nutrition means the translation and*
application of the scientific knowledge of foods and human nutrition towards the attainment, maintenance, and promotion of the health of individuals, groups, and the community (1). Some of the common elements found in other jurisdictions include health promotion/disease prevention, management of nutrition therapy, and translation of scientific principles into practice.

The revised scope of practice incorporating members’ suggestions was then distributed for member input. Significant increases were seen in both the proportion of RDs who felt the revised scope reflected their role (82% of respondents rated it a 4 or 5 on a 5-point Likert scale), and that it encompassed the essential activities and focus of dietetic practice (73%). Some RDs suggested that more descriptors be included such as reference to working with the determinants of health, more information about dietetic process and adding the functions of education and research.

The proposed scope of practice statement is more reflective of the extent of RDs’ involvement in population health, food systems management, and health promotion.

Key elements of the revised scope include:

- **Nutrition Therapy** – This encompasses the process of assessment of nutritional status, planning and implementing interventions, evaluating and monitoring response to treatment, which more accurately describes the process of nutrition care than the current scope of practice statement (2, 3). The need for ongoing monitoring, evaluation, and modification of nutrition interventions is more clearly defined by the term nutrition therapy. Equivalent terms used in many practice settings include medical nutrition therapy, clinical dietetics, therapeutic nutrition, and clinical nutrition.

- **Capacity-building** – RDs educate and empower their clients to make changes to promote health, at both the individual and population level. Lifestyle changes are affected through psychosocial counselling, broad information and communication initiatives, and education of the public, other health professionals, educators, and community leaders. Building the capacity of individuals may include teaching self-management of chronic diseases or increasing skills in shopping, label reading, and preparing foods. At the community level, capacity-building encompasses building networks, supportive environments, and knowledge transfer that support healthy lifestyles. Capacity-building includes monitoring and responding to the effects of the determinants of health on the individual and community.
Population health planning - Population health planning and health promotion are practiced by RDs in many settings, and are the main focus of RDs in public health, who in 2006/07 comprise approximately 9% of RDs practicing in Ontario. Population health planning includes involvement in surveillance of health trends and the use of surveillance data to plan, implement, and evaluate practices. Registered Dietitians in primary care settings are developing population-based planning as well.

Health Promotion – Registered Dietitians have strong health promotion roles in many settings at both the individual and population level. Registered Dietitians are involved in advocacy and policy development affecting food and nutrition at all levels of organizations and government.

Public Health RDs provide reliable nutrition information to the public, educators, health professionals, policy makers, and the mass media. These professionals plan, coordinate, deliver, and evaluate education and skill-building nutrition programs.

Health promotion and disease prevention also comprise a significant role for RDs working in Community Health Centres and Family Health Teams, which are growing areas of employment, and currently represent almost 10% of RDs in Ontario. These RDs use multiple methods to support the nutrition needs of patients and communities, including nutrition therapy for individual clients, community health promotion programming and disease prevention initiatives as members of the inter-professional team. Examples include: well-baby immunization and screening, hypertension and diabetes clinics, self-care programs for chronic disease and community health fairs.

Food Systems Management – A broad definition of food systems is needed to reflect the RD’s diverse roles:

- at the national and global level, food systems refer to sustainable agriculture, food production, marketing and distribution channels where RDs play roles in policy development, communications and health promotion.
- at a community level, food systems encompass food security of individuals and groups, school and institutional menu parameters, and accessibility to healthy food choices.
- in organizations, food systems involve programs and policies to promote health and provide safe, appropriate foods for clients in hospitals, long-term care homes, daycares, correctional institutions, and other organizations.
Proposed Changes to the Regulated Health Professions Act (RHPA) and Dietetics Act

The system of controlled acts in the RHPA was developed to ensure that only qualified persons perform health care procedures that carry a risk of harm. Registered Dietitians agree that public safety is paramount in professional practice and interprofessional care. The system of controlled acts can be an enabler of interprofessional collaboration on patient care as it facilitates overlapping professional activities while clearly controlling those activities that are risky if not done by a qualified person. Profession-specific Acts and delegation must give due consideration to the competence of professions and individual professionals in determining authority to perform controlled acts.

While apparently achieving the intent of public protection, the RHPA has also created barriers to providing interprofessional care that are in the best interest of the patient. Registered Dietitians’ diverse roles and competencies are not recognized under the current system of controlled acts, and this limits the RD’s ability to provide safe and effective care.

The following proposed changes in the RHPA and Dietetics Act are supported by the RDs’ current professional activities and are founded in existing dietetic knowledge, competencies and standards. While not all RDs currently perform all the proposed changes in legislated scope of practice, many currently do depending on the setting and on medical directives and delegation. The dietetic profession’s code of ethics, professional misconduct regulation, competency statements and standards of practice prohibit RDs from undertaking activities for which they are not personally competent (Appendix 2).
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<th>Proposed Change</th>
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<tbody>
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<td>#2 - Procedure below the dermis</td>
<td>That RDs be authorized to perform skin pricks for the purpose of monitoring capillary blood levels (currently mainly blood glucose)</td>
<td></td>
</tr>
<tr>
<td>#8 - Prescribing a drug as defined in the <em>Drug and Pharmacies Regulation Act</em></td>
<td>That RDs be authorized to make adjustments to insulin or oral hypoglycemic medications.</td>
<td>Limited to adjustments of an existing insulin/oral hypoglycemic regimen that has been prescribed by an MD or other authorized healthcare practitioner</td>
</tr>
<tr>
<td>#14 – psychotherapy</td>
<td>That RDs be involved in the definition of psychotherapy as it relates to dietetic scope of practice</td>
<td></td>
</tr>
<tr>
<td>NEW – Enteral and parenteral nutrition</td>
<td>Prescribing and managing enteral and parenteral nutrition</td>
<td></td>
</tr>
<tr>
<td>NEW – Therapeutic diets</td>
<td>Prescribing and managing a therapeutic diet</td>
<td></td>
</tr>
<tr>
<td>Legislation/Regulation</td>
<td>Proposed Change</td>
<td>Limitations</td>
</tr>
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<td>----------------------------------------------</td>
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</tr>
<tr>
<td>Public Hospitals Act</td>
<td>Add RD to the list of professionals authorized to order specified treatment and/or diagnostic procedures</td>
<td>Within the dietetic scope of practice, such as diet orders, enteral and parenteral nutrition, vitamin and mineral supplements, laboratory tests of particular relevance to managing nutrition therapy, body weight, assessments by other healthcare practitioners</td>
</tr>
<tr>
<td>Laboratory Specimens and Collection Centre Licensing Act</td>
<td>Add RD to the list of professionals authorized to order specified tests as prescribed in the regulation</td>
<td>Within scope of practice, limited to those of particular relevance to managing nutrition therapy, such as hemoglobin, albumin, glycolysated hemoglobin</td>
</tr>
<tr>
<td>Health Care Consent Act</td>
<td>Add RD to the list of professionals that may act as an “evaluator” for the purpose of determining capacity</td>
<td>In the homecare setting only, as related to admission to a long-term care home</td>
</tr>
<tr>
<td>The Long Term Care Act</td>
<td>As regulations are developed, specify that nutritional care is ordered and managed by the RD, including therapeutic diet orders and enteral and parenteral nutrition</td>
<td></td>
</tr>
</tbody>
</table>
13. How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?

For the sake of clarity, we will present the limitations presented by the current legislation, and the rationale for each proposed change separately, although there is overlap in some areas. Specific competency statements are referenced in the response to questions 26 and 27; a complete set of Competencies for entry-level RDs, and Essential Competencies for Dietetic Practice, are found in Appendix 2.

Controlled Act #1 – Communicating a Diagnosis

Registered Dietitians told us repeatedly of this scenario:

A patient comes for nutrition counselling to manage their diabetes but does not know why they are there. They may have been told that they have “a bit of high blood sugar”, but do not think that they have diabetes. The diagnosis is written [in the medical record]. Without the ability to communicate this information to the patient, valuable time is wasted and educational opportunities are lost.

Willingness to make lifestyle changes does not generally occur until the person has come to accept the diagnosis (4). Initial counselling sessions with the RD are not productive if the client does not fully understand the reason that the changes are needed. In some instances, the client may have been informed of the diagnosis by the physician or nurse practitioner, but if that is not clearly documented in the patient record, the RD may be reluctant to repeat this information in case they are “communicating a diagnosis” that the client had not yet been informed of. The RD may then feel obliged to refer the client back to their primary provider so that the diagnosis can be communicated, resulting in lost time for the client and both practitioners.

Communicating a diagnosis that has already been made and recorded by authorized health professionals provides much more streamlined and efficient care. The RD is able to discuss the nutritional implications of the diagnosis and ensure the client understands the rationale for lifestyle changes and nutrition therapy. Obtaining informed consent based on a diagnosis is a very important to the quality and effectiveness of nutrition therapy. In addition, the RD can reinforce health teaching initiated by other practitioners.
Controlled Act #2 – Procedure below the dermis

Skin pricking to obtain blood glucose readings is a simple procedure that is performed by patients on a daily basis, yet cannot legally be performed by an RD in practice. While the RHPA provides an exemption for routine activities of living that would enable RDs to perform skin pricking under this circumstance, there are some patients for whom the exemption does not apply, for example, where collecting a blood sample is for more occasional testing and when RDs are teaching a patient to do the skin pricking. Currently, RDs deal with this barrier by asking the patient to perform the test themselves, or have the patient see another healthcare provider such as an RN or MD. These arrangements are workable in some cases, but not when the patient is physically unable, or prefers not, to perform the test themselves, or the nurse/doctor is not available. The patient and other healthcare providers should not be inconvenienced by this barrier to efficient care. RDs need to be able to teach clients with diabetes how to use their glucometer to perform self blood glucose monitoring, which is an important element of disease management. Inability to perform skin pricking greatly limits the RDs ability to properly teach the skill to clients.

Evidence-based guidelines for the management of diabetes developed by the Canadian Diabetes Association provide recommended targets for glycemic control, with goals and strategies tailored to the individual patient (6). The guidelines state that, “in many situations, more frequent testing may be required to provide the information needed to make behavioural or treatment adjustments required to achieve desired blood glucose levels” (6). Registered Dietitians need blood glucose readings in order to accurately evaluate the patient’s response to prescribed diet therapy, to assess the need to implement treatment for hypoglycemia, and to develop appropriate meal plans and nutrition interventions. Limiting access to this information restricts the ability of the RD to provide high quality care. For the patient, this supports a seamless approach to providing services, which can reduce stress for the patient and their family (7).

Controlled Act #8 – Prescribing or dispensing, specifically for the adjustment of insulin or oral hypoglycemic regimens

Interprofessional team-based care in the area of diabetes management is an effective way to provide comprehensive, continuous care (8). As RDs assess the food intake and physical activity of the client, minor adjustments to insulin dosages or timing can be addressed to achieve optimal glycemic control. Clinical guidelines for the management of diabetes developed by the Canadian Diabetes Association indicate that dietitians are integral in the decision of which agent/regimen may be best suited for the eating habits and lifestyle of people with diabetes (6). Education on matching insulin to
carbohydrate content of the diet is recommended for people with diabetes on intensive insulin treatment regimens to optimize glycemic control and avoid hypoglycemic complications (6). Registered Dietitians working in Diabetes Education Centres and other settings instruct clients on how to adjust their insulin based on meal intake, activity level, and self blood glucose monitoring results.

Enabling RDs to make insulin adjustments for individuals with diabetes on existing insulin regimens supports effective interprofessional team-based care and contributes to patient self-management and safety by preventing hypoglycemia and reducing the risk of long term vascular complications (6).

Registered Dietitians are currently authorized to order or prescribe several medications, through medical directives or other authority mechanisms. In response to a 2008 survey of CDO members, RDs reported that they currently order or prescribe the following, primarily in the hospital setting:

- Vitamins, minerals, and nutritional supplements
- Insulin and oral hypoglycemic agents
- Phosphate binders
- Potassium supplements
- Lipid lowering agents
- Pancreatic enzymes
- Anti-emetics
- Motility agents
- Dialysate formulations
- Appetite stimulants

The recommended change to the Public Hospitals Act will enable RDs to continue to provide this care in the hospital setting. RD application of the dietetic knowledge, skills and judgment to recommending/ordering/prescribing controlled drugs outside of the hospital setting is an emerging area of practice. At this time, this activity will be monitored with respect to growth in the number of RDs who prescribe drugs under delegation with reference to patient benefits such as improved access to quality healthcare. In the future, consideration may be given to recommending changes to RDs prescribing abilities.

**Controlled Act #14 – Psychotherapy**

The controlled act of psychotherapy has a complex multi-prong definition in the RHPA and it is not yet clear what treatments/techniques will be encompassed. This lack of clarity prompts the need to ensure that RDs are active participants in discussions with the new College of Psychotherapy and other colleges whose members will have authority to do psychotherapy.

While we have been told that this controlled act will not restrict the behaviour modification and solution-focused techniques that are used
routinely by RDs in counselling (11), there is no clear delineation of the
techniques that will be included in the controlled act. Registered Dietitians
also work in specialized mental health, addictions and eating disorders
programs. These RDs self-identify as using psychotherapeutic techniques
in their practices (10). Employers attest to the appropriateness and
competence of the RDs in these settings. Client care will be seriously
compromised if the definition of psychotherapy restricts the ability of RDs to
provide these services as part of the interprofessional team. Psychosocial
counselling is used in nutrition therapy on a regular basis and forms part of
the competencies underpinning the professional education and training; if
the controlled act of psychotherapy impacts on the use of psychotherapy
techniques in psychosocial counselling, RDs must be authorized to perform
it within their scope of practice.

Key elements of the controlled act of psychotherapy include:

- Psychotherapy technique – the techniques have not been clearly
deefined for the purpose of the RHPA; RDs use cognitive behavioural
therapy, solution-focused therapy, and other defined techniques
which may be defined as psychotherapy techniques (12-14).

- Therapeutic relationship - is a purposeful, goal directed relationship
that is directed at advancing the best interest and outcome of the
client. The qualities of the therapeutic relationship include: active
listening, trust, respect, genuineness, empathy, and responding to
client concerns (15). The relationship between an RD and client
meets this definition, and would be considered a therapeutic
relationship, and are fundamental to dietetic practice.

- Serious disorder – Registered Dietitians counsel clients affected with
disorders that are serious in nature, including eating disorders such
as anorexia nervosa and complex eating behaviours associated with
morbid obesity. These are typically treated in an interprofessional
team, where all team members reinforce messages.

- Treating serious psychological disorders – With a few exceptions
acknowledged, RDs do not as a primary focus of therapy set out to
treat psychological disorders. Working with psychological disorders
using psycho-social counselling and, at times, recognized
psychotherapy techniques is typically secondary to nutrition therapy.

The ability of RDs to continue to do psycho-social counselling and use
psychotherapy techniques must be safeguarded as these are essential
components of nutrition therapy for many clients.
New Controlled Act — Prescribing and managing enteral and parenteral nutrition
Prescribing and managing enteral and parental nutrition (EN/PN) carries a substantial risk of harm. HPRAC recognized this in 2001 when recommending to the Minister of Health and Long Term Care, that a referral be made for investigating the creation of two new controlled acts related to nutrition therapy (EN/PN and therapeutic diets). CDO and DC have continued to gather evidence related to the risk of harm, and the RD’s role in mitigating that risk. While we appreciate that creation of new controlled acts is not undertaken lightly, we are confident that the evidence is strongly in favour of this approach. Please see responses to question 20 for a full discussion of EN/PN (definition, indications and complications) and questions 23 and 24 for additional discussion of issues related to this proposed new controlled act.

New Controlled Act — Prescribing and managing therapeutic diets
Therapeutic diets are individualized nutrition therapy designed to manage a disease or condition; as noted above, HPRAC recommended in 2001 that the Minister make a referral for investigation of a controlled act related to therapeutic diets. The risks of inappropriate prescription or design of therapeutic diets may be exacerbation of symptoms, or life-threatening irreversible damage, such as in phenylketonuria (PKU) or renal disease. We recognize that other regulated and unregulated practitioners are involved in making nutrition recommendations for a variety of conditions; our goal is to ensure public safety and to support interprofessional collaboration by delineating the situations of highest risk. Please see responses to question 20 for a full discussion of therapeutic diets and questions 23 and 24 for additional discussion of issues related to this proposed new controlled act.

Other Legislation
The Public Hospitals Act has been identified by many groups as a significant barrier to interprofessional care. The Act requires all treatment and diagnostic procedures to be authorized by a physician, midwife or dentist unless a medical directive is in place; this is particularly relevant for RDs in the areas of therapeutic diets, enteral and parenteral nutrition, vitamin/mineral supplements, and laboratory tests for nutrition assessment. Although the RD has the clinical competencies and skills to make these decisions, the Act provides no exception for RDs to write orders in these areas. Mechanisms to work around this barrier are in place in many hospitals, such as medical directives or delegations, or physicians orders that simply state “per RD”. While these mechanisms of transferring authority have been useful in many cases, they do not represent the best
use of limited resources in the health care system, and lead to inconsistencies in utilizing the expertise of the RD to achieve optimal patient care. A recent report released by HealthForce Ontario documents the benefits of interprofessional care, in which multiple health caregivers work collaboratively, on increasing access to health care, improving outcomes for people with chronic diseases and better utilization of clinical resources (16). Changes to the Public Hospitals Act are needed to realize these benefits of interprofessional collaboration.

Increasing use of medical directives demonstrates the interprofessional team’s reliance on the RD to assess, treat, and manage nutrition therapy, but the complicated and cumbersome process of creating these takes practitioners time away from direct patient care, and has caused some organizations to abandon the idea entirely. Liability concerns expressed by physicians are not always alleviated by the use of medical directives (17). Registered Dietitians, as members of a self-regulated profession, are accountable for the treatment decisions that are made; however this is not universally understood and appreciated given the provision of the legislation. Further information on the use of medical directives is found in the response to question 23.

It is important to note that the ability to independently order diagnostic and treatment procedures does not reduce RDs’ responsibility to communicate and consult with the interdisciplinary team. As noted in the profession’s Code of Ethics, Standards of Practice and Competencies (Appendix 2), the RD is prohibited from working outside of their personal area of competence, and has a responsibility to take steps to achieve competence as needed. The requirement to consult with appropriate others, including other members of the healthcare team, is clearly stated in the standards and competencies (see tables 4 – 6 and Appendix 2).

Changes to the **Laboratory Specimens and Collection Centre Licensing Act** are required to allow RDs to directly order bloodwork or other laboratory analyses required for appropriate nutritional assessment and management of nutrition therapy. Timely access to lab values improves and expedites patient care by enabling the RD to tailor nutrition therapy to the individual. Current processes in various settings include making recommendations for physicians/nurse practitioners to order, obtaining medical directives, or having pre-signed laboratory requisitions for the RD to use as needed. These alternatives do not contribute to improved patient care, and do not represent an efficient use of practitioners’ limited time. The lack of legal authorization of RDs to order lab tests related to the management of nutrition therapy does not fully use the knowledge and competence of RDs.

The Federation of Health Regulatory Colleges of Ontario (FHRCO) also considers this legislation a barrier to interprofessional collaboration, and
recommends changes to the Public Hospitals Act and Laboratory Specimens and Collection Centres Licensing Act to allow health professionals work to their maximum competence and capability (9). We consider this consensus of the regulatory bodies to be very significant, and supportive of the changes we are proposing.

Judicious ordering practices, and coordination with the entire healthcare team, is necessary to ensure patients are not subject to excessive blood draws and that costs are contained. This is recognized by the profession, and was voiced by many RDs during our consultation process.

In response to a 2008 survey of CDO members, RDs reported that they currently order laboratory tests including, but not limited to:

- Hemoglobin
- White Blood Cell differential
- AST (Aspartate Aminotransferase)
- ALT (Alanine Aminotransferase)
- GGT (Gamma Glutamyl transferase)
- Alkaline Phosphatase
- Total Bilirubin (conjugated and unconjugated)
- Total Cholesterol
- Triglycerides
- BUN (Blood Urea Nitrogen)
- Creatinine
- Total Protein
- Glycolysated Hemoglobin
- Albumin and PreAlbumin
- Sodium
- Potassium
- Chloride
- Bicarbonate
- Calcium
- Magnesium
- Phosphate
- Zinc
- Vitamin B12
- Folate
- Ferritin

The CDO will work with the College of Medical Laboratory Technologists of Ontario and the Association of Medical Laboratory Technologists and others in the development of the regulation that would set out the list of lab tests to be ordered by RDs. This collaborative work will consider the appropriateness of the tests related to the management of nutrition therapies and nutrition-related disorders, as well as communication protocols. The Ontario Laboratory Information System currently being developed for use province-wide provides an important tool to minimize duplication of lab tests and enhance communication across healthcare providers. Additional practice expectations to ensure appropriate communication with physicians and nurse practitioners and others treating the patient will also be developed to ensure optimal interprofessional care.

*The Health Care Consent Act*, as it applies to the homecare setting, specifically defines professions that are able to act as evaluators to determine capacity of an individual for the purposes of admission to a long-
term care (LTC) home. The professions currently listed include psychologists, nurses, physicians, occupational therapists, and social workers. This regulation prevents RDs from becoming Case Managers in Community Care Access Centres. Employers and RDs have expressed the need to have this changed in order to facilitate case management in the homecare setting. The Alliance of Professional Associations for Community-Based Therapy Services (APACTS), including DC, has been in discussions around this issue with the Ontario Association of Community Care Access Centres (OACCAC).

Regulations to support implementation of The Long Term Care Act are currently being written. Although not specifically written into current legislation governing LTC homes, a physician's order has been deemed to be required for diet orders. Many homes have developed policies or medical directives to enable the RD to write diet orders. It is important that the regulations currently being developed clearly indicate the RD’s responsibility and authority to prescribe and manage nutrition therapy.

Collaboration

14. Do members of your profession practice in a collaborative or team environment where a change in scope of practice and the recognition of existing or new competencies will contribute to multidisciplinary health care delivery? Please describe any consultation process that has occurred with other professions.

Registered Dietitians are strong supporters of collaborative, team-based care. In fact, most of RDs involved in direct client care currently work in team-based settings such as hospitals, Family Health Teams, LTC homes, home care and Community Health Centres. In addition, RDs in private practice collaborate with other health care providers as needed to provide optimal care for their clients.

We believe that the legislative barriers to full expression of the existing scope of practice do not allow patients and other healthcare professionals to benefit from the full expertise of the RD. As HPRAC’s jurisdictional review for Interprofessional Care has shown, there are many benefits to the patient and the overall health system when a coordinated team approach is used that utilizes the skills and competencies of each profession. Scope of practice rules and other regulations may inhibit the ability of professionals to deliver health care in the most efficient manner (18). There is recognition of the need for greater regulatory and legislative support to foster and promote the consistency and clarity of interprofessional collaborative partnerships (19). Responses to the Interprofessional Collaboration Discussion Guide, as posted on the HPRAC website, clearly support the need for health
professionals to work collaboratively and rely on the expertise of each team member.

Current literature supports the RD's role in collaborative teams. As primary care services developed, an interdisciplinary approach was used to determine the role of the RD in Family Health Teams. The role of the RD emerged as the team member responsible for managing all aspects of nutrition services, from needs assessment to program delivery, and supporting other providers' nutrition services (20). The benefits of RDs working with physicians in family practice are highly rated by both professionals and patients (21). An RD working with physicians in a team setting relates how an expanded scope of practice supports client care:

*Diabetes care is facilitated now that I'm able to order labs and monitor responses to medications at the same visit when food intake and exercise are assessed. I am able to counsel the patient more effectively as I have the whole picture. When there are blood sugar changes that can't be explained by meds, diet, or activity, we discuss this as a team and decide on next steps.*

In the process of creating this submission, DC and CDO discussed issues with professional associations, regulatory bodies, and practitioners from the professions most closely involved in working with RDs in health care and health promotion roles (medicine, nursing, pharmacy, medical laboratory technology). These groups expressed support for interprofessional collaboration and removal of barriers. As noted in the introduction, the changes being sought are primarily to legitimize current practices, where RDs are competently performing already through medical directives, delegations, or protocols. We have appreciated the support and input from our consultations and the input has helped shape the submission to HPRAC in providing:

- Greater clarity about the limits of the proposed authority to perform controlled acts, and
- Greater emphasis on the foundational knowledge, competencies and standards of the dietetic profession enabling safe practice in the public interest
Public Interest
15. Describe how the proposed changes to the scope of practice of the profession are in the public interest. Please consider and describe the influence of any of the following factors:

a. Gaps in professional services
Health human resources issues have created serious shortages of many health professionals across the province. It is crucial that all professions utilize their expertise in the most efficient manner to provide safe and effective patient care. Requiring physicians to delegate procedures that are competently performed by RDs is an ineffective and inefficient use of time for both the professions. Similarly, nursing involvement in processing additional orders or relaying RD recommendations to the physician to be ordered is time that would be better spent in direct patient care or true collaboration in management of patient care. Timeliness in implementation of nutrition therapy often results in improved outcomes. Consider the following example:

Example – Long-term care
Physicians caring for residents in LTC homes are generally on-site for a limited time each week, with contact by telephone as required between visits. These telephone calls may occur during the physician’s office hours, emergency department coverage, or even while in the operating room. It is difficult to argue that the physician’s time is more effectively spent approving a recommendation made by the RD for a diet change or enteral nutrition adjustment than attending to the patient they are treating. In the vast majority of cases, the physician defers to the RD’s assessment of the resident’s needs; thus the issue of patient safety is moot. Patient care is improved by ensuring more timely changes to nutrition therapy, and other professionals are able to devote their time to other patients.

The proposed changes in scope of practice will enable RDs to use their expertise in facilitating care for population groups that are especially at risk from gaps in professional services. An RD who works with Aboriginal clients related:

“I’m often the one clients come to for help in navigating the system, even if the problem isn’t strictly nutrition. The trust relationship takes a long time to develop with Aboriginal clients, but it is strong. Clients tell me I’m the one who really knows them. They feel comfortable with me monitoring their blood sugars, and we can discuss the things that are affecting their diabetes control. When I tell a client that they need to visit the doctor for medication changes [insulin adjustment], I see hesitation. If the team supported me to make those changes I think we would see better outcomes.”
b. Epidemiological trends in illness and disease

Chronic disease prevention and management is a top priority in health systems across the province. Every Local Health Integration Network (LHIN) has identified this in their priority-setting using a public engagement process, and it is a key strategic direction at the provincial level in both the Ministry of Health and Long-Term Care and the Ministry of Health Promotion (22-24). The cost associated with the treatment of diabetes, cardiovascular disease, osteoporosis, and other chronic diseases, are a major burden on the healthcare system, and are increasing rapidly (25). The number of Ontarians with diabetes is predicted to reach 1.2 million by 2010 (26). Nutrition plays a critical role in both prevention and management of all major chronic diseases (27-31). Registered Dietitians are essential contributors to strategies to promote health and prevent disease, and in formulating treatment plans for individuals to delay complications and treat symptoms of chronic diseases.

Dietitians of Canada has recently undertaken an extensive environmental scan and stakeholder review to articulate the future of the dietetic profession. This excerpt from Vision 2020 presents the epidemiological trends that are of particular relevance to dietetics:

Currently 1.3 million Canadians have diabetes and if the present trend continues, 600,000 will be diagnosed each year with the number of Canadians having diabetes doubling by 2016. Three quarters of Canadians with diabetes also have other chronic conditions. There is an estimated $80 billion price tag in health care costs and lost productivity to the economy each year.

The global epidemic of obesity is one of the biggest health hurdles of the century. More than 1.5 billion adults worldwide and 10 percent of children are now overweight or obese. In Canada in 2004, 5.5 million or 23 percent of adults were obese and more than a quarter or 26 percent of children 2-17 years of age were overweight or obese. The dietetic profession needs to plan for the impact of this health trend and its implications on the burden of chronic diseases.

The heightened recognition of the importance of chronic disease prevention and the renewed emphasis on health promotion, active living, and wellness will continue to impact services and service delivery. Efforts to design, test and implement new ways to deliver health care more cost effectively will be an important focus into 2020 and beyond. For example, the redesign of primary health care and mental health care and public health system renewal will continue to demonstrate how essential it is to support coordinated and collaborative change. These changes will require greater role clarity and more specialization for RDs. More RDs will be community
based and working in interdisciplinary collaborative teams. Interprofessional care (Shared Care), collaboration and coordination among practitioners and institutions will be the norm.

The holistic health movement, with an expanding range of complementary and alternative health care practitioners, will continue to grow. Consumers will be faced with a multiplicity of advice and information, posing challenges to RDs and the dietetic profession in supporting the public with evidence-based guidance.

There will be more emphasis on customized service delivery solutions to health and wellness concerns that may be either privately or publicly funded, providing increased options for RDs in both the public and private sectors.

Inpatient hospitals will be dedicated to highly acute and short-term service delivery with the majority of health care services provided in community settings (32). [end of excerpt]

The recommended changes to RD’s scope of practice will support the provision of care needed to deal with these trends. Public access to care and collaboration with other health professionals will be enhanced, allowing more effective management of chronic diseases and improved treatment of acute conditions. Please see 15 g. ‘Demographic Trends’ for further discussion on changing healthcare needs related to obesity and other conditions.

c. Changing public need for services and increased public awareness of available services

Chronic disease prevention and management initiatives universally include nutrition as a component of both prevention and treatment (5,6,27-31). Nutrition and lifestyle interventions can prevent or delay the onset of diabetes (33). Dietary advice given by RDs is proven effective in managing these increased public needs (34). Heightened public awareness of the need for proper nutrition, and professional advice to tailor eating plans for the individual, point to an increased need for RD services, and the public's expectation that RDs will provide comprehensive care. This underlines the need to give RDs the tools to more directly and efficiently manage nutrition therapy, such as ordering lab tests and adjusting insulin and oral hypoglycemic medications.

The Ministry of Health Promotion and DC worked together to launch EatRight Ontario (ERO), the phone and web-based dietitian advisory service. Some users of the ERO service need in-depth nutrition counselling that is beyond the mandate of the ERO RDs, and are referred to RDs in
primary care. Increasing call volume demonstrates growing public awareness of the ERO service (35). As these services are further promoted and utilized, growth is expected both in the need for general advice from the ERO staff, and increased capacity of RDs in primary care to provide comprehensive nutrition care.

Many government initiatives over the past few years have highlighted the importance of nutrition and the professional advice of RDs. Besides the ERO service, the creation of diabetes teams (RD and RN) in 2006, and the inclusion of RDs in Family Health Teams have all served to increase the public’s expectation of professional nutrition advice and counselling for health promotion and disease management.

RDs are identified by the public as the most trusted source of nutrition information (36). Patients and clients expect RDs to provide them with evidence-based nutrition information, individualized for their lifestyle, and to be able to provide complete nutrition care in all settings, such as ordering laboratory assessments to monitor response to nutrition therapy. As public needs for professional nutrition advice continue to grow due to increasing prevalence of chronic diseases, it is extremely important that RDs scope of practice enables them to provide comprehensive care.

d. Waiting times for health care services
Reducing wait times for selected services is a key priority for Ontario’s health system (37). Expert panel reports developed within the wait times initiative speak to the importance of interprofessional collaboration and utilizing the expertise of individual healthcare team members (38). The Diabetes Expert Panel identified the need for multidisciplinary teams made up of providers working to their maximum level of their training and skills (39). As referenced in many instances in this submission, current scope of practice and legislative barriers keep RDs from practicing to the full level of expertise and prevent other providers from utilizing their specialized skills for patient care. Physicians’ and nurse practitioners’ time spent approving orders related to nutrition therapy could be more appropriately used seeing other patients, thus reducing wait times.

Providing the right service at the right place at the right time, by the right provider, is a consistent theme of health services transformation and has been echoed throughout LHIN integration priority reports and MOHLTC communications (16,37-39). The changes proposed to dietetic scope of practice are fully aligned with this vision, and serve to improve quality of patient care as well as meet other health system priorities such as decreased wait times and chronic disease management.

Registered Dietitians’ management of nutritional care within the hospital setting, as facilitated by the changes proposed to the Public Hospitals Act,
has the potential to decrease length of stay, thus decreasing wait times for acute care beds; this has been proven in the provision of enteral and parenteral nutrition (40). Decreased length of stay attributed to nutrition therapy is also reported by RDs, such as decreased incidences of pressure ulcers, improved recovery time post-stroke and myocardial infarction (MI).

Improved management of chronic diseases and conditions in the community can also decrease wait times by reducing complications that would require acute care. Enabling RDs to perform skin pricking for monitoring blood glucose, order laboratory assessments, and adjust insulin as required supports enhanced glycemic control and fewer complications related to diabetes (6), which in turn reduces emergency room visits and hospital admissions, thus positively impacting wait times.

e. Geographic variation in availability and diversity of health care providers across the province
Northern Ontario is recognized as an under-serviced area for many professions; although RDs have not been formally recognized in these statements of shortages, there are significant difficulties with recruitment and retention. A health human resources survey completed by DC in 2005 identified numerous vacancies in RD positions, some of them vacant for over a year (41). Public health units are currently facing vacancies across the province, with all of the units in Northern Ontario having at least 1 FTE position vacant (42). Health human resources pressures make it especially important to ensure safe patient care as efficiently as possible. Enabling RDs to practice to their full competency increases efficiency and benefits the healthcare system. In addition, there is evidence to support that interprofessional care contributes to recruitment of caregivers and lower rates of staff turnover (19, 43).

f. Changing technology
Advancements in technology have affected the practice of dietetics by improving the availability of assessment data, and contributing to wider dissemination of research information and evidence-based practices. An RD’s assessment of a patient may include anthropometric measurements enhanced by body composition analysis and detailed computerized micronutrient analysis of intake. The level of detail and complexity of nutrition assessment and subsequent treatment decisions have advanced rapidly with technology. This progress is incorporated into dietetic education and training, and reflected in the revised scope of practice.

Another advancement in technology is the development of Practice-Based Evidence in Nutrition (PEN). Developed by RDs, the PEN database synthesizes current, graded evidence to provide practice guidance. Currently there are over 150 “knowledge pathways” in the PEN system, with more than 2300 practice questions, resources, and links to basic and
applied research, accessible through a web-based platform (44). Enabling access to these resources enhances nutrition care and dietetic practice. A similar project for nurses utilizing handheld devices to link to databases and Best Practices Guidelines has been funded by the MOHLTC to improve patient safety and efficiency of care (45).

The public also takes advantage of changing technology, using web-based tools such as DC’s EATracker® to enter their food intake and activity levels, generating feedback on how to improve their eating habits and match activity and intake (46). These types of technology serve to increase the data available to the RD for assessment, and can serve as an important adjunct to nutrition counselling. The popularity of these technologies emphasizes the public’s interest in nutrition and health and raises their expectations of service delivery from health care professionals. A high level of clinical knowledge and professional judgment, for which RDs are specifically trained, is expected by patients and clients. Accurate assessment of nutrient intake levels is possible, supporting the RD’s ability to make sound clinical decisions on the need for dietary changes, vitamin and mineral supplementation, or medication adjustment. For example, an RD working in renal care can review a detailed nutrient analysis of a patient’s food intake in relation to laboratory assessments, and alter the potassium content of the diet while changing the timing of phosphate binders.

Advancing technology is also related to the need for RDs to be authorized to perform a procedure below the dermis. Besides glucometers for monitoring blood glucose levels, similar technology is being used to provide readings for lipid levels. By enabling RDs to use this technology, patient care is expedited for purposes of screening for dyslipidemia and monitoring response to therapy.

Interprofessional care requires strong technology foundations in the form of shared, accessible electronic patient records. Development of the e-health record has been identified as a priority for Ontario’s healthcare system, and will be a key enabler for interprofessional care. Communication and information-sharing among the multidisciplinary team contributes to patient safety and effective care. The RD can access relevant data from the chart and integrate it with the nutrition assessment, as well as inform other providers of laboratory tests that are ordered.

g. Demographic trends
The aging population in Ontario has substantial implications for healthcare. The current proportion of Ontario residents aged 65 and over is approximately 13%, and will rise to 19% by 2026, when the “baby boomers” will be 61 to 80 years old (47). This is a driving force in rising healthcare
costs, along with overall population growth and higher cost of treatments (48).

Chronic diseases are more prevalent in the aging population and healthcare utilization is higher among the elderly (49). Registered Dietitians' roles in health promotion and disease prevention have a positive effect on the development and progression of chronic diseases; the change in the scope of practice statement is intended to reflect this important role. Access to specific controlled acts, and the ability to order laboratory tests, supports this role in health promotion by allowing the RD to manage nutrition therapy more appropriately, thus reducing long term health complications.

Obesity is the major nutrition related risk factor in the population, and Canada and Great Britain are now tied for third place in the world for the fatness of their citizens (50). Twenty–three percent (23%) of adults in Canada have a body mass index (BMI) ≥ 30, similar to the rates in the United States in the early 1990s. Only the United States (32%) and Mexico (30%) demonstrate higher obesity prevalence (51). Most worrying is that prevalence has been continuing to increase in all countries, putting citizens at risk for obesity associated health conditions, mainly diabetes, cardiovascular conditions, joint problems and some cancers. This may reverse current gains in longevity, increase morbidity, impose increased costs on health care systems, and impact on national economic productivity. Thus, there are sound social and economic reasons to reverse current trends. In Canada, substantial policy and research attention has been directed to the study of obesity. Current opinion is that multiple treatment and prevention strategies in several sectors will be needed to reverse current trends, including treatment services in the health care system (51-53). Registered Dietitians are integral to obesity prevention and management services; enabling RDs to work to their full competency supports the most efficient use of healthcare resources.

Hospitalized patients will also likely present with increasingly acute conditions requiring intensive nutrition therapy or nutrition support through enteral or parenteral nutrition. Changes proposed to the Public Hospitals Act are needed to allow the RD to customize nutrition therapy to meet the needs of the patient. Strict therapeutic diet restrictions may be needed, or the patient may need to have restrictions removed to improve nutritional status. For example, the complex therapeutic diet required for a patient with diabetes, cardiovascular disease, and renal failure is quite restrictive; food choices are limited based on carbohydrate, fat, protein, and micronutrient content. The RD needs to adjust the level of each nutrient to maximize intake and nutrient status, while avoiding vascular complications that affect disease progression. With the ability to order appropriate laboratory tests (e.g. albumin and pre-albumin, serum creatinine and blood urea nitrogen), therapeutic diets, and medications (e.g. adjust insulin dosage, re-allocate
phosphate binders), the RD is able to assess the effect of changes in nutrition therapy and make appropriate treatment decisions with the rest of the healthcare team.

Within the community health care sector, the aging population and emphasis on aging-at-home strategies will give rise to increasingly frail patients within homecare and LTC homes. The RD must have the ability to provide comprehensive care to these clients, as these settings present additional barriers to accessing other providers. For example, the RD caring for a client with diabetes in the homecare setting may need to perform blood glucose testing, assess those results in conjunction with diet, activity, and medication, and make appropriate adjustments to insulin dosage or timing. Under the current system, this would require the RD to ask a nurse or physician to perform blood glucose testing, which is unlikely to occur within the same day. After receiving those results and making an assessment, the RD would then contact the physician to recommend changes to the insulin regimen, the order would be given by the physician and relayed to the case manager or RN, who would then instruct the client or make the change in the client’s treatment plan. These additional steps may take place over hours or days, potentially placing the client at risk for hypoglycemia or other complications while waiting for the treatment plan to be adjusted.

Demographic trends point to an increase in immigration and the proportion of the Ontario population of differing cultural backgrounds. Registered Dietitians are trained to develop nutrition advice tailored to the lifestyle of the individual, and specifically, to develop meal plans based on culturally acceptable foods. This level of expertise positions RDs as the appropriate profession to manage nutrition therapy and health promotion strategies for this population. The proposed changes to the scope of practice enable RDs to provide this care. For example, when communicating a diagnosis the RD can anticipate the concerns of the patient and be prepared to respond in a culturally appropriate way.

h. Promotion of collaborative scopes of practice
Interprofessional care and collaborative scopes of practice are emphasized in Ontario’s healthcare transformation. The development of interprofessional education programs across the province reinforces this concept, as well as the RHPA amendment to promote collaboration amongst professional colleges. Registered Dietitians are strongly supportive of interprofessional care, and believe that the patient’s best interests are served when healthcare teams work collaboratively and maximize the expertise of all professions. Diabetes care provides a good example of collaborative scopes of practice, where RDs, nurses, and physicians, along with other professionals, provide comprehensive shared care. As noted in the Canadian Diabetes Association Clinical Practice
Guidelines, shared care assumes ongoing communication and participation of all members of the team (6). Diabetes educators manage treatment to prevent complications, with each team member contributing specialized expertise and reinforcing other providers’ advice. Expanded scope of practice for RDs is already a reality within Diabetes Education Centres, as well as other settings, through the use of medical directives, delegations, and protocols. Formal recognition of these competencies enhances patient care by allowing more timely initiation and adjustments to nutrition therapy, leading to better outcomes for the patient.

The Canadian Dietetic Registration Examination that is a requirement for a general certificate of registration with CDO, is based on the professional standards and competencies for dietetic practice. As such, it includes scenarios to assess knowledge and application, and critical thinking related to professional obligations such as interprofessional collaboration and consultation for patient care.

i. Patient safety
Patient safety is of utmost importance, and all of the recommendations contained in this report were carefully considered for potential risk of harm. For the sake of clarity, the potential risks and mitigating factors are laid out for each proposed change.

**Controlled Act #1 – communicating a diagnosis**
The risk to patient safety related to this controlled act is the patient’s likelihood of acting upon the information in the diagnosis. In the case of an RD providing counselling for diet and lifestyle changes in relation to the diagnosis of a nutrition-related disease or condition, the diagnosis must be discussed in order to expedite care and allow the patient to take ownership of the problem. Acting upon this knowledge is in fact the intent of the interaction between the RD and client. Counselling is only effective when the individual recognizes there is a problem and begins to take the necessary steps to address the problem (54, 55).

The terms “dietetic diagnosis” and “nutrition diagnosis” are used in other jurisdictions. In the United States (U.S.), nutrition diagnosis is the basis of the nutrition care process and the initiating factor for prescription of medical nutrition therapy. Nutrition Diagnosis is defined in the U.S. model as the identification and labelling of the specific nutrition problem that dietetics professionals are responsible for treating independently (56). This model has been adopted in some facilities in Canada. European countries include the ability to form a dietetic diagnosis in entry-level competencies (57). The dietetic diagnosis generally refers to the results of a nutrition assessment where the nutrition intervention is expected to focus. For example, the RD communicates that the client is “underweight” or has “increased need for calcium”. Registered Dietitians in Ontario use this type of terminology in
everyday practice when communicating the results of a nutrition assessment to a patient or client, and this is not considered “communicating a diagnosis” in the definition of the controlled act.

**Controlled Act #2 – skin pricking**
The risk of harm with this activity is extremely low; it is performed by thousands of people daily, including young children who have been taught to self-monitor their blood glucose levels. Infection control related to the proper use of disposable lancets and attention to technique are required, as well as adequate supplies for cleaning the fingertip (the most common site of skin pricking for the purposes intended). Similar procedures are performed by unregulated practitioners, such as body piercing and tattooing, that have potential to cause significantly more harm than skin pricking to obtain blood glucose levels by an RD.

**Controlled Act #8 – insulin and oral hypoglycemic agent adjustment**
Patient safety concerns include hyper- or hypoglycemia, which can pose severe acute health risks and longer-term damage such as micro- and macro-vascular complications (6). Registered Dietitians’ training provides strong foundational knowledge in the physiology and management of diabetes, and the effect of food intake, activity levels, and medications, on glycemic response. The CDO first published guidance in 2002 for RDs regarding teaching self-management of insulin dosages (58). Many RDs educate clients on how to manipulate the amount of insulin adjusted based on blood glucose levels, food intake, and physical activity. It is reasonable to extend that competence to writing down specific insulin dosages, as set out in Controlled Act #8.

The ability to adjust insulin accurately requires opportunities to practice within simulations or under supervision of experienced colleagues. Formal qualification as a Certified Diabetes Educator (CDE) through the Canadian Diabetes Educator Certification Board is one route that many RDs pursue to gain this advanced knowledge; approximately 300 RDs in Ontario are currently certified through this program. In 2004, the Diabetes Task Force reported that 86% of dietitians working in diabetes education centres were certified (8). Dietitians of Canada, through the PEN system, provides support and evidence-based best practice in diabetes management for dietitians (59). Further development of insulin/oral hypoglycemic agent adjustment educational programs could be considered through interdisciplinary professional programs.

**Controlled Act #14 – psychotherapy**
As noted, psychotherapy has not yet been clearly defined; our comments are confined to the current interpretation of the controlled act. The risk to patients from an RD performing psychotherapy is the potential to cause a
more serious disturbance of eating behaviours, which result in exacerbated physical or psychological consequences. This risk can be contained by collaborative team-based care and communication with other providers. Registered Dietitians are currently using many techniques to modify behaviour and approaches to eating, and doing so competently. As noted in Table 1, DC and CDO need to be included in discussions of definitions of psychotherapy, to prevent any undue restrictions on dietetic practice if the techniques defined in the controlled act overlap the techniques currently used by RDs in many settings.

**New Controlled Act – Enteral and Parenteral Nutrition**

Patient safety is the impetus behind our application for a new controlled act for the prescription and administration of enteral and parenteral nutrition (EN/PN). There are significant safety risks involved in selecting the mode of feeding, specific formulae, rate of delivery, and monitoring response to the therapy. These are presented in detail in the response to question 20.

Entry-level RDs are expected to be competent in the prescription and monitoring of enteral nutrition (Appendix 2); risks related to EN are handled within the current education and training requirements for entry-to-practice, and subsequently through the quality assurance program of CDO. In addition, resources are available through the PEN system and the Nutrition Support Network of DC (60).

Entry-level competencies ensure that RDs are able to accurately calculate formulations of total parenteral nutrition, as well as understand monitoring requirements (Appendix 2). Expertise in prescribing and managing parenteral nutrition is a more advanced level practice (61). As noted throughout this submission, RDs are fully aware of their responsibilities as a self-regulated profession and do not practice outside their area of personal competence. Further development of skills in PN is available through the American Society for Parenteral and Enteral Nutrition (ASPEN), with a rigorous program for certification as a Certified Nutrition Support Dietitian. The Nutrition Support Network of DC offers continuing education on EN/PN topics, and has expressed interest in developing a formalized certification program.

**New Controlled Act – Therapeutic Diets**

Consumer protection in the food and nutrition marketplace has been an ongoing concern of the profession for many years. Nutrition based therapies, sometimes for medical conditions, are frequently promoted, and consumers with medical conditions may look for alternative therapies. While freedom of choice in the marketplace is fundamental, patients in the health care system have the right to expect that prescribed therapeutic diets are based on the same standards for evidence of efficacy and effectiveness,
as for other treatments, by providers who have been appropriately trained in this specialized area.

General nutrition recommendations or advice made in the context of “healthy living” are made by many regulated and unregulated practitioners in the health care system. Most such advice is based on credible nutrition guidelines such as ‘Eating Well With Canada’s Food Guide’ (http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index-eng.php) or other published guidelines, and is highly encouraged in an interprofessional health promotion context. Of concern, however, is when specific recommendations involving supplements or exclusion of food groups are being made in a therapeutic context for specific medical conditions. Furthermore, title protection of “dietitian” does not prohibit other practitioners from using titles such as “nutritionist”, “nutrition consultant”, “registered nutritionist”, and similar that imply expertise in food and nutrition. We support the public’s right to choose, however we are concerned that the public is placed at risk by allowing these titles. Some of the practitioners are trained in basic sciences and make safe recommendations, but there are also many reports of potentially harmful and risky diets and supplements being recommended. The qualifications of these practitioners are not subject to intense training and quality assurance programs as are RDs, and the level of expertise cannot be assured. The creation of a controlled act for the prescription and management of therapeutic diets helps to ensure that other practitioners can provide general nutrition advice, while ensuring that patients are protected when therapeutic diets are prescribed.

Our goal is to ensure public safety and support interprofessional collaboration by delineating the situations of highest risk. Patient safety will be enhanced when prescription of therapeutic diets is a controlled act. Examples of RD interventions for common medical conditions are described in Appendix 1. The risks of inappropriate prescription or design of therapeutic diets may be exacerbation of symptoms (Crohn’s disease, allergies), disease progression (cancer or arthritis), irreversible damage (diabetes or inborn errors of metabolism like phenylketonuria), or loss of life (end-stage renal disease). These risks of harm are presented in more detail in the response to question 20.
Nutrition therapy, which often includes therapeutic diets, is based on a comprehensive assessment of an individual; safe prescription of a therapeutic diet must take into account all the factors involved in an assessment, such as:

- Anthropometric measures (height, weight, body composition, etc.)
- Review of established diagnoses and medical history
- Weight history, comparison of weight to established standards and usual weight
- Laboratory assessment (including CBC, albumin, creatinine, etc.)
- Medications, including over the counter and herbal supplements
- Dentition, chewing and swallowing ability
- Gastrointestinal and bowel function
- Usual food, fluid, and nutrient intake and comparison to Dietary Reference Intake standards
- Food allergies and intolerances
- Activity level and energy needs
- Functional and cognitive abilities
- Physical assessment related to nutrition status, completed by the RD or review of results of assessment completed by another health professional
- Lifestyle and psychosocial issues as related to food/fluid/nutrient intake and requirements
- Client goals
- Overall health team goals for the client

Due to the complex nature of the assessment process needed to plan a safe and effective therapeutic diet, patient safety can only be assured when the assessment is performed by a competent practitioner. Registered Dietitians are trained in assessment skills that allow them to critically evaluate numerous pieces of information and integrate them into a plan for nutrition therapy.

**Changes to other legislation**
Patient safety will be improved by the proposed changes to other legislation, by ensuring comprehensive care can be provided by RDs. Changes to the Public Hospitals Act and Laboratory Specimens and Collection Centres Licensing Act, that authorize RDs to order diagnostic and treatment procedures within their scope of practice, will allow individualized nutrition therapy to be appropriately initiated and monitored. Professional ethics and standards of practice require that the RD monitor and evaluate response to treatment.
j. Wellness and health promotion
Health promotion has become a major focus in Ontario; the formation of the Ministry of Health Promotion in 2005 points to the great emphasis on keeping people healthy and reducing the burden on the healthcare system. The importance of good nutrition in promoting health is well documented, and strongly supported by the Ministry of Health Promotion as evidenced by its support of the EatRight Ontario dietitian advisory service. Credible, reliable, evidence-based nutrition information from RDs is now available to Ontarians to support healthy eating habits. The proposed scope of practice statement encompasses the RD’s role in health promotion, which is not evident in the current statement. As well, the ability to order vitamins and minerals in appropriate amounts for health promotion, in hospitals and long-term care homes with the expertise to individualize the dosage to the patient’s requirements, supports health promotion. Registered Dietitians currently recommend unscheduled, “over the counter” and “behind the counter” vitamin and mineral supplements. The ability to make these orders within the hospital and long-term care facility settings enhances client care. Emerging evidence on the use of therapeutic doses of vitamins and minerals for health promotion, along with functional foods and constituents such as probiotics, requires the current, evidence-based clinical knowledge that dietetics is based on (62, 63).

Authorization to perform skin pricking supports wellness initiatives by allowing the RD to screen for changes in blood glucose levels and initiate treatment faster. Technology to use skin pricking for screening for lipid levels is emerging and supports wellness and health promotion efforts of RDs.

k. Health human resources issues
As noted in response to 15 a. ‘Gaps in Professional Services’, health human resources issues increase the need for professionals to work in the most efficient manner. The changes proposed for RDs scope of practice will expedite patient care and assist other team members in optimizing use of their time as well. As the government invests in programs to ease physician shortages, ineffective use of MD’s time is counter-productive. Registered Dietitians relate stories of MDs being paged while in surgery or attending to patients, to approve diet or tube feeding changes that the RD has recommended. These changes are routinely approved, as the physician recognizes the RDs expertise in making changes to nutrition therapy. Thus, the time spent contacting and processing the MD’s approval is not contributing to either patient care or effective use of health human resources.

Similarly, the shortage of RDs mandates effective use of RD time. Phone calls to physicians for approval of orders, and time spent waiting for
diagnostic tests to be ordered, are inefficient uses of the RD’s time. In LTC homes and homecare settings, where RDs and MDs are not available daily, a request for labwork to assess response to nutrition therapy may take over a week to be processed. Appropriate nutrition therapy may be delayed, resulting in suboptimal patient care.

I. Professional competencies not currently recognized
Registered Dietitians are recognized as food and nutrition experts by the public and health professionals. The changes proposed to RDs scope of practice are built upon a solid foundation of assessment skills and evidence-based practice, as noted in the competencies and standards of practice in response to questions 26 and 27 and Appendix 2. Many RDs are already competently performing these activities throughout the province, through a variety of authority mechanisms.

The extent of RD’s expertise is not universally recognized according to discussions with RDs. Some health professionals’ perception of RDs is limited to general nutrition counselling and meal planning, without the recognition of advanced clinical expertise. This has presented a barrier to interprofessional care in some cases. As noted by one RD “some of the team thinks the dietitian just hands out Canada’s Food Guide and recipes”. Mutual respect for team members’ knowledge and expertise is critical to interprofessional collaboration. The proposed changes to scope of practice may serve to educate other health professionals about the extent of RDs’ competencies.

The public perceives dietitians as a credible and reliable source of nutrition information (64). Registered Dietitians have reported that sometimes their advanced clinical expertise is not recognized by patients. Expansion and clarification of the scope of practice of dietetics will assure patients that their nutritional care is being managed by the expert in food and nutrition. Registered Dietitians report that their credibility is decreased when having to refer patients back to the physician for communication of their diagnosis, and by an inability to order laboratory tests. Patients and clients are also confused by therapeutic diet advice given by other practitioners that is inaccurate and must be subsequently contradicted by the RD. The creation of a controlled act for prescription and management of therapeutic diets will help reduce these inaccuracies and related risks to a person’s health by relying on the expertise of RDs and other competent health care professionals as appropriate.

m. Access to services in remote, rural or under serviced areas
As noted in the response to 15 a. and k. (‘Gaps in Professional Services’ and ‘Health Human Resource Issues’), streamlined, efficient care is needed to maximize productivity of professionals across the province. This is
particularly true in remote and under-serviced areas where access to health professionals is more severely limited. Registered Dietitians, nurse practitioners, physicians, and other professionals are in short supply in these areas. Time spent in additional tasks such as order sign-off is taken away from direct patient care. Professionals working in these areas must have the ability to work to their full scope of practice.

Although not unique to the rural area, barriers to effective service delivery in homecare are definitely exacerbated in remote areas, as related by a homecare RD:

> After driving over almost 2 hours to a client’s home, I found that the changes to the tube-feeding that I recommended on the last visit had not been implemented, and the labs I asked to be ordered weren’t done either. This client had been over a week with energy and nutrient intake below needs, and this visit was essentially a waste of time as I couldn’t assess response to the changes.

16. How would this proposed change in scope of practice affect the public’s access to health professions of choice?

Most members of the public would choose to be treated by the health professional with the most appropriate knowledge, skills, and judgment required for their condition. In the case of nutrition, that professional is the RD; as noted in response to 15 i., the public considers RDs to be a credible and reliable source of nutrition information. Patients requiring nutrition support in the form of enteral or parenteral nutrition, or therapeutic diets, would have confidence in knowing they will be treated by fully qualified and competent professionals. Patients will also appreciate the convenience of getting comprehensive care from one provider, rather than making numerous trips to various practitioners to have lab tests ordered and monitored.

A new controlled act for prescribing and managing therapeutic diets would restrict who would be able to formulate diets related to a diagnosed disease and nutrition-related related disorder. As discussed in response to question 15 i. (‘Patient Safety’) and question 20 (‘Risk of Harm’), these changes are intended to support interprofessional care by delineating the areas of highest risk related to therapeutic diets.

17. How would the proposed change in scope of practice affect current members of the profession? Of other health professions? Of the public? Describe the effect the proposed change in scope of practice might have on:

a. Practitioner availability
   
   Increased efficiency and more effective utilization of health practitioners’ time will result from the proposed changes. Research
has shown significant reductions in physician visits when patients received medical nutrition therapy from an RD for cardiovascular disease and diabetes (40). This frees up physician time to see other patients, attend to more complex cases, and participate in interprofessional collaboration.

b. **Education and training programs, including continuing education**
Undergraduate and graduate/dietetic internship programs already provide the basis for achieving the competencies outlined in the proposed scope of practice. Undergraduate curriculum is geared to the knowledge statements. Additional supports are available through DC’s PEN (Practice Based Evidence in Nutrition) system (see question 15 f.) and continuing education events. CDO’s Quality Assurance program provides a mechanism for ensuring that RDs engage in reflective assessment of their practice and needs for education or training. The College’s new on-site practice assessment program is being designed to assess the members’ specific area of practice and practice activities. Assessment tools and other supports will be offered to all RDs for their use in reflective practice and practice enhancement. Further detail on CDO’s Quality Assurance program, including practice assessment and jurisprudence, are found in response to questions 26 and 27.

Certification programs, for example the Certified Diabetes Educator program, or the ASPEN Certified Nutrition Support Dietitian program, are available as recognized programs for additional education.

c. **Enhancement of quality of services**
Numerous positive results are reported by RDs who are currently practicing within the recommended scope of practice, through medical directives or other authority mechanisms. Besides increases in efficiency, RDs report increased patient understanding and engagement in their nutritional care, enhanced patient safety, and more care provided consistent with evidence-based guidelines. For example, initiation of EN at full strength versus half strength, as per ASPEN guidelines, was reported by RDs. Monitoring and follow up of laboratory values has also been shown to be completed more consistently by RDs than by other practitioners in a retrospective study (64). Hospitalized patients assessed as malnourished or at risk or malnutrition were referred to the RD in less than 10% of cases in a British study (65). The expanded scope of practice as recommended will enhance the ability of RDs to initiate nutrition therapy and provide better patient care.
Ensuring that all RDs are able to practice to their full competency level will help avoid situations such as these reported by RDs:

- In the hospital, bloodwork may be ordered by the physician, who is not back to see the patient until the following day. Since the MD has not reviewed the laboratory results to formulate a diagnosis and communicate it to the patient, the RD cannot begin treatment until the diagnosis has been communicated. During this delay the patient may actually be discharged. Nutrition counselling then has to wait until the patient can be seen at an outpatient appointment.

- A client receiving nutrition counselling for elevated cholesterol is unable to get repeat bloodwork to assess the effectiveness of treatment as their family physician closed practice and the client has been unable to find a new doctor.

- Pharmacy is not sure who to call for clarification of TPN orders, as the RD wrote the order, but the doctor was required to sign it. The RD knows why that particular formulation is ordered, and the MD may or may not be aware of the rationale behind the formulation.

d. **Costs to patients or clients**

Patients/clients incur costs each time they visit a healthcare provider. Tangible costs include transportation, time away from paid employment and purchase of meals/snacks. Inconvenience, childcare arrangements and stress related to managing other commitments around medical appointments are more difficult to quantify, but are an additional cost to the patient. These costs are also incurred by family members or caregivers who accompany patients, as is often the case for the elderly or those with multiple medical conditions. Decreasing the number of visits, through increased efficiency of care as described in the expanded scope of practice, will result in savings.

There are also economic implications for failing to authorize RDs to communicate a diagnosis; consider this scenario related to us by an RD:

_Recently, I had a patient very upset with his MD as he was only told "He has a little bit of sugar". He went to the US, was hospitalized and is now being denied insurance reimbursement because he did not say on his insurance application that he has "Diabetes." The patient's position is that he was not "officially" told that he had "diabetes."_
This situation could have been mitigated had the RD been authorized to communicate the diagnosis of diabetes to the patient.

e. **Access to services and**

f. **Service efficiency**
By increasing efficiency, all health professionals will have the ability to provide more services, resulting in increased access for the public.

Efficiencies to the system have been noted throughout this document. The requested changes to scope of practice promote service efficiency by streamlining the care that is already being competently performed by RDs through medical directives or other authority mechanisms. This scenario provided by an RD explains the fragmentation in nutrition service delivery currently in place in a hospital:

> When I discuss patient care with a physician on the phone, I state my nutrition care plan and we agree on any changes, monitoring responsibilities, and so on. Then I have to pass the phone to the RN so that it can be given as a verbal order and processed.

**g. Inter-professional care delivery**
As noted in other responses, RDs are key members of interprofessional teams, and the recommended changes are intended to promote interprofessional care. The controlled acts identified in this submission are already being practiced by RDs across the province through various authority mechanisms; enhanced accountability may relieve some other professions’ concerns re: their own liability in delegating, as it will be apparent that the RD is accountable for their actions (17, 66). Responses to HPRAC’s Interprofessional Care Discussion Guide showed broad support for professionals working to their full competencies, and eliminating the barriers to care that exist within many current frameworks.

The proposed scope of practice is built upon the concepts of interprofessional collaboration and team communication. Increasing efficiency of care allows more time for building well-functioning teams and improving patient care through collaborative efforts.

**h. Economic issues**
The costs to the patient/client have been outlined in 17 d., and as noted, allowing RDs to practice to their full competencies has the potential to reduce those costs.
Savings to the overall health system are also evidenced when RDs manage nutrition therapy. Diabetes care with an RD case management approach was found to improve many aspects of health, at a minimal cost (66). In the United States, many studies have shown that RD management of medical nutrition therapy is cost-effective (67-69). Prevention or delay of complications from chronic disease results in fewer costs to the healthcare system. Better control of diabetes, which will be realized through RDs’ ability to more closely monitor blood glucose and adjust insulin or oral hypoglycemics as required, will result in fewer complications such as kidney failure and wounds. Savings will also be realized with the avoidance of repeat visits to other providers that are needed under the current system, and decreased drug costs when lifestyle changes can be used (70).

Health system cost savings related to the RD’s role have been suggested in primary health care, mental health, nutrition supplementation, discharge planning, and chronic disease management (71-74). Enhancing the RDs role may lead to further cost savings.

Economic benefits of RD services in the prescription of enteral and parenteral nutrition are documented; this is covered more fully in response to question 20.

i. Other impacts.
Enabling RDs to perform these activities under their own authority is also seen by the profession as a means of increasing job satisfaction. Job satisfaction is tied to recruitment and retention, which is particularly important in light of current health human resources issues.

18. Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the response achieved.

Broad consultation with RDs took place in 2006 as part of the DC/CDO Controlled Acts Working Group information gathering on use of medical directives, and in 2008 in preparation for this submission. The importance of these changes to the profession is evidenced by the rapid responses to electronic surveys sent in both 2006 and 2008. Within the first 24 hours, almost 200 responses were received.
Overall response rate to these surveys exceeded surveys that have been used for other topics with CDO membership; the 2008 survey on proposed changes to scope of practice resulted in 584 responses (21% response rate). The distribution of respondents over practice settings was similar to the overall membership as reported in the introduction; approximately half of the respondents were hospital-based clinical RDs. The majority of respondents for whom changes to the scope of practice are applicable (approximately 80%) are in favour of these changes, and cite the benefits to patient care that would result, such as more timely initiation of nutrition therapy, improved ability to adjust nutrition therapy based on client response, improved patient safety, and enhanced teamwork.

For those RDs who were not supportive of the changes, the reason cited most frequently was lack of experience in the area (for example, not currently working in clinical care). These findings support the assertion that RDs are very conscious of their individual scope of practice, and recognize the need for on-going education to address learning needs.

The second most frequently cited reason for not supporting the changes was lack of time or workload issues. A few RDs commented that they did not want to order laboratory tests as they were not sure they would be available to follow up on the results in a timely manner.

Detailed interviews with sector-specific action groups of DC (primary health care, long term care, home care, clinical nutrition leaders, educators) supported the results of the survey and provided additional detail on the impact of changes to the scope of practice in their settings.

19. Describe any consultative process with other professions that might be impacted by these proposed changes.
Both regulatory bodies and professional associations were contacted to discuss the proposed changes and its effect on interprofessional care.

Discussions were held with the Registered Nurses Association of Ontario (RNAO), Registered Practical Nurses Association of Ontario (RPNAO), Nurse Practitioners Association of Ontario (NPAO), Ontario Medical Association (OMA), and Ontario Society of Medical Technologists (OSMT). Due to scheduling difficulties, there was no meeting with the Ontario Pharmacy Association, although we recognize that pharmacists are especially important in discussions around parenteral nutrition and medications. In addition, the proposed changes were presented at a meeting of the Coalition of Regulated Health Professions Associations (CORPHA). No objections were voiced to the proposed changes. Clarification was requested, primarily around RDs foundational knowledge related to insulin adjustments, and current practices in ordering and monitoring EN/PN.
Regulatory bodies were consulted through individual meetings with the Ontario College of Pharmacists, the College of Physicians and Surgeons of Ontario and the College of Medical Laboratory Technologists of Ontario. These Colleges assisted in focusing the submission on dietetic competencies related to the proposed changes in scope of practice and provided emphasis on communication protocols and collaborative development of standards for implementation.

Organizations such as the Ontario Long Term Care Association were also contacted, and voiced support for measures that increase availability of health care professionals, including RDs, in LTC homes. Several organizations have indicated that they will be responding in writing to HPRAC’s consultation.

Risk of Harm

20. How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?

Risk of harm and patient safety related to the proposed changes, with the exception of enteral and parenteral nutrition and therapeutic diets, have been documented in response to question 15 i. ‘Patient Safety’. The risk of harm, and rationale for creation of new controlled acts, will be discussed in this section.

Enteral Nutrition (EN) and Parenteral Nutrition (PN) Definitions and Indications

EN and PN are common technologies to feed people through artificial means when they cannot take in their nutrition requirements orally. EN provides nutrition through a tube into the gastrointestinal tract and PN provides nutrients intravenously. PN is a feeding modality designed for patients whose gastrointestinal tract is not functional or cannot be accessed, and/or for patients who cannot be adequately nourished by oral diets or EN. PN is also referred to as total parenteral nutrition or TPN. When patients are unable to meet their nutrient requirements with an oral diet, EN is preferred over PN as the method of feeding, as it is associated with fewer complications, improved outcomes, and lower cost (75).

When the decision to use EN or PN is made, individual assessment determines the solution to be administered. This requires expertise to choose the most appropriate

- energy level (calories)
- macronutrients (carbohydrate, fat and protein)
- micronutrients (e.g vitamins and minerals),
- rate or flow of administration
- other additives (e.g. insulin)
- concentration of the formula (total volume of fluid)
- additional water required to meet patient needs

Enteral feeding is typically used for patients with: severe protein-energy malnutrition, hypermetabolism (e.g. trauma, burns), cancer, inability to support oral feeding due to head and neck surgery or neurological ailments (e.g. stroke with severe dysphagia, advanced amyotrophic lateral sclerosis (ALS), gastrointestinal (GI) surgery, organ failure, disorders that cause malabsorption (e.g. Crohn’s disease), and severe Anorexia Nervosa.

Parenteral Nutrition is usually recommended for patients for whom EN is not feasible, for example, patients whose GI tract is non-functional (e.g. prolonged diarrhea, short bowel syndrome, malabsorption), who require complete bowel rest (e.g. pancreatitis, some stages of Crohn’s disease, or ulcerative colitis), or who require more energy/nutrients than could provided by oral or enteral nutrition (e.g. severe burns, head trauma or sepsis).

Both EN and PN are complex nutrition interventions that include significant risks to patients if not prescribed and managed with the appropriate knowledge and skills. A 1997 report of procedures within US hospitals stated that EN and PN are among the procedures associated with the largest number of in-hospital deaths, highest inpatient mortality and longest hospital admissions (76).

Potential complications of EN include
- **GI intolerance** (including abdominal bloating, cramping, diarrhea, nausea, vomiting, constipation), due to inappropriate formula selection, rate of administration of formula, and possibly the mode of administration (e.g. bolus versus continuous feed).
- **Tube clogging**, due to the selection of a formula which is too viscous for the size of the feeding tube, inappropriate medication administration through the tube and/or inadequate flushing of the feeding tube.
- **Malnutrition**, due to provision of inadequate amounts of calories, protein and other essential nutrients
- **Over-nutrition**, due to provision of excessive amounts/imbalanced amounts of nutrients and/or energy, resulting in complications such as respiratory distress, elevated blood levels of glucose and triglycerides, and undesirable weight gain.
- **Aspiration**, when a patient has esophageal and/or gastric dysmotility, they may require a post-pyloric placement of the feeding tube, to avoid pulmonary aspiration, which could result in aspiration pneumonia (a potentially life-threatening complication).
- **Re-feeding Syndrome**, which is a potentially fatal condition involving significant and rapid reductions in serum electrolytes (e.g. sodium, potassium, magnesium, and phosphate), which in turn can result in cardiac arrest and death. This syndrome can occur when patients who have been significantly malnourished in the weeks/months prior to the initiation of nutrition support (EN or PN) are started on nutrition support at too high a rate, and advanced too quickly to their final rate.

Potential complications of PN include
- **Venous complications** due to inappropriate selection of formula, when access is via a peripheral vein, infections, blood clots, etc.
- **Malnutrition**, due to provision of inadequate amounts of calories, protein and other essential nutrients
- **Over-nutrition**, IV dextrose provides additional carbohydrates and calories. This can result in serious complications such as elevated blood glucose, respiratory distress and organ failure.
- **Liver complications**, including elevated levels of triglycerides and damage to liver cells
- **Re-feeding Syndrome**, as described above

All of these complications can lead to an increased length of stay for hospitalized patients, delayed wound healing and recovery, an increased frequency of readmissions to hospital, and for infants and children, significant growth delays and developmental impairments, some of which may be permanent. Failure to provide adequate nutrition early in the neonatal period leads to poor cognitive outcomes later in life.

Initially EN and PN were primarily utilized in acute care and chronic care hospitals. The use of these treatment modalities has expanded into a greater variety of settings, including rehabilitation and long-term care homes, as well as in the patient’s home. Home total parenteral nutrition (TPN) programs are now in place across the province. For example, the Home TPN program of London Health Sciences Centre currently has 26 patients per year, who are able to live and function in their homes with appropriate follow-up and monitoring.

Increased use of both EN and PN are reported in hospitals, for example:
- London Health Sciences Centre (LHSC): 16% of adult and 26% of pediatric patients referred to the RD were fed by EN, while 7.6% of adults and 8.1% of children referred to the RD were fed by TPN (2006 data)
- Over the past ten years, there has been an increase of 30% in the use of TPN for patients in the Hospital for Sick Children (Toronto).
- In three years from 2002/03 to 2005/06, the Milton District Hospital experienced 100% increase in the number of new TPN patients with a 50% increase in the total number of TPN days. Over the same time
period, there was close to an 81% increase in the number of EN patients with an 80% increase in total EN days.

In 2005, a joint working group of CDO and DC completed an extensive literature review related to prescription of nutrition therapy (107). The following excerpt from their report outlines the basis for the risk of harm argument related to enteral and parenteral nutrition.

**Prescription of Enteral and Parenteral Nutrition Therapy**

The American Society of Parenteral and Enteral Nutrition (ASPEN) has delineated the complexities of enteral and parenteral nutrition therapy, including the risk of potential harm from errors, omissions or inappropriate nutrition support (77).

Dietitians routinely identify patients who are unable to meet nutrition requirements by oral diet alone. They are members of interdisciplinary teams who develop nutrition support guidelines that aim to minimize complications (78,79). A retrospective review of post-gastrostomy patients reported decreased adverse events (e.g. infections, tube related problems and gastrointestinal side-effects) with the utilization of guidelines for gastrostomy feeding (80). Another prospective observational study validated the importance of nutrition support guidelines in maximizing the benefits of nutrition support while minimizing the inherent risks (81).

Dietitians have diverse knowledge regarding the efficacy of available enteral nutrition products to meet a patient’s individual needs (82,83) and employ the most cost-effective alternative (84,85). High quality care depends on a thorough knowledge of new product formulations and the clinical situations in which their efficacy has been proven. For example, perioperative provision of immune enhancing enteral formula has been demonstrated to reduce infection rates in patients undergoing upper gastrointestinal tract surgery (86).

A survey of enteral nutrition prescription practices revealed that physicians, compared to dietitians, did not have a strong understanding of the various enteral formulae and their specific indications (87). Another study concluded that physicians who implemented a dietitian’s recommendations for enteral nutrition therapy, improved nutrition intake and feeding tolerance (defined as absence of diarrhea, gastric distention, nausea, or vomiting) in their patients (88). The patients who received dietitian intervention also met their energy requirements faster, in four versus seven days, which was extremely beneficial for patients weaned from parenteral to enteral nutrition.

Shortening the duration of parenteral nutrition therapy reduces adverse effects associated with parenteral nutrition (89) and helps contain costs
Parenteral nutrition therapy is at least ten times the cost of standard enteral formulae. This is compounded by the higher risk for complications that further inflate health care costs.

Dietitian practice extends beyond recommending and prescribing enteral and parenteral nutrition therapy. Dietitians are involved in ongoing patient assessment of nutrition intake, tolerance to formulations, monitoring of laboratory data, clinical status and outcomes. Prescriptions for nutrition therapy must be modified to meet changing needs such as transitions from parenteral to enteral nutrition and subsequently to an oral diet (91-93). Dietitians are thorough in monitoring nutritionally relevant metabolic parameters (e.g. serum albumin, iron-binding capacity, nitrogen balance and energy and protein intake) to reduce complications (94).

Comprehensive nutrition assessment leads to appropriate prescription of parenteral nutrition therapy. Ongoing monitoring of individual patient tolerance and response to nutrition support is critical in parenteral nutrition therapy, which may be associated with common metabolic, infectious and technical complications (95).

Close metabolic monitoring by dietitians may prevent a variety of potential complications such as fluid imbalance, acid-base imbalance, hyperglycemia, hypoglycemia, hyperlipidemia, electrolyte abnormalities (91-93), respiratory difficulties secondary to lipid intolerance (94) and abnormal liver function due to overfeeding (95-98).

Liver disease is a known complication of long-term parenteral nutrition therapy and one cohort study reported early signs of liver disease within six months and significant disease within two to three years (98). Ongoing monitoring and adjustments in parenteral nutrition therapy also aim to reduce the risk for liver disease in children (99).

Dietitians work closely with physicians who order procedures to support enteral or parenteral nutrition therapy. Some dietitians in Canada have advanced training and authorization to insert and remove feeding tubes. There have been a few published cases where enteral nutrition has been inadvertently administered intravenously causing life-threatening complications in adults (100-102) and children (103,104). Dietitian involvement in protocol development and in-service training may minimize the occurrence of such adverse events. [End of excerpt]

Since the creation of the report in 2005, further research has confirmed the risk of harm in prescribing and monitoring enteral and parenteral nutrition, and the benefits to patients when RDs manage the process. A retrospective review showed that dietitians recommended changes to 92% of physician’s original orders for EN. When those recommendations were followed, the
patients’ nutritional status improved and they were discharged from the hospital significantly sooner than the group of patients who were not treated according to RD recommendations (40). Significant differences were found in EN/PN treatment in neonatal intensive care units based on the level of RD involvement (105). PN prescriptions in a tertiary medical center were found inappropriate according to ASPEN guidelines in 40% of cases with a total of $80,000 in potentially avoidable PN solution costs (106).

RD management of EN/PN improves patient safety; specific benefits cited by survey respondents to both the 2006 and 2008 survey included:

- Increased accuracy of EN and PN orders, leading to fewer complications and improved outcomes
- More appropriate selection of formula specific to patient needs
- More timely revisions to EN and PN orders
- Improved nutrition outcomes for patients
- Cost savings due to prevention of stage III and IV ulcers

Responses to this survey also included many examples of patients on EN or PN who suffered complications ranging from mild to life-threatening, when the healthcare provider who wrote the orders for these nutrition interventions did not have the level of knowledge, training and expertise required to do so in a safe and effective manner:

A frail, elderly patient has been NPO (i.e. no fluids or solids by mouth), and no nutrition support (i.e. EN or PN) for 10 days in hospital. The physician initiates PN, and starts the PN at the final rate. Usual practice is initiation of PN at 50% of the final rate, and gradually increasing to the final rate, in order to avoid re-feeding syndrome. (This syndrome occurs when a patient who has been significantly undernourished in the preceding weeks, is started on full nutrition support quickly, resulting in severe electrolyte abnormalities, which in turn can lead to cardiac and respiratory complications, potentially resulting in death). In this case, the patient developed re-feeding syndrome within 24 hours, with critically low levels of potassium, phosphorous and magnesium. The RD made the recommendation to reduce the rate of the TPN immediately, however the patient died within 24 hours.

A speech language pathologist performs a swallowing assessment and recommends that the patient’s tube feeding be reduced because the patient can safely tolerate an oral dysphagia diet. The physician writes the diet order and reduces the tube feeding by 50%. However, neither professional has integrated other clinical nutrition concerns
specific to this patient. The patient has diabetes complicated with renal disease and cannot tolerate regular thickened juice or high potassium juices. Two days later the patient has elevated blood glucose readings and high serum potassium. The patient is also showing signs of dehydration, caused by inadequate water provided via tube since it had also been decreased by 50%, and the patient is not consuming adequate fluids orally.

A pharmacist recommended a specific PN solution for a one day old neonate at the request of the physician. Bloodwork on the baby indicates low sodium so the solution recommended by the pharmacist contains a higher sodium content compared to a standard solution. The pharmacist did not appreciate that the cause of the low sodium was because the baby did not have any urine output yet and the low sodium was dilutional in nature and not from a low intake. Consequently, the infant did not get rid of the excess fluid as is physiologically normal during the first few days of life. The increased sodium intake caused more fluid retention. The increased fluid retention contributed to respiratory distress and a longer length of time on the ventilator.

Experience in other jurisdictions has demonstrated the recognition of this risk of harm; as noted in response to question 32, these activities are restricted in British Columbia, Quebec, and Alberta.

**Risk of Harm related to Prescription of Therapeutic Diets**
The Controlled Acts Working Group conducted a systematic literature review examining evidence of benefits and the risk of harm associated with prescription of complex nutrition therapy (107). Therapeutic Diets are

(i) Prescribed to manage, control, or ameliorate diseases and conditions through manipulation of macronutrients, micronutrients, electrolytes, fibre and volume of fluid intake.
(ii) Prescribed to meet energy requirements for anabolism, growth, pregnancy and lactation, or to attain or maintain reference weight range for height.
(iii) Prescription may include oral nutrition products such as modular, nutritionally complete or specialized supplements.
(iv) Prescription may include alterations in food texture and fluid consistency, which must be combined with the complete therapeutic diet order.

Examples of conditions that pose an especially significant risk if therapeutic diets are prescribed by unqualified practitioners are described below. This
is by no means an exhaustive list, and is meant only to show the severity of risk involved in therapeutic diet prescription and management.

- **Inborn errors of metabolism** such as phenylketonuria (PKU) – inappropriate diet prescription can lead to irreversible brain damage. Based on evidence of therapeutic diet interventions for the treatment of inborn errors of metabolism, cystic fibrosis and other pediatric populations, the systematic literature review concludes that “dietitian prescription of nutrition therapy can expedite patient care in pediatric populations” to support normalized growth and development (107).

- **High risk pregnancies** – e.g. multifetal pregnancies or pregnant women with pre-existing disease such as diabetes, lupus, PKU and end-stage renal disease require specialized treatment to prevent maternal, fetal and subsequent neonatal complications.

- **Renal disease** – electrolyte imbalances can be fatal. Based on several controlled trials, the systematic literature review concludes that “optimal prescription of nutrition therapy in renal disease and subsequent monitoring of treatment effectiveness are highly dependent upon dietitian expertise…Dietitian prescription of nutrition therapy can help reduce adverse effects associated with malnutrition in patients receiving dialysis treatment” (107).

- **Celiac disease** – gluten-containing foods can cause permanent damage to the intestinal mucosa. Based on evidence from published studies in celiac disease and other gastrointestinal disorders, the systematic literature review concludes that “dietitians incorporate recent scientific evidence to prescribe the most effect [sic] therapeutic diet...to prevent adverse effects when managing patients with various types of gastrointestinal disease” (107).

Registered Dietitians are the profession trained specifically to assess the need for, and plan implementation of, therapeutic diets. Optimal prescription of nutrition therapy is associated with improved outcomes. In contrast, errors, omissions or inappropriate prescription of nutrition therapy introduces the risk of harm, adverse effects, complications and increased mortality (107).

Therapeutic recommendations involving supplements or exclusion of food groups may carry a significant risk of harm when they are used inappropriately in the context of treatment for a medical condition. In addition to evidence from the systematic review cited above, other recent examples highlight the risk of harm to patients when therapeutic diets prescribed to treat medical conditions are based on traditional therapy and not on current, evidence-based practice. For example, the traditional management of patients with cirrhosis and hepatic encephalopathy includes a low protein diet; however recent guidelines recommend a high protein intake in these individuals as this prevents the higher breakdown of body protein that occurs when patients receive a low protein diet and does not
affect the outcome of hepatic encephalopathy (108). Another example comes from the management of kidney stones in which dietary calcium intake has traditionally been considered a risk factor and patients have been advised by clinicians to restrict their calcium intake. This advice risks calcium deficiency and bone loss and is not supported by recent evidence that demonstrates an increase in risk of kidney stones with a low calcium intake (109).

Registered Dietitians utilize evidence-based nutritional treatment for specific medical conditions that support optimal medical and nutrition outcomes and decrease risk of harm associated with alternative therapeutic diets.

21. What other regulated and unregulated professions are currently providing care with the competencies proposed as an expansion to your scope of practice? By what means are they performing it? (under delegation, supervision or on their own initiative?)

Physicians and NPs are the main professionals currently providing the care specified in the recommended changes. Registered Nurses also provide some of the care, on their own initiative or under delegation from an MD or NP. In addition, other professions are authorized to perform Controlled Acts #1, 2, and 8 within specific situations. Controlled Act #14 (psychotherapy) is authorized to medicine, nursing, psychotherapists, occupational therapists, and social work. A complete chart of professions authorized to perform each of the controlled acts is found at www.hprac.org

Unregulated practitioners currently perform procedures below the dermis, such as body piercing. Caregivers assisting with activities of daily living are also performing procedures below the dermis, such as blood glucose testing by glucometer, and insulin injections.

Prescription of EN and PN is currently done primarily by physicians and RDs. Therapeutic diets, or specific nutrition recommendations intended to treat a condition or symptom, are prescribed by a variety of regulated practitioners, such as physicians, nurse practitioners, nurses, speech-language pathologists, naturopaths, homeopaths, and chiropractors. In addition, numerous unregulated practitioners provide nutrition advice to the public.
22. Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice.

The current standards of practice and code of ethics governing dietetics emphasize the need for consultation and referral as appropriate (Appendix 2). The survey sent to CDO members in May 2008 for input on the proposed changes to scope of practice, asked specific questions about “when would you need to consult with or refer to another healthcare professional” for each of the proposed changes. Registered Dietitians’ responses indicated that some would “always” consult, while others provided specific circumstances, for example when there are co-morbidities, or questions about medication interactions. Many respondents noted that, as a member of an interdisciplinary team, consultation and collaboration is central to their practice.

For example, when a comprehensive nutrition assessment reveals abnormal laboratory values and other findings that could indicate renal failure, the RD would consult with the healthcare team for decisions to refer the patient for more extensive testing and a definitive diagnosis. This could be completed concurrently with the RD implementing medical nutrition therapy to assist the patient to make appropriate food choices.

23. If this proposal is in relation to a current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession’s need for independence/autonomy in practice.

While there is not a direct supervisory relationship, the Public Hospitals Act and organizational hierarchy have placed MDs, and in some cases Nurse Practitioners, in a position of approving RDs’ orders for nutrition therapy. Medical directives are in place in some organizations; individual delegation or workplace policies are used in other facilities to provide the RD mechanisms for managing nutrition therapy. In some instances, RDs report that the physicians provide them with pre-signed laboratory requisitions to be used at their discretion; similarly, orders such as “diet as per dietitian” or “dietitian to assess” are widely used, which acknowledge the RD’s expertise in prescribing and managing nutrition therapy.

In the 2006 survey of CDO members, medical directives or workplace policy authorizing RD orders for diets, EN/PN, labs, and medications were reported by survey respondents. The use of these mechanisms varied across practice setting, but on average 37% of respondents ordered therapeutic diets directly, 29% EN, and 14% PN. In hospital settings, these
figures were considerably higher. Laboratory orders were authorized to RDs in 14% of responses, and 8% of respondents indicated authorization to order medications. The 2008 survey shows an increase in the transfer of authority to RDs for these processes. These figures include the RDs who write “recommendations” which are then co-signed by the physician. Registered Dietitians indicate that in the vast majority of cases, physicians sign off on their orders, thus it represents a formality rather than an actual approval process. Several respondents indicated that their facility protocols specify that the order is to be implemented when the RD writes it, and the MD signature can be obtained at a later time.

Table 3: 2006 and 2008 CDO Membership survey results

<table>
<thead>
<tr>
<th>Procedure</th>
<th>2006 % of respondents in clinical care utilizing authority mechanism</th>
<th>2008 % of respondents in clinical care utilizing authority mechanism</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordering therapeutic diets</td>
<td>37%</td>
<td>95%</td>
<td>(2008) Only 4 respondents indicated that MD or NP orders all EN</td>
</tr>
<tr>
<td>Prescribing EN</td>
<td>29%</td>
<td>97%</td>
<td>(2008) 29 respondents indicated MD orders PN</td>
</tr>
<tr>
<td>Prescribing PN</td>
<td>14%</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>Ordering labs or other diagnostic tests</td>
<td>14%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Ordering medications</td>
<td>8%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

This marked increase in transfer of authority to RDs shows that the proposed changes are actually current practice, and practitioners are being unduly restricted by current legislation.

Members relate the challenges faced in developing and maintaining medical directives:

- “the directive needs to be signed and reviewed annually by at least 50 physicians and 20 dietitians. Whenever there is a new doctor or dietitian, the process has to be repeated”
• “it took over two years to get the medical directive written and approved by all the committees”
• “If one doctor decides not to sign on, the dietitian must do things differently for those patients”

CDO and DC do recognize and support the need for authority mechanisms such as delegation and medical directives in appropriate circumstances. However, the time spent by practitioners in developing and reviewing them is better used for specific situations, not activities which form a central part of dietetic practice.

24. Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled act or subset of an existing controlled act?

Authority to perform controlled acts #1, 2, 8, 14 as appropriate to dietetic scope of practice, is recommended. As noted throughout this submission, the authority is not an expansion of scope, but validation and “legalization” of current practice.

New controlled acts for the prescription and management of enteral and parenteral nutrition, and prescription and management of therapeutic diets, are proposed. These activities carry a significant risk of harm, require specialized knowledge and experience to appropriately prescribe, monitor, and adjust to patient response. Registered Dietitians have the knowledge, skills, and judgment to safely manage EN/PN and therapeutic diets. In fact, it is central to the profession of dietetics.

25. If the proposed change in scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have authority to perform and delegate this controlled act.

The evidence of risk for prescribing and managing enteral and parenteral nutrition requires that it be limited to only highly trained individuals. In the present system, only dietitians and some physicians have the necessary knowledge and competencies. Pharmacists have specialized knowledge they apply based on the assessment information provided by others. The CDO has not fully explored a prohibition on delegation of this potential new controlled act and will do so at the earliest indication that the HPRAC is recommending the creation of this new controlled act. The current view of
the College is that patients are well served by not limiting the performance of any controlled act by duly qualified/competent people.

It is contemplated that the profession of medicine would be considered for authority to perform this controlled act.

Prescription and management of therapeutic diets also presents substantial risks to patients and should be performed only by competent individuals. We expect that other regulated health professions may indicate they should be considered for authority to prescribe and manage therapeutic diets.

**Competencies / Educational requirements for practice**

26. Are the entry-to-practise (didactic and clinical) education and training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine this sufficiency? What additional qualifications might be necessary?

The changes proposed in the scope of practice are supported by the education and training requirements already in place for RDs in Ontario. A complete list of competencies is found in Appendix 2. Specific competencies and requirements that relate to each proposed change are included in Tables 4 - 6.

As demonstrated in the presentation of the competencies, used for entry to practice, we are of the view that the current education and training based on the competencies are sufficient to prepare dietitians for the proposed changes in scope of practice. It is again noted that, with the exception of undertaking capacity assessments, the proposed changes are ostensibly part of the current practice activities and expertise of dietitians. The nature of the proposed changes is to enable RDs to act on their own authority rather than through the authority of physicians.

Undergraduate education and internship programs are governed by a national accreditation process developed and administered by DC. New programs must prove that they incorporate foundational knowledge and experiences based on competencies approved by the College for entry to practice. This ensures that graduates are prepared to practice according to the profession’s standards of practice. On-going evaluation of programs, by an on-site peer review conducted on a regular basis, ensures education curriculum and practical training activities and intern evaluations deliver to the current entry to practice standards.

Two sets of competencies are presented in Appendix 2. The current standard for entry to practice upon which the Canadian Dietetic Registration Examination is based is the 1993 Entry to Practice Competencies. The
Essential Competencies have been developed by the 10 provincial dietetic regulatory bodies in Canada through the Alliance of Canadian Dietetic Regulatory Bodies. The Essential Competencies will be reviewed in 2008/09 before they are wholly incorporated into the registration exam. While the Essential Competencies are more detailed in presentation through the inclusion of performance indicators, they have not changed the underlying entry to practice expectations. Once fully implemented, they will be reviewed every 3-5 years to ensure that they continue to reflect dietetic practice in Canada. Educators in Ontario have demonstrated commitment to quality dietetic service and have the ability to incorporate material relevant to the Ontario jurisprudence and other Ontario-specific needs. CDO and DC in working with educators through the Dietetic Education Leadership Forum will continue to explore education and training issues that impact the quality of dietetic services specific to Ontario.

27. Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all members of the profession? 
The training and education of RDs provides them with the foundational knowledge and competencies needed for the proposed changes. As noted in the introduction, these changes are primarily legitimizing the activities RDs are already performing through a variety of authority mechanisms. As with any profession, experience and personal preferences determine the practice setting and scope of an RD’s role. All RDs possess the foundational knowledge and the skills to enable professional growth or specialization in areas such as diabetes management or critical care. A summary of competencies relevant to the proposed changes is included in Tables 4 – 6 (shown after question 29).

Undergraduate education and internship programs are governed by a national accreditation process developed and administered by DC. New programs must prove that they incorporate foundational knowledge and experiences to ensure that graduates are prepared to practice according to the profession’s standards of practice. On-going evaluation of programs, by an on-site peer review conducted at least every seven years, ensures education and training remains current.

Numerous resources and tools are available through CDO and DC to assist members to judge their competency in these areas and direct learning activities. The PEN system provides convenient access to current evidence based recommendations on a variety of dietetic topics, and the comprehensive QA program required by CDO provides assurance of competent practice.
28. What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current with the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practise with the proposed scope?

As noted in question 27, all RDs currently practicing have the foundational knowledge and skills to perform the activities in the proposed scope of practice. The College is committed to reviewing the components of its Quality Assurance Program with a view to modifying them to more explicitly focus on activities related to controlled acts for dietitians who perform them.

- The reflective practice tool (self-directed learning (SDL) tool) currently requires dietitians to assess themselves against standards, competencies, their current and future practice and client requirements and set two Professional Improvement Plans in keeping with their self-assessment. The activities and progress of these plans are reported on to the college in subsequent years. The College is now considering how to adapt the SDL tool to feature specific assessment and development plans related to controlled acts for those dietitians who would be performing them. Two of the specifics being explored are competency assessment tools specific to particular controlled acts and areas of practice and requiring that one of the professional improvement plans address competence related to the performance of the controlled acts performed by the RD.

- The College is currently developing the specific tools for on-site practice assessments. The framework for these practice assessments emphasizes that RDs would be assessed against their specific practice activities. The tools therefore will capture competence and other quality measures related to controlled acts.

- Every five years all dietitians are also required to complete an on-line Jurisprudence Knowledge and Assessment Tool. New members are required to complete the tool in the first year of practice. This tool will ensure that RDs know the authority and limits of the dietetic scope of practice as it changes. The Jurisprudence Handbook for Dietitians in Ontario developed by CDO as well as other publications, e-learning tools and workshops will be used to communicate changes in practice expectations and standards.

Numerous communications methods will be used to ensure RDs are made aware of changes; CDO and DC websites, broadcast emails, presentations at conferences and network meetings, CDO’s resume publication, and DC’s Members in Action newsletter will all be utilized.
29. How should the College ensure that members maintain competence in this area? How should the College evaluate the membership’s competence in this area? What additional demands might be put on the profession?

As noted in response to questions 28, CDO will use its Quality Assurance Program components to support and assess continuing competence related to all facets of dietetic practice including those related to controlled acts and autonomy of practice within a collaborative setting.

Additional demands upon practicing RDs may include a need for more “on-call” coverage to assess and monitor EN/PN and other types of medical nutrition therapy. It is expected that RDs will work closely with the interprofessional team to determine the most appropriate manner to ensure patient safety.
Table 4 – Selected Competencies and Standards Relevant to Proposed Changes in Scope of Practice

<table>
<thead>
<tr>
<th>Essential Competencies</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Practices with professional integrity</td>
<td></td>
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<tr>
<td>1.1 Practices in compliance with professional legislation and regulations.</td>
<td></td>
</tr>
<tr>
<td>1.2 Practices in compliance with professional standards, practice guidelines and codes</td>
<td></td>
</tr>
<tr>
<td>1.3 Provides services within scope of practice and personal competence</td>
<td></td>
</tr>
<tr>
<td>1.4 Refers individuals for consultation when issues are beyond scope of practice and competence</td>
<td></td>
</tr>
<tr>
<td>1.5 Accepts personal responsibility and accountability for actions and decisions.</td>
<td></td>
</tr>
<tr>
<td>Dietitians work according to existing legislation; practice according to professional standards and current practice guidelines. They ensure that the services that they provide are within the scope of practice of dietetics, as well as within their own personal competence. Dietitians recognize when required services go beyond the scope of practice of the profession or their own personal competence, and refer the clients to another professional.</td>
<td></td>
</tr>
<tr>
<td>2.0 Respects the individuality and autonomy of others</td>
<td></td>
</tr>
<tr>
<td>2.1 Respects individuals and their rights regardless of race, religious beliefs, color, gender, physical and/or mental disability, marital status, family status, economic status, education level, age, ancestry or sexual orientation</td>
<td></td>
</tr>
<tr>
<td>2.2 Respects the dignity and privacy of individuals</td>
<td></td>
</tr>
<tr>
<td>2.3 Obtains informed consent as required prior to providing services</td>
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</tr>
<tr>
<td>2.4 Provides services considering the best interests of the individual and their needs</td>
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<tr>
<td>The care of dietitians is client-centred. Dietitians are respectful of the individual’s rights to dignity, privacy and informed consent.</td>
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<tr>
<td>13.0 Applies critical thinking skills in problem solving and decision making</td>
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<tr>
<td>Performance indicators for this competency include gathering and analyzing relevant information, identifying and implementing the best solution, based on the analysis, and evaluating the success of the solution.</td>
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<tr>
<td>16.0 Contributes to client care through collaboration with interprofessional team.</td>
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<tr>
<td>16.1 Advocates on behalf of clients with the interprofessional team</td>
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<tr>
<td>16.2 Coordinates and integrates care processes to ensure quality and continuity of care</td>
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<tr>
<td>16.3 Refers clients to other members of the interprofessional team</td>
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<tr>
<td><strong>CDO Professional Misconduct Regulation</strong></td>
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<tr>
<td>5. Failing to maintain a standard of practice of the profession</td>
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<tr>
<td>18. Failing to inform the member’s employer of the member’s inability to accept specific responsibility in areas where specific training is required or where the member does not feel competent to function without supervision.</td>
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<tr>
<td>19. Treating or attempting to treat a condition that the member knew or ought to have known was beyond his or her expertise or competence.</td>
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<td>32. Contravening the Act, the Regulated Health Professions Act, 1991 or the regulations under either of them.</td>
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<td>34. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a facility where a member</td>
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<tr>
<td>Dietitians work according to existing legislation; practice according to professional standards and current practice guidelines. They ensure that the services that they provide are within the scope of practice of dietetics, as well as within their own personal competence. Dietitians recognize when required services go beyond the scope of practice of the profession or their own personal competence, and refer the clients to another professional.</td>
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</table>
Table 5 - Essential Competencies related to proposed changes to controlled acts.

<table>
<thead>
<tr>
<th>Controlled Act</th>
<th>Proposed Change</th>
<th>Training</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>#1 – Communicating a Diagnosis</td>
<td>That RDs be authorized to communicate a diagnosis that relates to nutrition therapy</td>
<td>5.0 Communicates clearly and effectively</td>
<td>Performance indicators for this competency include using active listening techniques, adapting communications styles to the individual or group, and interpreting and responding to non verbal cues.</td>
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<tr>
<td>#2 - Procedure below the dermis</td>
<td>That RDs be authorized to perform skin pricks for the purpose of monitoring capillary blood levels (currently mainly blood glucose)</td>
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<tr>
<td>#8 - Prescribing, a drug as defined in the Drug and Pharmacies Regulation Act</td>
<td>Specifically for the purpose of adjusting insulin or oral hypoglycemic medications.</td>
<td>6.2 Develops and plans and gathers accurate, comprehensive, relevant information. 17.3 Conducts and analyzes diet history 17.5 Analyzes and compares food intake with nutritional requirements. 17.7 Reviews and assesses relevant laboratory data. 17.8 Determines potential nutrient-drug interactions 17.9 Interprets findings of comprehensive nutrition assessment to identify normal, abnormal and deviant states of health. 17.10 Draws relevant conclusions from nutrition assessment data. 18.10 Assesses client progress in achieving planned outcomes</td>
<td>As part of ongoing management of diabetes care, the dietitian would review the client’s overall blood sugar control, trends in their blood sugar levels as well as their intake, and consider all other relevant information (e.g. medical history, co-morbidities, etc) to determine whether the current plan (i.e. diet and/or specified dose of insulin or oral hypoglycemic medication) are effective. If the current plan is not effective, the dietitian will again consider all of the relevant information to determine whether changing the diet, insulin/oral hypoglycemic, or both, would be most appropriate to achieve the desired outcomes.</td>
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<tr>
<td>Controlled Act</td>
<td>Proposed Change</td>
<td>Training</td>
<td>Comment</td>
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<tr>
<td>Enteral and parenteral</td>
<td>Prescribing and managing a substance by enteral or parenteral means</td>
<td>12.0 Applies current research and evidence-based practice findings into services provided. (This includes evaluating the evidence to determine whether it is credible and whether it is relevant/applies to the current situation).</td>
<td>In establishing nutrition support, the dietitian would use the information from their assessment to develop the nutrition care plan. This would include determining the most appropriate route for nutrition support, and the appropriate content of the enteral or parenteral solution. An important part of the ongoing management of nutrition support is reviewing the assessment data (e.g. lab values, weight, etc) to determine whether the nutrition support has achieved the desired outcomes and to modify the plan, as indicated by the ongoing monitoring of relevant data. Dietitians are able to access Dietitians of Canada’s “Practice-based Evidence in Nutrition” website, which supports them in gathering and interpreting relevant literature, to ensure that they are using the best available research evidence in their practice.</td>
</tr>
<tr>
<td>Therapeutic diets</td>
<td>Prescribing and managing therapeutic diets</td>
<td>17.0 Conducts comprehensive nutrition assessments (The performance indicators for a nutrition assessment include gathering relevant information from a variety of sources including laboratory data), interpreting the data that has been gathered, and drawing relevant conclusions from the nutrition assessment data.</td>
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<td>18.1 Integrates assessment data in developing the nutrition care plan.</td>
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<td>18.2 Considers co-morbidities in the development of the nutrition care plan.</td>
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<td>18.4 Identifies the nutrition goals and develops nutrition care plan to achieve planned outcomes in collaboration with clients.</td>
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<td>18.6 Determines appropriate formula and feeding route for clients.</td>
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<td>18.8 Coordinates implementation of nutrition care plan.</td>
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<td>18.10 Assesses client progress in achieving planned outcomes</td>
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<td>18.11 Evaluates effectiveness of nutrition care plan in achieving planned outcomes.</td>
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</tbody>
</table>
Table 6 - Essential Competencies related to proposed legislative changes:

<table>
<thead>
<tr>
<th>Legislation/Regulation</th>
<th>Proposed Change</th>
<th>Competencies</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Public Hospitals Act                   | Add dietitian to the list of professionals authorized to order specified treatment and/or diagnostic procedures | 13.1 Collects and analyzes relevant information related to an identified issue.  
16.2 Coordinates and integrates care processes to ensure quality and continuity of care.  
16.3 Refers clients to other members of the health care team.  
Assesses client nutritional status through physical observation and anthropometric measures.  
17.7 Reviews and assesses relevant laboratory data  
17.10 Draws relevant conclusions from nutrition assessment data  
17.11 Prioritizes identified health needs in consultation with clients/caregivers and inter-professional team. | In order to complete a comprehensive nutrition assessment, dietitians need information from a variety of sources. If this information is not available, waiting for a physician’s signature to order a test, or implement a dietitian’s recommendations (diet order, parenteral or enteral nutrition) creates unnecessary delays in being able to implement a client’s care.  
Dietitians consult members of the health care team, where relevant, as part of the assessment, planning and implementation processes, and refer to other members of the team when they identify issues that are beyond their scope of practice or personal competence. |
| Long Term Care Act                     |                                                                                 |                                                                              |                                                                                                                                                                                                       |
| Laboratory Specimens and Collection Centre Licensing Act | Add dietitian to the list of professional authorized to order specified tests | 6.2. Develops, and plans and gathers accurate, comprehensive, relevant information.  
6.4 Establishes plans based on outcome of information gathering activities  
16.2 Coordinates and integrates care processes to ensure quality and continuity of care.  
17.7 Reviews and assesses relevant laboratory data  
17.10 Draws relevant conclusions from nutrition assessment data | Laboratory values are often necessary as part of a comprehensive nutrition assessment or for the ongoing monitoring of a nutrition intervention/care plan. The lack of this information can either delay a dietitian’s intervention, require the client to make extra visits (in an outpatient setting), or result in sub-optimal care, as the dietitian is forced to develop a plan without the benefit of all relevant data. |
<table>
<thead>
<tr>
<th>Legislation/Regulation</th>
<th>Proposed Change</th>
<th>Competencies</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Health Care Consent Act</td>
<td>Add dietitian to the list of professionals that may act as an “evaluator” for the purpose of determining capacity</td>
<td>Academic requirements include 12 credits in humanities and social sciences; 3 credits in communication arts and up to 3 credits in advanced social sciences.</td>
<td>The academic requirements for dietitians include courses (18 credits) in Social Sciences and communication. The internship training is based on competencies that include appropriate communication and interviewing skills, as well as considering of psychosocial factors as part of the nutrition assessment and planning process. The performance indicators for this competency include using active listening techniques, adapting communications styles to the individual or group, and interpreting and responding to non verbal cues.</td>
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<tr>
<td></td>
<td></td>
<td><strong>Essential Competencies</strong>&lt;br&gt;5.0 Communicates clearly and effectively&lt;br&gt;13.1 Collects and analyzes relevant information related to an identified issue.&lt;br&gt;15.1 Uses a variety of assessment strategies, individualized to client needs.&lt;br&gt;15.2 Interviews clients to conduct needs assessments.&lt;br&gt;15.3 Considers that ability and resources of the clients to execute the nutrition care plan.&lt;br&gt;17.2 Determines psychosocial factors that may influence nutrition intake/status.&lt;br&gt;17.9 Implements strategies and supports for those unable to manage their own care.</td>
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</table>
30. Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?

Since November 1998, all dietitians in Canada, with the exception of Quebec, must pass the Canadian Dietetic Registration Exam administered by The Alliance of Canadian Dietetic Regulatory Bodies to qualify for registration as an RD. The Dietetic Mutual Recognition Agreement is available at: http://www.dieteticregulation.ca/en/index.php#mutualagreement.

As previously noted, undergraduate and internship programs are accredited by DC using national standards and competencies. Due to this common framework for dietetic practice across the country, labour mobility issues are not expected. CDO provides new members with the Jurisprudence Handbook for Dietitians in Ontario as well as other orientation and education materials. This material along with the requirement to complete a jurisprudence assessment ensures knowledge of the scope of practice and authority mechanisms specific to Ontario.

Public education

31. How do you propose to educate or advise the public of this change in scope of practice?

CDO and DC collaboratively produced a pamphlet explaining the role of the RD, and the role of the regulatory body and professional association. These pamphlets are provided to RDs to distribute in workplaces, health fairs, and other public events. A revised pamphlet and similar process would be followed to inform the public of the changes. In addition, CDO and DC would provide public education through their websites, newsletters, and publications.

Additional public education about the health professions scope of practice could also be conducted through other professionals, for example through the Federation and CORPHA. The Federation website currently features profession-specific information and links to College websites.

These strategies would complement the personal communication between dietitians, other health care providers and their clients.

The creation of new controlled acts, especially for prescribing and managing therapeutic diets, would require targeted communications with associations, schools and other forums and businesses that are affected by any new restriction on the diet advice they may be providing. In keeping with its
regulatory responsibilities, the College would undertake this targeted communication and reinforce it through repetition of the message and information.

**Other jurisdictions**

**32. What is the experience in other Canadian jurisdictions? Please provide copies of relevant statutes and regulations.**

<table>
<thead>
<tr>
<th><strong>Alberta</strong></th>
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<tr>
<td><strong>Restricted Activities authorized to dietitians:</strong></td>
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<tr>
<td>• To insert or remove nasoenteric, gastrostomy and jejunostomy tubes when providing nutritional support.</td>
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<td>• To prescribe parenteral nutrition, including schedule 1 drugs, when providing nutritional support.</td>
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<tr>
<td>• To prescribe and/or administer oral diagnostic imaging contrast agents during a video-fluoroscopic swallowing study when providing medical nutrition therapy.</td>
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<tr>
<td>• To distribute drugs regulated by a schedule to the Pharmaceutical Profession Act, according to a prescription when providing nutrition support or medical nutrition therapy.</td>
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<tr>
<td>• To perform a psychosocial intervention when providing psychonutrition therapy in the treatment of disordered eating.</td>
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<tr>
<td><strong>College of Dietitians of Alberta requires annual competency indicator checklists to be completed by dietitians who prescribe parenteral nutrition.</strong></td>
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<tr>
<td><strong>Dietitian Regulation</strong></td>
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<tr>
<th><strong>Quebec</strong></th>
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<td><strong>Dietitians determine the nutritional treatment and the feeding route and monitor the effectiveness of the nutrition treatment plan. Conditions exist for the prescription of nutrition therapy.</strong> Nutrition must be the determining factor in the treatment of an illness (and initiated or agreed to by the physician). The physician must order the installation of feeding tubes or catheters for enteral and parenteral nutrition therapy respectively.</td>
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<td><strong>Loi 90 english.pdf</strong></td>
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<th><strong>British Columbia</strong></th>
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<tr>
<td><strong>Dietitians have authority to perform three reserved acts:</strong></td>
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<td>• design, compound or dispense therapeutic diets if nutrition is administered through enteral means,</td>
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<tr>
<td><strong>Reserved Acts Interpretive Guide</strong></td>
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<tr>
<td><strong>Health Professions Act -- DIETITIANS REGULATION</strong></td>
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</tbody>
</table>
design therapeutic diets if nutrition is administered through parenteral means, or
administer a substance to a person by instillation through enteral or parenteral means.

33. What is the experience in other International jurisdictions?

**United States**
Regulatory restrictions vary depending on the use of licensure or certification in the particular state. Registered Dietitian expertise in the management of medical nutrition therapy is recognized through a variety of authority mechanisms similar to the current situation in Ontario. Long-standing practices of RDs writing orders without co-signing by an MD were challenged in 2005 when the Centres for Medicare and Medicaid issued a clarification a requirement for all orders in federally funded facilities must be approved by the physician. This was further clarified to include the use of protocols or policies enabling RDs to continue writing orders.

**United Kingdom**
Dietitians are authorized to order therapeutic diets, EN/PN, laboratory assessments, and to supply and administer medications under Patient Group Directives.

**Australia**
Dietitians have a form of self-regulation through the Dietitians Association of Australia, in the Advanced Practicing Dietitian program.

**Brazil**
All patients must have two prescriptions: The Medical Prescription determines the general guidelines of the nutrition prescription based on both the clinical and the nutritional diagnosis of the patient. The Dietetic Prescription determines the nutrient composition of the diet that more adequately matches the patient’s specific needs according to the medical prescription. It is the dietitian’s translation of the medical prescription into a selection of foods or products that fit to the medical prescription. Hospitals offering nutritional support must have a Nutritional Support Team in place comprised of a physician, dietitian, nurse, and pharmacist.
Costs/Benefits

34. What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors:
   1. Direct patient benefits/costs;
   2. Benefits and costs to the broader health care service delivery system;
   3. Benefits and costs associated with wait times;
   4. Workload, training and development costs;
   5. Costs associated with educational and regulatory sector involvement.

The actual costs of implementing these changes are minimal. Patients and clients of RDs will not incur additional costs, but they will reap the benefits of more efficient services delivered by the right practitioner at the right place and the right time (see question 15 a – c). Decreased wait times are expected, due to increases in practitioner availability resulting from streamlining processes and improved communication (see question 15 d).

Costs to the profession will primarily involve development of public education materials and tools/resources developed for RDs to complement existing QA program materials. Educators indicate that major changes will not be needed to their programs.

35. Is there any other relevant information that HPRAC should consider when reviewing your proposal for a change in scope of practice?

N/A
REFERENCES
17. College of Physicians and Surgeons of Ontario, Policy #4-03 Delegating a Controlled Act. Available at http://www.cpso.on.ca/Policies/delegation.htm
22. Local Health Integration Networks. Integrated Health Services Plan. Available from: www.lhins.on.ca and links to individual LHINs.


36. 2007 Omnitel Survey

38. Primary Care– Family Practice Wait Times Expert Panel; 2007
Available from:
http://www.health.gov.on.ca/transformation/wait_times/providers/reports/wt_primary_care_rep_02_20070110.pdf


47. Ontario Ministry of Finance. Demographic Quarterly; April 2008. Available from:
http://www.fin.gov.on.ca/english/economy/demographics/quarterly/dhi074.html


http://www.oecd.org/document/11/0,3343,en_2649_201185_16502667_1_1_1_1,00.html.


## Appendix 1 Examples of RD Interventions for Selected Medical Conditions

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>RD Intervention</th>
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</table>
| **Cancer**         | • Address food and nutrition needs specific to changes in metabolism, dysphagia, gastrointestinal (GI) tract obstructions, treatment modalities and/or side effects of treatments  
                      • Educate clients/caregivers regarding strategies for symptom management  
                      • Address anxieties/concerns regarding food intake  
                      • Assist/support with interpretation of alternative nutrition practices |
| **Neurological/ Neuromuscular Impairments** | • Address nutrition needs and feeding modalities with such disorders/conditions as: cerebral vascular accident (CVA), amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Parkinson's and acquired brain injury (ABI), which may result in hypermetabolism, obesity, cachexia or dysphasia  
                      • Collaborate with health care team to coordinate interventions to improve clients' quality of life, and to educate clients about feeding options in progressive diseases |
| **Medical/Surgical/ Wound Management** | • Address specific needs such as: anaemia, dehydration, pre-and post-surgical nutrition complications and organ transplant nutrition  
                      • Interventions to address energy, protein and specific nutrient needs to promote healing of wounds, decubitus ulcers and burns |
| **Cardiovascular and Respiratory Diseases** | • Individualize nutrition interventions for clients with hyperlipidemia, multiple risk factors for cardiovascular disease, post-cardiac surgery, chronic obstructive pulmonary disease (COPD) and obesity affecting medical conditions |
| **Diabetes Mellitus** | • Teach and support clients/caregivers regarding nutritional management of diabetes to achieve acceptable blood glucose levels, control symptoms and meet all recommended nutrient intakes  
                      • Liaise with other health care professionals to adjust care plans as necessary |
| **Immunodeficiency Disorders** | • Address nutrient needs of clients with HIV, AIDS and other autoimmune disorders  
                      • Counsel clients/caregivers regarding symptom management |
| **Gastrointestinal, Hepatic, Renal** | • Individualize nutrition interventions to address nutrient needs and dietary restrictions for digestive, absorptive, hepatic and renal disorders |
| **Palliative Care** | • Promote improved quality of life and maximize physical comfort through symptom management, adequate hydration and management of concurrent medical conditions  
                      • Address client/caregiver concerns/anxiety about food intake |
| **Dysphagia** | • Nutrition interventions based on client's oral and pharyngeal condition, individual tolerance, nutritional needs and food preferences  
                      • Assess fluid and electrolyte balance  
                      • Recommend enteral/parenteral feeding routes if appropriate |
Appendix 2 – Competencies, Standards of Practice and Code of Ethics for Dietitians

Competencies for Entry-level Dietitians

Essential Competencies

[College of Dietitians of Ontario Standards of Practice]

Code Of Ethics Interpretive Guide