Academy of Nutrition and Dietetics: Revised 2018 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Post-Acute and Long-Term Care Nutrition

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ABSTRACT

In a climate of change, the elevation of post-acute and long-term care (PALTC) services offered through community-based settings has optimized health care delivery. With the population age increasing, there is a growing need for community-based and residential care services, including for older inmates in the prison system. The Dietetics in Health Care Communities Dietetic Practice Group, with guidance from the Academy of Nutrition and Dietetics Quality Management Committee, has updated the Standards of Practice (SOP) and Standards of Professional Performance (SOPP), which describe three levels of practice (competent, proficient, and expert) for registered dietitian nutritionists (RDNs) working in PALTC nutrition. The SOP uses the Nutrition Care Process and clinical workflow elements for care and management of clients/residents in PALTC settings (eg, long-term acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospice, assisted living facilities, and corrections facilities). The SOPP describes six domains of professional performance: Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources. Within the SOP and SOPP standards, specific indicators provide measurable action statements that illustrate how the standards apply to practice. The SOP and SOPP are complementary resources for RDNs providing nutrition care and services for individuals receiving PALTC services, or in other PALTC nutrition-related areas, including research. The SOP and SOPP provide RDNs with a self-evaluation guide for assuring competence, identifying knowledge and skills to enhance expertise and advance level of practice in PALTC nutrition.

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Editor's note: Figures 1 and 2 that accompany this article are available at www.jandonline.org.

THE DIETETICS IN HEALTH CARE Communities Dietetic Practice Group (DHCC DPG) of the Academy of Nutrition and Dietetics (Academy), under the guidance of the Academy Quality Management Committee, has revised the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitians in Extended Care Settings originally published in 2011.[1] The Academy of Nutrition and Dietetics: Revised 2018 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Post-Acute and Long-Term Care Nutrition reflect advances in post-acute and long-term care (PALTC) practice during the past 7 years and replace the 2011 Standards. These documents build on the Academy of Nutrition and Dietetics: Revised 2017 SOP in Nutrition Care and SOPP for RDNs.[2] The Academy of Nutrition and Dietetics/Commission on Dietetic Registration's (CDR) Code of Ethics (Revised in 2018),[3] along with the Academy of Nutrition and Dietetics: Revised 2017 SOP in Nutrition Care and SOPP for RDNs[2] and Revised 2017 Scope of Practice for the RDN,[4] guide the practice and performance of RDNs in all settings.

Scope of practice in nutrition and dietetics is composed of statutory and individual components, includes code(s) of ethics (eg, Academy, other national organizations, and/or employer code of ethics), and encompasses the range of roles, activities, practice guidelines, and regulations within which RDNs perform. For credentialed practitioners, scope of practice is typically established within the practice act and interpreted and controlled by the

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Approved May 2018 by the Quality Management Committee of the Academy of Nutrition and Dietetics (Academy) and the Executive Committee of the Dietetics in Health Care Communities Dietetic Practice Group of the Academy. ***Scheduled review date: November 2024.*** *Questions regarding the Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists in Post-Acute and Long-Term Care Nutrition may be addressed to Academy quality management staff: Dana Buelsing, MS, manager, Quality Standards Operations; and Sharon McCauley, MS, MBA, RDN, LDN, FADA, FAND, senior director, Quality Management, at quality@eatright.org.*

All registered dietitians are nutritionists—but not all nutritionists are registered dietitians. The Academy's Board of Directors and Commission on Dietetic Registration have determined that those who hold the credential Registered Dietitian (RD) may optionally use "Registered Dietitian Nutritionist" (RDN). The two credentials have identical meanings. In this document, the authors have chosen to use the term *RDN* to refer to both registered dietitians and registered dietitian nutritionists.

agency or board that regulates the practice of the profession in a given state.[4] An RDN's statutory scope of practice can delineate the services an RDN is authorized to perform in a state where a practice act or certification exists. For more information see www.cdrnet.org/state-licensure-agency-list.

The RDN's individual scope of practice is determined by education, training, credentialing, experience, and demonstrating and documenting competence to practice. Individual scope of practice in nutrition and dietetics has flexible boundaries to capture the breadth of the individual's professional practice. Professional advancement beyond the core education and supervised practice to qualify for the CDR RDN credential provides RDNs practice opportunities, such as expanded roles within an organization based on training and certifications, if required; or additional credentials (eg, CDR Board-Certified Specialist in Gerontological Nutrition [CSG], Certified Case Manager [CCM], or Certified Professional in Healthcare Quality [CPHQ]). The Scope of Practice Decision Tool (www.eatrightpro.org/scope), an online interactive tool, guides an RDN through a series of questions to determine whether a particular activity is within his or her scope of practice. The tool is designed to assist an RDN to critically evaluate his or her personal knowledge, skill, experience, judgment, and demonstrated competence using criteria resources.[5]

The Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, Hospital[6] and Critical Access Hospital[7] Conditions of Participation now allow a hospital and its medical staff the option of including RDNs or other clinically qualified nutrition professionals within the category of "non-physician practitioners" eligible for ordering privileges for therapeutic diets and nutrition-related services if consistent with state law and health care regulations. RDNs in hospital settings interested in obtaining ordering privileges must review state laws (eg, licensure, certification, and title protection), if applicable, and health care regulations to determine whether there are any barriers or state-specific processes that must be addressed. For more information, review the Academy's practice tips that outline the regulations and implementation steps for obtaining ordering privileges (www.eatrightpro.org/dietorders), and the Revised 2017 Scope of Practice for the RDN[4] that addresses medical staff rules, regulations, bylaws, or other facility specific process.[8] For assistance, refer questions to the Academy's State Affiliate organization.

The Long-Term Care Final Rule published October 4, 2016 in the *Federal Register*, "allows the attending physician to delegate to a qualified dietitian or other clinically qualified nutrition professional the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law" and permitted by the facility's policies.[9] The qualified professional must be acting within the scope of practice as defined by state law; and is under the supervision of the physician that may include, for example, countersigning the orders written by the qualified dietitian or clinically qualified nutrition professional. RDNs who work in long-term care facilities should review the Academy's updates on CMS that outline the regulatory changes to §483.60 Food and Nutrition Services (https://www.eatrightpro.org/practice/quality-management/national-quality-accreditation-and-regulations/centers-for-medicare-and-medicaid-services.) Review the state's long-term care regulations to identify potential barriers to implementation; and identify considerations for developing the facility's processes with the medical director and for orientation of attending physicians. The CMS State Operations Manual, Appendix PP-Guidance for Surveyors for Long-Term Care Facilities contains the revised regulatory language (revisions are italicized and in red color).[10] CMS periodically revises the State Operations Manual Conditions of Participation; obtain the current information at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf.

ACADEMY QUALITY AND PRACTICE RESOURCES

The Academy's Revised 2017 SOP in Nutrition Care and SOPP for RDNs[2] reflect the minimum competent level of nutrition and dietetics practice and professional performance. The core standards serve as blueprints for the development of focus area SOP and SOPP for RDNs in competent, proficient, and expert levels of practice. The SOP in Nutrition Care is composed of four standards consistent with the Nutrition Care Process (NCP) and clinical workflow elements as applied to the care of patients/clients/populations in all settings.[11] The SOPP consist of standards representing six domains of professional performance: Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources. The SOP and SOPP for RDNs are designed to promote the provision of safe, effective, efficient, and quality food and nutrition care and services; facilitate evidence-based practice; and serve as a professional evaluation resource.

These focus area standards for RDNs in PALTC nutrition provide a guide for self-evaluation and expanding practice, a means of identifying areas for professional development, and a tool for demonstrating competence in delivering PALTC nutrition and dietetics services. They are used by RDNs to assess their current level of practice and to determine the education and training required to maintain currency in their focus area and advancement to a higher level of practice. In addition, the standards can be used to assist RDNs in general clinical practice with maintaining minimum competence in the focus area and by RDNs transitioning their knowledge and skills to a new focus area of practice. Like the Academy's core SOP in Nutrition Care and SOPP for RDNs,[2] the indicators (ie, measurable action statements that illustrate how each standard can be applied in practice) (see Figures 1 and 2, available at www.jandonline.org) for the SOP and SOPP for RDNs in PALTC Nutrition were revised with input and consensus of content experts representing diverse practice and geographic perspectives. The SOP and

SOPP for RDNs in PALTC Nutrition were reviewed and approved by the Executive Committee of the DHCC DPG and the Academy Quality Management Committee.

THREE LEVELS OF PRACTICE

The Dreyfus model[13] identifies levels of proficiency (novice, advanced beginner, competent, proficient, and expert) (refer to Figure 3) during the acquisition and development of knowledge and skills. The first two levels are components of the required didactic education (novice) and supervised practice experience (advanced beginner) that precede credentialing for nutrition and dietetics practitioners. Upon successfully attaining the RDN credential, a practitioner enters professional practice at the competent level and manages his or her professional development to achieve individual professional goals. This model is helpful in understanding the levels of practice described in the SOP and SOPP for RDNs in PALTC Nutrition. In Academy focus areas, the three levels of practice are represented as competent, proficient, and expert.

Competent Practitioner

In nutrition and dietetics, a competent practitioner is an RDN who is either just starting practice after having obtained RDN registration by CDR or an experienced RDN recently transitioning his or her practice to a new focus area of nutrition and dietetics. A focus area of nutrition and dietetics practice is a defined area of practice that requires focused knowledge, skills, and experience that applies to all levels of practice.[14] A competent practitioner who has achieved credentialing as an RDN and is starting in professional employment consistently provides safe and reliable services by employing appropriate knowledge, skills, behavior, and values in accordance with accepted standards of the profession; acquires additional on-the-job skills; and engages in tailored continuing education to further enhance knowledge, skills, and judgment obtained in formal education.[14] A general practice RDN can include responsibilities across several areas of practice, including, but not limited to: community, clinical, consultation and business, research, education, and food and nutrition management. A newly credentialed RDN or general practice RDN may utilize resources (see Figure 4), access the Academy's and CDR's Certificate of Training Programs, and seek out credentialed practitioners (eg, CSG, Certified Diabetes Educator [CDE], CDR Board Certified Specialist in Renal Nutrition [CSR], CDR Board Certified Specialist in Oncology Nutrition [CSO], Certified Nutrition Support Clinician [CNSC]) to add depth and breadth to their competence and responsibilities in PALTC nutrition.

Proficient Practitioner

A proficient practitioner is an RDN who is generally 3 or more years beyond credentialing and entry into the profession, and consistently provides safe and reliable service; has obtained operational job performance skills and is successful in the RDN's chosen focus area of practice. The proficient practitioner demonstrates additional knowledge, skills, judgment, and experience in a focus area of nutrition and dietetics practice. An RDN may acquire specialist credentials, if available, to demonstrate proficiency in a focus area of practice.[14] An RDN may have acquired the CSG, other certifications and credentials, and/or advanced degree(s) to gain proficiency and increased opportunities in PALTC nutrition.

Expert Practitioner

An expert practitioner is an RDN who is recognized within the profession and has mastered the highest degree of skill in, and knowledge of, nutrition and dietetics. Expert-level achievement is acquired through ongoing critical evaluation of practice and feedback from others. The individual at this level strives for additional knowledge, experience, and training. An expert has the ability to quickly identify "what" is happening and "how" to approach the situation. Experts easily use nutrition and dietetics skills to become successful through demonstrating quality practice and leadership, and to consider new opportunities that build upon nutrition and dietetics.[14] An expert practitioner may have an expanded or specialist role or both and may possess an advanced credential(s). Generally, the practice is more complex, and the practitioner has a high degree of professional autonomy and responsibility. These RDNs have extensive knowledge and practice experience in the care and management of clients/residents in PALTC settings and have one or more certifications and/or credentials (eg, CSG, CDE, CSR).

These Standards, along with the Academy/CDR Code of Ethics,[3] answer the questions: Why is an RDN uniquely qualified to provide PALTC nutrition and dietetics services? What knowledge, skills and competencies does an RDN need to demonstrate for the provision of safe, effective, and quality PALTC nutrition care and service at the competent, proficient, and expert levels?

OVERVIEW

In a climate of major change during the last decade, the elevation of PALTC services in long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, and other community programs (eg, PACE [Program of All-Inclusive Care for the Elderly], also called LIFE [Living Independence for the Elderly]) has optimized health care

PALTC is a continuum of care provided by community-based settings that can include long-term acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospice, assisted living facilities, and corrections facilities. An RDN may practice in all PALTC settings. A PALTC RDN uses a person-centered process to provide medical nutrition therapy for malnutrition, pressure injuries/ulcers, unintentional weight loss, specialized nutrition care for chronic conditions (eg, diabetes, chronic kidney disease, heart failure, dysphagia and neurological disorders), and/or post-surgical care and other nutrition and dietetics services (eg, management of clients/residents receiving enteral or parenteral nutrition and/or management of food/dining services) required between the hospital and returning home. Clients/residents in these settings have been hospitalized recently and usually have complicated needs. PALTC is normally temporary and continues only until a client/resident has recovered enough to no longer need services. In some cases, clients'/residents' needs for long-term care may continue throughout the remainder of their life, thus the need for a long-term care setting.

Standards of Practice are authoritative statements that describe practice demonstrated through four separate standards: nutrition assessment, nutrition diagnosis (problem identification), nutrition intervention (planning, implementation), and outcomes monitoring and evaluation; and the responsibilities for which registered dietitian nutritionists (RDNs) are accountable. The Standards of Practice (SOP) for RDNs in Post-Acute and Long-Term Care Nutrition presuppose that the RDN uses critical thinking skills; analytical abilities; theories; best available research findings; current accepted nutrition, dietetics, and medical knowledge; and the systematic holistic approach of the nutrition care process as they relate to the application of the standards. Standards of Professional Performance (SOPP) for RDNs in Post-Acute and Long-Term Care Nutrition are authoritative statements that describe behavior in the professional role, including activities related to Quality in Practice; Competence and Accountability; Provision of Services; Application of Research; Communication and Application of Knowledge; and Utilization and Management of Resources (six separate standards).

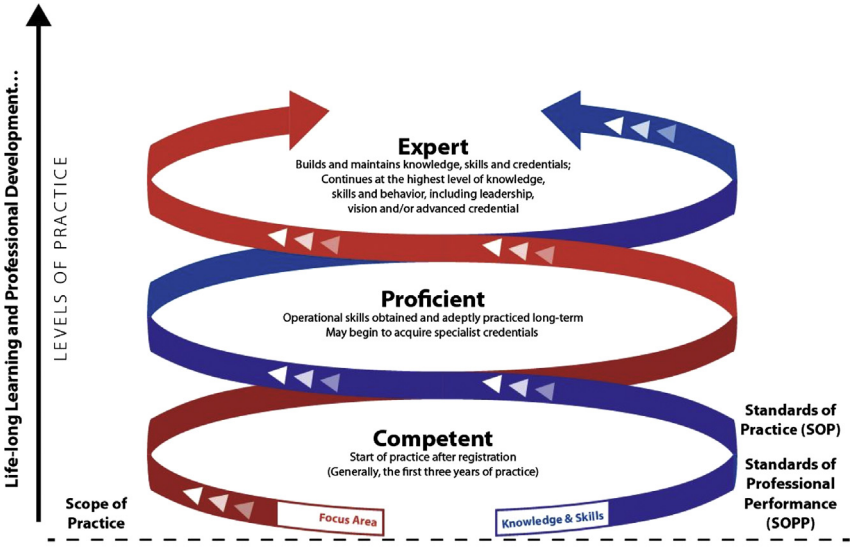
SOP and SOPP are evaluation resources with complementary sets of standards—both serve to describe the practice and professional performance of RDNs. All indicators may not be applicable to all RDNs' practice or to all practice settings and situations. RDNs operate within the directives of applicable federal and state laws and regulations, as well as policies and procedures established by the organization in which they are employed. To determine whether an activity is within the scope of practice of the RDN, the practitioner compares his or her knowledge, skill, and competence with the criteria necessary to perform the activity safely, ethically, legally, and appropriately. The Academy's Scope of Practice Decision Tool, which is an online, interactive tool, is specifically designed to assist practitioners with this process.

The term **client/resident** *is used in the SOP as a universal term as these Standards relate to direct provision of nutrition care and services. Client/resident could also mean client/patient, resident, inmate, participant, consumer, or any individual or group who receives food and nutrition services.* **Customer** *is used in the Standards of Professional Performance as a universal term. Customer could also mean client/patient, client/patient/customer, resident, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides services. These services are provided to clients/ residents who are adults 18 years and older. The SOP and SOPP are not limited to the clinical setting. In addition, it is recognized that the family and caregiver(s) of* clients/residents *of all ages, including individuals with special health care needs, play critical roles in overall health and are important members of the team throughout the assessment and intervention process. The term* **appropriate** *is used in the standards to mean: Selecting from a range of best practice or evidence-based possibilities, one or more of which would give an acceptable result in the circumstances.*

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

Standard definitions, rationale statements, core indicators, and examples of outcomes found in the Academy of Nutrition and Dietetics: Revised 2017 SOP in Nutrition Care and SOPP for RDNs have been adapted to reflect three levels of practice (competent, proficient, and expert) for RDNs in post-acute and long-term care nutrition (see figure below). In addition, the core indicators have been expanded to reflect the unique competence expectations of the RDN providing care and services in post-acute and long-term care settings.

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



Adapted from the *Dietetics Career Development Guide.* For more information, please visit www.eatrightPRO.org/futurepractice

Figure 3. Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) (Competent, Proficient, and Expert) in Post-Acute and Long-Term Care Nutrition.

delivery (see Figure 1 in the Academy Position Paper related to PALTC).[15] Approximately 40% of Medicare beneficiaries discharged from acute care hospitals receive PALTC services.[16,17] These 21st century care settings provide clients/residents with a myriad of services that include person-centered medical and therapeutic care, rehabilitation, and palliative/hospice care. PALTC settings offer care coordination and team collaboration that extends care and services beyond the hospital walls, faring well in a value-driven environment in which the traditional silos have given away to integrated care partnerships.[18,19] By becoming an extension of the hospital's care delivery model, PALTC providers create seamless continuing care models that meet the Triple Aim goals of improving client/resident experience of care (including quality and satisfaction), improving health of populations, and reducing the per capita cost of health care.[20]

The expanding PALTC landscape is driven by several changing global demographics:

- The aging population is living longer, with the average 65-year-old now expected to live to 83 years. Adults 65 years old are expected to double from 44 million to 70 million by 2050.[21] With an aging baby-boomer generation, there is a 75% increase in the number of adults 65 years or older requiring nursing home care, predicted to be 2.3 million in 2030, which is an increase from 1.3 million in 2010.[20] Demands for elder care will rise, as the 85 years or older population is projected to increase to 14.1 million by 2040.
- PALTC is no longer synonymous with "geriatric care." In 2014, the Society for Post-Acute and Long-Term Care, formerly the American Medical Directors Association, reported a doubling in the young adult (ages 31 to 64 years) population needing PALTC over the past 20 years.[22] These clients/patients typically have conditions that differ from traditional elder residents, including multiple sclerosis, amyotrophic lateral sclerosis, and serious brain or spinal cord injuries.[22] Their psychological, psychiatric, social, and sexual needs are different as well.[22] Consequently, providers face unique care challenges when integrating younger adults into the PALTC communities.
- According to a 2014 report from the Urban Institute titled, "Aging Behind Bars: Trends and Implications of Graying Prisoners in the Federal Prison Population," individuals 50 years and older make up the fastest growing age group in the federal prison population.[23] From 1990 to 2009, the number of inmates aged 55 years and older increased by 300%.[24] In addition, in 2011 there were approximately 5,000 prisoners aged 65 years and older, which is projected to triple by 2019.[23] Unfortunately, most correctional institutions were not designed to consider the older adult inmate. Medical nutrition therapy interventions for inmates with chronic disease (eg, hypertension, diabetes, and renal, pulmonary, and heart disease), frailty, substance abuse, disabilities, and cognitive impairment is on the rise.[25] The combination of age and higher rates of disabling conditions increase the need for PALTC services in the prison population.
- With the tsunami of people living longer comes a variety of serious chronic diseases and conditions, such as diabetes, heart disease, pulmonary disease, stroke, cancer, renal disease, dementia, and degenerative diseases,[26,27] that contribute to a lower quality of life, malnutrition (overnutrition or undernutrition), unintended weight loss, and functional limitations. Most older adults have at least two or more such conditions.[26] Management of chronic diseases requires a holistic approach that balances treatment with preventive measures and a plan of care based on the individual's unique needs, culture, values, and preferences.[28] CMS has defined *person-centered* as the need "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives."[10,29] The practice of including client/resident input into goal setting can significantly impact outcomes and in the long run can reduce the number of hospitalizations with their associated costs and burdens.[29] The person-centered care philosophy requires a take-charge approach enlisting support and shared decision making with the client/resident and family/caregivers at every step of the care process. This requires balancing of professional standards with the client/resident and family perspective in developing the person-centered care plan and acknowledging that the focus is on the individual. RDNs play a critical role in disease management for clients/residents when maintaining nutritional status is an essential goal of the plan of care.

The CMS Long-Term Care Conditions of Participation[9,10] have changed over the years, keeping pace with the increase in acuity and complexity of chronic diseases in the PALTC client/resident population. CMS's 2017 changes to the core quality of care regulations emphasize two central themes: the need to care for severely ill and frail elders during the post-acute period or during long-term stays in nursing facilities[30]; and the CMS strategic shift toward person-centered care that weighs client/resident choices and preferences in all care decisions.[31] The revised regulations have been enhanced with greater sensitivity and precision with significant updates to nutrition-related clinical areas, such as skin integrity/pressure injury/ulcer, mobility, assisted nutrition and hydration, parenteral fluids, and dialysis.[10] To facilitate coordinated care and improve Medicare beneficiary outcomes, the 2014 Improving Medicare Post-Acute Care Transformation Act (known as IMPACT Act of 2014) was enacted. The Act requires the standardization of post-acute care assessment data for quality, payment, and discharge planning, and includes home health agencies, skilled nursing facilities, long-term acute care hospitals, and inpatient rehabilitation facilities as providers.[32] This legislation also includes new survey and medical review requirements for hospice care. The overarching intent of the Act is to reform post-acute care payment and

Resource	Address	Description
Academy of Nutrition and Dietetics (Academy) Dietetics in Health Care Communities Dietetic Practice Group (DHCC DPG)	www.dhccdpg.org	The mission of DHCC DPG is to: "empower DHCC members to be the nation's food and nutrition leaders." DHCC DPG has sub-units for corrections and for dietetic technicians, and has many resources (including a quarterly newsletter) that guide members who are in a variety of practice settings within post-acute and long-term care, including rehabilitation, skilled nursing facilities, assisted living centers, home care, hospice, and corrections facilities.
Academy DHCC DPG Nutrition Care of the Older Adult: A Handbook for Nutrition Throughout the Continuum of Care, 3rd Edition	www.eatrightstore.org/product-type/books/nutrition-care-of-the-older-adult-third-ed	This book from the DHCC DPG is a hands-on reference that encompasses the entire outlook on person-centered nutrition and dietetics care for older adults.
Academy DHCC DPG Pocket Resource for Management	www.dhccdpg.org/store/products/food-service/pocket-resource-for-management	A quick reference for foodservice management. This resource contains essential information for all areas of foodservice, including personnel, education, kitchen design, quality, cost control, and survey information. Sections are available on Emergency Management, Quality Assurance and Performance Improvement, Quality Indicator Survey, Home Care, Corrections, and more.
Academy DHCC DPG Pocket Resource for Nutrition Assessment	www.dhccdpg.org/store/products/clinical/5006-pocket-resource-for-nutrition-assessment-2017/	This complete resource for nutrition assessment includes links and updated references and sections. This edition includes: Bariatric Nutrition, Estimating Nutrient Needs (as a stand-alone chapter), Neurological Disorders, Nutrition Support, Palliative Care, Regulatory Updates, and Skin Integrity. Chapters have been organized by topics.
Academy Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 website	www.eatrightpro.org/impact	Source of information and resources on the IMPACT Act for RDNs working in PALTC settings. The fact sheet "RDNs Making an Impact" includes details of the IMPACT Act, Long Term and Post-Acute Care Sector descriptions, and a brief description of measure domains (eg, Skin Integrity/Changes, and Hospital Readmission Rates). Resources include Case Studies, and Learning Modules with a Quiz to earn 1.0 CPEU Credit.
Academy Long Term Care Toolkit	www.eatrightstore.org/product/A7BAC6B7-23C1-446D-86DE-BAE813AB42A6	This toolkit is intended to provide RDNs with resources to aide in learning and applying the Nutrition Care Process in the long-term care setting. This should be used with the Nutrition Care Process Terminology, eNCPT.
Academy Malnutrition website	www.eatrightpro.org/practice/practice-resources/malnutrition	This malnutrition webpage provides links to resources such as: electronic clinical quality measures, American Society for Parenteral and Enteral Nutrition (ASPEN) Malnutrition Toolkit, Defeat Malnutrition Today, and many other useful malnutrition tools to help PALTC practitioners.

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Figure 4. Nutrition resources for post-acute and long-term care (PALTC) settings (not all inclusive).

Resource	Address	Description
Academy Nutrition Care Manual	www.nutritioncaremanual.org	The Nutrition Care Manual (NCM) is an internet-based professional practice manual for registered dietitian nutritionists; nutrition and dietetics technicians, registered; and allied health professionals that now includes the NCM Diet Manual. The NCM Diet Manual contains resources for PALTC settings including corrections, home care, and hospice.
Academy Nutrition Focused Physical Exam Pocket Guide, 2nd Edition	www.eatrightstore.org/product/EBB27B14-7C98-40E2-A0EF-6E78AD6FF7D8	This pocket guide is a key resource for clinicians with tools for nutrition assessment, including identification of malnutrition, documentation, and coding.
Academy Unintended Weight Loss in Older Adults Evidenced-Based Nutrition Practice Guideline Toolkit	www.eatrightstore.org/product/28D4ADFE-83C7-4EE9-A8B0-74F3A50B6E72	The Academy toolkit aids RDNs in applying the Academy Evidence Analysis Library Nutrition Practice Guideline on Unintended Weight Loss in Older Adults (www.andeal.org). The toolkit includes materials such as interactive sample documentation forms, outcomes monitoring forms, and case studies.
Agency for Health Research and Quality (AHRQ)	www.ahrq.gov/	"AHRQ is a US Department of Health and Human Services organization with a mission of producing evidence to increase the safety, quality, accessibility and affordability of health care. AHRQ's website maintains resources on topics such as end-of-life care, falls and injury, multiple chronic conditions, pressure ulcers and quality of life. AHRQ also provides training modules for improving patient safety in long term care facilities."
Association of Correctional Food Service Affiliates (ACFSA)	www.acfsa.org/index.php	This Association is comprised of foodservice professionals employed in correctional facilities and agencies who develop and promote educational programs related to the correctional segment of the foodservice industry.
Kidney Disease Outcomes Quality Initiative (KDOQI)	www.kidney.org/professionals/guidelines	Provides evidence-based clinical practice guidelines for all stages of chronic kidney disease and related complications. The National Kidney Foundation actively participates in developing and promoting KDOQI and its guidelines.
National Pressure Ulcer Advisory Panel (NPUAP)	www.npuap.org/	The NPUAP serves as the authoritative voice for improved patient outcomes in pressure injury prevention and treatment through public policy, education and research.
Pioneer Network: The New Dining Practice Standards for Nursing Homes	www.pioneernetwork.net/	The Pioneer Network advocates for a culture of aging in which individual voices are heard and individual choices are respected where food and dining are an integral component. They focus on helping providers transition from a medical institutional model of elder care to a more person-centered approach.

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Figure 4. *(continued)* Nutrition resources for post-acute and long-term care (PALTC) settings (not all inclusive).

Resource	Address	Description
The American Diabetes Association Position Statement: Management of Diabetes in Long-Term Care and Skilled Nursing Facilities	care.diabetesjournals.org/content/39/2/308	The American Diabetes Association issued a position statement on the management of diabetes in long-term care and skilled nursing facilities. This statement provides recommendations for the general approach to care and goals and strategies for glycemic control and diabetes management.
The International Dysphagia Diet Standardization Initiative (IDDSI)	iddsi.org	The IDDSI was developed with the overarching theme of safety for people with swallowing difficulties. The Academy of Nutrition and Dietetics and the American Speech-Language Hearing Association support IDDSI to assist people with swallowing disorders.
The Society for Post-Acute and Long-Term Care Medicine (formerly the American Medical Directors Association)	paltc.org/	This society represents health care professionals working in various post-acute and long-term care settings. A comprehensive list of practice guidelines can be found at: paltc.org/product-store/full-set-clinical-practice-guidelines.

Figure 4. *(continued)* Nutrition resources for post-acute and long-term care (PALTC) settings (not all inclusive).

reimbursement, while ensuring continued beneficiary access to the most appropriate setting for care. See the PALTC practice resources in Figure 4.

RDNs are an integral team member in PALTC settings by providing evidence-based care, coordination, and quality leadership through collaboration with other interprofessional team members. The following are considerations when collaborating with the interprofessional team:

- Evidence-based literature supports that the use of an interprofessional team in care of older adults can lead to better quality and continuity of care, improved health outcomes and lower costs.[32] Core members of the interprofessional team (eg, physician, nurses, social workers, RDNs, and others) includes care providers and the client/resident and family members or responsible party. It is important for all care team members to be involved—especially the RDN, who outlines risk factors identified during the nutrition assessment and monitoring process and options for person-centered nutrition interventions.
- Discharge planning is an important activity in any PALTC setting and is a process to decide what a client/resident needs for a smooth transition from one level of care to another.[33] While the actual process of discharge planning is completed by the case manager, nurse, or social worker in collaboration with other practitioners, the RDN is a vital part of the discharge process addressing diet and lifestyle choices consistent with medical conditions, providing simple meal preparation instructions and ideas for home-prepared or commercial nutritional supplements for those with unintentional weight loss.[34] RDNs coordinate with community resources consistent with the client's/resident's needs such as senior services, adult day care, fresh food pharmacies, and home-delivered meals. The RDN coordinates training and ordering of supplies with the home infusion provider when a client/resident is in need of enteral or parenteral nutrition in the home setting. Because nutrition-related medical conditions strongly influence how care plans are shaped, RDNs and nutrition and dietetics technicians, registered (NDTRs), when part of facility/program staff, play a significant role in the discharge and transitions of care process.[2,35]
- Quality of life and early nutrition and hydration interventions are key to caring for palliative and end-of-life clients/residents.[36,37] An advocate for "best practice," the RDN brings value by providing guidance to the nurses providing care. Agreed-upon nutritional goals are set with the client/resident, the family, and/or responsible party. Regular reviews and adaptation throughout any "disease or cancer journey" are paramount to minimize anxiety and distress.[38,39] The team approach supports ethical decision-making and assists in development of a person-centered nutrition care plan.[40]

To be a valued leader in PALTC settings, it is important that RDNs and NDTRs fully understand and embrace the opportunities and challenges that health care delivery and value-based payment systems present. They must be prepared and empowered to contribute and lead necessary changes.[41] RDNs bring expert knowledge and practice skills to PALTC settings by using medical nutrition therapies; promoting client-/resident-centered comprehensive and coordinated care; sharing evidence-based research and practice guidelines; and participating in systematic quality-improvement activities. As advocates for nutrition and dietetics best practices, RDNs help PALTC settings achieve client/resident satisfaction and positive clinical outcomes at a cost savings,

while improving quality of life for populations served. For additional information, see the "Position of the Academy of Nutrition and Dietetics: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post-Acute Care and Other Settings."[15]

The Academy supports a variety of DPGs, such as the DHCC DPG. The DHCC DPG is for professionals interested in PALTC practice, including corrections. The DHCC DPG mission is "to empower DHCC members to be the nation's food and nutrition leaders." DHCC DPG aims to meet that mission by providing professional development and networking opportunities for members. The DHCC DPG offers numerous opportunities for professional growth: continuing education through its newsletter and webinars; sub-units for Corrections and for Dietetic Technicians; publications such as the *Nutrition Care of the Older Adult* handbook[42]; and provides resources through the DPG's website at www.dhccdpg.org.

ACADEMY REVISED 2018 SOP AND SOPP FOR RDNs (COMPETENT, PROFICIENT, AND EXPERT) IN POST-ACUTE AND LONG-TERM CARE NUTRITION

An RDN can use the Academy Revised 2018 SOP and SOPP for RDNs (Competent, Proficient, and Expert) in PALTC Nutrition (see Figures 1 and 2, available at www.jandonline.org, and Figure 3) to:

- identify the competencies needed to provide nutrition and dietetics care and services in PALTC settings;
- self-evaluate whether he or she has the appropriate knowledge, skills, experience, and judgment to provide safe, effective, and quality PALTC nutrition and dietetics care and service for their level of practice;
- identify the areas in which additional knowledge, skills, and experience are needed to practice at the competent, proficient, or expert level of nutrition and dietetics practice in PALTC;
- provide a foundation for public and professional accountability in nutrition and dietetics care and services in PALTC;
- support efforts for strategic planning, performance improvement, outcomes reporting, and assist management in the planning and communicating of PALTC nutrition and dietetics services and resources;
- enhance professional identity and skill in communicating the nature of nutrition and dietetics care and services in PALTC;
- guide the development of PALTC nutrition- and dietetics-related education and continuing education programs, job descriptions, practice guidelines, protocols, clinical models, competence evaluation tools, and career pathways; and
- assist educators and preceptors in teaching students and interns the knowledge, skills, and competencies needed to work in PALTC nutrition and dietetics, and the understanding of the full scope of this focus area of practice.

APPLICATION TO PRACTICE

All RDNs, even those with extensive experience in other practice areas, must begin at the competent level when practicing in a new setting or new focus area of practice. At the competent level, an RDN in PALTC nutrition is learning the principles that underpin this focus area and is developing knowledge, skills, judgment, and gaining experience for safe and effective PALTC nutrition practice. This RDN, who may be new to the profession or may be an experienced RDN, has a breadth of knowledge in nutrition and dietetics and may have proficient or expert knowledge/practice in another focus area. However, the RDN new to the focus area of PALTC nutrition must accept the challenge of becoming familiar with the body of knowledge and available resources to support and ensure quality PALTC-related nutrition and dietetics practice.

At the proficient level, an RDN has developed a more in-depth understanding of PALTC nutrition practice and is better equipped to adapt and apply evidence-based guidelines and best practices than at the competent level. This RDN is able to modify practice according to unique situations. Examples include developing setting-specific evidence-based nutrition care guidelines or protocols for management of chronic diseases, skin integrity/pressure injury/ulcer, unintentional weight loss; providing staff training and education on vitamin and mineral supplements and food/dietary supplement drug interactions; or serving as a project manager for implementation of a computerized nutrition care documentation system. The RDN has acquired specialized knowledge, enhanced decision making skills, experience, and clinical competence for the management of multiple chronic diseases (eg, diabetes, heart disease, renal disease, cancer). The RDN at the proficient level may possess a specialist credential(s) (eg, CSG, CDE, and/or CSR).

At the expert level, the RDN thinks critically, reflecting breadth of knowledge and experience, and demonstrates a more intuitive understanding of PALTC nutrition and dietetics care and service, displays a range of highly developed clinical and technical skills, and formulates judgments acquired through a combination of education, experience, and critical thinking. Essentially, practice at the expert level requires the application of composite nutrition and dietetics knowledge, with practitioners drawing not only on their practice experience, but also on the experience of RDNs in PALTC in various disciplines and practice settings. Expert RDNs, with their extensive experience and ability to see the significance and meaning of PALTC nutrition and dietetics within a contextual whole, are fluid and flexible, and have considerable autonomy in practice. They not only develop and implement PALTC nutrition and dietetics services, but they also manage, drive, and direct care for individuals and/or groups; conduct and collaborate in research and advocacy; accept organization leadership roles (eg, lead development of organization's online resource library, lead quality assurance and performance program); engage in scholarly work (eg, conduct research and publish findings to contribute to body of knowledge in PALTC nutrition); guide interprofessional teams; and lead the advancement of PALTC nutrition and dietetics practice. They are recognized by others for their practice, leadership, and professional

contributions to further quality PALTC nutrition and education.

Indicators for the SOP and SOPP for RDNs in PALTC Nutrition are measurable action statements that illustrate how each standard can be applied in practice (Figure 1 SOP and Figure 2 SOPP, available at www.jandonline.org). Within the SOP and SOPP for RDNs in PALTC Nutrition, an "X" in the competent column indicates that an RDN who is caring for clients/residents is expected to complete this activity and/or seek assistance to learn how to perform at the level of the standard. A competent RDN in PALTC nutrition could be an RDN starting practice after registration or an experienced RDN who has recently assumed responsibility to provide PALTC nutrition care and services for clients/residents. The RDN reviews the SOP and SOPP for RDNs in PALTC Nutrition to develop their professional development portfolio with the goal of advancing his or her practice.

An "X" in the proficient column indicates that an RDN who performs at this level has a more in-depth understanding of PALTC nutrition and dietetics and has the ability to modify or guide therapy to meet the needs of clients/residents in various situations.

An "X" in the expert column indicates that the RDN who performs at this level possesses a comprehensive understanding of PALTC nutrition and dietetics and a highly developed range of skills and judgments acquired through a combination of experience and education. The expert RDN builds and maintains the highest level of knowledge, skills, and behaviors, including leadership, vision, and credentials.

Standards and indicators presented in Figure 1 and Figure 2 (available at www.jandonline.org) in boldface type originate from the Academy's Revised 2017 SOP in Nutrition Care and SOPP for RDNs[2] and should apply to RDNs in all three levels. Additional indicators not in boldface type developed for this focus area are identified as applicable to all levels of practice. Where an "X" is placed in all three levels of practice, it is understood that all PALTC RDNs are accountable for practice within each of these indicators. However, the depth with which an RDN performs each activity will increase as the individual moves beyond the competent level. Several levels of practice are considered in this document; thus, taking a holistic view of the SOP and SOPP for RDNs in PALTC Nutrition is warranted. It is the totality of individual practice that defines a practitioner's level of practice and not any one indicator or standard.

RDNs should review the SOP and SOPP in PALTC Nutrition at determined intervals to evaluate their individual focus area knowledge, skill, and competence. Consistent self-evaluation is important because it helps identify opportunities to improve and enhance practice and professional performance. This self-appraisal also enables PALTC RDNs to better utilize these Standards as part of the *Professional Development Portfolio* recertification process[43] that encourages CDR-credentialed nutrition and dietetics practitioners to incorporate self-reflection and learning needs assessment for development of a learning plan for improvement, and commitment to lifelong learning. CDR's updated system implemented with the 5-year recertification cycle that began in 2015 incorporates the use of essential practice competencies for determining professional development needs.[44] In the new three-step process, the credentialed practitioner accesses an online Goal Wizard (step 1), which uses a decision algorithm to identify essential practice competency goals and performance indicators relevant to the RDN's area(s) of practice (essential practice competencies and performance indicators replace the learning need codes of the previous process). The Activity Log (step 2) is used to log and document continuing professional education over the 5-year period. The Professional Development Evaluation (step 3) guides self-reflection and assessment of learning and how it is applied. The outcome is a completed evaluation of the effectiveness of the practitioner's learning plan and continuing professional education. The self-assessment information can then be used in developing the plan for the practitioner's next 5-year recertification cycle. For more information, see www.cdrnet.org/competencies-for-practitioners.

RDNs are encouraged to pursue additional knowledge, skills, and training, regardless of practice setting, to maintain currency and to expand individual scope of practice within the limitations of the legal scope of practice, as defined by state law. RDNs are expected to practice only at the level at which they are competent, and this will vary depending on education, training, and experience.[45] RDNs should collaborate with other RDNs in PALTC practice as learning opportunities and to promote consistency in practice and performance and continuous quality improvement. See Figure 5 for examples of how RDNs in different roles, at different levels of practice, may use the SOP and SOPP in PALTC Nutrition.

In some instances, components of the SOP and SOPP for RDNs in PALTC Nutrition do not specifically differentiate between proficient-level and expert-level practice. In these areas, it remains the consensus of the content experts that the distinctions are subtle, captured in the knowledge, experience, and intuition demonstrated in the context of practice at the expert level, which combines dimensions of understanding, performance, and value as an integrated whole.[46] A wealth of knowledge is embedded in the experience, discernment, and practice of expert-level RDN practitioners. The experienced practitioner observes events, analyzes them to make new connections between events and ideas, and produces a synthesized whole. The knowledge and skills acquired through practice will continually expand and mature. The SOP and SOPP indicators are refined with each review of these Standards as expert-level RDNs systematically record and document their experiences, often through use of exemplars. Exemplary actions of individual PALTC RDNs in practice settings and professional activities that enhance client/resident/population care and/or services can be used to illustrate outstanding practice models.

FUTURE DIRECTIONS

To enhance competitiveness in today's PALTC environment, generalist RDNs may need to broaden their skill set with additional credentials (eg, CSG, CSR, CDE, and/or CNSC), consistent with personal interests and skills needed to address client/resident population needs and preferences[47] and organization objectives. Certification(s) can be a step toward increased knowledge, professional recognition, and identification as a leader in the

Role	Examples of use of SOP and SOPP documents by RDNs in different practice roles[a]
PALTC clinical practitioner	A registered dietitian nutritionist (RDN) working in a skilled nursing facility notices an increase in new residents with type 2 diabetes. The RDN refers to the SOP and SOPP in Post-Acute and Long-Term Care (PALTC) Nutrition and the SOP and SOPP in Diabetes Care. Following the facility's medical director's approved policy and procedure, an attending physician delegates to the RDN the ordering and revising of diet orders, including therapeutic diets, enteral nutrition rate adjustments and supplemental water, and nutritional supplements. The RDN reviews resources listed in SOP and SOPP articles and indicators to increase knowledge; identifies areas for continuing education; and gains ideas for appropriate diet orders, menu adjustments, snacks and nutritional supplements supporting the population's cultural and nutritional needs.
Community nutrition practitioner	An RDN working part-time at the community hospital recently accepted a consultant role with the community's senior program that provides service to congregate meal sites, home-delivered meals, and an adult day-care center. To strengthen knowledge, skills, and resources (eg, federal and state regulations requirements for menus), the RDN reviews the SOP and SOPP in PALTC Nutrition for self-evaluation.
PALTC consultant RDN	A consultant RDN for an assisted living facility works with the food and nutrition services director who is a nutrition and dietetics technician, registered (NDTR). At the RDN's regular visit, the NDTR reports on a new resident's nutrition screening results, diet order concern, and lack of interest in eating. The RDN reviews the resident's medical record, hospital discharge plan, and transfer materials for relevant information. The RDN reflects on the SOP and SOPP for RDNs in PALTC Nutrition's emphasis on person-centered interventions and care in problem solving and shared decision making with the resident. By accommodating food preferences and liberalizing the diet order in consultation with the physician, the resident's intake improved.
Home health RDN	An RDN working for a home care agency oversees a number of patients/clients receiving palliative or hospice care. The RDN reviews the SOP and SOPP in PALTC Nutrition, the SOP and SOPP for Nutrition Support, and the Academy of Nutrition and Dietetics (Academy)/Commission on Dietetic Registration Code of Ethics. The RDN gains knowledge to educate and support patients/clients, families and interprofessional team members in understanding the overriding principal of respecting the individual's unique personal values and decisions that affirm their right to self-determination. The RDN consults with an experienced RDN colleague and the agency's social worker for advice and continuing education options to meet professional development goals in palliative and end-of-life care.
Prison system RDN	An RDN is employed by a prison system with a growing population of aging inmates/clients. The RDN provides nutritional care through a screening process; educates and counsels inmates/clients and staff with physiological, functional, cognitive, or sensory problems; uses the interprofessional team to ensure optimal inmate/client care; and oversees the menu adjustments and meal service managing within the system's safety and budgetary constraints. Striving for additional training, the RDN uses the SOP and SOPP in PALTC Nutrition to evaluate personal knowledge and skills for identifying performance goals that may include becoming a Board Certified Specialist in Gerontological Nutrition (CSG).

(continued on next page)

Figure 5. Role Examples of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Post-Acute and Long-Term Care Nutrition.

Role	Examples of use of SOP and SOPP documents by RDNs in different practice roles[a]
Quality assurance performance improvement (QAPI) coordinator	An RDN working in a rehabilitation center was asked by the administrator to assume the responsibilities of QAPI coordinator. This new role includes coordinating and monitoring the organization's identified quality indicators, proactively supporting survey readiness, and analyzing and reporting routine surveillance and outcomes data. The RDN refers to the SOP and SOPP for PALTC Nutrition found on the Academy website and QAPI resources located on the Centers for Medicare and Medicaid Services website. These tools assist with evaluating skills and competence, and developing a professional goal to include publishing the organization's performance improvement process project with outcomes of advancing knowledge, changing practice, and enhancing effectiveness of services.
Researcher	An RDN working in a research setting is awarded a grant to evaluate effectiveness of specific nutrition interventions on health outcomes of the pre-frail and frail older adults target population. The research will evaluate weight gain, muscle strength, activities of daily living, and hospital readmissions as measurable indicators that would demonstrate quality outcomes of interventions. The RDN uses the SOP and SOPP in PALTC Nutrition as a resource in designing the research protocol.
[a]For each role, the RDN updates professional development plan to include applicable essential practice competencies for post-acute and long-term nutrition care and services.	

Figure 5. *(continued)* Role Examples of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Post-Acute and Long-Term Care Nutrition.

complex ever-changing field of PALTC. Achieving certification or other credentials (eg, case manager, quality coordinator, or nursing home administrator) is an assured way to demonstrate RDNs are equipped to meet their next challenge and to expand opportunities.

The SOP and SOPP for RDNs in PALTC Nutrition are innovative and dynamic documents. Future revisions will reflect changes and advances in practice, changes to dietetics education standards, regulatory changes, and outcomes of practice audits. Continued clarity and differentiation of the three practice levels in support of safe, effective, and quality practice in PALTC nutrition remains an expectation of each revision to serve tomorrow's practitioners and their clients, residents, and customers.

SUMMARY

RDNs face complex situations every day. Addressing the unique needs of each situation and applying standards appropriately is essential to providing safe, timely, person-centered quality care and service. All RDNs are advised to conduct their practice based on the most recent edition of the Code of Ethics, the Scope of Practice for RDNs, and the SOP in Nutrition Care and SOPP for RDNs. The SOP and SOPP for RDNs in PALTC Nutrition are complementary documents and are key resources for RDNs at all knowledge and performance levels. These standards can and should be used by RDNs in daily practice who provide care to individuals in PALTC settings to consistently improve and appropriately demonstrate competence, and value as providers of safe, effective, and quality nutrition and dietetics care and services. These standards also serve as a professional resource for self-evaluation and professional development for RDNs specializing in PALTC nutrition-related practice. Just as a professional's self-evaluation and continuing education process is an ongoing cycle, these standards are also a work in progress and will be reviewed and updated every 7 years. Current and future initiatives of the Academy, as well as advances in PALTC nutrition care and services, will provide information to use in updates and in further clarifying and documenting the specific roles and responsibilities of RDNs at each level of practice. As a quality initiative of the Academy and the DHCC DPG, these standards are an application of continuous quality improvement and represent an important collaborative endeavor.

References

1. Roberts L, Cryst S, Robinson GE, et al. American Dietetic Association: Standards of Practice and Standards of Professional Performance (Competent, Proficient, and Expert) in Extended Care Settings. *J Am Diet Assoc*. 2011;111(4):617-624.e27.
2. Academy of Nutrition and Dietetics Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists. *J Acad Nutr Diet*. 2018;118(1):132-140.e15.
3. Academy of Nutrition and Dietetics (Academy)/Commission on Dietetic Registration (CDR). 2018 Code of Ethics

for the Nutrition and Dietetics Profession. Academy website. https://www.eatrightpro.org/practice/code-of-ethics/what-is-the-code-of-ethics. Accessed July 20, 2018.

4. Academy of Nutrition and Dietetics Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. *J Acad Nutr Diet*. 2018;118(1):141-165.

5. Academy of Nutrition and Dietetics Quality Management Committee and Scope of Practice Subcommittee of the Quality Management Committee. Academy of Nutrition and Dietetics Scope of Practice Decision Tool: A self-assessment guide. *J Acad Nutr Diet*. 2013;113 (6 suppl 2):S10.

6. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Operations Manual. Appendix A-Survey protocol, regulations and interpretive guidelines for hospitals (Rev. 176, 12-29-17); §482.12(a)(1) Medical Staff, non-physician practitioners; §482.23(c)(3)(i) Verbal Orders; §482.24(c)(2) Orders. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Accessed July 20, 2018.

7. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Operations Manual. Appendix W-Survey protocol, regulations and interpretive guidelines for critical access hospitals (CAHs) and swing-beds in CAHs (Rev. 165, 12-16-16); §485.635(a)(3)(vii) Dietary Services ; §458.635 (d)(3) Verbal Orders. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf. Accessed July 20, 2018.

8. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. 42 CFR Parts 413, 416, 440 et al. Medicare and Medicaid Programs; Regulatory provisions to promote program efficiency, transparency, and burden reduction; Part II; Final Rule (FR DOC #2014-10687; pp 27106-27157). http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10687.pdf. Accessed July 20, 2018.

9. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs; reform of requirements for long-term care facilities. 42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489. Final Rule (FR DOC#2016; pp 68688-68872) – Federal Register October 4, 2016; 81(192): 68688-68872; §483.30(f)(2) Physician services (pp 65-66), §483.60 Food and Nutrition Services (pp 89-94), §483.5 Definitions (p 161), §483.60 Food and Nutrition Services (pp 177-178). https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities. Accessed July 20, 2018.

10. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Operations Manual. Appendix PP-Guidance to surveyors for long-term care facilities. (Rev. 173, 11-22-17); §483.30 Physician Services, §483.60 Food and Nutrition Services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf. Accessed July 20, 2018.

11. Swan WI, Vivanti A, Hakel-Smith NA, et al. Nutrition Care Process and Model update: Toward realizing people-centered care and outcomes management. *J Acad Nutr Diet*. 2017;117(12):2003-2014.

12. Joint Commission Resources. The Joint Commission Glossary. In: *Comprehensive Accreditation Manual for Hospitals*. Oak Brook, IL: Joint Commission Resources; 2018.

13. Dreyfus HL, Dreyfus SE. *Mind over Machine: The Power of Human Intuition and Expertise in the Era of the Computer*. New York: Free Press; 1986.

14. Academy of Nutrition and Dietetics. Definition of terms list. www.eatrightpro.org/scope. Accessed July 20, 2018.

15. Dorner B, Friedrich EK. Position of the American Academy of Nutrition and Dietetics: Individualized nutrition approaches for older adults: Long-term care, post-acute care, and other settings. *J Acad Nutr Diet*. 2018;118(4):724-735.

16. Medicare Payment Advisory Commission. *Implementing a Unified Payment System for Post-Acute Care: Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPac; 2017: 3-32.

17. Legeer L. Post-Acute Care Integration: Today and in the Future. DHG Healthcare. www2.dhgllp.com/res_pubs/HCG-Post-Acute-Care-Integration.pdf. Accessed July 20, 2018.

18. Becker Hospital Review Staff. Beyond the walls of a hospital—Formalizing a post-acute care strategy for cross-continuum of care. https://www.beckershospitalreview.com/quality/beyond-the-walls-of-a-hospital-formalizing-a-post-acute-care-strategy-for-cross-continuum-care.html. Published August 1, 2017. Accessed July 20, 2018.

19. Mechanic R. Post-acute care—The next frontier for controlling Medicare spending. *N Engl J Med*. 2014;370(8): 692-694. www.nejm.org/doi/full/10.1056/NEJMp1315607. Accessed July 20, 2018.

20. Griffin KM, Gong J. How to build a successful acute/post-acute care continuum. Hospitals & Health Networks website. https://www.hhnmag.com/articles/7194-hospitals-building-a-successful-care-continuum. Published May 19, 2016. Accessed July 20, 2018.

21. Mather M, Jacobsen LA, Pollard KM. Aging in the United States. *Popul Bull*. 2015;70(2). http://www.prb.org/pdf16/aging-us-population-bulletin.pdf. Accessed July 20, 2018.

22. The Society for Post-Acute and Long-Term Care Medicine. AMDA receives $1.6 million to improve care of younger adults. *Caring Ages*. 2014;15(12):22.

23. Huaiquil A. Providers offer Ailing Prisoners a Helping Hand. Provider Long Term & Post-Acute website. http://www.providermagazine.com/archives/2017_Archives/Pages/0217/Providers-Offer-Ailing-Prisoners-A-Helping-Hand.aspx. Published February 2017. Accessed July 20, 2018.

24. American Academy of Family Physicians. Incarceration and health: A family medicine perspective (Position Paper). American Academy of Family Physicians website. http://www.aafp.org/about/policies/all/incarcerationandhealth.html. Published April 2017. Accessed July 20, 2018.

25. Driscoll J. Opportunity knocks for consultant dietitians-aging inmates. Academy of Nutrition and Dietetics: Dietetics in Health Care Communities Dietetic Practice Group. *Connections*. 2016;42(2):21-22.

26. Kaldy J. New care standards come to life. Provider Long Term & Post-Acute Care website. http://www.providermagazine.com/archives/2017_Archives/Pages/1017/New-Care-Standards-Come-to-Light.aspx. Published October 2017. Accessed July 20, 2018.

27. Resources for Integrated Care. Interdisciplinary Care Teams for Older Adults Webinar. Resources for Integrated Care website. https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2017_GCC_Webinar_Series/ICT. Published December 7, 2017. Accessed July 20, 2018.

28. Chen YM, Li YP. Holistic care for the elderly. *Hu Li Za Zhi*. 2004;51(3):7-10.

29. Evans J. Person-centered care and culture change. *Caring Ages*. 2017;18(8):6.

30. Wilkinson R, Arensberg ME, Hickson M, Dwyer JT. Frailty prevention and treatment: Why registered dietitian nutritionists need to take charge. *J Acad Nutr Diet*. 2017;117(7):1001-1009.

31. Kramer A. Navigating the new rule: Changes to quality of care regulations. Provider Long Term & Post-Acute Care website. http://www.providermagazine.com/archives/2017_Archives/Pages/0617/Navigating-the-New-Rule.aspx. Published June 2017. Accessed July 20, 2018.

32. Academy of Nutrition and Dietetics. The IMPACT Act of 2014. Academy of Nutrition and Dietetics website. www.eatrightpro.org/impact. Accessed July 20, 2018.

33. Center for Medicare Advocacy. Discharge planning: Rights and procedures for Medicare beneficiaries in various settings. Center for Medicare Advocacy website. http://www.medicareadvocacy.org/medicare-info/discharge-planning/. Accessed July 20, 2018.

34. Levine C. Hospital Discharge Planning: A Guide for Families and Caregivers. Family Caregiver Alliance: National Center on Care Giving website. https://www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers. Published 2009. Accessed July 20, 2018.

35. Academy of Nutrition and Dietetics Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice and Standards of Professional Performance for Nutrition and Dietetics Technicians, Registered. *J Acad Nutr Diet*. 2018;118(2):317-326.e13.

36. Boyce B. An ethical perspective on palliative care. *J Acad Nutr Diet*. 2017;117(6):970-972.
37. Gillespie L, Raftery AM. Nutrition in palliative and end-of-life care. *Br J Community Nurs*. 2014;19(suppl 7):15-20.
38. Quality Assurance and Professional Performance Improvement. In: Neidert K, Carlson MP, eds. *Nutrition Care of the Older Adult: A Handbook for Nutrition Throughout the Continuum of Care*. 3rd ed. Chicago IL: Academy of Nutrition and Dietetics; 2016.
39. Gallagher-Allred C. Ethics in action: Communication and education for families dealing with end-of-life decisions. *J Acad Nutr Diet*. 2012;112(2):309-310.
40. Schwartz DB. Ethics in action: Ethical decisions for withholding/withdrawing medically assisted nutrition and hydration. *J Acad Nutr Diet*. 2015;115(3):440-443.
41. Jortberg BT, Fleming MO. Registered dietitian nutritionists bring value to emerging health care delivery models. *J Acad Nutr Diet*. 2014;114(12):2017-2022.
42. Neidert K, Carlson MP, eds. *Nutrition Care of the Older Adult: A Handbook for Nutrition Throughout the Continuum of Care*. 3rd ed. Chicago IL: Academy of Nutrition and Dietetics; 2016.
43. Weddle DO, Himburg SP, Collins N, Lewis R. The professional development portfolio process: Setting goals for credentialing. *J Am Diet Assoc*. 2002;102(10):1439-1444.
44. Worsfold L, Grant BL, Barnhill C. The essential practice competencies for the Commission on Dietetic Registration's credentialed nutrition and dietetics practitioners. *J Acad Nutr Diet*. 2015;115(6):978-984.
45. Gates GR, Amaya L. Ethics opinion: Registered dietitian nutritionists and nutrition and dietetics technicians, registered are ethically obligated to maintain personal competence in practice. *J Acad Nutr Diet*. 2015;115(5):811-815.
46. Chambers DW, Gilmore CJ, Maillet JO, Mitchell BE. Another look at competency-based education in dietetics. *J Am Diet Assoc*. 1996;96(6):614-617.
47. Herndon MB, Schwartz LM, Woloshin S, et al. Older patients perceptions of "unnecessary" tests and referrals: A national survey of Medicare beneficiaries. *J Gen Intern Med*. 2008;23(10):1547-1554.
48. Schwartz DB. Enteral nutrition and dementia integrating ethics. *Nutr Clin Pract*. 2018;33(3):377-387.

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AUTHOR CONTRIBUTIONS

Each author contributed to editing the components of the article (eg, article text and figures) and reviewed all drafts of the manuscript.

Standards of Practice for Registered Dietitian Nutritionists in Post-Acute and Long-Term Care (PALTC[a]) Nutrition Standard 1: Nutrition Assessment

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

Rationale:

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

Indicators for Standard 1: Nutrition Assessment					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
1.1	***Patient/client/population history*: Assesses current and past information related to personal, medical, family, and psychosocial/social history**		**X**	**X**	**X**
	1.1A	Evaluates health status and disease condition(s) history for application to nutrition care (eg, cardiovascular disease/stroke/ heart failure; diabetes; underweight/overweight/obesity; kidney disease; cancer; bariatric surgery; and pulmonary disease)	X	X	X
	1.1B	Reviews nutrition risk screening data (eg, malnutrition) from referring facility/provider, if available, or incorporates into nutrition assessment data collection using validated tool	X	X	X
	1.1C	Evaluates psychosocial factors or issues—including family and significant other and social support, cognitive impairment support, presence of depression/anxiety, perceptions of his or her nutrition and disease-related care (eg, cultural, ethnic, religious, and lifestyle factors), and quality of life	X	X	X
	1.1D	Assesses for history of additional complex factors that would impact approach to nutrition care (eg, disordered eating or eating disorder; chronic depression; presence of dementia, mental and/ or behavioral health disorders; and intellectual and developmental disabilities)		X	X
1.2	***Anthropometric assessment*: Assesses anthropometric indicators (eg, height, weight, body mass index [BMI], waist circumference, arm circumference), comparison to reference data, and individual patterns and history**		**X**	**X**	**X**

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Figure 1. Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

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Each RDN:			**Competent**	**Proficient**	**Expert**
	1.2A	Evaluates height, usual body weight, weight as percent of usual body weight, and weight history in comparison to ethnic and appropriate age reference standards such as: • adults ages 18-64 BMI normal range >18.5 to <25 • 65 years and older BMI normal range >23 to <30 (National Quality Forum measure 0421 Preventive Care and Screening: Body Mass Index at www.qualityforum.org)	X	X	X
	1.2B	Estimates and changes anthropometric measurement method used, as appropriate (eg, amputations, degree of paralysis)	X	X	X
	1.2C	Evaluates for insidious/gradual unintended and significant changes in weight and body composition and possible causes	X	X	X
1.3	***Biochemical data, medical tests, and procedure assessment*: Assesses laboratory profiles (eg, acid–base balance, renal function, endocrine function, inflammatory response, vitamin/mineral profile, lipid profile), and medical tests and procedures (eg, gastrointestinal study, metabolic rate)**		**X**	**X**	**X**
	1.3A	Reviews lab results, findings of diagnostic tests/procedures and evaluates relevance to nutritional status using evidence-based criteria (eg, hemoglobin/hematocrit, glucose, hemoglobin A1c, vitamin D, blood lipids, electrolytes, swallow evaluation, barium swallow study, allergen testing)	X	X	X
	1.3B	Reviews and evaluates results of labs/tests/procedures considering: • appropriateness of tests ordered to assess current nutritional status • need for recommendations for additional testing (eg, vitamin/mineral levels post bariatric surgery)	X	X	X
	1.3C	Evaluates organizational practices on tests and procedures used to evaluate nutrition status in relation to current research/best practice in collaboration with the interprofessional[b] team		X	X
	1.3D	Applies critical thinking and experience to interpret tests, procedures and identify data to include in assessment protocols (eg, evaluation and interpretation of changes in sodium, protein, glucose levels)		X	X
	1.3E	Guides organizational practices with medical director and interprofessional team on tests and procedures used to evaluate nutrition and hydration status to reflect evidence-based standards			X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

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Each RDN:				**Competent**	**Proficient**	**Expert**
1.4	***Nutrition-focused physical examination (NFPE) may include visual and physical examination*: Obtains and assesses findings from NFPE (eg, indicators of vitamin/mineral deficiency/toxicity, edema, muscle wasting, subcutaneous fat loss, altered body composition, oral health, feeding ability [suck/swallow/breathe], appetite, and affect)**			**X**	**X**	**X**
	1.4A	Obtains physical assessment data through NFPE, reports of tests and procedures, and transfer forms that include, but is not limited to: identification of malnutrition or risk factors, visual impairments, oral and perioral structures, skin and related structures, swallow function/ability, and alterations in taste, smell, and dentition/chewing ability		X	X	X
	1.4B	Evaluates more complex issues (eg, degree of edema, muscle wasting, subcutaneous fat wasting)			X	X
	1.4C	Evaluates for presence of sarcopenia (eg, hand grip strength, muscle wasting, effect on activities of daily living)			X	X
	1.4D	Monitors use of organization/corporate/system NFPE protocols and tools used with specific populations, and appropriate use; revises and contributes to staff training				X
1.5	***Food and nutrition-related history assessment (ie, dietary assessment)*—Evaluates the following components:**					
	1.5A	**Food and nutrient intake, including the composition and adequacy, meal and snack patterns, and appropriateness related to food allergies and intolerances**		**X**	**X**	**X**
		1.5A1	Reviews food preferences, usual intake of food and fluids, adequacy of intake, and variation from customary intake through visual observation, review of intake records and/or communications with the family/advocate,[c] and interprofessional team	X	X	X
		1.5A2	Determines whether specific food groups are missing in the diet and cause (eg, cultural, religious, economic, behavioral, beliefs, and/or preferences)	X	X	X
		1.5A3	Considers whether food allergies/intolerances/dietary restrictions inhibit adequacy of diet	X	X	X
	1.5B	**Food and nutrient administration including current and previous diets and diet prescriptions and food modifications, eating environment, and enteral and parenteral nutrition administration**		**X**	**X**	**X**

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Each RDN:				**Competent**	**Proficient**	**Expert**
		1.5B1	Reviews history of therapeutic diets used, including enteral and parenteral nutrition and medical indications, and use of medical food supplements for application to nutrition interventions; consults with other care providers as indicated, including home infusion program, if applicable	X	X	X
		1.5B2	Evaluates the current nutrition prescription in relationship to reference standards and dietary guidelines, the client's/resident's health status, needs, wants, and desires	X	X	X
		1.5B3	Evaluates in order to determine level of support needed for self-directed food and fluid selection, attainment, preparation, and intake (eg, support of care providers, adaptive equipment, and literacy tools)		X	X
	1.5C	**Medication and dietary supplement use, including prescription and over-the-counter medications, and integrative and functional medicine products**		**X**	**X**	**X**
		1.5C1	Assesses safety and efficacy of over-the-counter medications and dietary supplements, including herbals, and actual or potential drug/nutrient interactions in consultation with pharmacist, if indicated	X	X	X
		1.5C2	Evaluates integrative and functional medicine usage, safety, and efficacy		X	X
		1.5C3	Reviews medications for nutrition-related side effects (eg, diabetes medication[s] and meal plan in achieving blood glucose goal); and effects on food intake, chewing and swallowing, gastrointestinal function, renal function, fluid balance [edema], and weight changes)		X	X
		1.5C4	Monitors use of protocols and assessment tools for nutrition-related medication management, including food/dietary supplement/drug interaction(s) in collaboration with pharmacist or interprofessional team			X
	1.5D	**Knowledge, beliefs, and attitudes (eg, understanding of nutrition-related concepts, emotions about food/nutrition/health, body image, preoccupation with food and/or weight, readiness to change nutrition- or health-related behaviors, and activities and actions influencing achievement of nutrition-related goals)**		**X**	**X**	**X**

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

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Each RDN:				**Competent**	**Proficient**	**Expert**
		1.5D1	Engages client/resident/advocate to identify personal preferences and goals for nutrition intervention in support of person-centered care	X	X	X
		1.5D2	Evaluates the client's/resident's/advocate's ability to understand concepts (eg, dementia, dysphagia)	X	X	X
		1.5D3	Consider client's/resident's/advocate's ability to understand the risks and benefits of food and beverage choices considering health condition(s)	X	X	X
		1.5D4	With input of advocate, if needed, evaluates client's/ resident's: food preferences, needs, wants, and desires; understanding of the risks and benefits from self-determination of food choices; readiness to learn; and incentive/willingness to accept behavior change	X	X	X
	1.5E	**Food security defined as factors affecting access to a sufficient quantity of safe, healthful food and water, as well as food/ nutrition-related supplies**		**X**	**X**	**X**
		1.5E1	Assesses food and water safety, access, and availability of healthy food/meals (eg, appropriate food preparation resources, family or caregiver available to assist with obtaining/preparing food, if needed, food environment, plans for emergency situations/disaster events)	X	X	X
		1.5E2	Evaluates food selection and preparation ability in conjunction with understanding of health conditions and need for/potential benefits of recommended dietary modifications		X	X
	1.5F	**Physical activity, cognitive and physical ability to engage in developmentally appropriate nutrition-related tasks (eg, self-feeding and other activities of daily living [ADLs]), instrumental activities of daily living (IADLs) (eg, shopping, food preparation)**		**X**	**X**	**X**
		1.5F1	Reviews and evaluates cognitive and physical ability to engage in nutrition-related ADLs (eg, dexterity, self-feeding skills, ability to use adaptive eating devices, and need for assistance with eating and drinking)	X	X	X
		1.5F2	Considers client's/resident's ability to make needs known, adherence to diet prescription, avoidance of foods/ beverages, binging/purging, and/or exhibits food-related behaviors at mealtimes	X	X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

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Each RDN:				**Competent**	**Proficient**	**Expert**
	1.5G	**Other factors affecting intake and nutrition and health status (eg, cultural, ethnic, religious, lifestyle influencers, psychosocial, and social determinants of health)**		**X**	**X**	**X**
		1.5G1	Reviews/evaluates client's/resident's: developmental, functional, and mental status; and food-related beliefs, behaviors, and traditions (eg, cultural, ethnic, family, and lifestyle)	X	X	X
		1.5G2	Reviews/evaluates quality of life/end-of-life choices, including advanced directives and/or preferences relevant to the nutrition plan of care	X	X	X
		1.5G3	Collaborates with other professionals as needed	X	X	X
1.6	***Comparative standards:* Uses reference data and standards to estimate nutrient needs and recommended body weight, BMI, and desired growth patterns**			**X**	**X**	**X**
	1.6A	**Identifies the most appropriate reference data and/or standards (eg, international, national, state, institutional, and regulatory) based on practice setting and patient-/client-specific factors (eg, age, and disease state)**		**X**	**X**	**X**
	1.6B	Refers to reference standards that are appropriate for the population and setting (eg, Academy of Nutrition and Dietetics [Academy] Evidence Analysis Library [EAL] www.andeal.org, *Nutrition Care of the Older Adult* [www.eatright.org/shop], *Unintended Weight Loss in Older Adults Evidence-Based Nutrition Practice Guideline Toolkit*, American Diabetes Association [ADA] Standards of Medical Care in Diabetes [www.diabetes.org]; see Figure 4)		X	X	X
	1.6C	Identifies reference standards to be included in organization's/corporate's/system's assessment tools			X	X
	1.6D	Recognizes and takes the lead in incorporating guidelines from other practice areas (eg, nutrition support, renal, diabetes, weight management, Society for Post-Acute and Long-Term Care [formerly American Medical Directors Association]) into assessment guidelines and practices for PALTC settings in collaboration with interprofessional team				X
1.7	***Physical activity habits and restrictions*: Assesses physical activity, history of physical activity, and physical activity training**			**X**	**X**	**X**

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Each RDN:			**Competent**	**Proficient**	**Expert**
	1.7A	Reviews and evaluates physical activity engaged in by the individual (eg, history, type, intensity, involuntary physical movement) and limitations (eg, vision, mobility, dexterity, medication contraindications)	X	X	X
	1.7B	Assesses ability and interest in participating in physical activity to facilitate rehabilitation, promote wellness, and improve quality of life	X	X	X
1.8	**Collects data and reviews collected and/or documented data by the nutrition and dietetics technician, registered (NDTR), other health care practitioner(s), patient/client/resident, or staff for factors that affect nutrition and health status**		**X**	**X**	**X**
	1.8A	Evaluates multiple factors through interviews, observations, medical records, and interprofessional team communications that contribute to identification of nutrition diagnosis(es): • potential impact of medical and mental health history on current/future health status • general nutrition concerns, such as food allergies, intolerances, preferences; and issues of clinical significance, such as malnutrition, alteration in taste and smell, chewing and/or swallowing; and ability to be independent with dining • client's/resident's or advocate's expressed wishes and preferences	X	X	X
1.9	**Uses collected data to identify possible problem areas for determining nutrition diagnoses**		**X**	**X**	**X**
	1.9A	Assesses evidence-based indicators (eg, lab values, weight status, protein-energy depletion) of nutrition and hydration-related complications for acute and chronic disease states	X	X	X
	1.9B	Identifies more complex nutrition issues related to food intake and clinical conditions (eg, impact of over-the-counter dietary supplement intake; specific diets/food preferences; limited food availability; and/or refusal of modified food texture or liquid consistency order)		X	X
	1.9C	Evaluates the impact of multiple comorbidities on the nutrition plan of care (eg, weight loss, pressure injury/ulcer, obesity, enteral and/or parenteral nutrition feedings, end-stage renal disease [with or without dialysis], and hyperglycemia or hypoglycemia)		X	X

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Each RDN:				**Competent**	**Proficient**	**Expert**
	1.9D	Identifies complex management issues related to food and fluid intake (oral or enteral), clinical complications, and current or anticipated treatment options (eg, potential medication interaction with enteral feeding, nutrient deficiency related to medications, excess fluid intake and labs [serum sodium changes], speech therapy due to altered swallow, and mental health-related food issues) for collaboration with interprofessional team				X
1.10	**Documents and communicates (consistent with regulations and organization standards):**			**X**	**X**	**X**
	1.10A	**Date and time of assessment**		**X**	**X**	**X**
	1.10B	**Pertinent data (eg, medical, social, behavioral)**		**X**	**X**	**X**
		1.10B1	Includes data used to determine current nutrition status (eg, labs, height, weight history, food and fluid intake, medications, drug–nutrient interaction)	X	X	X
	1.10C	**Comparison to appropriate standards (eg, BMI standard for older adults)**		**X**	**X**	**X**
	1.10D	**Patient/client/advocate/population perceptions, values and motivation related to presenting problems**		**X**	**X**	**X**
		1.10D1	Identifies the client's/resident's/advocate's ability/willingness to participate in resolving issues and development of nutrition care plan		X	X
	1.10E	**Changes in patient/client/advocate/population perceptions, values and motivation related to presenting problems**		**X**	**X**	**X**
	1.10F	**Reason for discharge/discontinuation or referral if appropriate**		**X**	**X**	**X**

Examples of Outcomes for Standard 1: Nutrition Assessment

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

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Standard 2: Nutrition Diagnosis
The registered dietitian nutritionist (RDN) identifies and labels specific nutrition problem(s)/diagnosis(es) that the RDN is responsible for treating.
Rationale:
Analysis of the assessment data leads to identification of nutrition problems and a nutrition diagnosis(es), if present. The nutrition diagnosis(es) is the basis for determining outcome goals, selecting appropriate interventions, and monitoring progress. Diagnosing nutrition problems is the responsibility of the RDN.

Indicators for Standard 2: Nutrition Diagnosis					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
2.1	**Diagnoses nutrition problems based on evaluation of assessment data and identifies supporting concepts (ie, etiology, signs, and symptoms)**		**X**	**X**	**X**
	2.1A	Organizes and groups data consisting of medical diagnoses, food and fluid intake data, clinical, physical function, behavioral, environmental, and other assessments to identify signs and symptoms to support the nutrition diagnosis (eg, significant weight loss, physical findings)	X	X	X
	2.1B	Evaluates findings systematically using critical thinking, and experience with the population when formulating the nutrition diagnosis (eg, inadequate energy intake related to 5% weight loss in 1 month); consults with interprofessional team as indicated	X	X	X
	2.1C	Analyzes factors related to food and fluid intake, clinical complications and management within an interprofessional decision making/ planning environment (eg, combination of diabetes, kidney disease, hypertension, neuropathy comorbidities) when formulating a nutrition diagnosis		X	X
2.2	**Prioritizes the nutrition problem(s)/diagnosis(es) based on severity, safety, patient/client needs and preferences, ethical considerations, likelihood that nutrition intervention/plan of care will influence the problem, discharge/ transitions of care needs, and patient/client/advocate perception of importance**		**X**	**X**	**X**
	2.2A	Evaluates assessment data to prioritize nutrition diagnosis(es) considering: • impact/urgency of the identified problems (eg, inadequate energy intake, inadequate oral intake, inadequate fluid intake, excessive carbohydrate intake) • complications of comorbid diseases or conditions (eg, diabetes, hypertension, anemia, chronic kidney disease, gastrointestinal disorders, cerebral vascular accident, urinary tract infection, dysphagia, non-healing pressure injury/ulcer) • client/resident/advocate perception of importance • evidence-based protocols and guidelines	X	X	X

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Indicators for Standard 2: Nutrition Diagnosis					
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Each RDN:			**Competent**	**Proficient**	**Expert**
	2.2B	Considers impact of quality of life preferences and/or end-of-life decisions (eg, risks and benefits, indications for tube feeding, hospice care)		X	X
	2.2C	Guides interprofessional team discussions to address nutrition needs and plans of care for clients/residents with multiple complex care and/or transition of care issues to achieve positive outcomes			X
2.3	**Communicates the nutrition diagnosis(es) to patients/clients/advocates, community, family members, or other health care professionals when possible and appropriate**		**X**	**X**	**X**
	2.3A	Communicates and confirms the nutrition diagnosis(es) using clinical judgment skills (eg, addresses urgent/critical problem(s), reflects wishes of client/resident/advocate, consistent with medical/ treatment care plan)	X	X	X
	2.3B	In addition to medical record documentation, understands and follows organization/program communication protocols and any decision-making pathways for reporting issues of concern to physician and/or interprofessional team, and client/resident or advocate (eg, significant weight loss, refusal of therapeutic diet); seeks assistance, if needed	X	X	X
	2.3C	Participates in developing communication protocols and pathways to meet the organization's/program's standards and work flow of the setting		X	X
2.4	**Documents the nutrition diagnosis(es) using standardized terminology and clear, concise written statement(s) (eg, using Problem [P], Etiology [E], and Signs and Symptoms [S] [PES statement(s)] or Assessment [A], Diagnosis [D], Intervention [I], Monitoring [M], and Evaluation [E] [ADIME statement(s)])**		**X**	**X**	**X**
	2.4A	Presents the nutrition diagnosis as a PES statement (eg, suboptimal/ inadequate oral intake related to difficulty swallowing, as evidenced by significant weight loss of 5% in 30 days)	X	X	X
	2.4B	Documents and explains nutrition diagnosis(es) in order of importance and in a manner that clearly describes the client's/ resident's nutrition status and needs	X	X	X
2.5	**Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available**		**X**	**X**	**X**
	2.5A	Revises nutrition diagnosis(es) as needed, using available information that impacts nutrition diagnosis(es), and communicates change to interprofessional team, and client/resident/advocate as appropriate in a timely manner	X	X	X

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Examples of Outcomes for Standard 2: Nutrition Diagnosis

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

Standard 3: Nutrition Intervention/Plan of Care

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

Rationale:

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

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

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

Indicators for Standard 3: Nutrition Intervention/Plan of Care

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Each RDN:			**Competent**	**Proficient**	**Expert**
Plans the Nutrition Intervention/Plan of Care:					
3.1	**Addresses the nutrition diagnosis(es) by determining and prioritizing appropriate interventions for the plan of care**		**X**	**X**	**X**
	3.1A	Based on nutrition diagnosis(es), considers the following when determining the nutrition interventions: • client's/resident's needs, wants, and desires • immediacy of the problem and severity of nutrition risk or malnutrition, if present • readiness of client/resident to receive selected nutrition interventions • presence of comorbid diseases or conditions that impact nutrition plan (eg, dialysis, dysphagia, heart failure, non-healing pressure injury/ulcer) • transitions of care needs/plans	X	X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

Indicators for Standard 3: Nutrition Intervention/Plan of Care					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	3.1B	Considers non-traditional interventions with integrative and functional therapies, behavior modification, not typically used (eg, access to nocturnal snacks, aromatherapy, music therapy, relaxation techniques, alternative dining venue)		X	X
3.2	**Bases intervention/plan of care on best available research/evidence and information, evidence-based guidelines, and best practices (eg, Academy EAL, Academy Nutrition Care Manual, *Nutrition Care of the Older Adult*, Agency for Healthcare Research and Quality Guidelines, National Commission on Correctional Health Care [www.ncchc.org])** (See Figure 4)		**X**	**X**	**X**
	3.2A	Uses current, evidence-based research knowledge and information about the client/resident population to personalize strategies	X	X	X
	3.2B	Considers policies and standards in planning for risks and benefits of initiating, modifying, or liberalizing therapeutic diet/meal plan or initiation/discontinuation of enteral/parenteral nutrition; recommends a change in nutrition care plan to interprofessional team and/or physician as appropriate[48]	X	X	X
	3.2C	Identifies and uses evidence-based protocols and guidelines to define options to consider for the nutrition care plan	X	X	X
	3.2D	Recognizes when it is appropriate and safe to deviate from established nutrition guidelines and protocols		X	X
	3.2E	Draws on experiential knowledge, clinical judgment, and research to tailor strategy in complicated, unpredictable, unusual situations (eg, non-healing pressure injury/ulcer of morbidly obese client with significant weight loss who is unhappy, not compliant with interventions/plan of care)			X
3.3	**Refers to policies and procedures, protocols, and program standards**		**X**	**X**	**X**
	3.3A	Refers to policies, procedures, and protocols throughout the planning process to promote positive nutrition outcomes while considering client's/resident's preferences/choices	X	X	X
	3.3B	Adapts nutrition protocols as appropriate to facilitate goal achievement consistent with client's/resident's/advocate's choices and treatment plan		X	X
	3.3C	Serves as a resource to other practitioners and the interprofessional team on application of nutrition protocols and guidelines to an individual client/resident or the population			X

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Indicators for Standard 3: Nutrition Intervention/Plan of Care					
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Each RDN:			**Competent**	**Proficient**	**Expert**
3.4	**Collaborates with patient/client/advocate/population, caregivers, interprofessional team, and other health care professionals**		**X**	**X**	**X**
	3.4A	Initiates and directs communication with health care providers, and/or client/resident and/or advocate regarding nutrition care	X	X	X
	3.4B	Makes referrals to other professionals as needed	X	X	X
	3.4C	Organizes and leads communications with the client/resident, advocate, caregiver, family, and acts as nutrition case manager to coordinate and organize care, plan for discharge, in collaboration with the interprofessional team		X	X
	3.4D	Collaborates with community providers (eg, dialysis center, wound center) on standards of care and procedures to incorporate in organization/program treatment plans and nutrition care plans, if applicable; and for safe home discharge (eg, home care provider, home delivered meals)			X
3.5	**Works with patient/client/advocate/population and caregivers in support of person-centered care to identify goals, preferences discharge/transitions of care needs, plan of care, and expected outcomes**		**X**	**X**	**X**
	3.5A	Considers clinical and health status, client/resident ability to participate in care process and shared decision making, client's/resident's/advocate's wishes and goals (eg, weight status, fluid and electrolyte balance, prevention of infection, development and resolution of symptoms, and quality of life); seeks additional information and input from interprofessional team, if needed	X	X	X
	3.5B	Engages client/resident/advocate in identifying nutrition goals, care plan, and outcomes that reflect client/resident needs and wishes and identified nutrition diagnosis(es) (eg, client/resident will gain 1 lb in the next 30 days)	X	X	X
	3.5C	Explains to client/resident/advocate the risks and benefits of the nutrition care options; obtains guidance from more experienced practitioner, if needed	X	X	X
	3.5D	Recognizes need to look beyond first impression to evaluate client's/resident's ability to participate in care process; and consults with advocate/caregiver, if needed, to individualize care to maximize outcomes and client's/resident's quality of life, satisfaction with nutrition care, including food/dining experience	X	X	X

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Indicators for Standard 3: Nutrition Intervention/Plan of Care					
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Each RDN:			**Competent**	**Proficient**	**Expert**
	3.5E	Addresses with client/resident and/or advocate the risks/burdens and benefits of nutrition and hydration or withholding/ withdrawing enteral/parenteral nutrition when applicable; collaborates with interprofessional team or more experienced practitioner, if needed[48]	X	X	X
	3.5F	Provides guidance to interprofessional team for clients/residents with complex nutrition care needs, including end-of-life care to facilitate integrated care interventions that maximize care outcomes and quality of life goals in support of client/resident autonomy		X	X
3.6	**Develops the nutrition prescription and establishes measurable patient-/ client-focused goals to be accomplished**		**X**	**X**	**X**
	3.6A	Selects specific intervention strategies that are focused on etiology of the problem(s), treatment/care goals, and client/resident/ advocate wishes: • considers condition-specific food/nutrition requirements (eg, dysphagia, food intolerances, allergies, diabetes meal planning approach [eg, carbohydrate counting, carbohydrate controlled], diet liberalization, pressure injuries/ulcers, unintentional weight loss) • addresses nutritional needs (ie, energy, protein, fluid, vitamins, and minerals, as indicated) including enteral or parenteral nutrition formula in collaboration with pharmacist, if indicated • individualizes for least-restrictive meal plan, including food-first plan, snacks, and/or medical nutrition supplement, and identifies nutrition counseling/education needed; • information that may be needed for client/resident returning home or to be followed in the home setting; seeks assistance, if needed	X	X	X
	3.6B	Considers pharmacotherapy and impact on meal plan (ie, timing of meals and snacks, diabetes medication [oral, insulin and type], dietary adjustments for anticoagulant medication, if needed)	X	X	X
	3.6C	Considers the educational needs of the client/resident/advocate or caregiver, taking into account cultural competency, health literacy, food access, and preparation skills, if applicable to achieve person-centered goals	X	X	X
	3.6D	Develops discharge nutrition care and education plan and provides education materials to improve the care of clients/residents as they transition from PALTC setting to home or another PALTC setting (eg, home care agency with home delivered meals, or home infusion therapy)	X	X	X

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Indicators for Standard 3: Nutrition Intervention/Plan of Care					
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Each RDN:			**Competent**	**Proficient**	**Expert**
	3.6E	Identifies or develops, and provides nutrition education materials, booklets, or programs to address client/resident needs for safe transition to home (eg, preparing mechanically altered food/fluids safely/correctly; enteral feeding information; ready-to-use products for use as supplementation)		X	X
3.7	**Defines time and frequency of care including intensity, duration, and follow-up**		**X**	**X**	**X**
	3.7A	Identifies time and frequency of care based on client/resident needs, established goals and outcomes, and expected response to interventions(s) reflecting organization/program accreditation standards and/or regulations	X	X	X
	3.7B	Provides or develops guidelines reflecting regulations, practice guidelines, organization/program standards to orient new and/or entry-level staff (eg, RDN, NDTR, certified dietary manager, dining service supervisor, or other staff)		X	X
3.8	**Uses standardized terminology for describing interventions**		**X**	**X**	**X**
3.9	**Identifies resources and referrals needed**		**X**	**X**	**X**
	3.9A	Identifies resources to assist the client/resident/advocate in using educational services and community programs appropriately to meet needs (eg, support groups, health care services, meal programs, evidence-based websites)	X	X	X
	3.9B	Identifies referrals needed to assist the client/resident/advocate with care-related issues (eg, financial, psychological, functional status, therapy services [physical, occupational, and/or speech], mental health [psycho/social, addictions, eating disorders])	X	X	X
	3.9C	Creates a list of nutrition and other resources specific to client/resident population in collaboration with interprofessional team members to support education and transitions of care/support from the community		X	X
Implements the Nutrition Intervention/Plan of Care:					
3.10	**Collaborates with colleagues, interprofessional team, and other health care professionals**		**X**	**X**	**X**
	3.10A	Determines communication process for program/setting relative to diet order or other nutrition intervention recommendations when delegated orders do not apply	X	X	X
	3.10B	Contributes to plan of care, guides nutrition components, and determines needs and plans for discharge or transition of care to another organization/setting when applicable	X	X	X

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Indicators for Standard 3: Nutrition Intervention/Plan of Care						
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Each RDN:				**Competent**	**Proficient**	**Expert**
	3.10C	Facilitates and fosters active communication, learning, partnerships, and collaboration with interprofessional team and others as appropriate			X	X
	3.10D	Identifies and seeks out opportunities for interprofessional and interagency collaboration, specific to client's/resident's needs				X
3.11	**Communicates and coordinates the nutrition intervention/plan of care**			**X**	**X**	**X**
	3.11A	Ensures that client/resident and, as appropriate, family/advocate/caregivers, understands and can articulate goals and other relevant aspects of care plan and nutrition interventions		X	X	X
	3.11B	Ensures communication of nutrition intervention/plan of care and transfer of nutrition-related data between care settings (eg, acute care, home health, community services)		X	X	X
	3.11C	Collaborates with interprofessional team and other agencies to coordinate nutrition care (eg, referring organization nutrition staff, home health, home infusion program, dialysis center, group home)			X	X
	3.11D	Using experience and knowledge of population, recognizes when there may be multiple factors contributing to the client's/resident's perspective and willingness to participate in care decisions/recommendations, and facilitates referral(s) to appropriate team member, if indicated				X
3.12	**Initiates the nutrition intervention/plan of care**			**X**	**X**	**X**
	3.12A	**Uses approved clinical privileges, physician/non-physician practitioner[d]-driven orders (ie, delegated orders), protocols, or other facility-specific processes for order writing or for provision of nutrition-related services consistent with applicable specialized training, competence, medical staff[e]/medical director, and/or organizational policy**		**X**	**X**	**X**
		3.12A1	**Implements, initiates, or modifies orders for therapeutic diet, nutrition-related pharmacotherapy management, or nutrition-related services (eg, medical foods/nutrition/dietary supplements, food texture modifications, enteral and parenteral nutrition, intravenous fluid infusions, laboratory tests, medications, and education and counseling)**	**X**	**X**	**X**
		3.12A2	**Manages nutrition support therapies (eg, formula selection, rate adjustments, addition of designated medications and vitamin/mineral supplements to parenteral nutrition solutions or supplemental water for enteral nutrition)**	**X**	**X**	**X**

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Indicators for Standard 3: Nutrition Intervention/Plan of Care							
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Each RDN:					**Competent**	**Proficient**	**Expert**
			3.12A2i	Consistent with delegated orders, if applicable, or organization/program guidelines, regulations, and physician orders, manages or oversees care for clients/residents receiving enteral or parenteral nutrition in collaboration with physician or interprofessional team; seeks assistance, if needed	X	X	X
		3.12A3		**Initiates and performs nutrition-related services (eg, bedside swallow screenings, inserting and monitoring nasoenteric feeding tubes, and indirect calorimetry measurements, or other permitted services)**	**X**	**X**	**X**
	3.12B			Uses interpersonal teaching, coaching, counseling, and/or technological approaches, tools, materials, and aids as appropriate to meet client's/resident's/advocate's needs	X	X	X
	3.12C			Uses knowledge regarding the population's unique needs and implements the plan of person-centered nutrition care based on client's/resident's/advocate's needs, goals, preferences, priorities, and willingness for change	X	X	X
	3.12D			Uses analytical and critical thinking skills to prioritize nutrition interventions and plans that: • consider client's/resident's/advocate's specific needs consistent with goals preferences, and willingness for change • tailor nutrition intervention to the cognitive stage of the client/resident when making changes to the interventions • combine multiple approaches to provide guidance to achieve desired outcomes	X	X	X
	3.12E			Uses knowledge of the population and environment to develop creative approaches for clients/residents with multiple or complex care issues to meet needs and preferences for desirable outcomes		X	X
3.13	**Assigns activities to NDTR and other professional, technical, and support personnel in accordance with qualifications, organizational policies/ protocols, and applicable laws and regulations**				**X**	**X**	**X**
	3.13A	**Supervises professional, technical, and support personnel**			**X**	**X**	**X**
	3.13B			Provides professional, technical, support personnel with information and guidance needed to complete assigned activities	X	X	X
	3.13C			Monitors accuracy and completion of activities to assure compliance with program/organization quality standards and applicable regulations		X	X

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Indicators for Standard 3: Nutrition Intervention/Plan of Care						
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Each RDN:				**Competent**	**Proficient**	**Expert**
3.14	**Continues data collection**			**X**	**X**	**X**
	3.14A	Collaborates with interprofessional team in the collection of pertinent data, such as changes in food and fluid intakes, labs, skin condition, advance directives, and weights		X	X	X
	3.14B	Coordinates data and insight from other interprofessional team members to reflect on client's/resident's progress and potential need for change in nutrition care, meal plan, and/or discharge/transitions of care plan		X	X	X
3.15	**Documents:**					
	3.15A	**Date and time**		**X**	**X**	**X**
	3.15B	**Specific and measurable treatment goals and expected outcomes**		**X**	**X**	**X**
	3.15C	**Recommended interventions**		**X**	**X**	**X**
	3.15D	**Patient/client/advocate/caregiver/community receptiveness**		**X**	**X**	**X**
		3.15D1	Client/resident preferences/informed choices influencing optimal nutritional outcomes (eg, declines thickened liquids)	X	X	X
	3.15E	**Referrals made and resources used**		**X**	**X**	**X**
	3.15F	**Patient/client/advocate/caregiver/community comprehension**		**X**	**X**	**X**
		3.15F1	Understanding/comprehension of risks and benefits	X	X	X
	3.15G	**Barriers to change**		**X**	**X**	**X**
		3.15G1	Influencing factors or barriers affecting ability and/or willingness to implement and adhere to nutrition care plan (eg, living environment, psychosocial factors, emotional intelligence, cognitive impairment, change in mental or physical ability, financial status)	X	X	X
	3.15H	**Other information relevant to providing care and monitoring progress over time**		**X**	**X**	**X**
	3.15I	**Plans for follow-up and frequency of care**		**X**	**X**	**X**
	3.15J	**Rationale for discharge or referral, if applicable**		**X**	**X**	**X**

Examples of Outcomes for Standard 3: Nutrition Intervention

- Goals and expected outcomes are appropriate and prioritized
- Patient/client/advocate/population, caregivers, and interprofessional teams collaborate and are involved in developing nutrition intervention/plan of care

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- Appropriate individualized patient/client-centered nutrition intervention/plan of care, including nutrition prescription, is developed
- Nutrition intervention/plan of care is delivered, and actions are carried out as intended
- Discharge planning/transitions of care needs are identified and addressed
- Documentation of nutrition intervention/plan of care is:
  - Specific
  - Measurable
  - Attainable
  - Relevant
  - Timely
  - Comprehensive
  - Accurate
  - Dated and Timed

Standard 4: Nutrition Monitoring and Evaluation

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

Rationale:

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

Indicators for Standard 4: Nutrition Monitoring and Evaluation						
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Each RDN:				**Competent**	**Proficient**	**Expert**
4.1	**Monitors progress:**			**X**	**X**	**X**
	4.1A	**Assesses patient/client/advocate/population understanding and compliance with nutrition intervention/plan of care**		**X**	**X**	**X**
		4.1A1	Determines barriers to understanding that are present and impacting the client's/resident's/advocate's acceptance of the nutrition intervention/plan of care	X	X	X
	4.1B	**Determines whether the nutrition intervention/plan of care is being implemented as prescribed**		**X**	**X**	**X**
		4.1B1	Reviews the medical record documentation and consults with interprofessional team to determine whether recommendations have been acted upon and, if not, reason/rationale documented	X	X	X

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Indicators for Standard 4: Nutrition Monitoring and Evaluation						
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Each RDN:				**Competent**	**Proficient**	**Expert**
		4.1B2	Observes and discusses with client/resident/advocate and consults with staff for input to gain ideas for adjusting interventions to achieve desired outcomes	X	X	X
		4.1B3	Determines whether tools and methods need to be tailored to ensure desired outcomes		X	X
4.2	**Measures outcomes:**			**X**	**X**	**X**
	4.2A	**Selects the standardized nutrition care measurable outcome indicator(s)**		**X**	**X**	**X**
		4.2A1	Reviews and evaluates assessment data and the PES statement(s) to identify indicators and data for monitoring consistent with resolving the nutrition diagnosis and/or for monitoring status	X	X	X
		4.2A2	Uses multiple data sources to assess progress Examples include: • adequacy of food/nutrient intake from all sources • changes in body weight, composition • laboratory and other test results • positive/negative effects of pertinent medications and dietary supplements • changes in cognitive and functional status • changes in skin integrity	X	X	X
		4.2A3	Monitors food intake, changes in appetite, and decreased ADLs when evaluating for unintentional weight loss	X	X	X
		4.2A4	Considers client/resident-centered outcomes (eg, quality of life, functional status, socialization)	X	X	X
		4.2A5	Examines comorbidities related to the nutritional needs of the client/resident when progress not achieved (eg, blood glucose outside goal range, non-healing pressure injury/ulcer, continued unplanned weight loss)	X	X	X
	4.2B	**Identifies positive or negative outcomes, including impact on potential needs for discharge/transitions of care**		**X**	**X**	**X**
		4.2B1	Documents progress in meeting desired goals (eg, weight gain or maintenance/loss, improved meal/snack/supplement intake, increased physical activity)	X	X	X
		4.2B2	Evaluates positive and/or negative effects related to interventions, complex problems, and related comorbidities		X	X

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Indicators for Standard 4: Nutrition Monitoring and Evaluation						
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Each RDN:				**Competent**	**Proficient**	**Expert**
		4.2B3	Uses knowledge of the population, experience, and critical thinking in evaluating complex changes in condition, impact of interventions, and other factors on achievement of outcomes			X
4.3	**Evaluates outcomes:**			**X**	**X**	**X**
	4.3A	**Compares monitoring data with nutrition prescription and established goals or reference standard (eg, Academy EAL, *Unintended Weight Loss in the Older Adults Evidence-Based Nutrition Practice Guideline Toolkit, Nutrition Care of the Older Adult*)**		**X**	**X**	**X**
		4.3A1	Completes a comprehensive analysis of the indicators for each problem referencing protocols and reference standards, client's/resident's/advocate's goals, and determines change in interventions as needed		X	X
		4.3A2	Evaluates impact of client's/resident's right to self-determination and its effect on the planned interventions and achieving desired health outcomes and/or quality of life		X	X
	4.3B	**Evaluates impact of the sum of all interventions on overall patient/client/population health outcomes and goals**		**X**	**X**	**X**
		4.3B1	Assesses need for continuation of interventions based on outcomes and clinical data (eg, weight now within normal limits necessitating re-evaluation of need for supplement) with interprofessional team		X	X
		4.3B2	Completes analysis and trending of indicators to evaluate complexity of problems and correlates one problem to another using advanced clinical judgment skills (eg, dialysis client/resident on therapeutic diet who persistently frequents the vending machines)			X
	4.3C	**Evaluates progress or reasons for lack of progress related to problems and interventions (eg, emotional, social, cognitive, behavioral, environmental)**		**X**	**X**	**X**
		4.3C1	Evaluates subjective responses from client/resident/advocate and interprofessional team members; uses critical thinking skills to identify progress consistent with goals and seeks assistance as needed	X	X	X

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Indicators for Standard 4: Nutrition Monitoring and Evaluation						
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Each RDN:				**Competent**	**Proficient**	**Expert**
		4.3C2	Recognizes problems that are beyond the scope of nutrition that are interfering with interventions and achieving desired outcomes; makes referrals or consults with interprofessional team to address issues		X	X
		4.3C3	Leads discussions with interprofessional team to address needs and plans for client/resident with complex needs (eg, non-healing stage IV pressure ulcer)			X
	4.3D	**Evaluates evidence that the nutrition intervention/plan of care is maintaining or influencing a desirable change in the patient/ client/ population behavior or status**		**X**	**X**	**X**
		4.3D1	Monitors and interprets laboratory and other data that may reflect a change in the client/resident behavior or status	X	X	X
		4.3D2	Evaluates factors (physical, social, cognitive, environmental) that may influence response to nutrition intervention and consults with interprofessional team as needed	X	X	X
	4.3E	**Supports conclusions with evidence**		**X**	**X**	**X**
4.4	**Adjusts nutrition intervention/plan of care strategies, if needed, in collaboration with patient/client/population/advocate/caregiver and interprofessional team**			**X**	**X**	**X**
	4.4A	**Improves or adjusts intervention/plan of care strategies based upon outcomes data, trends, best practices, and comparative standards**		**X**	**X**	**X**
	4.4B	Consults with interprofessional team when nutrition outcomes are not being achieved to gain ideas for addressing with client/resident/ advocate and potentially for adjusting nutrition plan		X	X	X
	4.4C	Adjusts intervention strategies such as change in living/care situation; seeks assistance, if needed		X	X	X
	4.4D	Educates/counsels client/resident/advocate on the risks and benefits of suggested changes, of refusal, and offers alternative interventions		X	X	X
	4.4E	Makes adjustments in unpredictable situations (eg, death of spouse/ family member/close friend)			X	X
	4.4F	Leads in analysis of data and discussions with interprofessional team when outcomes are not achieved to revise nutrition diagnosis and plan/interventions			X	X

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

Indicators for Standard 4: Nutrition Monitoring and Evaluation					
Bold Font Indicators are Academy Core RDN Standards of Practice Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
4.5	**Documents:**		**X**	**X**	**X**
	4.5A	**Date and time**	**X**	**X**	**X**
	4.5B	**Indicators measured, results, and the method for obtaining measurement**	**X**	**X**	**X**
	4.5C	**Criteria to which the indicator is compared (eg, nutrition prescription/goal or a reference standard)**	**X**	**X**	**X**
	4.5D	**Factors facilitating or hampering progress** Examples: • change in clinical, health status, or functional outcomes • change in client/resident level of understanding and food-related behaviors • self-determination decision by client/resident/advocate affecting acceptance of nutrition interventions • change in family situation, advocate, caregiver	**X**	**X**	**X**
	4.5E	**Other positive or negative outcomes**	**X**	**X**	**X**
	4.5F	**Adjustments to the nutrition intervention/plan of care, if indicated**	**X**	**X**	**X**
	4.5G	Communications with physician and/or interprofessional team	X	X	X
	4.5H	**Future plans for nutrition care, nutrition monitoring, and evaluation, follow-up, referral, transition to home, another setting, or discharge**	**X**	**X**	**X**

Examples of Outcomes for Standard 4: Nutrition Monitoring and Evaluation

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

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Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

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

[a]**PALTC:** *Post-Acute and Long-Term Care (PALTC)* is a continuum of care provided by community-based settings that can include long-term acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospice, assisted living facilities, corrections facilities, and other settings.

[b]**Interprofessional:** The term *interprofessional* (also refers to interdisciplinary or multidisciplinary) is used in this evaluation resource as a universal term. It includes a diverse group of team members (eg, physicians, nurses, dietitian nutritionists, pharmacists, psychologists, social workers, and speech, occupational and physical therapists, dentist, wound specialist, dialysis center staff, home care or hospice staff, nutrition and dietetics technician, registered, nursing assistant, certified dietary manager, dining service staff), depending on the needs of the client/resident/advocate.

[c]**Advocate:** An *advocate* is a person who provides support and/or represents the rights and interests at the request of the resident/patient/client. The person may be a family member or an individual not related to the individual (surrogate decision maker) who is asked to support the individual with activities of daily living or is legally designated to act on behalf of the individual, particularly when the individual has lost decision making capacity. (Adapted from definitions within The Joint Commission Glossary of Terms[12] and the Centers for Medicare and Medicaid Services, Hospital Conditions of Participation[6]). Advocate could also mean surrogate decision maker.

[d]**Non-physician practitioner:** A *non-physician practitioner* includes physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, qualified dietitian or qualified nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[6,7] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services Long-Term Care (LTC) Regulations. With publication of the Final Rule revising the Conditions of Participation for LTC facilities effective November 2016, post-acute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutrition supplements or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law, and organization policies.[9,10]

[e]**Medical staff:** *Medical staff* is composed of doctors of medicine or osteopathy and may in accordance with state law, including scope of practice laws, include other categories of physicians, and non-physician practitioners who are determined to be eligible for appointment by the governing body.[6]

Figure 1. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. The terms *patient, client, resident, inmate, individual, person, group* or *population* are used interchangeably with the actual term used in a given situation dependent on the setting and the population receiving care or services. Completed assessments follow federal and state regulations, and organization/facility guidelines (ie, timeframes, documentation requirements, information reporting to interprofessional team for care plan development/revision, transition of setting note).

Standards of Professional Performance for Registered Dietitian Nutritionists in Post-Acute and Long-Term Care (PALTC) Nutrition

Standard 1: Quality in Practice

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

Rationale:

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

Indicators for Standard 1: Quality in Practice					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
1.1	**Complies with applicable laws and regulations as related to his/her area(s) of practice**		**X**	**X**	**X**
	1.1A	Participates on state regulatory boards to create regulations that may impact future PALTC[a] nutrition practice		X	X
1.2	**Performs within individual and statutory scope of practice and applicable laws and regulations**		**X**	**X**	**X**
	1.2A	Incorporates scope of practice, defined by state and federal rules and regulations, accreditation, or other applicable standards in PALTC; reviews and assures job description/contract specifications comply with defined scope of practice, identified role, and professional responsibilities	X	X	X
	1.2B	Follows scope of practice requirements related to additional credentialing or employment position (eg, Board Certification as a Specialist in Gerontological Nutrition [CSG], Board Certification as a Specialist in Renal Nutrition [CSR], and/or Certified Diabetes Educator [CDE])		X	X
1.3	**Adheres to sound business and ethical billing practices applicable to the role and setting**		**X**	**X**	**X**
	1.3A	Develops an understanding of the payment and reimbursement environment for PALTC settings (eg, Medicare and Medicaid Services)	X	X	X
	1.3B	Complies with organization position description and processes; or consultant contract that contributes to accurate budgeting and data reporting, for example: • employee: hours and other required information • consultant: services provided and hours • client/resident care documentation in medical record (electronic or manual) • other processes used to report actions or recommendations	X	X	X

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Figure 2. Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 1: Quality in Practice					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	1.3C	Provides organization with data and requested information to support documentation for value-based payment system; seeks assistance if needed	X	X	X
	1.3D	Develops and follows recognized, and ethical business practices for PALTC settings. Practices include for example: • contract(s) that outline services, deliverables, fees, and billing processes with PALTC setting • contract(s) with RDN provider(s) or others who are independent contractors, providing contracted services for PALTC setting		X	X
1.4	**Uses national quality and safety data (eg, National Academies of Sciences, Engineering, and Medicine: Health and Medicine Division, National Quality Forum [NQF], Institute for Healthcare Improvement, National Institutes of Health, Centers for Disease Control and Prevention) to improve the quality of services provided and to enhance customer-centered service**		**X**	**X**	**X**
	1.4A	Educates interprofessional[b] team on pertinent quality and safety initiatives (eg, food safety, International Dysphagia Diet Standardization Initiative)		X	X
	1.4B	Identifies local/state/national quality initiative efforts to support PALTC nutrition goals and best practices		X	X
	1.4C	Leads local/state/national and/or international quality initiative efforts to support PALTC nutrition goals and best practices			X
	1.4D	Leads interprofessional performance improvement initiatives within the organization			X
1.5	**Uses a systematic performance improvement model that is based on practice knowledge, evidence, research, and science for delivery of the highest-quality services**		**X**	**X**	**X**
	1.5A	Participates in quality management (eg, quality assurance performance improvement [QAPI]) activities, including identifying performance improvement criteria, training, mentoring, data collection, evaluation of performance, and implementation of corrective actions	X	X	X
	1.5B	Develops implementation strategies for quality management activities (eg, identification/adoption of evidence-based practice guidelines/protocols, skills training/reinforcement, organizational support)		X	X
	1.5C	Leads interprofessional performance improvement initiative(s) across the organization or system			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 1: Quality in Practice						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
1.6	**Participates in or designs an outcomes-based management system to evaluate safety, effectiveness, quality, person-centeredness, equity, timeliness, and efficiency of practice**			**X**	**X**	**X**
	1.6A	**Involves colleagues and others, as applicable, in systematic outcomes management**		**X**	**X**	**X**
		1.6A1	Assists interprofessional team and other staff with development and implementation of appropriate quality measures for nutrition and dietetics care and services	X	X	X
	1.6B	**Defines expected outcomes**		**X**	**X**	**X**
		1.6B1	Identifies quality outcome indicators to measure (eg, Centers for Medicare and Medicaid Services [CMS], NQF, organization-specific measures)		X	X
	1.6C	**Uses indicators that are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)**		**X**	**X**	**X**
		1.6C1	Selects criteria for data collection, and advocates for and participates in the development of data collection tools (eg, clinical, operational, and financial)		X	X
	1.6D	**Measures quality of services in terms of structure, process, and outcomes**		**X**	**X**	**X**
		1.6D1	Uses and/or develops systematic quality improvement approach to collect data from multiple sources to measure quality of services against desired outcomes	X	X	X
		1.6D2	Routinely assesses current services using culturally competent engagement processes considering identified performance criteria to evaluate nutrition care and services		X	X
		1.6D3	Seeks out and uses or adapts, existing systems for evaluating nutrition and food/dining service structures, processes, and outcomes specific to the population and setting		X	X
		1.6D4	Leads the development, monitoring, and evaluation of practice-specific benchmarks for use in evaluating nutrition quality of care and services			X
	1.6E	**Incorporates electronic clinical quality measures to evaluate and improve care of patients/clients at risk for malnutrition or with malnutrition** (www.eatrightpro.org/emeasures)		**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 1: Quality in Practice						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		1.6E1	Using clinical quality measures applicable to setting, collects data on patient/client population risk factors, screening timeframes, number at risk or with malnutrition, and services provided (eg, nutrition assessment, menu adjustments, enteral or parenteral nutrition, discharge plan, post-discharge services)	X	X	X
	1.6F	**Documents outcomes and patient-reported outcomes (eg, PROMIS[c])**		**X**	**X**	**X**
		1.6F1	Documents outcomes per organization procedure, and participates in evaluation and reporting	X	X	X
		1.6F2	Evaluates customer and service outcomes using identified criteria (eg, weight loss, number of pressure injuries/ulcers) to reinforce current practices or implement changes in care practices or services		X	X
		1.6F3	Synthesizes and publishes effectiveness outcomes on programs and services			X
	1.6G	**Participates in, coordinates, or leads program participation in local, regional or national registries and data warehouses used for tracking, benchmarking, and reporting service outcomes**		**X**	**X**	**X**
		1.6G1	Actively promotes the inclusion of RDN-provided medical nutrition therapy and PALTC nutrition service components in local, regional, state, and/or national data registries		X	X
1.7	**Identifies and addresses potential and actual errors and hazards in provision of services or brings to attention of supervisors and team members as appropriate**			**X**	**X**	**X**
	1.7A	Evaluates and ensures safe PALTC food and/or nutrition services; seeks assistance as needed		X	X	X
	1.7B	Conducts and documents nutrition care and/or food/dining service audits at least monthly or per organization policy to identify performance deficiencies; works with organization staff to reduce errors and hazards		X	X	X
	1.7C	Identifies industry wide trends in food and nutrition deficiency areas to guide organization or foodservice practices to prevent errors			X	X
	1.7D	Contributes to developing systems to problem-solve and prevent errors (eg, medication and food/dietary supplement interactions, infection control, hyperglycemia, and hypoglycemia) in collaboration with interprofessional team			X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 1: Quality in Practice						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	1.7E	Prioritizes identified issues (eg, food safety) and with organization leaders develops a plan of correction			X	X
	1.7F	Leads interprofessional team in root-cause analysis of errors and hazards and persistent problems impacting achieving desired outcomes				X
1.8	**Compares actual performance to performance goals (ie, Gap Analysis, SWOT [Strengths, Weaknesses, Opportunities, and Threats] Analysis, PDCA [Plan-Do-Check-Act] Cycle, DMAIC [Define, Measure, Analyze, Improve, Control])**			**X**	**X**	**X**
	1.8A	**Reports and documents action plan to address identified gaps in care and/or service performance**		**X**	**X**	**X**
		1.8A1	Develops or revises plan of action in association with customers served, organization staff to meet expected outcomes		X	X
	1.8B	Benchmarks organizational performance with national programs and referring organization(s) standards				X
1.9	**Evaluates interventions and workflow process(es) and identified service and delivery improvements**			**X**	**X**	**X**
	1.9A	Participates in or conducts data analysis as part of quality management (eg, QAPI); develops or contributes to report of outcomes, and provides recommendations		X	X	X
	1.9B	Analyzes data and synthesizes results of action plans in reaching customer and organization/program outcome goals; communicates to key stakeholders			X	X
	1.9C	Guides the development, testing, and redesign of organization/program evaluation systems				X
1.10	**Improves or enhances patient/client/population care and/or services working with others based on measured outcomes and established goals**			**X**	**X**	**X**
	1.10A	Systematically improves processes of nutrition care and services by identifying problem areas and recommending new/updated quality/safe practices			X	X
	1.10B	Investigates and develops or improves system processes and programs that support best practices in nutrition; shares within PALTC community through presentations and publications				X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Examples of Outcomes for Standard 1: Quality in Practice

- Actions are within scope of practice and applicable laws and regulations
- National quality standards and best practices are evident in customer-centered services
- Performance improvement program specific to program(s)/service(s) is established and updated as needed; is evaluated for effectiveness in providing desired outcomes data and striving for excellence in collaboration with other team members
- Performance indicators are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)
- Aggregate outcomes results meet pre-established criteria
- Quality improvement results direct refinement and advancement of practice

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

Indicators for Standard 2: Competence and Accountability					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
2.1	**Adheres to the codes of ethics (eg, Academy of Nutrition and Dietetics (Academy)/Commission on Dietetic Registration (CDR), other national organizations, and/or employer code of ethics)**		**X**	**X**	**X**
2.2	**Integrates the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) into practice, self-evaluation, and professional development**		**X**	**X**	**X**
	2.2A	**Integrates applicable focus area(s) SOP and/or SOPP into practice (eg, diabetes care, renal nutrition, nutrition support, management of food and nutrition systems) (www.eatrightpro.org/sop)**	**X**	**X**	**X**
	2.2B	Understands and uses the SOP and SOPP for RDNs in PALTC Nutrition; identifies areas in own practice to target for additional learning and skill development for quality practice and advancement	X	X	X
	2.2C	Reviews and recommends, or updates organization/program policies, guidelines, and/or human resource materials reflecting the SOP SOPP for RDNs in PALTC Nutrition, other focus areas; seeks assistance and approvals if needed		X	X
	2.2D	Uses practice experience and knowledge to define specific actions for levels of practice (competent, proficient, expert) reflecting the SOP and SOPP for RDNs in PALTC Nutrition			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 2: Competence and Accountability						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	2.2E		Develops and/or facilitates staff orientation/training on corporate/organizational policies, guidelines, human resources policies and resources (eg, job-related competencies, acceptable performance levels) using applicable SOP and/or SOPP and other relevant setting or population-specific resources as a guide			X
2.3	**Demonstrates and documents competence in practice and delivery of customer-centered service(s)**			**X**	**X**	**X**
	2.3A		Displays professionalism and strives for improvement in practice (eg, manages change effectively; demonstrates assertiveness, listening, and conflict resolution skills; demonstrates ability to build coalitions)	X	X	X
	2.3B		Documents examples of expanded professional responsibility reflective of level of practice (eg, QAPI leadership responsibilities, corporate-/system-level role(s), state and/or national advisory board participation)		X	X
2.4	**Assumes accountability and responsibility for actions and behaviors**			**X**	**X**	**X**
	2.4A		**Identifies, acknowledges, and corrects errors**	**X**	**X**	**X**
2.5	**Conducts self-evaluation at regular intervals**			**X**	**X**	**X**
	2.5A		**Identifies needs for professional development**	**X**	**X**	**X**
		2.5A1	Self-evaluates current practice, needs of work setting(s), and goals for professional growth to consider for future educational/development needs. Considers: • new/expanded knowledge/skills needed for role and responsibilities and achieving outcomes • results of any organization/program accreditation or licensing surveys with implications for nutrition and/or food/dining services when applicable • new knowledge/skills or training for professional growth to achieve future goals (eg, training on performance improvement techniques, participating in scholarly review of professional articles, serving as a reviewer of professional or lay articles or publications, participating in an Evidence Analysis Library (EAL] workgroup)	X	X	X
		2.5A2	Applies self-evaluation findings to strengthen professional development for consistency with evidence-based guidelines, best practices, and current research findings	X	X	X
		2.5A3	Seeks formal/informal feedback from colleagues, members of interprofessional teams, and supervisors to identify development needs and continuing education resources	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 2: Competence and Accountability						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
2.6	**Designs and implements plans for professional development**			**X**	**X**	**X**
	2.6A	**Develops plan and documents professional development activities in career portfolio (eg, organizational policies and procedures, credentialing agency[ies])**		**X**	**X**	**X**
		2.6A1	Creates development plan, seeks guidance from a mentor, if desired, and implements to gain appropriate knowledge and skills that lead to advancement in personal practice	X	X	X
2.7	**Engages in evidence-based practice and uses best practices**			**X**	**X**	**X**
	2.7A	Reads/reviews lay- and peer-reviewed journals, clinical practice guidelines, and websites and participates in discussions on current topics via electronic mailing lists, journal clubs, seminars, and webinars		X	X	X
	2.7B	Identifies and uses evidence-based PALTC nutrition, and food/dining service resources related to practice settings (eg, Pioneer Network Dining Standards, Society for Post-Acute and Long-Term Care Medicine [formerly the American Medical Directors Association (AMDA)]; see Figure 4)		X	X	X
	2.7C	Evaluates scientific evidence, practice guidelines and client/resident/advocate[d]-based preferences to apply knowledge and skills to determine the most appropriate plans of care that may include consults or referrals to other members of the interprofessional team		X	X	X
	2.7D	Participates in research activities and publication of results to advance evidence and best practices			X	X
	2.7E	Integrates research findings and evidence into peer-reviewed publications and recommendations for practice				X
2.8	**Participates in peer review of others as applicable to role and responsibilities**			**X**	**X**	**X**
	2.8A	Demonstrates knowledge and skills to train, mentor, and guide nutrition and dietetics practitioners and other support staff			X	X
	2.8B	Serves as an author, reviewer, or editorial board member for professional organizations, journals, and books			X	X
	2.8C	Leads an editorial board for scholarly review, including but not limited to, professional articles, chapters, and books				X
2.9	**Mentors and/or precepts others**			**X**	**X**	**X**
	2.9A	Participates in mentoring entry-level and RDNs new to PALTC; and serves as a preceptor for education programs; seeks guidance as needed		X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 2: Competence and Accountability					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	2.9B	Develops and directs mentoring or practicum opportunities for nutrition and dietetics practitioners, and health care practitioners of other disciplines		X	X
	2.9C	Provides expertise and counsel to education programs related to food and nutrition care and services, industry standards, practice guidelines, and practice roles for nutrition and dietetics practitioners			X
2.10	**Pursues opportunities (education, training, credentials, certifications) to advance practice in accordance with laws and regulations, and requirements of practice setting**		**X**	**X**	**X**
	2.10A	Obtains credentials and certifications necessary for area(s) of practice (eg, ServSafe Certificate)	X	X	X
	2.10B	Completes applicable Academy/CDR Certificate of Training Programs: Nutrition Focus Physical Exam, Weight Management, or other education and skill development to enhance and advance practice (http://www.eatrightpro.org/resources/practice/professional-development)	X	X	X
	2.10C	Obtains and maintains specialty certification (eg, CSG, CDE, CSR) to support customer population needs to advance practice opportunities		X	X
	2.10D	Develops programs, tools, and resources in support of assisting RDNs in obtaining specialty certification (eg, CSG, CDE, CSR)			X

Examples of Outcomes for Standard 2: Competence and Accountability

- Practice reflects:
  - Code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics)
  - Scope of Practice, Standards of Practice, and Standards of Professional Performance
  - Evidence-based practice and best practices
  - CDR Essential Practice Competencies and Performance Indicators
- Practice incorporates successful strategies for interactions with individuals/groups from diverse cultures and backgrounds
- Competence is demonstrated and documented
- Services provided are safe and customer-centered
- Self-evaluations are conducted regularly to reflect commitment to lifelong learning and professional development and engagement
- Professional development needs are identified and pursued
- Directed learning is demonstrated
- Relevant opportunities (education, training, credentials, certifications) are pursued to advance practice
- CDR recertification requirements are met

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

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

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
3.1	**Contributes to or leads in development and maintenance of programs/ services that address needs of the customer or target population(s)**			**X**	**X**	**X**
	3.1A	**Aligns program/service development with the mission, vision, principles, values and service expectations and outputs of the organization/business**		**X**	**X**	**X**
		3.1A1	Designs, promotes, and seeks executive/administrator, medical staff/director commitment to new services and goals for nutrition and/or food/dining services		X	X
		3.1A2	Leads in the development of new products and services to support PALTC services			X
	3.1B	**Uses the needs, expectations, and desired outcomes of the customers/populations (eg, patients/clients, families, community, decision makers, administrators, client organization[s]) in program/service development**		**X**	**X**	**X**
		3.1B1	Conducts ongoing needs assessment of the PALTC environment to identify opportunities to deliver additional services		X	X
	3.1C	**Makes decisions and recommendations that reflect stewardship of time, talent, finances, and environment**		**X**	**X**	**X**
		3.1C1	Advocates for staffing and resources that support client/ resident population, census, program services/goals, and federal and state regulatory compliance applicable to organization or setting		X	X
	3.1D	**Proposes programs and services that are customer-centered, culturally appropriate, and minimize health disparities**		**X**	**X**	**X**
		3.1D1	Adapts practices to minimize or eliminate health disparities associated with culture, race, sex, socioeconomic status, age, and other factors	X	X	X
3.2	**Promotes public access and referral to credentialed nutrition and dietetics practitioners for quality food and nutrition programs and services**			**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	3.2A		**Contributes to or designs referral systems that promote access to qualified, credentialed nutrition and dietetics practitioners**	**X**	**X**	**X**
	3.2B		**Refers customers to appropriate providers when requested services or identified needs exceed the RDN's individual scope of practice**	**X**	**X**	**X**
		3.2B1	Receives referrals from and makes referrals to other health care professionals; builds relations to assist with referrals when client/resident need(s) is outside RDN's scope of practice	X	X	X
		3.2B2	Participates in or designs processes to receive or make referrals to other providers that address the needs of customer population (eg, primary care, social services, physical/occupational/speech therapy, mental/behavioral health professional, community-based services)		X	X
	3.2C		**Monitors effectiveness of referral systems and modifies as needed to achieve desirable outcomes**	**X**	**X**	**X**
		3.2C1	Documents sources of referrals to monitor effectiveness (ie, appropriate, timely) and modifies referral tools/systems in collaboration with others as needed		X	X
		3.2C2	Provides organization data needed to improve/update the nutrition-related information included with referrals			X
3.3	**Contributes to or designs customer-centered services**			**X**	**X**	**X**
	3.3A		**Assesses needs, beliefs/values, goals, resources of the customer, and social determinants of health**	**X**	**X**	**X**
		3.3A1	Recognizes the influence that culture, health literacy, and socioeconomic status have on health/illness experiences and the customer population use of health care services; adapts practice to meet needs (eg, selecting and using translators, culturally appropriate education)	X	X	X
	3.3B		**Uses knowledge of the customer's/target population's health conditions, cultural beliefs, and business objectives/services to guide design and delivery of customer-centered services**	**X**	**X**	**X**
		3.3B1	Participates in the design and maintenance of program/services to meet the needs of diverse populations in PALTC settings	X	X	X
		3.3B2	Identifies and uses ethnic/cultural resources applicable to customer population(s); collaborates with health care professionals to communicate available options to influence and support health-related decision making		X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		3.3B3	Develops, manages, and updates processes to identify, track, and monitor utilization of customer population resources within the specific ethnic/cultural community, and collaborates as appropriate			X
	3.3C	**Communicates principles of disease prevention and behavioral change appropriate to the customer or target population**		**X**	**X**	**X**
		3.3C1	Understands behavior change and counseling theories and is able to apply theories in practice	X	X	X
		3.3C2	Adapts communications, nutrition counseling, and education to reflect customer populations' cultural beliefs regarding chronic disease and the need for/benefit of addressing health and nutrition concerns	X	X	X
	3.3D	**Collaborates with the customers to set priorities, establish goals, and create customer-centered action plans to achieve desirable outcomes**		**X**	**X**	**X**
		3.3D1	Collaborates with clients/residents/advocates, caregivers, health care providers, and other support resources to create person-centered action plans that reflect customers' needs, wishes, desired outcomes, and the organization/service objectives	X	X	X
		3.3D2	Documents decisions for treatment priorities, goals, and plans according to organization/program guidelines	X	X	X
		3.3D3	Guides customers and their support networks (eg, caregivers, family) in health-related decision making and goal setting to maximize outcomes		X	X
		3.3D4	Directs efforts to improve collaboration between clients/residents/advocates and other care providers			X
	3.3E	**Involves customers in decision making**		**X**	**X**	**X**
		3.3E1	Follows and participates in organization discussions and planning with health care providers and staff to ensure person-centered care and services	X	X	X
		3.3E2	Facilitates clients'/residents'/advocates' participation in health care decision making and goal setting, including preferences for use of enteral or parenteral nutrition, and as part of end-of-life care when applicable		X	X
		3.3E3	Leads interprofessional discussions to develop or improve collaboration on an organization or systems level			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
3.4	**Executes programs/services in an organized, collaborative, cost-effective, and customer-centered manner**			**X**	**X**	**X**
	3.4A	**Collaborates and coordinates with peers, colleagues, stakeholders, and within interprofessional teams**		**X**	**X**	**X**
		3.4A1	Identifies or develops communication processes with organization leaders and interprofessional team/ members, keeping in mind the communication process when the RDN is not present	X	X	X
		3.4A2	Directs or serves as the consultant for the organization's food/dining services when applicable; this includes standard operations, food safety standards, accreditation standards, and/or regulatory compliance, organization requirements, and industry trends	X	X	X
		3.4A3	Facilitates interprofessional discussions and care planning for clients/residents with complex nutrition needs to achieve nutrition outcomes (eg, non-healing wounds, persistent weight loss, mental health, or addiction disorders impacting care and recovery)		X	X
		3.4A4	Leads/facilitates active communication, and collaboration with the interprofessional team and organization staff, and other providers as needed			X
	3.4B	**Uses and participates in, or leads in the selection, design, execution, and evaluation of customer programs and services (eg, nutrition screening system, medical and retail foodservice, electronic health records, interprofessional programs, community education, and grant management)**		**X**	**X**	**X**
		3.4B1	Incorporates food and/or nutrition services standards for customer population using evidence-based guidelines and regulations when designing programs and services for the organization/program setting; seeks assistance if needed	X	X	X
		3.4B2	Collaborates on, develops, or monitors organization process for nutrition screening and/or referral	X	X	X
		3.4B3	Provides requested information and data to support the organization's customer and stakeholder evaluation processes	X	X	X
		3.4B4	Monitors, revises, or provides recommendations for maintaining food and nutrition—related services to achieve customer and organization goals		X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		3.4B5	Leads and facilitates interprofessional collaborations for changes and process revisions for organization's nutrition and/or dining, and other services			X
	3.4C	**Uses and develops or contributes to selection, design, and maintenance of policies, procedures (eg, discharge planning/ transitions of care), protocols, standards of care, technology resources (eg Health Insurance Portability and Accountability Act [HIPAA]—compliant telehealth platforms), and training materials that reflect evidence-based practice in accordance with applicable laws and regulations**		**X**	**X**	**X**
		3.4C1	Uses evidence-based guidelines (eg Academy, Society for Post-Acute and Long-Term Care, National Pressure Ulcer Advisory Panel), practice guidelines applicable to population, CMS regulations and interpretive guidance, and state and local regulations for populations served to create and/or update policies, procedures, and nutrition-care protocols applicable to setting	X	X	X
		3.4C2	For applicable policies/procedures/protocols, facilitates review and approval by organization/program leaders, medical staff/director and others (eg, interprofessional or QAPI team) following specified process	X	X	X
		3.4C3	Collaborates with the interprofessional team or in-services staff on new or revised policies/procedures/protocols; monitors the success/follow-through, and amends as needed	X	X	X
		3.4C4	Systematically evaluates outcomes of nutrition care protocols and collaborates with interprofessional team on revisions to improve outcomes where necessary		X	X
		3.4C5	Guides colleagues/organizations in interpreting laws, regulations, and best evidence applicable to food and nutrition services (eg, food/dining service delivery systems/requirements) considering specific populations served			X
	3.4D	**Uses and participates in or develops processes for order writing and other nutrition-related privileges, in collaboration with the medical staff[e] or medical director (eg, post-acute care settings, dialysis center, public health, community, free-standing clinic settings), consistent with state practice acts, federal and state regulations, organization policies, and medical staff rules, regulations, and bylaws**		**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services							
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators					**The "X" signifies the indicators for the level of practice**		
Each RDN:					**Competent**	**Proficient**	**Expert**
		3.4D1	**Uses and participates in or leads development of processes for privileges or other facility-specific processes related to (but not limited to) implementing physician/non-physician practitioner[f]-driven delegated orders or protocols, initiating, or modifying orders for therapeutic diets, medical foods/nutrition supplements, dietary supplements, enteral and parenteral nutrition, laboratory tests, medications, and adjustments to fluid therapies or electrolyte replacements**		**X**	**X**	**X**
			3.4D1i	Consistent with regulations allowing attending physicians to delegate nutrition-related order writing, RDN collaborates with medical director and administrator to develop, revise, or maintain policy and procedure, and orient attending physicians; seeks assistance if needed	X	X	X
			3.4D1ii	Adheres to organization-approved provider protocols/delegated orders for including in scope of work: ordering or revising diet, enteral or parenteral nutrition, nutrition or vitamin/mineral supplements, or other nutrition-related orders	X	X	X
			3.4D1iii	Participates with the pharmacist in the development of organization and provider-approved pharmacotherapy protocols (eg, monitoring and adjusting insulin dosages, treatment for hypoglycemia or hyperglycemia, and monitoring for food/dietary supplement and drug interactions)		X	X
			3.4D1iv	Contributes to the development of nutrition order-writing options for RDNs with advanced credentials (eg, CDE)		X	X
			3.4D1v	Negotiates and/or establishes nutrition-related privileges at a systems level for new advances in practice			X
		3.4D2	**Uses and participates in or leads development of processes for privileging for provision of nutrition-related services, including (but not limited to) initiating and performing bedside swallow screenings, inserting, and monitoring nasoenteric feeding tubes, providing home enteral nutrition or infusion management services (eg, ordering formula and supplies) and indirect calorimetry measurements**		**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services							
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators					**The "X" signifies the indicators for the level of practice**		
Each RDN:					**Competent**	**Proficient**	**Expert**
			3.4D2i	Assures that role and direct care activities with home infusion clients are consistent with home health/infusion program policy and physician orders, and demonstrated and documented competence		X	X
	3.4E	**Complies with established billing regulations, organization policies, grant-funder guidelines, if applicable to role and setting, and adheres to ethical and transparent financial management and billing practices**			**X**	**X**	**X**
	3.4F	**Communicates with the interprofessional team and referring party consistent with the HIPAA rules for use and disclosure of customer's personal health information (PHI)**			**X**	**X**	**X**
		3.4F1	Follows regulations and organization/program policies for accessing, transporting, and storing information containing PHI when working in multiple sites; seeks assistance if needed		X	X	X
		3.4F2	Develops process and tools to monitor adherence to HIPAA rules and/or address breaches in the protection of PHI and use of electronic medical record (onsite or through remote access)			X	X
3.5	**Uses professional, technical, and support personnel appropriately in the delivery of customer-centered care or services in accordance with laws, regulations, and organization policies and procedures**				**X**	**X**	**X**
	3.5A	**Assigns activities, including direct care to patients/clients/ residents, consistent with the qualifications, experience, and competence of professional, technical, and support personnel**			**X**	**X**	**X**
		3.5A1	Assesses and determines capabilities/expertise of professional, technical, and support staff in working with clients/residents in PALTC to determine tasks that may be delegated; seeks assistance if needed		X	X	X
	3.5B	**Supervises professional, technical, and support personnel**			**X**	**X**	**X**
		3.5B1	Trains professional, technical, and support personnel and evaluates their competence following organization/ program guidelines			X	X
	3.5C	Uses or develops competence evaluation tools				X	X
3.6	**Designs and implements food delivery systems to meet the needs of customers**				**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	3.6A	**Collaborates in or leads the design of food delivery systems to address health care needs and outcomes (including nutrition status), ecological sustainability, and to meet the culture and related needs and preferences of target populations (ie, health care patients/clients, employee groups, visitors to retail venues, schools, child and adult day care centers, community feeding sites, farm to institution initiatives, local food banks)**		**X**	**X**	**X**
		3.6A1	Participates in or leads periodic review of foodservice operations applicable to role and setting (eg, food/dining service in long-term care, senor services congregate meal site or in-home meal program, adult day care) to meet regulations, organization standards, and customer population needs and preferences	X	X	X
		3.6A2	Consults on design, evaluation, and/or revision of food delivery systems and nutrition-related services (eg, menu system, dining options, operational processes) in PALTC settings, considering industry standards, expectations expressed in relevant regulations, and population preferences		X	X
		3.6A3	Leads or participates in new design or renovation of existing dining and food production facilities			X
	3.6B	**Participates in, consults/collaborates with, or leads the development of menus to address health, nutritional, and cultural needs of target population(s) consistent with federal, state, or funding source regulations or guidelines**		**X**	**X**	**X**
		3.6B1	Reviews or develops and approves menus reflecting national nutrition standards, and applicable regulations as required by setting; modifies or approves cycle menu offerings for population with special dietary needs (eg, allergy or intolerance to food/ingredient) or to accommodate preferences within therapeutic diet guidelines	X	X	X
		3.6B2	Develops nutrition and PALTC-related menu guidelines reflecting national standards (eg, Academy EAL, Dietary Guidelines for Americans) and applicable federal or state regulations (eg, meal timing and food assistance program regulations) to guide foodservice program according to population served		X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	3.6C		**Participates in, consults/collaborates with, or leads interprofessional process for determining medical foods/ nutritional supplements, dietary supplements, enteral and parenteral nutrition formularies, and delivery systems for target population(s)**	**X**	**X**	**X**
		3.6C1	Provides nutrition expertise in the selection of enteral formulary products, nutritional supplements, and enhanced foods	X	X	X
3.7	**Maintains records of services provided**			**X**	**X**	**X**
	3.7A		**Documents according to organization policies, procedures, standards, and systems, including electronic health records**	**X**	**X**	**X**
		3.7A1	Maintains records of nutrition referrals (eg, weight reports, pressure injury/ulcer reports), documentation, and recommendations for clients/residents	X	X	X
		3.7A2	Completes reports according to organization policy and procedures	X	X	X
		3.7A3	Uses and/or participates in the selection/design/revision of electronic health records		X	X
	3.7B		**Implements data management systems to support interoperable data collection, maintenance, and utilization**	**X**	**X**	**X**
		3.7B1	Uses or develops data collection tools to support reporting requirements (eg, weight monitoring, meals served, food temperatures, services provided and hours)	X	X	X
		3.7B2	Contributes to design of manual or electronic health record system to capture data needed to document care and monitor outcomes		X	X
		3.7B3	Seeks opportunities to contribute expertise to national bioinformatics/medical informatics projects as applicable/ requested			X
	3.7C		**Uses data to document outcomes of services (ie, staff productivity, cost–benefit, budget compliance, outcomes, quality of services) and provide justification for maintenance or expansion of services**	**X**	**X**	**X**
		3.7C1	Analyzes and uses data to communicate value of services (eg, nutrition, food/dining services, expanded role activities) in relation to customer and organization outcomes/goals		X	X
	3.7D		**Uses data to demonstrate program/service achievements and compliance with accreditation standards, laws, and regulations (eg, survey plan of correction)**	**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
		3.7D1	Prepares and presents reports for organization and organization licensure and/or accrediting bodies, if applicable; seeks assistance if needed	X	X	X
3.8	**Advocates for provision of quality food and nutrition services as part of public policy**			**X**	**X**	**X**
	3.8A	**Communicates with policy makers regarding the benefit–cost of quality food and nutrition services**		**X**	**X**	**X**
		3.8A1	Interacts with policymakers, community leaders, and insurers, when applicable, to contribute and influence nutrition issues (eg, submits comments [e-mail, phone, letters] to lawmakers, attends town halls or hearing committees on issues impacting nutrition care and food safety)	X	X	X
		3.8A2	Swiftly disseminates public policy information to stakeholders for use in commenting or implementation	X	X	X
		3.8A3	Offers expertise to lawmakers and regulatory agencies to contribute and influence support for nutrition and other services		X	X
		3.8A4	Provides expertise when collaborating with Academy and other stakeholder organizations in the development of public policy positions impacting nutrition, food assistance programs, and food safety			X
		3.8A5	Contributes to development/review/comments/ recommendations on policy, statutes, administrative rules, and regulations			X
	3.8B	**Advocates in support of food and nutrition programs and services for populations with special needs and chronic conditions**		**X**	**X**	**X**
		3.8B1	Advocates with lawmakers and decision makers in support of food and nutrition programs for seniors and populations served by PALTC settings	X	X	X
	3.8C	**Advocates for protection of the public through multiple avenues of engagement (eg, legislative action, establishing effective relationships with elected leaders and regulatory officials, participation in various Academy committees, workgroups and task forces, Dietetic Practice Groups, Member Interest Groups, and State Affiliates)**		**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Examples of Outcomes for Standard 3: Provision of Services

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

Standard 4: Application of Research

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

Rationale:

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

Indicators for Standard 4: Application of Research

Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
4.1	**Reviews best available research/evidence and information for application to practice**		**X**	**X**	**X**
	4.1A	**Understands basic research design and methodology**	**X**	**X**	**X**
	4.1B	Identifies resources for accessing timely research-based information (Dietetics in Health Care Communities Dietetic Practice Group, National Pressure Ulcer Advisory Panel, The Society for Post-Acute and Long-Term Care [formerly AMDA], Pioneer Network, Academy EAL)	X	X	X
	4.1C	Identifies key clinical and management questions and uses systematic methods to extract evidence-based research and information, interprets study conclusions, answers questions, and evaluates relevance to practice		X	X
	4.1D	Identifies PALTC-related questions and uses a systematic approach for applying research and evidence-based guidelines (eg, Academy EAL) in making informed decisions; guides others with process			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 4: Application of Research					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	4.1E	Functions as a primary or senior author of research, and academic and/or organization position and practice papers or other scholarly work			X
4.2	**Uses best available research/evidence and information as the foundation for evidence-based practice**		**X**	**X**	**X**
	4.2A	Shares available scientific literature and evidence-based practice guidelines with the interprofessional team	X	X	X
	4.2B	Critically evaluates, and applies the available scientific literature in situations where evidence-based practice guidelines for PALTC population/setting are not established		X	X
	4.2C	Leads in the development of nutrition care evidence-based guidelines			X
4.3	**Integrates best available research/evidence and information with best practices, clinical and managerial expertise, and customer values**		**X**	**X**	**X**
	4.3A	Interprets research findings, industry trends, and practice guidelines for application to care and services (eg, nutrition care, foodservice/dining, home care), policies/procedures, and protocols		X	X
	4.3B	Mentors others in identifying and applying best available research/evidence and integrating best practices			X
4.4	**Contributes to the development of new knowledge and research in nutrition and dietetics**		**X**	**X**	**X**
	4.4A	Participates in efforts to extend research to practice (eg, journal clubs, focus groups, interprofessional discussions, or participates in research workgroups)	X	X	X
	4.4B	Participates in development and/or implementation and reporting of practice-based data collection and process improvement	X	X	X
	4.4C	Collaborates with peers working in PALTC to share best practices and collaborate on projects to advance practices	X	X	X
	4.4D	Participates in data collection for facility and Institutional Review Board—approved research studies	X	X	X
	4.4E	Mentors RDNs and other health care professionals to develop skills for accessing and critically analyzing research and applying to practice		X	X
	4.4F	Serves as a primary or senior investigator on collaborative research teams that examine relationships between nutrition, food/dining services and population outcomes in PALTC settings (eg, incidence of non—disease-related unintended weight loss)			X
	4.4G	Serves as advisor, preceptor, and/or committee member for research			X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 4: Application of Research					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
4.5	**Promotes application of research in practice through alliances or collaboration with food and nutrition and other professionals and organizations**		**X**	**X**	**X**
	4.5A	Collaborates with interprofessional and/or interorganizational teams to perform and disseminate PALTC food and/or nutrition-related research		X	X
	4.5B	Leads interprofessional and/or interorganizational research activities and integration of research data into publications and presentations related to PALTC			X

Examples of Outcomes for Standard 4: Application of Research

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

Standard 5: Communication and Application of Knowledge
The registered dietitian nutritionist (RDN) effectively applies knowledge and expertise in communications.
Rationale:
The RDN works with others to achieve common goals by effectively sharing and applying unique knowledge, skills, and expertise in food, nutrition, dietetics, and management services.

Indicators for Standard 5: Communication and Application of Knowledge					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
5.1	**Communicates and applies current knowledge and information based on evidence**		**X**	**X**	**X**
	5.1A	**Demonstrates critical thinking and problem-solving skills when communicating with others**	**X**	**X**	**X**
	5.1B	Investigates/researches food, nutrition, management, and other practice-related topics for application to practice and sharing with others	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 5: Communication and Application of Knowledge						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	5.1C		Evaluates and translates public health trends, epidemiological reports, regulatory, accreditation, reimbursement programs, and standards specific to PALTC population care, services, and education (eg, federal, state, local, and The Joint Commission) and applies to practice		X	X
	5.1D		Builds and maintains relationships between research and decision makers to facilitate effective knowledge transfer			X
	5.1E		Consults as an expert on complex PALTC service issues with other health care professionals, organizations, and community stakeholders			X
5.2	**Selects appropriate information and the most effective communication method or format that considers customer-centered care and the needs of the individual/group/population**			**X**	**X**	**X**
	5.2A		**Uses communication methods (ie, oral, print, one-on-one, group, visual, electronic, and social media) targeted to various audiences**	**X**	**X**	**X**
		5.2A1	Adapts communications with customers to consider health literacy, culture, preferred language, educational level, and hearing or vision disabilities	X	X	X
		5.2A2	Assesses staff's ability to understand information and instructions (considering literacy, primary language, and education level) and communication approaches; provides consultation and training with organization/program or community resources		X	X
		5.2A3	Investigates target audience needs, learning style(s), and desired outcomes, and planned actions for audience to identify effective communication method(s) for achieving goal			X
	5.2B		**Uses information technology to communicate, disseminate, manage knowledge, and support decision making**	**X**	**X**	**X**
		5.2B1	Identifies and uses computerized reports/electronic health records to organize data, complete assessments and reports; communicates to customers and interprofessional team	X	X	X
		5.2B2	Identifies new electronic resources and provides timely accurate communication on practice applications		X	X
		5.2B3	Leads education on the use of electronic resources for RDNs, NDTRs, and other interprofessional team members			X
5.3	**Integrates knowledge of food and nutrition with knowledge of health, culture, social sciences, communication, informatics, sustainability, and management**			**X**	**X**	**X**

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 5: Communication and Application of Knowledge						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	5.3A		Contributes to the body of knowledge for the profession (eg, presentations, publications, research, office/committee volunteer)	X	X	X
	5.3B		Applies current and emerging knowledge of nutrition when considering an individual's health status, behavior barriers, communication skills, interprofessional team involvement; seeks collaborative guidance as needed		X	X
5.4	**Shares current, evidence-based knowledge, and information with various audiences**			**X**	**X**	**X**
	5.4A		**Guides customers, families, students, and interns in the application of knowledge and skills**	**X**	**X**	**X**
		5.4A1	Contributes to the education and professional development of students/interns and other health care practitioners through formal and informal mentoring and teaching	X	X	X
		5.4A2	Develops educational programs for students/interns and PALTC providers that promote person-centered nutrition and food/dining services		X	X
		5.4A3	Contributes formally and informally to the customer and interprofessional team (eg, shares relevant articles and new knowledge, investigates queries)		X	X
	5.4B		**Assists individuals and groups to identify and secure appropriate and available educational and other resources and services**	**X**	**X**	**X**
		5.4B1	Develops a referral base in collaboration with social services to assist customers with additional information and services (eg, Alzheimer's Association, Area Agency on Aging, or senior meal programs)	X	X	X
		5.4B2	Identifies and secures appropriate and available resources/services (eg, access to food and nutrition services to reduce nutrition-related weight loss readmissions in acute, post-acute and long-term care settings, assisted living and skilled nursing facilities)		X	X
		5.4B3	Develops or manages systematic process to identify, track, and monitor resources used by the population, and the impact on outcomes			X
	5.4C		**Uses professional writing and verbal skills in all types of communications**	**X**	**X**	**X**
		5.4C1	Sharpens written and oral communication skills to address needs of various audiences	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 5: Communication and Application of Knowledge						
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators				**The "X" signifies the indicators for the level of practice**		
Each RDN:				**Competent**	**Proficient**	**Expert**
	5.4D	**Reflects knowledge of population characteristics in communication methods**		**X**	**X**	**X**
		5.4D1	Reflects knowledge of population characteristics in communication with customers (eg, literacy and numeracy levels, need for translation of written materials and/or a translator, communication skills)	X	X	X
5.5	**Establishes credibility and contributes as a food and nutrition resource within the interprofessional health care and management team, organization, and community**			**X**	**X**	**X**
	5.5A	Educates organizations and members of the interprofessional team regarding the specialized knowledge and skills of the RDN and those with specialty certifications that may assist in addressing the health care needs of the population (eg, CSG, CSR, CDE)			X	X
	5.5B	Participates in interprofessional collaborations at the organization or systems level (eg, state or community advisory boards, nonprofit organizations/agencies)			X	X
	5.5C	Leads in the development of innovative approaches to complex clinical and management issues in PALTC				X
5.6	**Communicates performance improvement and research results through publications and presentations**			**X**	**X**	**X**
	5.6A	Presents evidence-based research to community groups and colleagues		X	X	X
	5.6B	Participates on planning committees (program planning, publication planning) or professional committees focused on PALTC issues		X	X	X
	5.6C	Presents performance improvement and evidence-based research to health care professionals via oral presentations at conferences (regional, national, international) and publications (eg, newsletters, pocket resources, professional journals, and education materials)			X	X
	5.6D	Serves in a leadership role planning and organizing educational conferences (local, regional, national, and international)			X	X
	5.6E	Writes and reviews or edits peer-reviewed materials (eg, newsletters, journal articles, pocket resources, and books)			X	X
	5.6F	Leads in the generation of expert knowledge (eg, guidelines, protocols, programs, policies, and research)				X
	5.6G	Presents research applicable to nutrition care and food/dining services to professional and community groups to increase knowledge and understanding of issues impacting PALTC				X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 5: Communication and Application of Knowledge					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
5.7	**Seeks opportunities to participate in and assume leadership roles with local, state, and national professional and community-based organizations (eg, government-appointed advisory boards, community coalitions, schools, foundations, or non-profit organizations serving the food insecure) providing food and nutrition expertise**		**X**	**X**	**X**
	5.7A	Serves on regional, national, or international committees/task forces for health-related professions, industry, and the community		X	X
	5.7B	Contributes nutrition-related expertise to local, regional, or national projects and professional organizations (see Figure 4)		X	X
	5.7C	Proactively seeks opportunities at local, regional, national, and international levels to promote nutrition and management standards developed by the Academy and related health care and management organizations		X	X
	5.7D	Serves as a local, national, and international PALTC food and nutrition media spokesperson			X
	5.7E	Acts as an expert resource for other health care providers, outside agencies, and community groups/organizations related to nutritional needs of the PALTC population			X
	5.7F	Identifies new opportunities for leadership across discipline boundaries to promote nutrition and dietetics practice in a broader context			X

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

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

Standard 6: Utilization and Management of Resources
The registered dietitian nutritionist (RDN) uses resources effectively and efficiently.
Rationale:
The RDN demonstrates leadership through strategic management of time, finances, facilities, supplies, technology, natural and human resources.

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 6: Utilization and Management of Resources					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
6.1	**Uses a systematic approach to manage resources and improve outcomes**		**X**	**X**	**X**
	6.1A	Participates in, provides consultation, or leads operational planning and delivery of food and nutrition programs and services applicable to setting (eg, nutrition care, food/dining services, budgeting, staffing, menu planning, purchasing processes, education program/services)	X	X	X
	6.1B	Participates in, consults on, or determines electronic nutrition and food/dining service management systems used in PALTC settings (eg, purchasing, inventory control, recipe and menu development, nutrition care-related activities [eg, diet orders/tracking, nutritive value of menus])	X	X	X
	6.1C	Participates in or leads the evaluation of new products and equipment for organization/system		X	X
	6.1D	Develops and directs nutrition and dietetics business providing consultation services to PALTC settings (eg, RDN clinical services, menu development, food/dining service consultation)		X	X
	6.1E	Evaluates and monitors current PALTC practices at the systems level considering business best practices, meeting budget goals, and formulates revisions based on data			X
6.2	**Evaluates management of resources with the use of standardized performance measures and benchmarking as applicable**		**X**	**X**	**X**
	6.2A	**Uses the Standards of Excellence Metric Tool to self-assess quality in leadership, organization, practice, and outcomes for an organization** (www.eatrightpro.org/excellencetool)	**X**	**X**	**X**
	6.2B	Participates in analyzing customer population outcomes data against goals, program resource utilization, service participation, and expense data to evaluate and adjust programs and services	X	X	X
	6.2C	Monitors, documents, and evaluates program and service resource usage against budget or other criteria (eg, staff hours, staff to client/resident ratio, referral requests, program participation rates, and supplies, training, technology, professional development, and food costs, as applicable)		X	X
	6.2D	Manages or consults on effective delivery of food and/or nutrition programs and services applicable to setting (eg, delivery of program/services and compliance with regulatory/accreditation requirements)		X	X
6.3	**Evaluates safety, effectiveness, efficiency, productivity, sustainability practices, and value while planning and delivering services and products**		**X**	**X**	**X**
	6.3A	Assures nutrition and dietetics services comply with regulations (eg, food safety and safe practices for use of local farm or organization-grown produce) and accreditation standards when applicable	X	X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 6: Utilization and Management of Resources					
Bold Font Indicators are Academy Core RDN Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RDN:			**Competent**	**Proficient**	**Expert**
	6.3B	Analyzes safety and sustainability practices in meeting needs of PALTC population and program/service goals		X	X
	6.3C	Leads effectiveness review process of program/service goals; analyzes cost in planning and delivering services and products at the organization and systems level			X
6.4	**Participates in QAPI and documents outcomes and best practices relative to resource management**		**X**	**X**	**X**
	6.4A	Participates in quality management (eg, QAPI), including collecting, documenting, and analyzing relevant data to assure continued resource utilization (eg, personnel, services, fiscal, materials, and supplies)	X	X	X
	6.4B	Reviews or collects and evaluates customer satisfaction with dining experience (eg, dining environment, timing, menu offerings, food quality, and snacks)	X	X	X
	6.4C	Reviews and reports findings according to organization's process (eg, participating in the QAPI meetings); develops or revises procedures reflecting decisions	X	X	X
	6.4D	Participates in or plans and coordinates under direction of the administrator, organization/program quality management program (eg, QAPI) with administrative and interprofessional team (eg, data collection/reports, analysis, development of corrective actions including responses to licensing or accreditation survey citations, and reporting of results and outcomes)		X	X
	6.4E	Identifies and analyzes key performance measures for food, non-food, and labor costs; uses knowledge and judgment to implement actionable improvement plans			X
6.5	**Measures and tracks trends regarding internal and external customer outcomes (eg, satisfaction, key performance indicators)**		**X**	**X**	**X**
	6.5A	Identifies or collects/reports and reviews clients/resident/advocate and staff reported information related to satisfaction with nutrition and dietetics care and services; addresses or participates in organization/interprofessional process to evaluate, address, document, and report; seeks assistance as needed	X	X	X
	6.5B	Develops or modifies programs and services to improve stakeholder (eg, client/resident/advocate, caregivers, employees, administration) satisfaction with PALTC nutrition services		X	X

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Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.

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

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

[a]**PALTC:** *Post-Acute and Long-Term Care (PALTC)* is a continuum of care provided by community-based settings, which may include long-term acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospice, assisted living facilities, corrections facilities, and other settings.

[b]**Interprofessional:** The term *interprofessional* (also refers to interdisciplinary or multidisciplinary) is used in this evaluation resource as a universal term. It includes a diverse group of team members (eg, physicians, nurses, dietitian nutritionists, pharmacists, psychologists, social workers, and speech, occupational and physical therapists, dentist, wound specialist, dialysis center staff, home care or hospice staff, nutrition and dietetics technician, registered, nursing assistant, certified dietary manager, dining service staff), depending on the needs of the client/resident/advocate.

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

[d]**Advocate:** An *advocate* is a person providing support and/or representing the rights and interests at the request of the resident/patient/client. The person may be a family member or individual not related to the individual (surrogate decision maker) who is asked to support the individual with activities of daily living or is legally designated to act on behalf of the individual, particularly when the individual has lost decision making capacity. (Adapted from definitions within The Joint Commission Glossary of Terms[12] and the Centers for Medicare and Medicaid Services, Hospital Conditions of Participation.[6]) Advocate could also mean surrogate decision maker.

[e]**Medical staff:** *Medical staff* is composed of doctors of medicine or osteopathy and may in accordance with state law, including scope of practice laws, include other categories of physicians, and non-physician practitioners who are determined to be eligible for appointment by the governing body.[6]

[f]**Non-physician practitioner:** A *non-physician practitioner* may include a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, qualified dietitian or qualified nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[6,7] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services Long-Term Care (LTC) Regulations. With publication of the Final Rule revising the Conditions of Participation for LTC facilities effective November 2016, post-acute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutrition supplements, or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law and organization policies.[9,10]

Figure 2. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs) in Post-Acute and Long-Term Care Nutrition. *Customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/resident/advocate, participant, inmate, consumer, or any individual, group, or organization to which the RDN provides service.