

Improving Nutrition Care and Enabling Interprofessional Collaboration

Submission to the Ministry of Health and Long-Term Care
Regarding the Health Professions Regulatory Advisory Council's
Recommendations on Scope of Practice of Dietetics

Submitted by
The College of Dietitians of Ontario
And
Dietitians of Canada (Ontario)

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The College of Dietitians of Ontario (CDO) and Dietitians of Canada (DC) appreciate the opportunity to provide the Ministry of Health and Long-Term Care additional perspectives on the dietetic scope of practice review and the recommendations made by the Health Professions Regulatory Advisory Council (HPRAC) in the *Interim Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals: Phase II, Part I*. We acknowledge and appreciate the extensive consultative process that HPRAC undertook, and the enormity of the task of preparing advice on complex patient care and professional practice issues.

The context of the scope of practice reviews – enabling collaborative health care practice - was an important underpinning for our joint dietetic scope of practice submission to HPRAC. Our recommendations on scope of practice changes addressed many of the enablers of collaborative practice as articulated by the Ministry of Health and Long-Term Care and HPRAC with reference to enhancing the quality, effectiveness and timeliness of nutrition care for patients in Ontario. Central in our submission were considerations of efficient use of professionals in the health care system, optimum use of the expertise and competence of professionals, and continued focus on improving meaningful communication and consultation within the care team. If adopted, these recommendations would meet the Ministry's objectives of enabling efficient and effective collaborative interprofessional care.

Several recommendations made in our scope of practice submission have been supported by HPRAC, and we strongly encourage the Minister of Health and Long-Term Care to proceed with legislation amendments to implement these recommendations in order to benefit patient care and support interprofessional collaboration.

The focus of the additional remarks in this paper is to clarify portions of the HPRAC report and comment further on the recommendations which were not supported by HPRAC. The most important issue at this time for the dietetic scope of practice review is the need for an amendment to the Public Hospitals Act regulation to enable collaborative care by permitting Registered Dietitians (RD) to order nutrition treatments in public hospitals.

Amendments to the Public Hospitals Act Regulation

The absence of support for Registered Dietitians to order diagnostics and treatment procedures under the Public Hospitals Act is most concerning. As stated in our submission, and supported by the public consultation, the inability of RDs to directly order nutrition treatments seriously impedes appropriate patient care in public hospitals. It is the most significant barrier to timely and effective patient care and to effective use of the expertise of RDs. The requirement for a physician's signature on a nutrition care plan does not contribute to inter-professional care. It is an out dated authority mechanism that wastes resources that would be better utilized on meaningful interprofessional dialogue and reviews of complex patient care issues. Continued

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growth in the discipline-specific body of knowledge and evidence for safe effective health care, has led to an ever-increasing reliance on RDs for assessing nutrition needs related to medical conditions, and specifying the content of clinical nutrition treatment plans. This is the very nature of the unique role and expertise of clinical dietitians.

We are perplexed by the recommendation to amend the Public Hospitals Act to allow physiotherapists to make direct orders, while excluding dietitians. The report uses identical wording on page 151 (dietetics) and page 180 (physiotherapy) regarding concerns raised about medical directives. We concur with HPRAC's concerns about medical directives and also recognize they can be used effectively in some situations. The College has supported use of the medical directives framework developed by members of the Federation of Health Regulatory Colleges of Ontario. The use of such directives to enable dietetic practice has grown phenomenally, as presented in our submission. However, we are also aware of hospitals that refuse to invest in the development of medical directives because of the drain on resources for development, approval and maintenance. HPRAC recommended that "medical directives should be further explored" for dietetic practice where with the same rationale they recommended a change in the Public Hospitals Act regulation to enable physiotherapists to order treatment or diagnostic procedures in hospitals. Given the evidence of how RDs are increasingly relied on to apply their unique expertise in assessment and nutrition treatment planning, this is an omission that warrants serious consideration to address the inconsistencies between professions.

We note that the Ontario Hospital Association's (OHA) submission is linked with the physiotherapy review and not with the dietetic scope of practice review, although the OHA provided one response to all scope of practice reviews. The OHA submission states that "Certain elements of the legislation, for example, the PHA provisions which limit treatment orders to physicians, midwives, dentists or registered nurses (extended class), could be amended to appropriately align with the provisions set out in the RHPA and to better reflect and support an interprofessional collaborative practice environment." We also note the submission of the Federation of Health Regulatory Colleges of Ontario to HPRAC, *Building on Strength: Creating a Regulatory Environment that Fosters Interprofessional Collaboration* representing the position of the 21 health professional Colleges. The Federation submission commented that the Public Hospitals Act regulatory provisions limiting who can order diagnostic and treatment procedures "interfere with professional autonomy by restricting the ability of various regulated health professionals to work to their maximum competence and capability."

To provide context for our position that RDs should be authorized to order specified diagnostic and treatment procedures under the Public Hospitals Act, the present system of ordering nutrition care in hospitals is presented: After a comprehensive nutritional assessment, the RD

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specifies a diet which may have a specific energy level, restrictions or additions of specific nutrients or fluid, and/or texture modifications. It is at this point that an additional order is needed to enable the RDs nutrition treatment plan to be implemented, unless there is a medical directive in place. There are many common “work-arounds” such as “Dietitian to see”, “Diet per RD”, and “Diet as Tolerated” that are commonly used by physicians. While they are convenient, they tend to confuse the accountability for the nutrition treatment. The RD is the professional qualified to specify the nutrition treatment based on comprehensive nutrition assessment with reference to medical diagnosis, and the responsibility and accountability for these decisions should rest with the RD. In the assessment and treatment planning role, the College holds the RD accountable for collaborative practice including effective communications and consultations with team members as indicated by the patient condition and nutrition care outcomes.

Ongoing nutritional care involves monitoring the patient’s response to treatment (for example, tolerance to a therapeutic diet or enteral or parenteral feeding, biochemical responses such as changes in blood glucose levels or markers of protein status). The authority to order lab tests to monitor response to treatment is very important to supporting appropriate nutrition care, but without the ability to then order changes to the nutrition treatment, the RD cannot act on the information provided by the laboratory reports.

The RD is the professional qualified to specify the nutrition care treatment, and as a member of the interprofessional health care team should be practicing to their full scope utilizing their specialized knowledge and skills. Collaboration and consultation are inherent in the RD’s professional practice, and are supported by facility protocols that outline referral processes. We fully support interprofessional care and the need for all disciplines to be aware of changes to the patient’s care. We also fully acknowledge those specialized circumstances (treatment of inborn errors, neonatal intensive care, complex gastro-intestinal diseases) where physicians with specialist expertise in clinical nutrition may wish to maintain ultimate control of diet orders. These specialized circumstances can be dealt with using facility protocols. RDs already work with such specialists on teams, and have over many years. The delay in providing appropriate nutrition treatment to the vast majority of patients, however, while waiting for a physician’s approval of the RD’s order, is wasteful and does not promote excellent patient care. Given the limited nutrition training most physicians receive in medical school, and the frequency of physician request for the RD to provide the diet order, we believe it is in the best interest of patient care that the regulatory framework should support the RD’s ability to order diagnostics and treatment procedures. Collaboration with other disciplines is a standard of practice for dietitians, as is the need to consult with other professionals for any treatment decision outside the individual’s scope of practice. For these reasons, we advise the Minister to amend the Public Hospitals Act to permit RDs to order diagnostics and treatment procedures in hospitals.

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Scope of practice statement

The College of Dietitians of Ontario and Dietitians of Canada have recommended that the scope of practice statement for dietitians be amended to read:

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

The key added elements in the recommended scope of practice statement are the focus on population health, management of food systems, health promotion and nutrition related means.

HPRAC maintains that a scope of practice statement “serves to provide the parameters within which a regulated health professional can exercise his or her authority to perform controlled acts”. While we agree that this is true, it is only one of several purposes of the scope of practice statements. The additional purposes are to:

- Inform the public and the profession about the activities of a profession
- Provide the general parameters for professional activities that Colleges regulate in addition to general professional conduct
- Inform the application of the Harm Clause of the RHPA

We suggest that the purpose of the scope of practice statement be considered more broadly than strictly within the context of controlled acts, as we note that all regulated health professions have a scope of practice statement while many of them do not have authority to perform controlled acts. This is true today as it was when the RHPA and profession-specific Acts were created late 1980’s and passed in 1991.

We are also concerned about the HPRAC statement that appears to suggest that the regulatory system for health professionals should be limited to patient care and to controlled acts rather than to public domain activities (p. 150). The health care system and the focus of government activities have evolved with greater emphasis on health promotion and population health. Many of the regulated health professions have similarly evolved with this focus. For instance, the dietetic profession is now supported with Masters and doctoral level education in community health/health promotion and in nutrition communication. The College, education system and the professional association recognize and support a breadth of activities that go well beyond patient care. The three core areas of dietetic practice are food service

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administration, community health and clinical nutrition. The College regulates all areas of dietetic practice. We note that CDO has investigated and considered complaints related to nutrition information provided by RDs in their publications and public statements. RDs are certainly held accountable for providing accurate, evidence-based nutrition information whether they provide it to patients, groups, other health professionals, or the general public. This is an example of how non-patient care activities are very much part of what the College regulates.

While foodservice management is not part of any controlled acts, it is directly related to patient care. Appropriate foodservice in hospitals, long term care homes, and other institutions has a definite contribution and impact on patient care, and in some cases is the primary means of managing patient health conditions. The broader definition of food systems recognizes the RD's role in supporting and managing healthy eating environments to contribute to population health goals. Health promotion activities contribute to patient care by decreasing the burden on the healthcare system and allowing resources to be directed to the most acutely ill.

There is precedent for inclusion of health promotion and population health components in a scope of practice statement, as shown in the following examples. Note the current scope of practice statement for **nursing**, which also includes the element of health promotion and activities not directly related to a controlled act

“The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.

HPRAC recommends that the scope of practice statement for **pharmacy** be amended (p. 71)—the revised wording is not articulated, but the recommendations from the College of Pharmacists and Ontario Pharmacists' Association both include...*promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy...*

Recently developed scope of practice statements also include health promotion:

*The practice of **homeopathy** is the assessment of body system disorders and treatment using homeopathic techniques to promote, maintain or restore health.*

*The practice of **naturopathy** is the assessment of diseases, disorders and dysfunctions and the naturopathic diagnosis and treatment of diseases, disorders and dysfunctions using naturopathic techniques to promote, maintain or restore health.*

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The dietetic profession has clearly indicated that their present practice is not fully reflected in the current scope of practice statement. We would welcome the opportunity to work collaboratively with MOHLTC to craft a statement that describes the regulated practice of dietetics more accurately.

Adjusting insulin

The statement found on page 144, “The College told HPRAC that Certified Diabetes Educator certification is not sufficient to obtain competencies” is **not correct**. Our assertion is that the CDE certification is not the **only** way to obtain the needed competencies. The CDE program offers recognized credentialing and a systematic process for certification and renewal; the same knowledge and application skills can also be attained through other means.

Concerns expressed by representatives of dietetics educational programs (page 144) are valid, however the report does not include the fact that all educational programs would be able to provide further exposure to medication adjustment upon the approval of this recommendation. The individual competency of each dietitian, and the requirement to not perform activities outside of this competency, is fundamental to all regulated health professionals. Methods to ensure competency in insulin adjustment would become part of the quality assurance program of the CDO. As with any profession, full competency for every aspect of a scope of practice is not expected at entry level or by each and every member of a profession. However, that does not preclude the members of the profession who have the competency from performing these activities. A similar rationale is found on page 173 and 176 of the report, in the discussion of granting physiotherapists access to controlled acts for treating a wound and assessing incontinence. In both these situations, HPRAC acknowledges that there are a small number of physiotherapists in Ontario currently performing these acts, and that post-graduate training can be added.

Development of standards of practice around any controlled act authorized to the profession is understood, and the College and DC are prepared to undertake the steps necessary to ensure public safety through appropriate training and education of their members.

On page 145 HPRAC expresses concern around the fact that insulin and oral hypoglycemic agents were included in one request. We are fully aware of the differences between insulin and oral hypoglycemic agents; the reasoning for including both in one request was due to the similarities in the client group that RDs would be involved in counseling (i.e. those with diabetes).

As noted, drug interactions or adverse effects should be identified at the time of initial prescription. Although HPRAC’s definition of prescribing includes adjustment of a prescription, limitations that would be imposed on an RD’s adjustment would substantially eliminate this

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risk. We acknowledge that there are risks inherent with drug interactions however, the minor adjustments to dosage or timing that are proposed for RD authority are not the same as the risks involved in initiating a new prescription.

CDO's position statement on insulin adjustments, quoted on p. 145 states that adjustment is "...distinct and different from prescribing..." The intent of this statement was to clarify the difference between an initial prescription for specific units to be given at a specific time, and the RDs role in advising the client to increase/decrease the number of units or to change the time of injection. It must be remembered that CDO's statement was developed in 2002, and intended to provide guidance to members within the constraints of the current controlled acts. Practice has evolved to the point where RDs are much more likely to be involved in the adjustment of insulin as part of the management of diabetes. The provincial government has made diabetes management a priority, and authorizing insulin/OHA agent adjustments to RDs is aligned with this mandate.

Psychotherapy

As noted in our submission, we did not specifically request authorization for the controlled act of psychotherapy but to ensure that the definition of psychotherapeutic techniques, when formalized by the transitional council of the College of Psychotherapy, does not restrict RDs from using behavior modification, solution focused therapy, and other counseling techniques currently used by RDs. The report does not seem to capture the intent of our request.

Controlled Acts for Enteral and Parenteral Nutrition (EN/PN) and Therapeutic Diets

While we respect the findings of HPRAC around the creation of new controlled acts, it must be acknowledged that enteral and parenteral nutrition and therapeutic diets can pose a substantial risk to the public. We will continue to work with other groups, including professional associations and regulatory bodies, to address these risks. In order to capture the extent of risk, a system is required that records "near-misses" and details results of improper diet/EN/PN orders to patients. We believe that systems to ensure patient safety must include methods to track these incidents, and the resultant harm.

We support HPRAC's conclusion that the provision of EN/PN is a multidisciplinary process, with many professionals contributing expertise. However, the high risk nature of these treatments does require that there be a professional who is ultimately responsible for the management of these therapies, with the input of other disciplines. Given the experiences of many RDs who provide training to the physicians and nurses on use of EN/PN, it is appropriate that the authority for changes to these treatments be restricted.

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Recommendations supported in HPRAC's report

HPRAC supported the professions' recommendations for the following changes based on the evidence provided in the DC/CDO submission, provincial roundtable discussions, and their own research. We strongly urge the Ministry of Health and Long Term Care to adopt these recommendations in order to provide more appropriate nutrition care for Ontario residents by implementing the legislative changes recommended on page 153 and 154.

- That RDs be authorized to take blood samples by skin pricking for the purpose of monitoring capillary blood levels.
- That section 24 of the Hospital Management Regulation made under the Public Hospitals Act be amended to authorized dietitians to order specified laboratory tests relative to nutritional assessment and monitoring.
- That Regulation 682 and Regulation 683 under the Laboratory and Specimen Collection Centre Licensing Act 1991 be amended to allow dietitians to order specified laboratory tests relevant to nutritional assessment and monitoring outside the hospital setting.
- That dietitians be added to the list of health professionals authorized as evaluators under the Health Care Consent Act, 1996.

Thank you for the opportunity to provide a response to HPRAC's review of the scope of practice of dietetics. For further information or clarification on any of these topics, please contact Mary Lou Gignac, Registrar & Executive Director of College of Dietitians of Ontario, or Linda Dietrich, Regional Executive Director with Dietitians of Canada.

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