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Verified standards of professional practice for South African dietetics professionals. Part 1: The standards

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Changes affecting the health care system increasingly demand that dietetics professionals provide quality nutritional care. To meet this challenge, the American Dietetic Association (ADA) developed standards of professional practice for dietetics professionals.[1,2] These standards provide dietetics professionals with a tool for evaluating and improving their professional services, as well as for guiding their careers.[2]

The life cycle of the dietetic profession, including that in South Africa (SA), can be compared to the life cycle of any organisation or business, being characterised by four phases: inception, growth, maturation and decline.[3] The dietetic profession in SA may have to apply creative strategic decisions to avoid entering the phase of decline, e.g. adopting and using standards of professional practice for dietetics professionals. Without the consistent use of such standards, varying degrees of quality in dietetic practice will prevail.[4] To measure quality, the concept of what quality comprises needs to be translated into more concrete terms that are quantifiable to some degree, i.e. standards.[5,6]

The verification of the ADA standards of professional practice for dietetics professionals for use in SA hospitals provides SA hospital dietitians with an instrument that could serve as a tool for measuring SA dietitians' performance, as well as an instrument allowing them to measure their own performance against that of USA dietitians; thus, internal and external benchmarking would be possible.

The purpose of the research behind this paper was to verify whether the ADA standards can be utilised as such in therapeutic nutrition in SA hospital environments, in terms of their applicability (i.e. their relevance) and importance. In the first phase of the study, the value of these standards (as perceived by hospital dietitians) was determined to provide insight into the existing culture among hospital dietitians in accepting and applying these standards in the workplace. The commitment or willingness of dietitians to adhere to these standards was also determined.[7] During the second phase, indicators were developed and verified that could be used in monitoring of the standards.[7]

Prior to verification of the ADA standards, the scope and role of SA dietitians had to be clarified. Although professional standards developed by other professional dietetic organisations (e.g. the Canadian Dietetic Association) were considered, a core group of 12 experienced hospital dietitians involved in the verification agreed on the ADA standards. The congruence between the scope of practice of local and USA dietitians provided a base for verifying the ADA standards (phase 1).[7] The role of the therapeutic dietitian was assessed in terms of dietitians' role functions, frequency of involvement and level of risk.[7]

Methods

Design

A cross-sectional descriptive survey in the quantitative domain was carried out in two phases during the period 1999 - 2002. Permission for using the ADA standards was obtained from the ADA.

Population and sample selection. All the dietitians of different ranks (N=121) employed at the Gauteng (N=20) and Mpumalanga (N=10) provincial hospitals and the 3 hospitals of the South African National Defence Force were included in the sample. Dietitians at the provincial head offices, who had an input in the management of the dietetics departments at the hospitals, especially on matters regarding policy-making, were also included in the study group although they were not based at a hospital *per se*.

Ethics. The Ethics and Protocol Committee of the Faculty of Health Sciences, University of Pretoria, approved the protocol. Respondents were assured of confidentiality.

Data collection and analysis

Data collection was by means of structured self-administered questionnaires sent to all dietitians employed at the participating hospitals. See Table I for a summary of the questionnaires used for confirmation of the scope of practice and role, respectively, of SA dietitians. A conceptual definition for and

Table I. Questionnaires used for confirmation of scope of practice and role of SA dietitians

Measure	Description	Instrument	Origin[7,12,13,14,15,16,17,18,19]
Scope of practice described as major responsibilities in terms of: 1. Applicability/relevance 2. Involvement 3. Importance	Description of the responsibilities related to the scope of practice of dietitians	Likert questionnaire 1. 3-point scale 2. 6-point scale 3. 4-point scale	ADA scope of practice of the dietitian and dietetic technician Role delineation of the SA dietitian (a 1994 concept)
Role in terms of: 1. Function 2. Frequency 3. Perceived risk	Description of the activities performed by dietitians in providing therapeutic nutritional care	Likert questionnaire 1. 5-point scale 2. 6-point scale 3. 3-point scale	ADA role delineation Role delineation of the SA dietitian (a 1994 concept)

'operationalisation' of the scope and role are included in the discussion of the results.

Questionnaires were posted at various stages to avoid/reduce respondent fatigue. Reliability of measuring instruments was improved by using clear, well-defined conceptual definitions. A core group of 12 experienced hospital dietitians assessed all the measuring instruments for understanding and clarity of the statements as well as the applicability thereof within the SA public/provincial/military hospital context, thereby also controlling for face and content validity.

The following additional data were collected during phase 1:

- The demographic data, which were provided by the dietitian in charge of the hospital's department/division of dietetics/nutrition
- The biographical data provided by each respondent.

Data were analysed to identify trends and relationships. Descriptive statistics were compiled and the data presented as frequencies, means, standard deviations and modes using SAS Version 8.2.

Results

Description of the study group

Dietitians participating in the research study were employed at 33 hospitals. A total of 113 posts for dietitians were available at hospitals, and 8 at the provincial and SANDF head offices at the initiation of the research study. Dietitians who were appointed at the provincial head offices (2 in Gauteng and 4 in Mpumalanga) and 2 dietitians at the SANDF headquarters were not counted as employees working at the hospitals.

Whereas 121 dietitians completed the questionnaires at the onset of the research study, the number of participants declined during phase 1 to 84 dietitians completing the last set of questionnaires on the ADA standards. The 30.6% decline in return rate could be ascribed to dietitians who resigned from their posts, dietitians who were on leave/sick leave/maternity leave, or dietitians who were unwilling to complete the questionnaires because of time constraints.

The dietitians responsible for rendering a therapeutic nutrition service at provincial and military hospitals were of a young age (mean 29.5±7.5 years). Four ranks for dietitians in the provincial hospitals (viz. Dietitian, Senior dietitian, Principal dietitian and Assistant director) existed. Dietitians of all ranks had work experience in the broad field of dietetics, ranging from 1 year to 37 years (mean 5.7±5.9), while dietitians' experience in therapeutic dietetics varied from 0 to 22 years for all ranks (mean 4.4±3.7). Dietitians employed at the provincial hospitals who were responsible for the nutritional care of patients had little work experience. Only 7 dietitians (5.8%) had >10 years' experience in therapeutic nutrition.

Standards of professional practice for dietetics professionals

Value of standards. Sixteen statements, which describe the value of standards in general, were identified from the literature. Dietitians' level of agreement with the statements portraying the value of standards was determined by requesting dietitians to indicate whether they *strongly agree, agree, disagree, strongly disagree* or *don't know/unsure* with each statement. The sum of ratings for *strongly agree* and *agree* indicated dietitians' agreement with the value of a statement. More than 70% (mean 90.1 - 98.4%) of dietitians indicated agreement (summated frequency of *strongly agree* and *agree*) with all 16 statements (Table II). The 2 statements that were ranked first when ranking the statements according to agreement (summated frequency for *strongly agree* and *agree*), were 'Standards of practice should be used in monitoring the quality of therapeutic nutritional care in a hospital', and 'If the standard of therapeutic nutritional care in a hospital is known, planning for the therapeutic nutritional care of patients could be improved'. However, dietitians were to a lesser extent

Table II. Frequency of dietitians' (*N*=121) agreement with value statements for standards of professional practice

Statement	Level of agreement* *N* (%)		
	Strongly agree	Agree	Sum of strongly agree and agree
1. Setting standards for therapeutic dietetic practice is one of the active processes in total quality management	75 (61.98)	43 (35.54)	**118 (97.52)**
2. Standards of practice provide a minimum level of practice to assure safe and effective therapeutic nutritional care to patients	76 (62.81)	36 (29.75)	**112 (92.56)**
3. Application of standards of practice establishes common ground for ensuring the delivery of equitable quality of practice irrespective of the locality of a hospital	65 (53.72)	48 (39.67)	**113 (93.39)**
4. Standards of practice could be used in monitoring the quality of therapeutic nutritional care in a hospital	57 (47.11)	62 (51.24)	**119 (98.35)**
5. Feedback regarding non-conformance to standards of practice could be obtained	43 (35.54)	73 (60.33)	**116 (95.87)**
6. The quality of therapeutic nutritional care could be improved on a continuous basis using the standards of practice	80 (66.12)	38 (31.40)	**118 (97.52)**
7. Results of evaluation using standards of practice provide supporting data to justify the value of therapeutic nutritional care	56 (46.28)	53 (48.80)	**109 (90.08)**
8. The degree of variation in the quality of therapeutic nutritional care could be determined using standards of practice	35 (28.93)	79 (65.29)	**114 (94.21)**
9. Standards of practice ensure the dietitian's accountability as a professional to the public and other professions	61 (50.41)	56 (46.28)	**117 (96.69)**
10. If the standard of therapeutic nutritional care in a hospital is known, planning for the therapeutic nutritional care of patients could be improved	63 (52.07)	56 (46.28)	**119 (98.35)**
11. The performance of individual dietitians involved with therapeutic nutritional care of patients could be monitored against the standards of practice	48 (39.67)	64 (52.89)	**112 (92.56)**
12. The periodic measurement of individual performance, using standards of practice, could be carried out by dietitians themselves	47 (38.84)	67 (55.37)	**114 (97.52)**
13. Standards of practice are an aid in professional goal development based on self-evaluation	48 (39.67)	70 (57.85)	**118 (97.52)**
14. Standards of practice assist in defining specific responsibilities of the dietitian	50 (41.32)	67 (55.37)	**117 (96.69)**
15. Standards of practice could be used in the development of job descriptions	50 (41.32)	65 (53.72)	**115 (95.04)**
16. Standards of practice could be used to develop performance evaluation criteria for various job positions	47 (38.84)	65 (53.72)	**112 (92.56)**

* Frequencies ≥70% indicated in **bold**.

in agreement regarding the value of standards where the performance of the individual dietitians was concerned, as well as with statements that had an evaluative component (i.e. statement numbers 4, 5, 7, 8, 11, 12, 13 and 16) (Table II).

Statements of standards of professional practice for dietetics professionals. Six statements relating to standards to be achieved by dietetic professionals were developed by the ADA.[2] Dietitians evaluated the standards in terms of their **relevance** to dietetics in SA hospitals as well as their **importance.** The cut-off values of ≥70% responses indicating low-level agreement, ≥80% responses indicating moderate-level agreement, and ≥90% responses indicating high-level agreement, correspond with the cut-off values in a study performed by Witte *et al.* on developing standards of practice criteria for clinical nutrition managers in the USA in 1996.[7]

Relevance of the ADA standards of professional practice for dietetics professionals in the SA hospital environment. Dietitians' perception of the **relevance (applicability)** of standards was conceptualised as the level of dietitians' agreement with the relevance of standards to dietetics practice in SA. Dietitians were requested to rate their agreement with the relevance of the 6 statements describing the standards as being high or low, or that there was no relevance. A total rating for *high* and *low relevance* (per standard) (summated frequencies for *high* and *low relevance*) of ≥70% responses by dietitians was obtained for all the standard statements (Table III). For standard statements 1 (provision of services) and 4 (utilisation and management of resources), the summated frequency for *high* and *low relevance* was 100% response. Five of the 6 standard statements were perceived by ≥70% dietitians to have *high relevance* and could be considered as most applicable to the profession of dietetics in SA. The only statement not considered to have *high relevance* was the statement dealing with the application of research (Standard 2), for which a mean of 62.8% (*N*=76) dietitians indicated *high relevance*. However, the summated frequency (*high* and *low relevance*) for Standard 2 was ≥70% responses. None of the statements was considered irrelevant.

The lowest rating for *high relevance* for Standard 2 was given by senior dietitians, who also gave the lowest rating for *high relevance* to Standard 4 (utilisation and management of resources). For the other standards, there was an increase in the rating for high relevance with progression in the ranks of dietitians.

Importance of the ADA standards of professional practice for dietetics professionals in the SA hospital environment. Dietitians' perception of the **importance** of standards was conceptualised as an indication of the utility of standards for the maintenance and improvement of the quality of nutritional care delivered by a dietitian. Dietitians were requested to rate the 6 standard statements as being *critical, essential, necessary, desirable* or *unimportant,* as an indication of the utility of the standard for the maintenance and improvement of the quality of nutritional care delivered by a dietitian in his/her work situation. The results did not show the cut-off value of ≥70% responses for any one of the ratings for importance (Table IV). The cut-off value of ≥70% responses for the rating *critical* (lack in achieving the standard interfered with appropriate nutritional care) (69.1%; *N*=47) (Table IV) was almost achieved for only 1 standard statement, viz. Standard 3 (communication and application of knowledge). None of the statements was considered *unimportant.* The summated frequency of the scores for *critical* and *essential* resulted in ≥90% dietitians considering 4 of the 6 standards as critical and essential, i.e. Standards 1 (provision of services), 3 (communication and application of resources), 4 (utilisation and management of resources), and 6 (continued competence and professional accountability). The exceptions were Standard 2 (application of research) for which a mean of 70.6% (*N*=48) dietitians and Standard 5 (quality in practice), for which a mean of 79.4% (*N*=54) dietitians, indicated that these standards were *critical* and *essential.*

It would appear that dietitians' opinions on the importance of these standards were influenced by the rank they had and their number of years of experience in the broad field of dietetics. In most instances, there was an increase in the ratings for *critical* with an increase in rank and years of experience. However, a decline in the ratings for *critical* was observed for 2 standards (viz. Standard 2 (application of research) and Standard 6 (continued competence and professional accountability)) with dietitians in the higher ranks and dietitians with ≥11 years' experience.

Commitment/willingness to adhere to the standards. Dietitians' **commitment** was conceptualised as a reflection of their willingness to adhere to a standard and their dedication to provide quality nutritional care to patients in SA hospitals. Dietitians were requested to indicate whether they were *highly committed, committed, decided, concerned* or *unconcerned* to adhering to the standards. The results did not show the cut-off value of ≥70% responses for any one of the ratings for commitment/willingness (Table V). The summated frequency of *highly committed* and *committed* resulted in ≥90% dietitians indicating they were *highly committed* and *committed* to adhere to 4 of the 6 standards, viz. Standards 1 (provision of services), 3 (communication and application of knowledge), 4 (utilisation of resources) and 6 (continued competence and professional accountability). These are the same standards that ≥90% dietitians considered to be critical and essential. Less than 90% of the dietitians indicated

Table III. Frequency (%) of dietitians' opinion (*N*=121) on the relevance of standards of professional practice for dietetics professionals

Standard of professional practice statements[2]	Relevance* *N* (%) High	Low	Sum of high and low
Standard 1: Provision of services			
Develops, implements and promotes quality services based on client expectations and needs			
Rationale:			
Dietetics professionals provide, facilitate and promote quality services based on client needs and expectations, current knowledge and professional experience	**103 (85.12)**	18 (14.88)	**121 (100.00)**
Standard 2: Application of research			
Effectively applies, participates in or generates research to enhance practice			
Rationale:	76 (62.81)	39 (32.23)	**115 (95.04)**
Effective application, support and generation of dietetics research in practice encourages continuous quality improvement and provides documented support for the benefit of the client			
Standard 3: Communication and application of knowledge			
Successful dietetics professionals apply knowledge and communicate effectively with others			
Rationale:	**111 (91.74)**	9 (7.44)	**120 (99.17)**
Dietetics professionals work with and through others while using their unique knowledge of food, human nutrition and management, as well as skills in providing services			
Standard 4: Utilisation and management of resources			
Uses resources effectively and efficiently in practice			
Rationale:	**103 (85.12)**	18 (14.88)	**121 (100.00)**
Appropriate use of time, money, facilities and human resources facilitates delivery of quality services			
Standard 5: Quality in practice			
Systematically evaluates the quality and effectiveness of practice and revises practice as needed to incorporate the results of evaluation			
Rationale:	**98 (80.99)**	21 (17.36)	**119 (98.35)**
Quality practice requires regular performance evaluation and continuous improvement of services			
Standard 6: Continued competence and professional accountability			
Engages in lifelong self-development to improve knowledge and skills that promote continued competence			
Rationale:	**106 (87.60)**	13 (10.74)	**119 (98.35)**
Professional practice requires continuous acquisition of knowledge and skill development to maintain accountability to the public			

*Frequencies (70% indicated in **bold.**

Table IV. Frequency (%) of dietitians' opinion (*N*=68) on the importance of standards of professional practice for dietetics professionals

Standards of professional practice statements[2]	Importance* *N* (%)					Mode†
	Critical	Essential	Necessary	Desirable	Unimportant	
Standard 1: Provision of services						
Develops, implements, and promotes quality service based on client expectation and needs	39 (57.35)	27 (39.71)	2 (2.94)	0	0	4
Standard 2: Application of research						
Effectively applies, participates in or generates research to enhance practice	16 (23.53)	32 (47.06)	16 (23.53)	4 (5.88)	0	3
Standard 3: Communication and application of knowledge						
Successful dietetics professionals apply knowledge and communicate effectively with others	47 (69.12)	19 (27.94)	2 (2.94)	0	0	4
Standard 4: Utilisation and management of resources						
Uses resources effectively and efficiently in practice	32 (47.06)	31 (45.59)	3 (4.41)	2 (2.94)	0	3
Standard 5: Quality in practice						
Systematically evaluates the quality and effectiveness of practice and revises practice as needed to incorporate the results of evaluation	23 (33.82)	31 (45.59)	13 (19.12)	1 (1.47)	0	3
Standard 6: Continued competence and professional accountability						
Engages in lifelong self-development to improve knowledge and skills that promote continued competence	44 (64.71)	20 (29.41)	3 (4.41)	1 (1.47)	0	4

*Frequencies ≥70% indicated in **bold**.
†Ratings: 0 = unimportant, 1 = desirable, 2 = necessary, 3 = essential, 4 = critical.

that they were *highly committed* or *committed* to Standards 2 (application of research) and 5 (quality in practice); ≤90% dietitians indicated that they considered Standards 2 and 5 to be *critical* and *essential*. A mean of 82.1% (*N*=55) dietitians indicated that they were *highly committed* and *committed* to adhere to standard 5. Less than 70% dietitians indicated that they were *highly committed* and *committed* to adhere to Standard 2 dealing with the application of research. Standard 2 was the only standard which received a rating of *unconcerned* by one dietitian.

When dietitians' commitment/willingness to adhere to these standards was categorised according to rank, results varied among the ranks of dietitians for the ratings *highly committed, committed* and *decided*. The summated frequency of *highly committed* and *committed* resulted in dietitians in the ranks of Dietitian and Senior Dietitian having more or less the same frequency for Standards 1 (provision of services), 3 (communication and application of knowledge), 4 (utilisation and management of resources) and 6 (continued competence and professional accountability) (≥90% responses), as well as in an increased frequency with progression in rank (100% responses). For Standards 2 (application of research) and 5 (quality in practice), there was a decrease in the summated frequency of *highly committed* and *committed*, with progression in rank (78.1% in rank of Dietitian; 33.3% in rank of Assistant Director). These results should, however, be interpreted with caution due to the small number of Assistant Directors who participated in the research study.

Discussion

The standards define desirable and achievable levels of performance by dietitians and acknowledge the common dimensions of dietetic practice in the hospital environment by describing the responsibilities for which dietitians are accountable,[2,8] and also describing the unique services that dietitians could provide within the health care team, reflecting the *Batho pele* principles.[9] The standards also provide provincial authorities with a yardstick for evaluating nutritional care service at a hospital for the purposes of both internal and external benchmarking and for accrediting hospitals for training of dietetic students.[10]

The ADA maintains that the six standards of professional practice for dietetics professionals encompass the key characteristics of the dietetic profession in the USA, and that the standards should be adopted by all dietitians to ensure that they will continue to be recognised by

Table V. Frequency (%) of dietitians' commitment (*N*=68) to adhere to standards of professional practice for dietetics professionals

Standards of professional practice statements[2]	Commitment* *N* (%)				Mode†
	Highly committed	Committed	Decided	Concerned	Unconcerned	
Standard 1: Provision of services						
Develops, implements, and promotes quality service based on client expectation and needs	37 (55.22)	27 (40.30)	2 (4.48)	0	0	4
Standard 2: Application of research						
Effectively applies, participates in or generates research to enhance practice	12 (17.91)	34 (50.75)	13 (19.40)	7 (10.45)	1 (1.49)	3
Standard 3: Communication and application of knowledge						
Successful dietetics professionals apply knowledge and communicate effectively with others	41 (61.19)	24 (35.82)	2 (2.99)	0	0	4
Standard 4: Utilisation and management of resources						
Uses resources effectively and efficiently in practice	29 (43.28)	34 (50.75)	4 (5.97)	0	0	3
Standard 5: Quality in practice						
Systematically evaluates the quality and effectiveness of practice and revises practice as needed to incorporate the results of evaluation	23 (34.33)	32 (47.76)	10 (14.93)	2 (2.99)	0	3
Standard 6: Continued competence and professional accountability						
Engages in lifelong self-development to improve knowledge and skills that promote continued competence	43 (64.18)	22 (32.84)	1 (1.49)	1 (1.49)	0	4

*Frequencies ≥70% indicated in **bold**
†Ratings: 0 = unconcerned, 1 = concerned, 2 = decided, 3 = committed, 4 = highly committed.

the public as the most valued and credible sources of food and nutrition information.[2] Through the adoption of the ADA standards by SA dietitians, the local dietetic profession should benefit in the following ways, as described by the Quality Management Committee of the ADA:[2,10,11]

- Dietitians should have access to guidance regarding the knowledge, skills, judgement and attitudes required in their practice. Kulkarni *et al.* state that knowledge is gained not only through studying theory and principles, but also through the embodiment of those principles in daily practice, combined with mentoring.[11] Dietitians could achieve competence by using the standards and comparing changes in their own professional performance.[2] The importance of lifelong learning through continuing education and mentoring is incorporated into the standards.
- A uniform set of standards should be available for judging dietitians' performance, that could be used by: patients/clients as the users of nutritional care services; hospitals as the employers of dietitians; and colleagues.[11] Using these standards could help dietitians to identify areas in which additional knowledge and skills are needed to maintain competence despite new developments.
- Development and improvement of the nutritional care service in a hospital could take place through strategic direction by application of the data obtained when using the standards. (The standards themselves are an application of continuous quality improvement concepts reflecting a commitment to ongoing improvement.)[11]
- The standards provide dietetics professionals with the opportunity to generate research by incorporating research into their clinical duties as well as encouraging them to critically evaluate research in order to determine evidence of good practices.[10,11] Opportunities for research ought to be exploited to validate dietetics practice in the

hospital environment, the services to be provided by the dietitian, and the effectiveness of nutritional care services in hospitals. The dietetic profession will thus be in a position to evaluate itself, and, through research, evidence-based practice could be documented.

- Using the standards should provide the dietetic profession with data describing the profession's identity, which could be applied in validating dietetics practice in the hospital environment. The periodic review and revision of the standards could contribute towards the continuous improvement of the standards *per se* as well as the dietetic profession.[2]

SA hospital dietitians had a positive mindset towards the value of standards regarding the planning and monitoring of therapeutic nutritional care that should be conducive to the successful implementation of *standards of professional practice for dietetics professionals* leading to improvement in service delivery.[10] Dietitians should, however, be convinced that, through evaluating their own performance by using these standards, they could make a valuable contribution to the collective performance of the nutritional care service, which will be a reflection of the quality service rendered by the nutritional care service of the hospital.

Dietitians' willingness to adhere to the *standards of professional practice for dietetics professionals* could further contribute to implementing the standards. However, clear evidence of dietitians' willingness to adhere to the standard dealing with the application of research was lacking, especially among the older and more experienced dietitians. These are also the dietitians acting as role models for students and newly qualified dietitians entering the profession. Dietitians in top echelons of the dietetic hierarchy of an institution would need a change in mindset and to adopt an attitude fostering the willingness of the newly qualified dietitians to participate in research and provide such opportunities to them. Participation in research should aid in raising the professional profile of the therapeutic/clinical dietitians working in the hospital environment thereby making each dietetic professional a more sought-after source of nutrition information.

Conclusion and recommendations

The standards developed by the ADA were verified in terms of their relevance and importance for utilisation in SA hospitals. Dietitians indicated a willingness to adhere to these standards and displayed a positive mindset towards the value of standards. The reported findings cannot be generalised to all SA but can be used to improve the quality of nutritional care services in provincial/public hospitals in Gauteng/Mpumalanga and the military hospitals by obtaining baseline data on current performance and identifying shortcomings, followed by corrective action and re-evaluation.

However, this requires that the scope of practice of dietetics professionals working in a specific hospital should be confirmed, job descriptions of individual dietitians should be in place, and each dietitian should determine how each standard relates to his/her specific area of practice before selecting the indicators appropriate to his/her practice.[10] Communicating the standards to dietitians and developing training on how to use the standards needs to be co-ordinated. Training activities could include workshops, lectures and practical sessions at the nutritional care services of individual hospitals. Training should also include a motivational component on the importance of adopting standards, the link between standards and the broader professional development process, the importance of conducting professional self-assessment, and how individual dietetics professionals will benefit from using the standards.[2,10] The study should be repeated in provincial hospitals in other provinces to strengthen the verification of the standards.

The ADA standards should be verified among dietitians practising in areas other than public/provincial/military hospitals, thereby allowing the standards to be applied in all areas of dietetic practice. Because the standards reflect changes in market trends, transitions in the work environment and expectations of the public, they should be regularly reviewed and revised as the needs of the dietetics profession, especially regarding the work environment, change. Dietitians should accept responsibility for evaluating their practice and maintaining professional competence as well as evaluating these standards for contributing to the advantage of the dietetics profession in SA.[2]

1. American Dietetic Association. Standards of practice for the profession of dietetics. *J Am Diet Assoc* 1985; 85 (6): 723-6.
2. American Dietetic Association. The American Dietetic Association standards of professional practice for dietetics professionals. *J Am Diet Assoc* 1998; 98 (1): 83-7.
3. Schiller MR, Gillbride JA, O'Sullivan-Maillet J. *Handbook for Clinical Nutrition Services Management.* Aspen: Gaithersburg, 1991.
4. The South African Medical and Dental Council. Regulations defining the scope of the profession of dietetics. *Government Gazette* No. R. 891. 26 April 1991: 82.
5. Graham NO. *Quality in Health Care. Theory, Application, and Evaluation.* Gaithersburg: Aspen, 1995.
6. Shoaf LR, Bishirjian KO, Schlenker ED. The gerontological nutritionists standards of professional practice for dietetics professionals working with older adults. *J Am Diet Assoc* 1999; 99 (7): 863-867.
7. Viviers CM. Verified standards of professional practice for dietetics professionals. MDietet thesis, University of Pretoria, 2006.
8. Witte SS, Escott-Stump S, Fairchild MM, Papp J. Standards of practice criteria for clinical nutrition managers. *J Am Diet Assoc* 1997; 97 (6): 673-678.
9. White paper (Batho Pele Paper) on transforming Public Service Delivery. *Government Gazette,* Vol 388, Notice 1459 of 1997, No. 18340, October 1997.
10. Kieselhorst KJ, Skates J, Pritchett E. American Dietetic Association: Standards of practice in nutrition care and updated standards of professional performance. *J Am Diet Assoc* 2005; 105 (4): 641-645.
11. Kulkarni K, Boucher JL, Daly A, *et al.* American Dietetic Association: Standards of practice and standards of professional performance for registered dietitians (generalist, specialty, and advanced) in diabetes care. *J Am Diet Assoc* 2005; 105 (5): 819-824.
12. Kane MT, Estes CA, Colton DA, Eltoft CS. Role delineation for dietetic practitioners: Empirical results. *J Am Diet Assoc* 1990; 90 (8): 1124-1133.
13. Digh EW, Dowdy RP. A survey of management tasks completed by clinical dietitians in the practice setting. *J Am Diet Assoc* 1994; 94 (12): 1381-1384.
14. Kris Etherton PM, Lindsay CA, Smutz WD, Chernoff R. A profile of clinical dietetics practice in Pennsylvania. *J Am Diet Assoc* 1980; 76 (6): 564-70.
15. Sneed J, Burwell EC, Anderson M. Development of financial management competencies for entry-level and advanced-level dietitians. *J Am Diet Assoc* 1992; 92 (10): 1223-1229.
16. Finlay DH, Simons JM. Role perception of consultants in Iowa nursing homes. *J Am Diet Assoc* 1986; 86 (8): 1042-1046.
17. Gilbride JA, Simko MD. Role functions of dietitians in New York State nursing homes. *J Am Diet Assoc* 1986; 86 (2): 222-227.
18. Jones MG, Bonner JL, Stitt KR. Nutrition support service: Role of the clinical dietitian. *J Am Diet Assoc* 1986; 86 (1): 68-71.
19. Rose JC, Zolber K, Vyhmeister I, Abbey D, Burke K. Performance task functions by ADA dietetic technicians. *J Am Diet Assoc* 1980; 76 (6): 563-569.