

CANADIAN DIETETIC
REGISTRATION EXAMINATION
(CDRE)

Preparation Guide[®]

2008

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Regulation of Dietetic Practice in Canada

The Alliance of Canadian Dietetic Regulatory Bodies (the Alliance) strives to maintain a uniform standard of entry into the dietetic profession that allows dietitians to have their qualifications recognized when seeking employment across Canada. Members of the Alliance share common requirements for academic and practical training, entry-level competencies*, scopes of practice, professional standards, and codes of ethics.

The Canadian Dietetic Registration Examination (the Exam) is a requirement for registration as a dietitian in Canada in all provinces except Quebec.

This Preparation Guide[®] has been developed to help you understand the Exam process. To obtain more information contact your provincial dietetic Regulatory Body (Appendix E).

*Competencies for the Entry-Level Dietitian (Dietitians of Canada, 1996) (the COMPETENCIES - Appendix C)

This is the only guide that has been approved for the
Canadian Dietetic Registration Examination.

No other examination guide has been authorized, reviewed for reliability, or in any way confirmed to be representative of the Exam questions in style, content or format. Adequate preparation is the responsibility of each candidate, and ultimately is confirmed when the COMPETENCIES have been met.

**The Alliance assumes no responsibility for information about the Exam
obtained from unauthorized sources.**

Also available in French: *Examen canadien d'autorisation d'entrée à la pratique des diététistes—Guide de préparation*

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1. Purpose of the Exam

Regulatory Bodies (Colleges, Associations and Boards) protect the public by assuring that dietitians are properly educated and trained, thus maintaining the high quality of nutrition care in Canada. The Exam is your entry into the dietetic profession, through registration with the Regulatory Body in the jurisdiction in which you have chosen to practice. It is not an exit exam from an internship or practical training program. It is designed to confirm that your practice-based knowledge, application and critical thinking skills are at the level of minimal competence and that you are safe to practice.

The Exam is the final step in the registration process to become a registered dietitian and it has one purpose only:

- **to distinguish between competent and non-competent practitioners**

2. Who Can Write the Exam?

To be eligible to write the Exam, you must meet the academic, practical training and any other requirements of registration as designated by the Regulatory Body which issued you a temporary membership or which deemed you to be eligible to write the examination. These requirements include:

- completion of a four-year baccalaureate degree in an accredited program in foods and nutrition at a Canadian university or equivalent, and
- attainment of the *COMPETENCIES* (Appendix C) through an accredited internship or equivalent

Refer to your Regulatory Body for any additional registration requirements.

3. Applying to Write the Exam

The application process includes the following steps:

- obtain an application form and directions from the Regulatory Body in the province where you wish to PRACTICE
- confirm the date of the next Exam and the deadline for submitting your application. The deadlines are normally 2 to 3 months prior to the scheduled date of the Exam
- submit to the Regulatory Body, a completed application package including the application form, application fee and all the necessary supporting documents before the deadline date

You will be informed of your eligibility to write the Exam once your Regulatory Body determines that you meet the registration requirements. Your name will be added

to the Exam roster and further instructions will follow when your Regulatory Body receives:

- the Exam fee and, if applicable, temporary registration fee (the latter is set by each Regulatory Body)
- a passport size photo of yourself with your name printed on the front and signature on the back that has been verified by a Registered Dietitian

To receive information concerning the Exam, it is important to keep the Regulatory Body informed of any changes in your contact address and telephone number.

Temporary Registration

In some provinces a candidate may be able to apply for Temporary Registration to practice while waiting to write the Exam. Temporary Registration is granted for a limited time period and is only available when you have applied to write the Exam. Check with your Regulatory Body to see if this option is available.

Exam Fee

The Exam fee is \$400 (plus applicable taxes). Contact your Regulatory Body for details on fee payments and due dates.

Exam Date, Frequency and Site

Upon registration for the Exam, you will receive confirmation of the date, time and location of the Exam directly from your Regulatory Body.

Date and Frequency

The Exam is generally administered twice each year, in May (second Saturday) and November (third Saturday). You can obtain the exact date of each Exam from your Regulatory Body.

Site

Each Regulatory Body is responsible for arranging an Exam site for the province. A request for an ALTERNATE SITE can be considered. Any such request must be made at the time that you apply to write the examination.. Contact your Regulatory Body to confirm whether there are any additional costs associated with the arrangement of an alternate site.

Language Options

The Exam is available in both English and French. You must indicate your choice of language on your Exam application. Candidates receive only one language version. (See Section 4). The Regulatory Body may ask you whether you are comfortable receiving the examination instructions from an English speaking invigilator or whether you require a French speaking invigilator.

Special Accommodations

Disability

If you have a disability, temporary disability or a special need and wish to request special accommodation you must:

- request this in writing when you apply for the Exam
- provide documentation of your disability and needed accommodation(s) from a regulated health professional who is specialized in assessing individuals with the type of disability

Your Regulatory Body will endeavour to provide mutually satisfactory accommodations. There is no additional fee for special accommodation. All Exam sites are wheelchair accessible.

In all circumstances, the Exam may not be written more than 1 day before the scheduled Exam date.

Religious Reasons

If your religious convictions prevent you from writing the Exam on the scheduled Exam date, you may write the Exam on the day preceding the scheduled Exam date. To arrange an alternate Exam DATE, if your religious convictions prevent you from writing on the date scheduled, you must:

- request this in writing when you apply for the Exam
- provide written confirmation in the form of an original letter on letterhead from a religious institution official (i.e. minister, priest, rabbi or pastor).

There is no additional fee for this arrangement. Contact your Regulatory Body for more information and the security measures that apply.

Refunds

To WITHDRAW your application or to SWITCH TO ANOTHER DATE:

- you must request this in writing from your Regulatory Body
- this must be postmarked WITHIN 14 calendar days following the deadline date for receipt of the Exam fee.

If you do not withdraw your application within 14 calendar days following the Exam fee deadline, OR do not write the Exam, the Exam fee may be FORFEITED. Contact your Regulatory Body for details.

Exceptions - Compelling Reasons

If you are unable to write the Exam due to compelling reasons beyond your control, you may apply to your Regulatory Body for:

- an extension of the Exam eligibility period
- a refund of the Exam fee
- withdrawal of candidacy
- an extension of your Temporary Registration (if applicable) in accordance with the regulations and policies of your Regulatory Body.

Consideration will be given, but is not limited, to:

- accidents
- bereavement
- illness
- weather or travel disruption

To be eligible for a refund, you or your designate must:

- notify your Regulatory Body within TWO business days following the day of the Exam
- apply in writing to your Regulatory Body, clearly stating the circumstances of why you were unable to write the Exam. This must be RECEIVED within 30 calendar days following the Exam date. Please include any supporting documentation.

The Regulatory Body will inform you of its decision within 45 days of receipt of your request. If your request for a refund is approved, the Exam fee will be refunded and you will receive information regarding the next administration.

If you held Temporary Registration prior to the Exam date, check with your Regulatory Body for an extension.

<p>NO REFUND OF THE EXAM OR APPLICATION FEE WILL BE GIVEN TO CANDIDATES WHO FAIL THE EXAM</p>
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4. Preparing to Write the Exam

What you Need to Know About this Exam

The following information will help you to understand more about the Exam process and how questions are developed.

Facts: The EXAM	What this Means
<ul style="list-style-type: none"> is a CRITERION-REFERENCED exam 	<ul style="list-style-type: none"> it compares all candidates to a single criterion, which is MINIMAL COMPETENCE this is how it differs from most of the other exams you have written which are norm-referenced, and compare each candidate's performance to an arbitrarily set pass score
<ul style="list-style-type: none"> reflects current dietetic practice in Canada is based on the COMPETENCIES 	<ul style="list-style-type: none"> there are six categories of competencies: <i>Professional Practice, Assessment, Planning, Implementation, Evaluation and Communication</i> these were developed and validated with national input in 1995 by the Canadian Dietetic Association (now Dietitians of Canada)
<ul style="list-style-type: none"> is NOT a diagnostic test of competence result is Pass/Fail 	<ul style="list-style-type: none"> the Exam is designed only to confirm whether you have demonstrated minimal competence it is not designed to measure HOW competent you may be therefore the result is PASS (you demonstrated minimal competence) or FAIL (you did not demonstrate it) should you fail the Exam, this is the only reliable information that can be provided to you following a failure, a thorough review of the COMPETENCIES (Appendix C) is indicated
<ul style="list-style-type: none"> undergoes thorough and multiple screenings and review this accounts for the cost of the Exam which is NOT profit-generating 	<ul style="list-style-type: none"> a contracted Testing Agency with recognized expertise oversees the Exam development the EXAM COMMITTEE, ITEM WRITERS, ITEM APPRAISERS and the FRENCH TRANSLATION REVIEW COMMITTEE are comprised of REGISTERED DIETITIANS with experience and expertise representing all areas of practice; academic and practical programs and all provinces are also represented each question undergoes at least ten screenings, to ensure the Exam tests: <ul style="list-style-type: none"> - the Entry-Level Competencies - realistic and practical aspects of dietetic practice that is national in scope

The Exam Blueprint													
<p>Exam and Question Format</p>	<ul style="list-style-type: none"> • written in two 3-hour sessions (morning and afternoon) • you may leave a session anytime AFTER the first 1½ hours • 200-220 multiple-choice questions • 20-30% case-based questions (3-6 questions related to a single case) • 70-80% independent questions 												
<p>Cognitive Domain</p> <ul style="list-style-type: none"> • each question tests one of three levels of ability 	<p>20-30% KNOWLEDGE/COMPREHENSION (ability to recall/understand previously learned material)</p> <p>45-55% APPLICATION (ability to apply knowledge to new, practical situations)</p> <p>20-30% CRITICAL THINKING (ability to judge relevance of data, deal with abstractions, problem-solve)</p>												
<p>Competence Grouping</p> <ul style="list-style-type: none"> • each question targets a competency, NOT an area of practice • some COMPETENCIES are more important and are used more frequently than others 	<ul style="list-style-type: none"> • each question tests one of the COMPETENCIES while the SETTINGS are varied to represent practice areas • therefore a question could be a PLANNING or EVALUATION question, but not a CLINICAL or ADMINISTRATIVE question • candidates frequently focus on the setting information, rather than the point of the question, which will always be a competency; this is the most persistent misconception about the Exam • this is reflected in the proportion of questions on the Exam devoted to each group: (see Appendix C) <table style="margin-left: 20px;"> <tr> <td>Group 1A</td> <td>Very Important - High Frequency</td> <td>40-50%</td> </tr> <tr> <td>Group 1B</td> <td>Very Important - Low Frequency</td> <td>30-40%</td> </tr> <tr> <td>Group 2A</td> <td>Important - High Frequency</td> <td>15-25%</td> </tr> <tr> <td>Group 2B</td> <td>Important - Low Frequency</td> <td>1-10%</td> </tr> </table>	Group 1A	Very Important - High Frequency	40-50%	Group 1B	Very Important - Low Frequency	30-40%	Group 2A	Important - High Frequency	15-25%	Group 2B	Important - Low Frequency	1-10%
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Group 2B	Important - Low Frequency	1-10%											
<p>Contextual Variables</p> <ul style="list-style-type: none"> • CLIENT AGE/GENDER • CULTURE • HEALTH CARE SETTING 	<ul style="list-style-type: none"> • questions are designed to provide a cross-section of settings representing Canadian entry-level practice • cultural issues are integrated in the Exam without introducing stereotypes and CONTENT TOPICS (Appendix D) provide a framework for question development 												

Questions and Comments from Previous Candidates

Commonly Asked Questions and Comments	Exam Committee Responses
<i>"Can I take my calculator into the exam?"</i>	<ul style="list-style-type: none"> no, security prohibits the use of calculators in the Exam room
<i>"Will I have to do calculations and remember lab values?"</i>	<ul style="list-style-type: none"> you will be expected to be familiar with, and interpret the lab values an entry-level dietitian would deal with, but you will not have to calculate or remember lab values necessary conversions are provided e.g. "Mr. Peters weighs 99 kg, is 180 cm tall (BMI= 30.6)..."
<i>"How is the French Exam developed?"</i>	<ul style="list-style-type: none"> the English Exam is professionally translated each question is then reviewed by the FRENCH TRANSLATION REVIEW COMMITTEE (French Committee) composed of practicing francophone dietitians representing all areas of practice high quality and equivalence to the English version is the goal content accuracy, technical terminology and consistency in language are scrutinized and verified with recognized French resources expressions not common to all provinces are avoided special consideration is given to word count to match the length of the English version
<i>"I want to write the French exam. Why can't I have an English exam as well?"</i>	<ul style="list-style-type: none"> Alliance Policy states that candidates writing in French will receive only the French booklets this prevents disadvantaging candidates by losing reading time the French Committee ensures that any terms that may be problematic will be provided in BOTH English and French, on the French Exam
<i>"How is the passing score set?"</i>	<ul style="list-style-type: none"> the passing score is set individually for each Exam and is not released; the difficulty of each question is assessed first this ensures the fairest score in setting the competence/non-competence line it is just as important NOT to fail a competent candidate, as it is to fail the candidate who has not demonstrated minimal competence

Questions and Comments (cont'd)

Commonly Asked Questions and Comments	Exam Committee Responses
<p><i>"The exam was too long. You could have confirmed my competence with fewer questions."</i></p>	<ul style="list-style-type: none"> • statistically a minimum number of questions is required since no such exam can assess a total body of knowledge • a minimum of 200 questions ensures assessment is VALID and RELIABLE • training and experience vary and you may be above minimal competence
<p><i>"There wasn't enough information provided."</i></p>	<ul style="list-style-type: none"> • irrelevant information is excluded because it MISLEADS • ALL information needed to answer correctly is there • if you think something is missing, read again - it is most likely you made an incorrect assumption
<p><i>"There were too many questions on...e.g. food-service, diabetes, etc"</i></p>	<ul style="list-style-type: none"> • this perception is not unlikely considering the relatively small number of settings an entry-level dietitian is exposed to • however, there are 145 competencies you must meet • look past the setting to see what COMPETENCY is being tested • any given setting could be used to test many competencies (ASSESSMENT vs IMPLEMENTATION), or even the SAME competency at different levels of ability (KNOWLEDGE vs CRITICAL THINKING)
<p><i>"I expected more knowledge-based questions."</i></p>	<ul style="list-style-type: none"> • a dietitian's work is DOING not just knowing • competent practice requires appropriate APPLICATION and CRITICAL THINKING • questions assessing these also confirm KNOWLEDGE
<p><i>"The exam should be essay format so I can explain my answers."</i></p>	<ul style="list-style-type: none"> • Multiple Choice format eliminates subjective marking • scientific methodology confirms the VALIDITY and RELIABILITY of the Exam • results are available within 6-8 weeks (vs months) • there are no TRICK questions (they would INVALIDATE the Exam)

Questions and Comments (cont'd)

Commonly Asked Questions and Comments	Exam Committee Responses
<p><i>"Questions were repetitive and redundant."</i></p>	<ul style="list-style-type: none"> • some types of client situations occur more frequently than others in dietetic practice • the Exam attempts to reflect real practice • no two questions will repeat the same setting and test the same competency, although it may seem like it at the time of writing
<p><i>"The exam should be: ..shortened.. ..written as one 4-hr session.. ..written on two days.."</i></p>	<ul style="list-style-type: none"> • the needs of all candidates must be considered and while many candidates say they did not need the full three hours, others did • feedback has been obtained from candidates and the majority clearly indicates that the current two 3-hour sessions should be maintained
<p><i>"It was unfair because in my internship/setting... ..I didn't have a rotation in pediatrics* or ..work with computers* ..there was no administrative dietitian*"</i></p>	<ul style="list-style-type: none"> • remember that what you are being tested on is the COMPETENCIES, not settings • you are expected to transfer your skills from one setting to another <p><i>* These should not imply that the Exam includes or excludes questions related to these, which are offered only as examples.</i></p>
<p><i>"Some questions have more than one correct answer."</i></p>	<ul style="list-style-type: none"> • each question has four options: 1 correct answer and 3 distractors • distractors are designed to be plausible with faulty reasoning, inadequate reading or inappropriate assumptions <p><i>See "How to Read and Exam Question" (next page)</i></p>

How to Read an Exam Question

Occasionally you may come across an aspect of a question's content that is not consistent with your own experience, or that may not seem plausible to you. Accept the scenario as presented. Remember, you are being tested on your ability to apply the *COMPETENCIES* in new settings. Internships, practical training and upgrading practicums differ across the country and what may seem unlikely to you, has been judged *REALISTIC* and *ENTRY-LEVEL* in repeated screenings by experts.

STEP 1							
<p>Read the TEXT of the question first to determine:</p> <p>a) cognitive level</p> <p>b) competency category</p>	<ul style="list-style-type: none"> • avoid classifying the question as a 'diabetes' or 'clinical' etc. question; details describe the SETTING in which a COMPETENCY is being tested • determine the cognitive level of the question: are you asked... <ul style="list-style-type: none"> - for information? (KNOWLEDGE/COMPREHENSION) - to apply information? (APPLICATION) - to analyse information? (CRITICAL THINKING) • relate the question to one of the six competency categories: Are you asked to demonstrate competence in... <table border="0"> <tr> <td>PROFESSIONAL PRACTICE?</td> <td>IMPLEMENTATION?</td> </tr> <tr> <td>ASSESSMENT?</td> <td>EVALUATION?</td> </tr> <tr> <td>PLANNING?</td> <td>COMMUNICATION?</td> </tr> </table> 	PROFESSIONAL PRACTICE?	IMPLEMENTATION?	ASSESSMENT?	EVALUATION?	PLANNING?	COMMUNICATION?
PROFESSIONAL PRACTICE?	IMPLEMENTATION?						
ASSESSMENT?	EVALUATION?						
PLANNING?	COMMUNICATION?						
STEP 2							
<p>Re-read the text along with the options provided.</p>	<ul style="list-style-type: none"> • determine if there is a temporal aspect (point in time) to the question i.e. Are you being asked for an INITIAL step in a process, a CONCLUDING step etc? 						
STEP 3							
<p>Choose the correct option of those provided.</p>	<ul style="list-style-type: none"> • remember there are no trick questions • wrong options are there to act as distractors to reveal FAULTY knowledge, application or critical thinking • thinking there is not enough information is an indication that you need to go back to Step 1. and read more carefully • all the information needed to answer questions correctly IS provided • irrelevant information is excluded because it wastes time and can mislead 						
<p>Try this 3-step process on the Exercise on the following page.</p>							

Exercise

1.

A public health dietitian in collaboration with community partners, has developed an education program for grade 3 students on healthy snacks. The program was piloted with children in two different schools and is now ready for use in all city schools. What is the best strategy for the dietitian to take?

1. Contact the School Board to have the information put onto the Board's website
2. Send copies of the program to all Grade 3 teachers and offer in-service classes
3. Write a newsletter outlining the program plan and send to all school principals
4. Present the program to the Parent School Council in each school

cognitive level _____ *competency category* _____ *temporal aspect* _____

2.

In a small community hospital, a new product has been purchased to thicken liquids for clients with dysphagia. A new recipe has been developed. What should the administrative dietitian do next?

1. Add the recipe to the Nourishment binder and flag it for staff
2. Have foodservice staff attend an in-service to learn about the product and recipe
3. Write a memo about the product and send to all foodservice staff with their pay stub
4. Ask the clinical dietitian to do a presentation on dysphagia to the foodservice staff

cognitive level _____ *competency category* _____ *temporal aspect* _____

3.

Mrs. Cole, an inactive senior with chronic constipation is referred for counselling. The dietitian concludes that Mrs. Cole is following *Canada's Food Guide to Healthy Eating* and her diet contains at least 35 g of fibre. What should the dietitian do next to assist Mrs. Cole?

1. Document the assessment in Mrs. Cole's chart and refer her to the physiotherapist
2. Tell Mrs. Cole that she needs to exercise more frequently
3. Tell Mrs. Cole that she is eating well and does not need to change her diet
4. Discuss Mrs. Cole's activity needs with her and the physiotherapist

cognitive level _____ *competency category* _____ *temporal aspect* _____

Answers on next page.

Exercise Answers and Rationales (Correct option **bold**)

On first reading, you might mistakenly classify these as COMMUNITY, FOOD SERVICE and CLINICAL questions. These labels correctly apply to the settings, but not to the intent of the questions. In fact all three questions target the SAME competency.

COMPETENCY: IMPLEMENTATION Group 2A

4-1a *activates the plan by communicating the plan to the client and appropriate others*

Q1		(Application)
Option 1.	leaves communication up to the client, no active communication by the dietitian	
Option 2.	the dietitian communicates the program to the clients (teachers) who will use it; thoroughness is demonstrated by offering an in-service	
Option 3.	leaves it to principals to communicate with clients, no active communication by dietitian	
Option 4.	although it reaches some parents, it does not communicate with teachers and children	

Q2		(Application)
Option 1.	leaves communication up to client, no active communication by dietitian	
Option 2.	the dietitian communicates the new product information to those using it	
Option 3.	assigns a lesser priority to the initiative by putting it in with the pay stubs; does not communicate with the staff who will use the new product	
Option 4.	the presentation is on dysphagia, not on the new product/recipe <i>(As written, this option could be acceptable as a next step in the implementation process. This emphasizes the need to read the 'temporal' aspect of questions.) Although not all small community hospitals employ both an administrative and clinical dietitian, you are asked to accept this scenario in this question.</i>	

Q3		(Application)
Option 1.	no active communication with the client	
Option 2.	telling the client what to do is not effective implementation/communication	
Option 3.	eliminates any communication with the client about what the best plan is	
Option 4.	the dietitian communicates plan with the client and appropriate other	

5. Writing the Exam—Rules

Candidate Declaration to Maintain Confidentiality

The Exam is protected by copyright. All questions are confidential and the property of the ALLIANCE OF CANADIAN DIETETIC REGULATORY BODIES.

The Exam is the final requirement for entrance into the dietetic profession in Canada. Identifying candidates who have not attained minimal competence is the sole purpose of the Exam, and ensures that only competent individuals are allowed to practice.

MAINTAINING INTEGRITY AND CONFIDENTIALITY, is part of the dietitian's professional oath in the *Code of Ethics for the Dietetic Profession in Canada*. By declaring that you will maintain strict confidentiality about the Exam, you will also be meeting the dietitian's responsibility for PROMOTING AND MAINTAINING HIGH STANDARDS.

ANY DISCUSSION of the Exam, including the informal or organized sharing of and distribution of questions based on memory or recall, once the Exam has been written, is not permitted, and means that you have breached confidentiality, as well as compromised your integrity and the standard of entry to the dietetic profession.

Upon application to write the Exam you will be asked by your Regulatory Body to sign the *CANDIDATE'S DECLARATION TO MAINTAIN CONFIDENTIALITY* (the DECLARATION), which will be kept in your permanent file.

On the day of the Exam, prior to writing, you will be required to sign the DECLARATION a second time, as a reminder of your commitment. This copy of your Declaration is on your Exam booklet and is kept on file with the Testing Agency.

On the Day of the Exam:

- arrive at least 30 minutes before the Exam is scheduled to begin to confirm your registration
- register with the invigilator before the morning AND afternoon session
- 15 minutes before the start time, you will be allowed into the Exam room where you will receive instructions on the Exam procedures
- bring a soft eraser

- follow all directions given by the invigilator(s)
- stay for both the morning and afternoon session to write the entire Exam
- you can leave any time AFTER the first 1½ hours of each session
- do not write beyond the allotted time allowed (unless special accommodation has been given)

If for whatever reason you arrive up to 1 ½ hour late for the Exam, you will be given the option of writing the Exam within the remaining time or writing the Exam on the next scheduled date. If you decide to write the Exam, you will be asked to sign an acknowledgement and accept the risk associated with not having the full amount of time to answer the Exam questions.

These are NOT allowed at the desks:

- calculators or other aids
- study materials, such as books or notes
- electronic devices such as a cell phones and PDA unless they are turned off
- food or liquid products with the exception of water contained in a clear bottle that does not have a label

Please note that special accommodations for food and liquids will be made based on medical need at the discretion of the Regulatory Body. Please refer to the "Special Accommodation" in section 3 (Applying to Write the Exam)

You may keep a wallet or small purse under your seat in the Exam Room but will not be able to look into it or take something from it without being supervised by an Exam invigilator.

Distractions in the Exam Room

Creating an environment that is conducive to Exam candidates being able to concentrate is important. Please note that the Exam invigilator has the right to direct a candidate to remove apparel and accessories, such as jewelry, that make distracting sounds.

Exam Schedule

<u>Time Zone</u>	<u>Province</u>	<u>AM Session</u>	<u>PM Session</u>
NL Standard	NL	9:30-12:30	13:30-16:30
Atlantic	NS	9:30-12:30	13:30-16:30
Atlantic	NB	9:30-12:30	13:30-16:30
Atlantic	PEI	9:30-12:30	13:30-16:30
Eastern	ON	9:00-12:00	13:00-16:00
Central	MB	8:30-11:30	12:30-15:30

Central	SK	8:30-11:30	12:30-15:30
Mountain	AB	8:00-11:00	12:00-15:00
Pacific	BC	8:00-11:00	12:00-15:00

Cheating and Disqualification

Cheating can include, but is not limited to, any one or more of the following:

- having a non-registered individual pose as a registered candidate
- bringing study materials to your desk
- referring to electronic devices during the exam
- attempting to observe another candidate's work
- seeking or giving aid to another candidate
- communication of any kind with another candidate
- attempting to remove Exam materials from the Exam site
- failure to follow an invigilator's direction

**CONTRAVENTION OF EXAM PROTOCOL (CHEATING) WILL RESULT IN IMMEDIATE
DISQUALIFICATION AND REMOVAL FROM THE EXAMINATION**

6. Exam Scoring

The Exam is PASS/FAIL. The passing score is based on the degree of difficulty of each question, which determines the overall score required to pass the Exam. You will not receive a grade score. A percentage mark would imply your skills were being evaluated, which would be misleading.

Your answer sheets will be computer-scored. Results will be sent to you by your Regulatory Body SIX to EIGHT weeks following the Exam. Your PASS/FAIL status is released only to you and only in writing (generally through the mail).

Verification of Scores

The only type of re-scoring available is confirmation of the computer grading of the answer sheets. EXAMINATION BOOKLETS ARE NOT AVAILABLE FOR REVIEW. If you fail the Exam and want to request a re-score, HAND-SCORING of your answer sheets by the Testing Agency is available for a fee of \$25.00 (plus applicable taxes)

Your request for re-scoring must be submitted to your Regulatory Body within 30 calendar days from the notice date of your Exam results. The re-scoring fee must accompany the request. This fee is non-refundable unless, upon verification of scores, it is found that you passed the Exam.

7. Release of Statistical Information on Exam Results

An acknowledgement that Exam results (personally non-identifiable) can be released for statistical purposes, is included on the Exam application form. Only under your written instruction will your Exam results be released to a third party.

8. Appeals

You have the right to appeal your Exam results based on irregularities in the Exam administration and content. The appeal procedure is:

- send a written request detailing the nature of your appeal to your Regulatory Body; this must be received within 15 calendar days of the date on the letter notifying you of your Exam result
- include a \$75 appeal fee with your appeal; this will be refunded if your appeal is successful
- contact your Regulatory Body for more information on the appeal procedure

IF YOUR APPEAL IS SUCCESSFUL:

You are allowed to write the next Exam at no additional cost.

If you held Temporary Registration prior to writing the Exam, check with your provincial Regulatory Body for reinstatement.

9. Failure and Re-application

Candidates will be informed of the procedure for the next administration of the Exam at the time of notification of failure. A candidate who fails his or her first attempt will have TWO further attempts to pass the Exam. Additional education and/or practical training is required AFTER A SECOND FAILURE, as determined by the Regulatory Body, before the applicant can make a third and final attempt. An Exam fee is charged for each attempt.

Appendix A Sample Exam Questions

These are samples of the type of questions that appear on the Exam. Answers and rationales are provided. The *COMPETENCY* and *DOMAIN* being tested are identified to assist you. Settings are derived from the *CONTENT TOPICS* (Appendix D) and varied to reflect entry-level practice. (Note: This *MIXTURE* of questions is not reflective of the *BLUEPRINT* i.e. this is not a 'mini-Exam'.)

CASE 1

A dietitian has been consulted to review the puréed menu in a long-term care facility. The dietitian was also asked to provide recommendations on the feasibility of using outsourced products to address their food safety concerns with the preparation of puréed foods. The present non-selective puréed menu provides 30-40 g of protein and 6800-9200 kJ (1600-2200 kcal) per day. In addition, residents are offered three between-meal nourishments. The last audit indicated that 40% of the time residents did not accept the nourishments offered.

QUESTIONS 1 to 4 refer to this case.

1. What is the primary concern with the puréed menu?
 1. Inadequate energy
 2. Inadequate protein
 3. Inadequate number of nourishments
 4. Inadequate number of meals

2. What action should the dietitian recommend initially regarding the unaccepted nourishments?
 1. Switch to other nourishments
 2. Discuss possible solutions with the facility manager
 3. Identify the problem with the clients
 4. Eliminate the nourishments and increase meal amounts

3. The dietitian recommends purchasing outsourced puréed entrées on a one-month trial. The entrées will be evaluated on many factors during the trial. When the dietitian makes a final recommendation, which should be the deciding factor?
 1. Cost savings in labour hours
 2. Refrigerator and freezer storage space
 3. Acceptance of the entrées by residents
 4. Cost of outsourced pureed entrées

4. Using outsourced products on a trial basis will require changes in kitchen routines. What action should the dietitian recommend for initiating the trial?
 1. Approach the manufacturer's representative to coordinate the trial
 2. Meet with staff to discuss the new products and handling procedures
 3. Instruct a supervisor to test the new products and assign staff later
 4. Contact Public Health and speak to nursing staff to build consensus

END OF CASE

CASE 2

Mr. Hill, 25 years old, has cerebral palsy (CP). His motor, mental and communication functions are partly affected by his CP. He lives in a group home and is presently experiencing End-Stage Renal Disease (ESRD). Dialysis treatment in the future is inevitable. The dietitian knows Mr. Hill well and is planning to meet with him to discuss his short-term and long-term nutrition goals.

QUESTIONS 5 to 10 refer to this case.

5. How are diets for Pre-End-Stage Renal Disease (Pre-ESRD) and dialysis different?
 1. The recommended amount of dietary protein for Pre-ESRD is lower than that for dialysis
 2. The recommended amount of dietary protein for Pre-ESRD is higher than that for dialysis
 3. The recommended amount of dietary fat for Pre-ESRD is lower than that for dialysis
 4. The recommended amount of energy for Pre-ESRD is higher than that for dialysis

6. To decide on the type of dialysis for Mr. Hill, who should be consulted, in addition to the administrator of the home?
 1. Mr. Hill and the hospital renal team
 2. A designated decision-maker for Mr. Hill and the hospital renal team
 3. Mr. Hill and/or a designated decision-maker and the hospital kidney transplant team
 4. Mr. Hill and/or a designated decision-maker and the hospital renal team

7. If Mr. Hill goes on hemodialysis, which conditions should the dietitian consider in the long term?
 1. Hypokalemia and hyperphosphatemia
 2. Hyperlipoproteinemia and osteodystrophy
 3. Hyperkalemia and hypophosphatemia
 4. Hypotension and diabetes

8. Mr. Hill is known to consume large amounts of fresh fruits, vegetables and snacks such as potato chips. Which condition will most likely result if he continues this diet?
1. Hyperkalemia
 2. Hyperphosphatemia
 3. Hyponatremia
 4. Elevated urea
9. The administrator of the home calls the dietitian to report that Mr. Hill has been eating potato chips again. He has some edema and his blood pressure is rising. What action should the dietitian take next?
1. Discontinue services for Mr. Hill
 2. Explain to the administrator that Mr. Hill has been advised about his diet already
 3. Ask the administrator to monitor the situation
 4. Meet with Mr. Hill and/or a designated decision-maker to discuss the situation
10. One year later, Mr. Hill is on hemodialysis and arrives for dialysis with a weight gain of 2 kg over the prescribed limit. He has a normal serum sodium. What is the most likely cause of Mr. Hill's weight gain?
1. Too much phosphorous and potassium
 2. Too much fluid and potassium
 3. Too many fruits and vegetables
 4. Too much fluid and sodium

END OF CASE

INDEPENDENT QUESTIONS

QUESTIONS 11 to 19 do not refer to a case.

11. An 83 year-old woman was admitted to hospital for shortness of breath, nausea, vomiting and ascites. She reports a recent rapid weight gain of 7 kg (height: 160 cm, weight 67 kg). Upon admission, lab data reveal a low serum albumin and normal liver function tests. Her diet provides about 6000 KJ (1400 kcal) and 60 g protein. Which conclusion should the dietitian make based on this data?
1. Weight gain is a positive indicator of improved nutritional status
 2. Recent weight gain reflects an increased oral intake
 3. Serum albumin is low due to the intake of a low-protein, high-fat diet
 4. Recent weight gain is related to low serum albumin

12. An 18 year-old client, is referred to the dietitian for an initial visit about his lactose intolerance. The referral form indicates that he is apprehensive and reluctant to discuss his symptoms. Which action would be most effective when counselling him?
1. Engage Mr. Dumont in dialogue to assess his verbal and non-verbal responses
 2. Give Mr. Dumont a list of foods to avoid
 3. Provide Mr. Dumont with a list of lactose-free products
 4. Outline for Mr. Dumont the changes he will have to make in his diet
13. Mrs. Gordon, 75 years old, has arthritis and low serum albumin. She has a reduced appetite and is edematous. What action by the dietitian would be most effective in improving Mrs. Gordon's nutrition and health status?
1. Provide counselling on a high energy, high protein diet
 2. Ask Mrs. Gordon to complete a 3-day food record
 3. Recommend that an appetite enhancer be ordered by the physician
 4. To eliminate the possibility of error, suggest the serum albumin test be repeated
14. The hospital dietitian was asked to prepare a heart health nutrition class for businessmen from the local community. What is the most effective marketing activity for the dietitian to take?
1. Post an advertisement on the hospital bulletin board
 2. Advertise in the local monthly business bulletin
 3. Mail announcements to all city households
 4. Advertise on the bulletin board at the local community centre
15. Which of the following manifestations are characteristic of bulimia nervosa?
1. Knuckle calluses, unwillingness to discuss food intake, amenorrhea
 2. Erosion of dental enamel, knuckle calluses, psychological distress
 3. Hypertension, low blood sugar, history of weight change
 4. Ketoacidosis, hypotension, edema
16. The hospital dietitian would like to make use of a survey she recently conducted in the community. Her goal is to increase revenues in her department. The survey revealed that 43% of males over the age of 70 years live at home and purchase ready-to-serve meals. Which strategy should the dietitian use to maximize revenues?
1. Develop a menu of hospital-produced, ready-to-serve meals to be delivered to these clients
 2. Form a partnership with a local restaurant to provide ready-to-serve meals
 3. Assess the feasibility of marketing hospital-produced, ready-to-serve meals to these clients
 4. Conduct a hospital-designed survey to verify that the community results can be replicated

17. The dietitian in a long-term care facility goes into the kitchen and sees a tray of egg salad sandwiches sitting on the counter. An hour later the sandwiches are still there. According to Hazard Analysis Critical Control Point guidelines, what should the dietitian do first?
1. Ask the cook when the sandwiches were prepared
 2. Take the temperature of the sandwiches
 3. Discard the sandwiches and substitute
 4. Refrigerate the sandwiches immediately until service
18. The dietitian is developing education materials to use in a pre-retirement worksite health promotion program. She wants to be sure the audience understands the messages. The participants include several ethnic groups with a range of literacy skills. Which strategy would be most effective for the dietitian to use?
1. Hold a focus group with a representative sample of participants to pilot the material
 2. Distribute a questionnaire at the end of the workshop to assess understanding
 3. Use pictures, charts and diagrams to reinforce information presented in text form
 4. Assess readability to confirm all materials are written at grade 6 level
19. A 13 year-old baseball player refuses to consume dairy products. Which recommendation would best meet her nutritional needs?
1. Supplement daily with calcium and vitamin D
 2. Insist that she consume one serving of yoghurt daily
 3. Increase intake of other calcium-rich foods she likes
 4. Consume 250 mL soya beverage daily
20. A group of people living independently in a senior citizen's complex, ask the community dietitian for information about shopping and cooking for one. What action should the dietitian take first?
1. Discuss with the group their concerns about the food they are currently buying and cooking
 2. Organize a grocery store tour to point out the single serving foods available
 3. Conduct a written survey with the seniors to determine food preferences and nutrition knowledge
 4. Suggest that the group shop and cook their meals together
21. A 3-month-old breast-fed boy is referred to the dietitian. His weight is at the 5th percentile and his length is at the 40th percentile. No other medical problems are identified. His mother reports that he feeds frequently and requires four diaper changes per day. What should the dietitian do first?
1. Advise his mother to feed him more frequently
 2. Refer his mother to a support group that promotes breastfeeding
 3. Obtain more information on his mother's milk supply and breastfeeding technique
 4. Suggest his mother supplement breastfeeding with an infant formula

22. A client satisfaction survey conducted by the foodservice department in a children's hospital showed a low rating on the fruit/dessert choice. Food return audits also showed a high level of fresh fruits returned. The dietitian is concerned that the children are not meeting the recommendations in *Canada's Food Guide* during their hospital stay. Which action should the dietitian take to promote healthy eating during hospitalization?
1. Provide nutrition education to clients on the daily menu to promote selection of healthy choices
 2. Provide age appropriate raw and canned fruits and vegetables and re-audit
 3. Replace whole fruits with fruit juices and serve soup twice a day
 4. Replace whole fruits on the menu with ice cream and increase vegetable portion sizes
23. A 70-year-old man is referred to the dietitian, with anemia of unknown cause. The diet history shows an adequate intake from all food groups in *Canada's Food Guide*. He mentions he has been taking herbal products for fatigue. Which action should the dietitian take first?
1. Recommend a daily iron supplement taken with orange juice
 2. Assess his intake of foods rich in iron, vitamin B₁₂, and folate
 3. Research the herbal products he is taking
 4. Determine his living circumstances before giving advice
24. A 53-year-old man with bowel cancer is recovering from surgery, where much of the colon was removed. What is the dietitian's main concern for this patient?
1. Increased loss of calcium
 2. Decreased absorption of vitamin B₁₂
 3. Decreased absorption of fat soluble vitamins
 4. Increased loss of fluids and electrolytes
25. An 80-year-old male resident in a long-term care facility meets with the dietitian to discuss his frequent constipation. Investigations have ruled out any underlying medical concern. The resident reports he has an excellent appetite and consumes all meals and snacks offered at the home. Which of the following options would be the most likely contributing factor?
1. Low dietary fibre intake
 2. Excessive consumption of cheese
 3. Lack of physical activity
 4. Inadequate fluid consumption

26. A 75-year-old woman on hemodialysis for chronic renal failure is referred to a dietitian for dietary assessment/review. The client weighs 50 kg and is consuming 20g protein per day. What should the dietitian recommend?
1. Refer the client to her family physician
 2. Instruct the client on an increased protein intake
 3. Refer the client to a more experienced dietitian
 4. Instruct the client on a decreased protein intake
27. A consulting dietitian has been hired by a 200-bed nursing home to provide clinical nutrition services. While charting in the foodservice department, the dietitian notes a 20 L mixer bowl of hot pudding being wheeled into the refrigerator for chilling. What should the dietitian do?
1. Suggest to the foodservice supervisor that they should use instant puddings that require no heating
 2. Document the details of the incident and monitor staff food handling techniques
 3. Continue with the clinical services for which the dietitian was contracted and recommend more staff training
 4. Inform the foodservice supervisor to ensure the pudding is safely handled
28. The dietitian at a large health club wants to offer a 'Heart Smart' class on a pay-per-session basis. The manager is unsure if the demand exists with the club members. What is the best way for the dietitian to assess present demand?
1. Interview all club members
 2. Hold a focus group with club members
 3. Offer an information session for club members
 4. Survey all club members by questionnaire
29. The dietitian in a women's prison has been asked to implement a perpetual inventory system in the kitchen. Which of the following choices is the main advantage of this system?
1. It provides a running balance of all food items
 2. There is a separate card for all food items on hand
 3. Food items can be easily counted once a month
 4. Food items are listed in alphabetical order
30. A group of overweight women want to learn more about food composition and food labelling in order to buy lower energy foods. Which activity would be most useful for the dietitian to arrange for these clients?
1. A grocery store tour with discussion of their concerns
 2. A presentation on the new food labelling system in Canada
 3. A taste test of a variety of lower energy foods
 4. A presentation on healthy eating and exercise

31. A 21-year-old man was referred to the dietitian to increase his weight. One of the goals set with the dietitian was for him to consume two cans of high-energy liquid supplement per day. Three weeks later he remains at his previous weight and states he did not take any of the supplements. Which action should the dietitian take now?
1. Review the previous goals and gently remind him to take the supplement
 2. Reset goals in collaboration with the client
 3. Suggest making milkshakes which are less expensive
 4. Recommend more portable foods such as cookies and fruits
32. Following a case of suspected food borne illness, the foodservice dietitian is designing a food safety training program for employees. Which of the following procedures is the most effective way for staff to prevent food borne illness?
1. Preparation of potentially hazardous food in small batches
 2. Rapid cooling of leftovers in shallow pans
 3. Wearing hairnets and gloves at all times
 4. Accurate labelling and dating of all foods in the refrigerator
33. For a nutrition month project, a dietitian managing a high school cafeteria introduced a daily low fat special. Attractive pricing and signage were unsuccessful in promoting sales. What action should the dietitian take?
1. Discontinue the low fat menu option
 2. Review the pricing of all regular items
 3. Remove fried food choices from the menu
 4. Explore other low fat options with students
34. The dietitian has been asked to develop a lesson plan on breakfast for grade 3 students. The lesson will be delivered by teachers and parents. What should the dietitian do first?
1. Develop learning objectives after discussion with parents and teachers
 2. Develop learning activities appropriate for children in grade 3
 3. Investigate computer games that appeal to children in grade 3
 4. Investigate breakfast-eating practices of the teachers and parents
35. What is the ultimate goal of a dietetic regulatory Quality Assurance Program?
1. To assist dietitians in reviewing skills and identifying learning needs
 2. To ensure public safety by confirming dietitians' competence
 3. To systematically identify all dietitians' personal learning objectives
 4. To be flexible enough to meet the learning needs of dietitians practicing in every segment of dietetics

Answers and Rationales for Sample Questions (Correct option bold)

Case 1

- Q1** **Competency: ASSESSMENT Group 1A** **(Application)**
2-7 *formulates conclusions based on the interpretation and integration of data*
-
- Option 1. Energy is within recommended intake for an elderly person.
Option 2. 30-40 g of protein is inadequate. Between 54 g and 73 g per day or 10-15%
of daily calories from protein is recommended for an elderly person.
Option 3. 3 nourishments a day is acceptable, standard practice.
Option 4. 3 meals a day is adequate especially when completed with nourishments.

- Q2** **Competency: ASSESSMENT Group 1B** **(Application)**
2-4 *uses effective data collection techniques*
-
- Option 1. Making changes without seeking the source of the problem may not solve the
problem and could lead to bigger problems
Option 2. The facility manager is likely unaware residents aren't accepting the
nourishments or the reasons for this. Same as Option 1.
Option 3. The most accurate data will be collected directly from the clients. Then
the problem can be analysed.
Option 4. Same as Option 1.

Q3 Competency: ASSESSMENT Group 1A (Application)

2-1 *identifies and confirms issues which have dietetic implications*

- Option 1. Labour savings are important but there won't be savings or quality service if clients don't eat the product and/or request something else.
- Option 2. Storage space won't matter if residents don't accept the product.
- Option 3.** Client's acceptance of the product is the most important factor in selecting menu items. If clients aren't satisfied all the other factors won't matter—product will not be eaten and nutritional status may be further impaired.
- Option 4. Product costs are important but there won't be savings if the residents don't eat the product and request something else.

Q4 Competency: PLANNING Group 1B (Application)

3-5k *develops, with client & appropriate others, plans of action for managing the safe provision of foods/nutrients*

- Option 1. Staff are more familiar with kitchen routines than a representative, less biased, and are more likely identify other relevant issues.
- Option 2.** The most appropriate method of initiating any trial is to discuss the trial products/changes in routine with the users (i.e. the staff preparing the product).
- Option 3. The supervisor should be aware of the changes to tasks, but it is the staff who should work with the products during a trial to assess fully.
- Option 4. These groups are neither the consumer nor the user. You could seek feedback from Nursing re client acceptance during the trial.

Case 2

Q5 Competency: ASSESSMENT Group 1B (Knowledge)

2-6c *integrates and interprets health record data*

- Option 1.** Pre-ESRD is lower in protein because kidneys are unable to filter protein molecules. Dialysis helps this process allowing increased protein intake.
- Option 2. See Option 1.
- Option 3. Fat does not impact on kidney function.
- Option 4. Energy intakes does not impact on kidney function.

- Q6 Competency: COMMUNICATION Group 1A (Critical Thinking)**
6-1 *collaborates with clients, colleagues, agencies, etc, during all phases of practice*
-
- Option 1. Mr. Hill might not be able to fully understand/decide for himself because of his affected mental and communication functions.
- Option 2. Mr. Hill might still be able to be involved in decisions concerning his condition but he was excluded.
- Option 3. The hospital kidney transplant team should not be involved at this time. Mr. Hill's disease is not at this stage yet.
- Option 4.** Administrator should be consulted about equipment availability. Mr. Hill might still be able to be involved in decisions, but may need a designated decision maker to be present. The renal team needs to assess Mr. Hill's condition.

- Q7 Competency: IMPLEMENTATION Group 1A (Knowledge)**
4-4 *modifies the plan, as indicated through the monitoring process or as the result of unexpected circumstances*
-
- Option 1. Hyperphosphatemia should be monitored, but it's hyperkalemia (not hypokalemia) that should be considered in the long term.
- Option 2.** Atherosclerosis is the most frequent cause of death among patients maintained on long-term hemodialysis. Osteodystrophy can be caused by hyperphosphatemia which resorbs the calcium from the bones.
- Option 3. Hyperkalemia should be monitored, but it's hyperphosphatemia (not hypophosphatemia) that should be monitored.
- Option 4. Hypertension and diabetes should be monitored, not hypotension.

- Q8 Competency: ASSESSMENT Group 1B (Knowledge)**
2-6c *integrates and interprets health record data*
-
- Option 1.** Fruits and vegetables including potatoes are high in potassium and could lead to hyperkalemia.
- Option 2. Fruits and vegetables aren't high in phosphorous.
- Option 3. Fruits and vegetables are low in sodium but would not cause hyponatremia.
- Option 4. Elevated urea indicates ineffective dialysis; would not be caused by high fruit and vegetable consumption.

Q9 Competency ASSESSMENT Group 1B (Application)

5-2c *evaluates the process with respect to client satisfaction*

- Option 1. Dietitian must continue services until otherwise ordered by Mr. Hill's physician.
- Option 2. Dietitian should not disregard the administrator's concerns, especially if Mr. Hill's blood pressure is rising and he has edema.
- Option 3. Dietitian should monitor the situation, not ask the Administrator to do this.
- Option 4.** Dietitian should meet with client to discuss his eating habits, and evaluate the situation.

Q10 Competency: ASSESSMENT Group 1B (Application)

2-6c *integrates and interprets health record data*

- Option 1. Phosphorous and potassium won't affect weight.
- Option 2. Fluid intake would affect weight, but potassium wouldn't.
- Option 3. It is unlikely that fruit and vegetable consumption would affect weight.
- Option 4.** Weight gain in renal disease is usually linked to edema and can be caused by too much sodium (retains water). Total fluid consumption is also crucial, because declined renal function prevents elimination of excess fluids.

INDEPENDENT QUESTIONS

Q11 Competency: ASSESSMENT Group 1B (Critical Thinking)

2-6c *integrates & interprets health record data*

- Option 1. Low serum albumin precludes an improved nutritional status.
- Option 2. An energy intake of only 1400 kcal could not be responsible for such a weight gain.
- Option 3. Protein intake is within the recommended amount for the client. There is no mention of her dietary fat intake in the data.
- Option 4.** Rapid and significant weight gain is most likely due to a shift in fluid balance. This is supported by the low albumin level, which can result in edema, confirmed by Mrs. Hall's ascites.

Q12 Competency: COMMUNICATION Group 1A (Application)

6-11 *seeks, recognizes and responds appropriately to feedback*

- Option 1.** Drawing client out gently, puts him at ease and establishes rapport. Nonverbal communication is a reliable indicator of client apprehension.
- Option 2. Dietitian shouldn't give client information before confirming his symptoms and condition. This disregards the referral information provided.
- Option 3. Same as Option 2.
- Option 4. Same as Option 2.

Q13 Competency: IMPLEMENTATION Group 2A (Application)

4-2a *executes the plan by managing the delivery of programs, products and services*

- Option 1.** A high energy/protein diet will help elevate Mrs. Gordon's serum albumin which in turn will reduce her edema. It will improve her nutritional status as well.
- Option 2. A 3-day food record only confirms what is already known, that the client has a reduced appetite and is not eating enough. Does not address her nutritional status.
- Option 3. Recommending medication or supplements should only be considered after efforts to improve Mrs. Gordon's oral intake fail.
- Option 4. Low serum albumin is consistent with inadequate nutrition and edema and supported by other signs of deficiency. Based on the information provided there is no basis for questioning the test results.

Note: The temporal aspect of this question places you at the outcome of "improved nutrition and health status 'for Mrs Gordon.' If the question asked was, "What initial action should the dietitian take?", the correct answer would be 'complete a nutritional assessment'.

Q14 Competency: COMMUNICATION Group 1B (Critical Thinking)

6-8 *communicates effectively considering the client's profile*

- Options 1. The hospital personnel, visitors and patients aren't the target audience.
- Option 2.** This will reach the largest number of the local businessmen (clients).
- Option 3. City households aren't the target for this class.
- Option 4. The community centre is not necessarily visited by local business personnel.

Q15 Competency: ASSESSMENT Group 1B (Knowledge)

2-6c *integrates and interprets health record data*

- Option 1. Amenorrhea is mostly seen in anorexia clients, seldom in bulimic clients who are often of normal weight.
- Option 2.** Repeated scraping of knuckles on teeth when purging results in calluses. Habitual vomiting erodes tooth enamel. Bulimic clients are often depressed/have mood swings.
- Option 3. Hypertension and history of weight change are common in bulimic clients, but not low blood sugar.
- Option 4. Hypotension and edema are common in bulimic clients, but ketoacidosis is not.

- Q16 Competency: ASSESSMENT Group 2A (Application)**
2-6i *integrates and interprets marketing data*
-
- Option 1. A new menu should not be developed before assessing the situation. It could actually cost the department money.
- Option 2. Profit would be shared with the local restaurant, which would not maximize revenues for the department.
- Option 3.** The dietitian uses survey results to determine feasibility of project. To be cost effective, all costs must be considered.
- Option 4. Conducting a second survey to replicate results would be costly and not achieve anything.

- Q17 Competency: IMPLEMENTATION Group 1B (Application)**
4-3h *monitors the achievement of the plan's objectives according to safe provision of foods/nutrients*
-
- Option 1. The cook's information only becomes relevant after the temperature is taken.
- Option 2.** The temperature is the critical element that will determine whether the food is safe. *Note the temporal aspect: this is the first action needed.*
- Option 3. The sandwiches may not have to be discarded or substituted, once temperature is known.
- Option 4. Refrigeration at this point provides a potential for serving unsafe food.

- Q18 Competency: ASSESSMENT Group 2B (Application)**
2-2j *identifies/obtains relevant data including factors affecting learning*
-
- Option 1.** Piloting the material in this way allows for revision as needed.
- Option 2. This permits use of ineffective and inappropriate material.
- Option 3. This may not suit participants' learning abilities.
- Option 4. Participants may be above or below grade 6 reading level. Does not consider the various ethnic groups.

- Q19 Competency: PLANNING Group 1A (Application)**
3-6b *develops a specific plan of action with the client and appropriate others to meet the objectives for nutrition promotion and clinical nutrition by identifying the appropriate approach (dietary regimen)*
-
- Option 1. Before recommending supplements, alternate food sources should be considered. Exposure to sun playing baseball should ensure adequate vit. D.
- Option 2. You cannot force her to change eating habits. The client has to be open to change.
- Option 3.** Other food sources of calcium should be explored with Lucy first.
- Option 4. Soya beverages aren't always enriched with calcium and 250 mL is not adequate to meet daily calcium needs.

Q20 Competency: PLANNING Group 1A (Application)

3-6c *develops a specific plan of action with the client and appropriate others to meet the objectives for nutrition promotion and clinical nutrition by determining content.*

OPTION 1. The dietitian cannot develop a plan of action without first learning what the group of people are doing now.

OPTION 2. The dietitian needs to confirm what the actual concerns are first, before providing a solution such as this.

OPTION 3. Written surveys may limit the number of respondents due to barriers such as literacy or physical impairments to reading.

OPTION 4. This is not a realistic solution as each person lives independently and it does not address their stated needs.

Q21 Competency: ASSESSMENT Group 2B (Application)

2-2C *identifies/obtains relevant data including health record data (e.g., anthropometric, biochemical, clinical, dietary, psychosocial)*

OPTION 1. It is the mother's perception that the infant feeds frequently The dietitian needs to assess the situation first.

OPTION 2. Immediate action is required for the infant, whose growth is poor. Support is useful but does not address the issue.

OPTION 3. More information is needed to identify the cause of poor growth before forming a plan of action.

OPTION 4. This may be a possible solution, but initially, more information is needed to identify the cause of poor growth before forming a plan of action.

Q22. Competency: ASSESSMENT Groups 1B (Critical Thinking)

2-6h *integrates and interprets quality management data (e.g., client satisfaction questionnaire, standards of practice audit).*

OPTION 1. Population turnover precludes this as an effective approach.

OPTION 2. The dietitian integrates data from quality assurance tools to improve the menu to help clients meet their nutritional needs.

OPTION 3. This could negatively impact fibre intake and nutrient density.

OPTION 4. This action does not address the issue. Increasing portion size does not guarantee children will eat the foods.

Q23. **Competency: ASSESSMENT Groups 2B** **(Critical Thinking)**
2-2c *identifies/obtains relevant data including health record data (e.g., anthropometric, biochemical, clinical, dietary, psychosocial)*

- OPTION 1. The type of anemia has not been confirmed.
OPTION 2. When there is insufficient information the dietitian explores the problem and obtains additional information through assessment, before attempting to solve the problem.
OPTION 3. This is reasonable to do later, after the diagnosis is confirmed and the diet assessed.
OPTION 4. This is reasonable to do at a later time.

Q 24 **Competency ASSESSMENT Group 1A** **(Knowledge)**
2-7 *formulates conclusions based on the interpretation and integration of data*

- OPTION 1. This occurs more commonly with duodenum and jejunum resection.
OPTION 2. This occurs more commonly with ileum resection.
OPTION 3. This is most common with surgery of the duodenum and ileum.
OPTION 4. This is most common with colon resection.

Q25 **Competency: ASSESSMENT Group 1A** **(Knowledge)**
2-3 *recognizes factors affecting an issue (e.g., psychosocial, cultural, political, legal, ethical, religious)*

- OPTION 1. If the client consumes all meals/snacks offered at the facility his dietary fibre intake should be adequate.
OPTION 2. This deals with the myth that cheese causes constipation. It is also unlikely excessive cheese would be on a LTC menu due to cost.
OPTION 3. Many elderly people experience constipation due to decreased physical activity.
OPTION 4. If the client consumes all meals/snacks offered at the facility, fluid needs should be met.

Q26 **Competency: ASSESSMENT Group1B** **(Knowledge)**
2-6b *integrates and interprets dietary intake data (e.g., 24 hour recall, food frequency and food record).*

- OPTION 1. The dietitian is the appropriate health care professional to assess protein needs.
OPTION 2. The client requires more than 20 grams of protein daily. Hemodialysis usually consists of 3-5 hours of treatment three times per week. Dietary protein needs are 1.2 g/kg, about 50% high biologic value protein, to make up losses through the dialysate.

Q 30 **Competency: EVALUATION Group 1B** **(Knowledge)**
5-2d *evaluates the process with respect to impact (e.g., financial, community, psychosocial and nutritional benefit).*

- OPTION 1.** A hands-on tour in the store addresses both labelling and purchasing and is likely to have the greatest impact on the women's future purchases of lower energy foods.
- OPTION 2. Passive learning, although it may increase the women's knowledge, is not as effective as application of that knowledge.
- OPTION 3. The women want information about food composition and buying lower energy foods, not just how they taste.
- OPTION 4. This does not address the women's needs.

Q31 **Competency: PLANNING Group 1A** **(Application)**
3-6b *develops a specific plan of action with the client and appropriate others to meet the objectives for nutrition promotion and clinical nutrition by identifying the appropriate approach (e.g., program, advocacy, feeding route, dietary regimen).*

- OPTION 1. The dietitian would have to first determine why he did not take the supplements to see if this is a viable option to suggest.
- OPTION 2.** Goals should be determined in collaboration with the client.
- OPTION 3. Expense has not been indicated as a barrier to this point.
- OPTION 4. Supplements are also portable, and portability has not been identified as a barrier to this point.

Q32 **Competency: PLANNING Group 1B** **(Knowledge)**
3-5a *develops, with client and appropriate others, plans of action for managing human resources (e.g., recruiting, orienting, training, supervising, evaluating, scheduling).*

- OPTION 1.** This is a good idea but if proper techniques are not used, batch size does not matter.
- OPTION 2.** Rapid cooling reduces the opportunity for bacterial growth, which reduces the risk of food borne illness.
- OPTION 3. Wearing hairnets does not decrease food borne illness and gloves can be misused.
- OPTION 4. Labelling, which includes dating is important but if the product has been improperly cooled, proper labelling will not prevent potential harm to clients.

Q33 **Competency: PROFESSIONAL PRACTICE Group 2A** **(Application)**
1-9a *applies a research approach to problem solving by examining a problem.*

- OPTION 1. Further investigation of the problem is needed before acting.
OPTION 2. Pricing may not be the issue. See Option 1.
OPTION 3. This is a reasonable thing to do but fried foods may not be related to the lack of sales.
OPTION 4. The dietitian needs to find out more about the problem from the client before deciding on a course of action.

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Q34. **Competency: PLANNING 1A** **(Application)**
3-1 *establishes, with the client and appropriate others, realistic goals consistent with the assessment, ethical considerations, legislation, and policies.*

- OPTION 1.** Learning objectives must be defined before planning a program.
OPTION 2. Learning activities would be planned to meet the learning objectives so would follow Option 1.
OPTION 3. See Option 2.
OPTION 4. This is not relevant as the lesson is for Grade 3 students. This might be done as a way of engaging parents and teachers who deliver the program, but would not be a first step.

Q35. **Competency: PROFESSIONAL PRACTICE Group 2A** **(Knowledge)**
1-3b *commits to a high standard of professional competence through continuous learning and self-development by identifying development needs in practicing dietetics.*

- OPTION 1. This is only one step in the QA process, which ultimately ensures the protection of the public.
OPTION 2: The mandate of all dietetic regulatory bodies is to protect the public interest. The QA program plays a critical role in this process by confirming member's competence on an ongoing basis.
OPTION 3: Identifying learning objectives is an *initial step* for the dietitian in the QA process. Objectives may be appropriate, inappropriate, met or not met.
OPTION 4: Flexibility is a desirable quality in any QA program and individual learning needs can be met in a variety of settings. However, flexibility does not address the *incompetent* practitioners, who are the target of a QA program

Appendix B Some References Currently used in Canadian Programs

The following are some of the publications currently in common use throughout Canadian institutions providing accredited food and nutrition, baccalaureate programs and internships/practicums. This list does not attempt to include all acceptable references nor is it suggested that the Exam is necessarily based on these references. This list is provided as general reference guidance only.

In preparing for the Exam, it is recommended that you review the Entry-Level Competencies (Appendix C) to identify those areas you may need to strengthen. As a well-prepared candidate:

- you will have a firm understanding of basic sciences (e.g. human physiology, biochemistry) as related to competent dietetic practice
- You should feel capable of fulfilling each of the Professional Practice, Assessment, Planning, Implementation, Evaluation and Communication competency statements, in all areas of dietetic practice
- You will have reviewed the competency statements and your own self-assessment to help identify references to consult

Remember, the purpose of this Exam is to confirm minimal competence (entry level ability), not to assess all of your dietetic knowledge or skill areas.

Government Publications/Nutrition Standards

Institute of Medicine

- Dietary Reference Intakes. The DRIs are published as a series of reports by the National Academy of Sciences. The reports can be viewed online and ordered from the National Academy Press at:
http://search.nap.edu/nap_cgi/naptitle.cgi?Search=dietary+reference+intakes

Health Canada Publications (available at www.hc-sc.gc.ca)

For example:

- Canada's Food Guide to Healthy Eating (1992)
- Canada's Food Guide to Healthy Eating: Focus on Preschoolers (1995)
- Canada's Food Guide to Healthy Eating: Focus on Children Six to Twelve Years (1997)
- Canadian Guidelines for Body Weight Classification in Adults (2003)
- Food Guide Facts: Background for Educators and Communicators (1992)
- Nutrition for Health: An Agenda for Action, Joint Steering Committee (1996)
- Nutrition for a Healthy Pregnancy: National Guidelines for the Childbearing Years (1999)
- Nutrition for Healthy Term Infants. Statement of the Joint Working Group: Canadian Paediatric Society, Dietitians of Canada, Health Canada (1998) (refer to Health Canada website for updates)
- Nutrition Labelling Toolkit for Educators (2003)

- Physical Activity Guide to Healthy Active Living (1998); ...For Older Adults (1999),...For Children and Youth (2002)
- The Vitality Approach: A Guide for Leaders (1999)

Community Nutrition

- Boyle MA, Morris DH. Community nutrition in action: An entrepreneurial approach (3rd ed.). Belmont, CA: Wadsworth Publishing Company, 2003.
- Glanz K, Lewis F, Rimer B (Eds.). Health behaviour and health education (2nd ed.). San Francisco: Jossey-Bass Publishers, 1997.
- Kaufman M. Nutrition in public health: A handbook for developing programs and services. Rockville, MD: Aspen Publishers, 1990.
- National Cancer Institute. Theory at a glance. A guide for health promotion practice. National Institutes of Health, 1997. (available at www.nci.nih.gov)
- National Cancer Institute. Making health communication programs work. A planner's guide. National Institutes of Health, 2002. (available at www.nci.nih.gov)
- Owen A, Splett P, Owen G. Nutrition in the community: The art and science of delivering services (4th ed.). Boston, MA: WCB/McGraw-Hill, 1999.
- Pederson AP, O'Neill M, Rootman I. Health promotion in Canada. Toronto, ON: W.B. Saunders Company Canada, 1994.
- Webb G. Nutrition: A health promotion approach. New York: Oxford University Press, 2002.
- Young T. Population health: Concepts and methods. New York: Oxford University Press, 1998.

Professional Standards (available at www.dietitians.ca and provincial regulatory body websites)

- Dietitians of Canada. The Code of Ethics for the Dietetic Profession in Canada, 1996.
- Dietitians of Canada. Professional Standards for Dietitians in Canada, 1997
- Provincial Regulations: Contact your Regulatory Body.

Nutrition Care

- Dietitians of Canada and the American Dietetic Association. Manual of clinical dietetics (6th ed.). Chicago, IL: American Dietetic Association, 2000
- Ordre professionnel des diététistes du Québec: Manuel de nutrition clinique. révision, 2000.

Clinical Nutrition

Texts such as:

- Coulston A, Rock C, Monsen E (Eds.). Nutrition in the prevention and treatment of disease. New York: Academic Press, 2001.
- Good health eating guide resource manual. Toronto, ON: Canadian Diabetes Association.
- Guidelines for the nutritional management of diabetes mellitus in the new millenium. A position Statement by the Canadian Diabetes Association. Can J Diabetes Care 23(3):56-69. (available at www.diabetes.ca)
- Mahan LK, Escott-Stump S. Krause's food, nutrition & diet therapy (10th ed.). Philadelphia: W.B. Saunders Co, 2000.
- Shils ME, Olson JA, Shike M, Ross AC (Eds.). Modern nutrition in health and disease (9th ed.). Baltimore: Williams & Wilkins, 1999.

Communication

- Bauer K, Sokolik C. Basic nutrition counselling skill development. Toronto, ON: Nelson/Thomson Learning, 2002.
- Chernoff R. Communicating as professionals (2nd ed.). Chicago, IL: American Dietetic Association, 2002.
- Curry KR, Jaffe A. Nutrition counselling and communication skills. Philadelphia: Saunders, 1998.
- Holli BB, Calabrese RJ. Communication and education skills for dietetic professionals (3rd ed.). Baltimore, MD: Williams & Wilkins, 1998.
- Snetselaar LG. Nutrition counselling skills: Assessment, treatment and evaluation (3rd ed.). Englewood Cliffs, NJ: Merrill, 1995.

Metabolism and Human Nutrition

- Mann EJ, Truswell AS (Eds.). Essentials of human nutrition. New York: Oxford University Press, 1998.
- Rolfes SR, DeBruyne LK, Whitney EN. Life span nutrition: Conception through health (2nd ed.). Belmont, CA: Wadsworth, 1998.
- Worthington-Roberts BS, Rothwell-Williams BS. Nutrition throughout the life cycle (4th ed.). Boston, MA: McGraw-Hill, 2000.

Research

- Ireton-Jones CS, Gottschlich MM, Bell SJ. Practice-oriented nutrition research: An outcomes measurement approach. Gaithersburg, MD: Aspen Publishing, 1998.
- Monsen ER. Research. Successful approaches (2nd ed.). Chicago, IL: American Dietetic Association, 2003.
- Paisley JA., Keller H, Ledermann B. Research works: a practice-based research manual for diabetes educators. Toronto, ON: Canadian Diabetes Association; 2000.
- Polgar S, Thomas SA. Introduction to research in the health sciences. Melbourne, AUS: Churchill Livingstone, 1995.
- The Health Communications Unit Resources. Resources include: Conducting focus groups, conducting survey research, how to's in health communication, interviewing, logic models. (available at <http://www.thcu.ca>)

Food Service Management

- Canadian Restaurant and Foodservice Association. The sanitation code for Canada's foodservice industry. Toronto, ON, 1993.
- Hudson N. Management practice in dietetics. Belmont, CA: Wadsworth/ Thomson Learning, 2000.
- Jackson, R. Nutrition and food services for integrated health care. Gaithersburg, MD: Aspen Publishing, 1997.
- Khan, M. Nutrition for foodservice managers: Concepts, applications and management. New York: Nostrand Reinhold, 1998.
- Payne-Palacio J, Theis M. West and Wood's introduction to foodservice (9th ed.). Upper Saddle River, NJ: Prentice Hall, 2001.
- Spears M. Foodservice organizations: A managerial and systems approach (4th ed.). Upper Saddle River, NJ: Prentice Hall, 2000.

Appendix C Exam Blueprint Groups of the Entry-Level Competencies*

GROUP 1A Competencies	(Very Important, High Frequency)
ASSESSMENT (2)	#
<ul style="list-style-type: none"> • identifies and confirms issues that have dietetic implications. 	(2-1)
<ul style="list-style-type: none"> • recognizes factors affecting an issue (e.g., psychosocial, cultural, political, legal, ethical, religious, linguistic, environmental, social, economic, organizational, and biomedical factors). 	(2-3)
<ul style="list-style-type: none"> • formulates conclusions based on the interpretation and integration of data. 	(2-7)
PLANNING (3)	
<ul style="list-style-type: none"> • establishes, with the client and appropriate others, realistic goals consistent with the assessment, ethical considerations, legislation, and policies. 	(3-1)
<ul style="list-style-type: none"> • determines, with the client and appropriate others, measurable objectives. 	(3-2)
<ul style="list-style-type: none"> • formulates, with the client and appropriate others, strategies to meet the objectives. 	(3-4)
<ul style="list-style-type: none"> • develops a specific plan of action with the client and appropriate others to meet the objectives for nutrition promotion and clinical nutrition by: <ul style="list-style-type: none"> a) defining framework. b) identifying the appropriate approach (e.g., program, advocacy, feeding route, dietary regimen). c) determining content. d) developing time lines. e) identifying the responsibilities and accountability of the client and appropriate others. f) identifying, accessing, managing and/or creating resources required to implement the plan of action. g) identifying collaborators and support services (e.g., self-help groups, community agencies, local businesses). h) determining monitoring parameters. i) determining monitoring methods. j) determining decision point criteria. k) establishing outcome measures. l) addressing the implications of the plan with the client and appropriate others. m) addressing constraints to implementing the plan. n) determining implementation strategies (e.g., media, lobbying, counselling strategies). o) establishing short and long-term plans. p) establishing evaluation procedures to measure the effectiveness of the plan. q) adjusting the plan of action as required. 	
	(3-6a)
	(3-6b)
	(3-6c)
	(3-6d)
	(3-6e)
	(3-6f)
	(3-6g)
	(3-6h)
	(3-6i)
	(3-6j)
	(3-6k)
	(3-6l)
	(3-6m)
	(3-6n)
	(3-6o)
	(3-6p)
	(3-6q)
IMPLEMENTATION (4)	
<ul style="list-style-type: none"> • executes the plan by utilizing/developing resources (e.g., education materials, practice-based research, discussion with colleagues). 	(4-2d)
<ul style="list-style-type: none"> • modifies the plan, as indicated through the monitoring process or as the result of unexpected circumstances. 	(4-4)
COMMUNICATION (6)	
<ul style="list-style-type: none"> • collaborates with clients, colleagues, agencies, etc. during all phases of practice (i.e., assessment, planning, implementation, and evaluation). 	(6-1)
<ul style="list-style-type: none"> • uses appropriate communication channels (e.g., formal, informal, focus groups, community action). 	(6-2)
<ul style="list-style-type: none"> • applies principles of education (e.g., adult education, learning challenged). 	(6-4)
<ul style="list-style-type: none"> • recognizes and responds to nonverbal communication (e.g., resistance to change, lack of understanding). 	(6-5)
<ul style="list-style-type: none"> • provides information at the appropriate comprehension level. 	(6-10)
<ul style="list-style-type: none"> • demonstrates effective oral and written communication skills. 	(6-12)
<ul style="list-style-type: none"> • effectively demonstrates the following communication skills when appropriate: <ul style="list-style-type: none"> d) interviewing. f) counselling. 	(6-13d)
	(6-13f)
<ul style="list-style-type: none"> • documents at each stage of the process according to policy, established time lines, and legal requirements. 	(6-14a)

*Numerical identifiers correspond to those in the document, *Competencies for the Entry-Level Dietitian*, DC, 1996.

GROUP 1B Competencies		(Very Important, Low Frequency)
PROFESSIONAL PRACTICE (1)		#
<ul style="list-style-type: none"> practices dietetics in accordance with the ethics of the profession by maintaining confidentiality. 		(1-1d)
<ul style="list-style-type: none"> practices within areas of competence. 		(1-7)
ASSESSMENT (2)		
<ul style="list-style-type: none"> uses effective data collection techniques (e.g., interviews, surveys, literature reviews, focus groups). 		(2-4)
<ul style="list-style-type: none"> translates raw data into interpretable data (e.g., height/weight to BMI, foods to nutrients, financial data to budget variance). 		(2-5)
<ul style="list-style-type: none"> integrates and interprets: <ol style="list-style-type: none"> needs assessment data dietary intake data (e.g., 24 hour recall, food frequency, and food record). health record data (e.g., anthropometric, biochemical, clinical, dietary, psychosocial). team/stakeholder meetings data (formal and informal). physical nutritional assessment data (e.g., height, weight, anthropometrics). operational parameters (e.g., physical layout, staffing levels, union contracts). financial data (e.g., enteral feeding product cost, socio-economic status of clients, monthly budget reports). quality management data (e.g., client satisfaction questionnaire, standards of practice audit). factors affecting learning. product data (e.g., product specifications). legal and contractual information. 		(2-6a)
		(2-6b)
		(2-6c)
		(2-6d)
		(2-6e)
		(2-6f)
		(2-6g)
		(2-6h)
		(2-6i)
		(2-6k)
		(2-6m)
PLANNING (3)		
<ul style="list-style-type: none"> priorizes, with the client and appropriate others, the objectives. 		(3-3)
<ul style="list-style-type: none"> develops, with client and appropriate others, plans of action for managing: <ol style="list-style-type: none"> human resources (e.g., recruiting, orienting, training, supervising, evaluating, scheduling). financial resources (e.g., inventory management). the quality of programs, products, and services. practice-based research. operations (e.g., schedules, safety, policies and procedures, emergency response, contractual agreements). technology (e.g., computer utilization). facilities and equipment. the safe provision of foods/nutrients (e.g., menu planning, production, distribution, choice of nutritional products). the marketing of programs, products, and services. 		(3-5a)
		(3-5b)
		(3-5c)
		(3-5g)
		(3-5h)
		(3-5i)
		(3-5j)
		(3-5k)
		(3-5l)
IMPLEMENTATION (4)		
<ul style="list-style-type: none"> activates the plan by confirming the responsibilities and accountability of the client and appropriate others. 		(4-1b)
<ul style="list-style-type: none"> executes the plan by: <ol style="list-style-type: none"> using a variety of strategies to meet client needs. managing human resources. 		(4-2b)
		(4-2e)
<ul style="list-style-type: none"> monitors the achievement of the plan's objectives according to: <ol style="list-style-type: none"> client acceptance/satisfaction. human resource utilization (e.g., supervision, performance evaluation, workload measurement). safe provision of foods/nutrients (e.g., intake assessment, product dating). behaviour/attitude change. 		(4-3a)
		(4-3c)
		(4-3h)
		(4-3i)

GROUP 1B (cont'd)	
EVALUATION (5)	#
• evaluates the achievement of the planned objectives with respect to outcomes.	(5-1a)
• evaluates the process with respect to:	
a) effectiveness.	(5-2a)
b) efficiency.	(5-2b)
c) client satisfaction.	(5-2c)
d) impact (e.g., financial, community, psychosocial and nutritional benefit).	(5-2d)
• evaluates the outcomes with respect to:	
d) client satisfaction.	(5-3d)
e) impact (e.g., financial, community, psychosocial and nutritional benefit).	(5-3e)
COMMUNICATION (6)	
• communicates effectively considering the client's profile (e.g., positioning marketing strategies).	(6-8)
• effectively demonstrates the following communication skills when appropriate: facilitating.	(6-13g)

GROUP 2A Competencies	(Important, High Frequency)
PROFESSIONAL PRACTICE (1)	#
<ul style="list-style-type: none"> • practices dietetics in accordance with the ethics of the profession by: <ul style="list-style-type: none"> a) demonstrating integrity in professional practice. b) demonstrating empathy in professional practice. c) maintaining objectivity. f) working in the best interest of the client. 	(1-1a) (1-1b) (1-1c) (1-1f)
<ul style="list-style-type: none"> • promotes a high standard of professional practice by disseminating nutrition knowledge and information. 	(1-2d)
<ul style="list-style-type: none"> • commits to a high standard of professional competence through continuous learning and self-development by: <ul style="list-style-type: none"> a) assessing personal and professional strengths and limitations. b) identifying development needs in practicing dietetics. c) identifying development needs in practicing dietetics. d) monitoring a plan for self-development. 	(1-3a) (1-3b) (1-3c) (1-3d)
<ul style="list-style-type: none"> • manages time efficiently. 	(1-4)
<ul style="list-style-type: none"> • practices effectively to achieve desired outcomes. 	(1-5)
<ul style="list-style-type: none"> • utilizes research to improve practice. 	(1-8)
<ul style="list-style-type: none"> • applies a research approach to problem solving by: <ul style="list-style-type: none"> a) examining a problem. b) reviewing related literature/resources. c) applying research findings to the problem. d) evaluating the results of the solution. 	(1-9a) (1-9b) (1-9c) (1-9d)
ASSESSMENT (2)	
<ul style="list-style-type: none"> • identifies/obtains relevant data including dietary intake data (e.g., 24 hour recall, food frequency, and food record). 	(2-2b)
<ul style="list-style-type: none"> • integrates and interprets: <ul style="list-style-type: none"> i) marketing data. 	(2-6i)
<ul style="list-style-type: none"> <ul style="list-style-type: none"> l) appropriate literature/resources (e.g., epidemiological, demographic, practical research). 	(2-6l)
PLANNING (3)	
<ul style="list-style-type: none"> • develops, with client and appropriate others, plans of action for managing: <ul style="list-style-type: none"> d) communication. e) education. f) community action. 	(3-5d) (3-5e) (3-5f)
IMPLEMENTATION (4)	
<ul style="list-style-type: none"> • activates the plan by communicating the plan to the client and appropriate others. 	(4-1a)
<ul style="list-style-type: none"> • executes the plan by: <ul style="list-style-type: none"> a) managing the delivery of programs, products, and services (e.g., delegating when appropriate). c) creating an environment conducive to executing the plan. f) managing within the established budget. g) utilizing practice-based research approaches. h) applying pertinent legislation, standards, and contractual agreements. 	(4-2a) (4-2c) (4-2f) (4-2g) (4-2h)
<ul style="list-style-type: none"> • monitors the achievement of the plan's objectives according to: <ul style="list-style-type: none"> b) quality of products and services. d) financial performance (e.g., cost effectiveness, budget variance). f) operations (e.g., time plan, safety, and sanitation). g) facilities, equipment, and technology availability and utilization. j) other monitoring parameters as identified (e.g., laboratory results, cafeteria revenue). 	(4-3b) (4-3d) (4-3f) (4-3g) (4-3j)
EVALUATION (5)	
<ul style="list-style-type: none"> • evaluates the achievement of the planned objectives with respect to: <ul style="list-style-type: none"> a) goals. b) effectiveness. 	(5-3a) (5-3b)
<ul style="list-style-type: none"> • determines the need for further evaluation. 	(5-4)
<ul style="list-style-type: none"> • determines the need for future action. 	(5-5)

GROUP 2A (cont'd)	
COMMUNICATION (6)	#
• uses a variety of opportunities for teaching.	(6-3)
• seeks, recognizes, and responds appropriately to feedback.	(6-11)
• effectively demonstrates the following communication skills when appropriate:	
b) negotiation.	(6-13b)
e) teaching.	(6-13e)
• documents at each stage of the process in an appropriate format (e.g., concise and organized style).	(6-14b)

GROUP 2B Competencies		<i>(Important, Low Frequency)</i>
PROFESSIONAL PRACTICE (1)		#
<ul style="list-style-type: none"> • practices dietetics in accordance with the ethics of the profession by: <ul style="list-style-type: none"> e) observing conflict of interest guidelines. g) identifying and acting appropriately in dealing with unethical or incompetent behaviour. • promotes a high standard of professional practice by: <ul style="list-style-type: none"> a) supporting colleagues in the pursuit of their professional development. b) supporting the training and education of others. c) supporting the advancement of dietetic practice, research, and knowledge. • accepts accountability in performing responsibilities. 		(1-1e) (1-1g) (1-2a) (1-2b) (1-2c) (1-6)
ASSESSMENT (2)		
<ul style="list-style-type: none"> • identifies/obtains relevant data including: <ul style="list-style-type: none"> a) needs assessment data. c) health record data (e.g., anthropometric, biochemical, clinical, dietary, psychosocial). d) team/stakeholder meetings data (formal and informal). e) physical nutritional assessment data (e.g., height, weight, anthropometrics). f) operational parameters (e.g., physical layout, staffing levels, union contracts). g) financial data (e.g., enteral feeding product cost, socioeconomic status of clients, monthly budget reports). h) quality management data (e.g., client satisfaction questionnaire, standards of practice audit). i) marketing data. j) factors affecting learning (e.g., literacy, language comprehension, readiness to learn). k) product data (e.g., product specifications). l) appropriate literature/resources (e.g., epidemiological, demographic, practical research). m) legal and contractual information. 		(2-2a) (2-2c) (2-2d) (2-2e) (2-2f) (2-2g) (2-2h) (2-2i) (2-2j) (2-2k) (2-2l) (2-2m)
IMPLEMENTATION (4)		
<ul style="list-style-type: none"> • monitors the achievement of the plan's objectives according to communications (e.g., feedback, response to the plan) 		(4-3e)
EVALUATION (5)		
<ul style="list-style-type: none"> • evaluates the outcomes with respect to efficiency. 		(5-3c)
COMMUNICATION (6)		
<ul style="list-style-type: none"> • uses appropriate terminology for the client, team members, and appropriate others • communicates using appropriate technology (e.g., television, slides, computers). • actively participates with individuals and groups. • effectively demonstrates the following communication skills when appropriate: <ul style="list-style-type: none"> a) advocacy. c) lobbying. 		(6-6) (6-7) (6-9) (6-13a) (6-13c)

The following list deals with question content only as it applies to comprehensive entry-level practice. This is not considered an all-inclusive list. Topics can be applied to numerous settings including:

Public Health Units, Home Care Agencies, Community Health Centres, Hospitals and other primary/tertiary institutional health care facilities, Long-term Care Facilities, Hospice and palliative Care, Business and Industry, Government and non-governmental Agencies (i.e. not for profit associations), Unionized/Non-unionized, Cafeterias, Food Banks, Day Care, Restaurants, Private Practice, Primary Care Settings, Family Practice, Food and Pharmaceutical Companies.

Communication and Education Principles (1)

- 101** Communication: principles of counselling, formal/informal, direct/indirect, verbal/non-verbal, group/individual, written.
- 102** Education: implementation and evaluation, literacy, mass media, principles of education.
- 103** Factors Influencing Education: cultural, religious, holistic/spiritual, literacy, health and behaviour theory.

Food and Nutritional Science (2)

- 201** Food Technology (e.g., chemical composition, effects of food preparation on physical and chemical properties of foods, food additives, functional foods, nutraceuticals)
- 202** Fundamentals of Human Nutrition (e.g., chemistry, physiology, metabolism)
- 203** Laboratory Assessment/Interpretation (e.g., function of indicators, significance/purpose of test, clinical implications for the following tests: hemoglobin, electrolytes, minerals, glucose, lipoproteins, hematocrit, HbA_{1c} (glycated hemoglobin), MCHC (Mean Corpuscular Hematocrit), MCV (Mean Corpuscular Volume), leukocytes, albumin, liver function tests, urea, creatinine, ferritin)
- 204** Nutrition through the Life Cycle (e.g., adult, pregnancy, lactation, infant, toddler and pre-school, school age, adolescent, elderly)
- 205** Nutrition Standards (e.g., indices to assess energy, protein, and fluid requirements, body composition, data collection techniques, conditions suggesting nutritional risk, diet assessment, computer assisted assessment, anthropometric assessment, drug-nutrient interaction, biochemical assessment, subjective global assessment, physical assessment)
- 206** Population Health and Nutrition Data (e.g., Heart Health Survey, National Population Health Survey, food composition data at national and household level)

Food and Nutrition Systems (3)

- 301** Distribution and Service (e.g., portion control, guest check analysis, client relations)
- 302** Food Service Systems (e.g., conventional vs cold plating, equipment selection, facility layout, organizational structure, sanitation), computer systems, (e.g., diet office, menu management, inventory management).
- 303** Inventory Management (e.g., number of turns)

Food and Nutrition Systems (3) (cont'd)

- 304 Menu Planning (e.g., customer trends, selective vs non-selective, pilferage, cycle length, modified menus—special and therapeutic needs, ethnic and religious considerations)
- 305 Procurement (e.g., purchasing standards, purchasing groups/prime vendor)
- 306 Production (e.g., quantity preparation, recipe standardization, outsourcing)

Health Promotion/Disease Prevention (4)

- 401 Community Development
- 402 Disease Prevention (e.g., cancer, heart disease, eating disorders, HIV)
- 403 Food Safety
- 404 Food Security
- 405 Principles of Health Promotion (e.g., coalition building, program planning, social marketing)
- 406 Program Management: planning, implementation and evaluation

Management (5)

- 501 Financial Management (e.g., budgeting, revenue generation, cost-effectiveness, profit/loss, staffing)
- 502 Human Resources (e.g., interviewing and selection, orientation and training, job analysis, Human Rights Code, Employment Standards, conflict resolution, labour relations, staff scheduling) employee evaluation, performance reviews, attendance management
- 503 Monitoring Controls (e.g., menu pricing, computer application i.e., POS [Point-of-Sale], spreadsheets), performance indicators, meal days
- 504 Sales Process (e.g., target development, sales analysis, account management, business development)

Nutrition Care (6)

For each disease/condition:

- diagnostic criteria, if applicable
 - effect on nutrition
 - rational for nutrition
 - matching diet to condition & treatment
 - effect of treatment (nutritional/drug/medical/social therapy)
 - monitoring/evaluation of therapy
- 601 Cardiovascular (CVD) (e.g., atherosclerosis, hyperlipidemia, coronary heart disease, hypertension)
 - 602 Diabetes Mellitus (e.g., type 1/type 2 diabetes mellitus)
 - 603 Eating Disorders (e.g., obesity, anorexia, bulimia)
 - 604 Food Allergies/Intolerances
 - 605 Gastrointestinal (GI) Tract Diseases and Disorders (e.g., swallowing disorders, reflux, peptic ulcer, irritable bowel, ulcerative colitis, dumping syndrome, Crohn's disease, celiac), pancreatitis, constipation/diarrhea)
 - 606 Hepatic Disease
 - 607 Hyper/Hypo Metabolism (e.g., starvation, metabolic response to starvation, trauma, stress, burns, thyroid conditions)

Nutrition Care (6) (cont'd)

- 608 Hypoglycemia/Hyperglycemia
- 609 Immunosuppression (HIV/AIDS)
- 610 Lifestyle Nutrition (e.g., sports nutrition, vegetarianism, socioeconomic status, alternative/complementary care)
- 611 Mental Health (e.g., food intake problems, drug/nutrient interaction)
- 612 Micronutrient Malnutrition: indicators and effects
- 613 Neurological Disorders and Injury (e.g., stroke) dysphagia, dementia degenerative disease and immobility
- 614 Nutrition Support (e.g., TPN and Enteral Nutrition, product specification, routes of administration and monitoring), transitional feeding
- 615 Osteoporosis
- 616 Obesity
- 617 Oncology, palliative care
- 618 Protein/Energy Malnutrition: indicators and effects (e.g., failure to thrive) refeeding syndrome
- 619 Renal Disease (e.g., nephrotic syndrome, hemodialysis, CAPD [continuous ambulatory peritoneal dialysis], ARF [acute renal failure], end-stage renal disease, ERI [early renal insufficiency])
- 620 Respiratory Disease (e.g., COPD [Chronic Obstructive Pulmonary Disease], cystic fibrosis)

Policies and Standards (7)

- 701 DC Code of Ethics
- 702 Documentation
- 703 Nutrition Education: nutrition policy and guidelines, e.g., Nutrition for healthy term infants
- 704 Nutrition Standards: (e.g., RNI, DRIs, Canada's Guidelines for Healthy Eating, Canada's Food Guide to Healthy Eating)
- 705 Practice Guidelines (e.g., ethical/legal—sharing information/colleagues confidentiality)
- 706 Professional Standards/Scope of Practice (e.g., ethics [e.g., feeding the terminally ill], consent issues, abuse prevention)
- 707 Public Policy (e.g., Nutrition for Health: An Agenda for Action, Nutrition Labelling)
- 708 Quality Assurance: Tools, Process, Indicators, Systems (e.g., HACCP [Hazard Assessment Critical Control Point], CQI [Continuous Quality Improvement]/TQM [Total Quality Management], Risk Management)

Research (8)

- 801 Consumer Research
- 802 Market Research (e.g., client satisfaction, merchandising, 4P's-product, price, place, promotion)
- 803 Practice-based research
- 804 Research Process (e.g., critical appraisal of the literature, needs assessment, survey, sampling methods, study design, reliable and valid measures, analysis, and interpretation)

Appendix E Canadian Dietetic Regulatory Bodies

Province	Contact Information
British Columbia College of Dietitians of British Columbia (CDBC)	Registrar, Fern Hubbard College of Dietitians of British Columbia Suite 103 - 1765 West 8th Avenue Vancouver, BC V6J 5C6 Telephone (604) 736-2016; Facsimile (604) 736-2018 email: info@collegeofdietitiansbc.org
Alberta College of Dietitians of Alberta (CDA)	Registrar, Lynda Heyworth Suite 740 –10707-100 Avenue Edmonton, AB T5J 3M1 Phone: (780) 448-0059 Fax: (780) 489-7759 Toll free : 1-866-493-4348 e-mail: office@collegeofdietitians.ab.ca
Saskatchewan Saskatchewan Dietitians Association (SDA)	Registrar, Lana Moore 17-2010 - 7 th Ave, Regina, SK S4R 1C2 Phone: (306) 359-3040 Fax: (306) 359-3046 e-mail: registrar@saskdietitians.org
Manitoba College of Dietitians of Manitoba (CDM)	Registrar, Michelle Hagglund 36-1313 Border Street Winnipeg, MB R3H 0X4 Phone: (204) 694-0532 Fax: (204) 889-1755 e-mail: office,cdm@mts.net
Ontario College of Dietitians of Ontario (CDO)	Registrar, Mary Lou Gignac 1810—5775 Yonge Street, Box 30 Toronto, ON M2M 4J1 Phone: (416) 598-1725 Fax: (416) 598-0274 Toll free : 1-800-668-4990 Email: gignacm@cdo.on.ca
Quebec Ordre professionnel des diététistes du Québec (OPDQ)	Registrar, Annie Chapados 1220 - 2155 rue Guy Montréal, PQ H3H 2R9 Phone: (514) 393-3733 Fax: (514) 393-3582 e-mail: opdq@opdq.org
Nova Scotia Nova Scotia Dietetic Association (NSDA)	Jennifer Garus 212-1496 Bedford Highway Bedford NS B4A 1E5 Phone: (902) 835-0253 Fax: (902) 835-0523 e-mail: info@nsdassoc.ca
New Brunswick New Brunswick Association of Dietitians (NBAD/ADNB)	Registrar, Janet Von Weiler Box 22024 Lansdowne Postal Outlet Saint John, NB E2K 4T7 Phone (506) 642-9058 Fax: (506) 636-8900 e-mail javw@nbnet.nb.ca
Newfoundland and Labrador Newfoundland and Labrador College of Dietitians (NLCD)	Marjorie Scott P.O. Box 1756 St. John's NL A1C 5P5 Phone:(709) 753-4040 Fax: (709) 777-4343 e-mail: mscott@nf.sympatico.ca
Prince Edward Island Prince Edward Island Dietitians Registration Board (PEIDRB)	Registrar, Katherine Schaefer 153 Spring Street Summerside, PEI C1N 3G2 Phone: (902) 436-2438 Fax: (902) 436-2438 e-mail: peidrb@pei.sympatico.ca

www.dieteticregulation.ca