College of Dietitians of Ontario

résumé

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This article focuses on collaborative team leadership which enables synergetic relationships and effective working partnerships to achieve effective client-centred care.

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Tax Receipts Are Available Online

The College will not send receipts in the mail. Please download them from the College website anytime. Simply login to your Member Home Page using your RD number and your password, scroll down to Print Receipts under Membership on the left hand side of the screen.

Transparency and Accountability

Elizabeth Wilfert,
Public Councillor & President

The College of Dietitians of Ontario exists to regulate and support all Registered Dietitians in the interest of the public of Ontario.

We are dedicated to the ongoing enhancement of safe, ethical and competent nutrition services provided by Registered Dietitians in their changing practice environments.

Transparency and accountability are both essential to the smooth sailing of *Good Governance*. Just as sail boats have fundamental parts such as the sail or keel, *Good Governance* also needs essential components and CDO is committed to ensuring that both transparency and accountability are fully in place.

Organizations must be transparent about what they do, allowing stakeholders to see their actions. Accountability is crucial to a moral obligation allowing others to judge whether the standard promised has been met. An organization must be fully accountable for its actions and the access to this information must be transparent and easy to find to keep the *Good Governance* ship balanced and going in the right direction.

At CDO, being accountable is of utmost importance. It is a part of our mindset, our culture and our strategic conscience. At Council and committees meetings, we are constantly asking ourselves, 'Is this action going to reflect our accountability?'

Transparency and accountability are not easily separated; combined they become our moral compass getting us to our destination. Just as sailors check the ship's equipment and have tools to make sure they successfully complete their journey. CDO has many checks to keep us steadfast with Good Governance. Accountability involves the measuring or tracking of what is going on. Our tools include: policies, financial reports, audits, management reports and outcome indicators; all essential to keep us focused on what is important to achieve our public protection mandate and obligations.

Reporting tools shine the light that provides transparency into an organization. At the College we strive to be transparent not only in Council, but to all stakeholders, including the Ministry and the Fairness Commissioner. The most important venues include:

- the College website;
- annual reports available online and in print form;
- *résumé* newsletters, where members and other stakeholders are informed of college activities including Council highlights, and evaluations of tools, services and programs;
- open Council meetings where members, the public and government officials are welcome to attend. Council meeting dates are posted on the website under *Public meetings and Hearings*, at the top of the home page; and
- annual workshops which provide members with College updates and an opportunity to ask questions about its activities.

Since it is vital that stakeholders trust that we are both transparent and accountable, we have commenced upon a comprehensive assessment of our governance policies to ensure that they are grounded in best practices. We are always ready to listen to our members and not only hear their concerns but act upon them where possible, in keeping with our mission statement and mandate. All of this is necessary to keep our *Good Governance* ship upright and 'to stay the course'.

Why Serve as a College Council Member

Mary Lou Gignac, MPA
Registrar & Executive Director

The College works hard to create an environment that supports and enables Council members to fulfill their role effectively. We appreciate the contribution of every Council and committee member.

Council Members

Professional Members

Cynthia Colapinto RD
Lesia Kicak RD
Susan Knowles RD
Barbara Major-McEwan RD
Erica Sus RD
Deion Weir RD
Krista Witherspoon RD
Erin Woodbeck RD

Public appointees

Edith Brown
Elsie Petch
Carole Wardell
Elizabeth Wilfert

In January, the College called for nominations to fill three positions on Council for SW Ontario and for the Toronto/York Region. If our recent survey of RDs in Northern Ontario is any indication, potential interest in members serving on Council may well be affected by limited knowledge about what Council members do and how the organization supports their important work.

The College Council is the board of directors for the organization. This means that Council members are the decision-makers when it comes to setting standards for the profession and deciding the direction of the College's work and financial allocations to protect the public. They collectively also oversee the management of the organization making sure that programs, finances and staff resources are managed effectively and are coordinated to achieve the desired results. That's how the College benefits from the work of Council members.

Here is how Council members benefit in return:

- They make a meaningful contribution to safe, ethical and competent dietetic services to people in Ontario.
- They have an opportunity to give direction to the College in its regulatory mandate.
- They receive formal and informal professional and personal development especially as it relates to planning and evaluation, communications, governance, including financial oversight.
- They develop and exercise leadership skills.
- They are exposed to health profession regulation, legislation and the complexities of the sector.
- They receive compensation for meeting and preparation time and are reimbursed for all out of pocket expenses.

The College works hard to create an environment that supports and enables Council members to fulfill their governance role. A learning environment has been created with many external and internal opportunities available throughout the year. At times, external consultants and lawyers are brought in to facilitate and lend expertise to complex issues discussed at Council meetings. Council members find the work both professionally meaningful and, at times, even fun.

The College appreciates the dedicated work of all its Council and committee members. We make sure they know they are appreciated.

If you wish to know more, please call me or talk to a Council member.

Consent Basics

Deborah Cohen, MHSc, RD
Practice Advisor & Policy Analyst

cohend@cdo.on.ca

The College's Practice Advisory Service often receives questions about consent to treatment and consent for disclosure of health information. This article clarifies the fundamental concepts of consent and substitute decision-making based on the *Health Care Consent Act* (HCCA). The key HCCA and College requirements and implementation issues related to informed consent are listed in the blue box on the right and highlighted in the practice scenario on the next page: "An RD's Responsibilities Related to Consent."

CLIENT-CENTRED DIETETIC SERVICES

The HCCA articulates the fundamental principles to engage clients in exploring their treatment options so that they can make informed decisions about their care. In the HCCA, treatment is defined as, "Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan."[1] The College interprets this definition to include conducting nutrition assessments.

The fundamental principles and laws about consent are all based on respect for clients' rights to make informed decisions about their treatment and that clients must be engaged in exploring treatment options. This approach is the basis for client-centred dietetic services.

Key HCCA and College Requirements for Informed Consent

1. Informed consent is required for all treatment.
2. There is no minimum age of consent; consent is based on capacity, not age.
3. If a client is not capable of giving informed consent, a substitute decision-maker must be identified.
4. The health care provider who is giving a treatment is responsible for ensuring that there is consent before the treatment is administered.
5. Consent must be informed.
6. Consent can be given for a multi-faceted treatment plan and course of treatment.
7. Depending on the situation, consent can be implied or given verbally or in writing.
8. Clients have the right to refuse treatment and/or withdraw consent at any time.
9. Verbal and written consent or the withdrawal of consent/refusal of treatment must be documented.

Practice Scenario

An RD's Responsibilities Related to Consent

A Registered Dietitian (RD) works in a hospital unit with clients who have varying mental health issues, including dementia and psychosis. Recently, the RD was consulted to recommend a tube feeding regimen for an 85 year old male client with dementia who recently had a G-tube inserted.

What are the RD's responsibilities related to consent to treatment?

1. INFORMED CONSENT IS REQUIRED FOR ALL TREATMENT

As per the definition of the HCCA, tube feeding is considered treatment and requires consent. The following sections of the scenario illustrate how consent was obtained prior to implementing the tube feeding treatment for this client.

2. CONSENT IS BASED ON CAPACITY, NOT AGE

If capacity has not already been established, the RD would need to determine whether the client has the ability to provide informed consent, meaning that he:

A) understands the information that is relevant to making a decision about the treatment; and

B) appreciates the reasonably foreseeable consequences of a decision or lack of decision.[1]

Although, the presence of a mental illness may bring into question a client's ability to understand and appreciate the treatment being proposed, a psychiatric diagnosis such as dementia does not automatically mean that they are not capable to make decisions about nutrition care.

It is also important to recognize that a person may be incapable of providing consent for some treatments and capable with respect to others; and/or a person may be incapable of providing consent to treatment some days (or periods within a day) and not others.[1]

In this scenario, the client has quite severe dementia and has been found not to be capable of providing informed consent to treatment. He is consistently unable to understand the information that is relevant to making a decision about his health care and to appreciate the reasonably-foreseeable consequences of making a decision or a lack of decision.

3. IF A CLIENT IS NOT CAPABLE OF PROVIDING CONSENT TO TREATMENT, A SUBSTITUTE DECISION-MAKER MUST BE IDENTIFIED

There is a note in the client's chart which indicates that the client's son is the substitute decision-maker. In cases where the substitute decision-maker is not yet assigned, section 20(1) of the HCCA provides the hierarchy of who is eligible for this role.[1]

Even if a client is deemed incapable of providing consent to treatment, RDs should strive to involve the client as best as possible in any consent to treatment decisions. The College has developed guidelines for dealing with incapable clients (see the *Jurisprudence Handbook for Dietitians in Ontario,* p. 82).[2]

4. THE HEALTH CARE PROVIDER WHO IS GIVING A TREATMENT IS RESPONSIBLE FOR ENSURING THAT THERE IS CONSENT BEFORE THE TREATMENT IS ADMINISTERED.

The HCCA specifies that on behalf of all the health practitioners involved in the treatment, one health care practitioner may propose the plan of treatment.[1] The RD should be able to assume that the physician who ordered the G-tube has obtained informed consent for treatment. In this scenario, she was able to verify the consent by looking at the signed consent form in the client's health record.

5. CONSENT MUST BE INFORMED

The requirement for informed consent rests on the principle that clients (or their substitute decision-makers) have the right to consent or refuse treatment based on what is

important to them. This self-determination may be expressed directly by the client or through their substitute decision-maker. In this case, to obtain consent for treatment, the physician would have addressed the following points with the substitute decision-maker:

- the nature of the treatment or assessment;
- who will be providing the intervention;
- reasons for the intervention;
- material effects, risks and side-effects of the intervention;
- alternatives to the intervention;
- consequences of declining the intervention; and
- specific questions or concerns expressed by the substitute decision-maker.[1]

The RD is well positioned to answer specific nutrition-related questions surrounding the tube feeding regimen (e.g., formula properties, rate of administration, side effects, etc.). Her role would be to engage the substitute decision-maker in the decision-making process to ensure he clearly understands the treatment being proposed and to address further questions or concerns.

6. CONSENT CAN BE GIVEN FOR A MULTI-FACETED TREATMENT PLAN AND COURSE OF TREATMENT

The HCCA defines "plan of treatment" as a plan that:

> "(a) is developed by one or more health practitioners;
>
> (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition; and
>
> (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition."[1]

In addition, section 12 of the HCCA specifies:

> "Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,
>
> (a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and
>
> (b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered."[1]

In this scenario, the physician obtained consent from the substitute decision-maker for the tube feeding treatment. As per section 12 of the HCCA, the RD can presume that this consent includes adjustments to the client's tube feeding regimen (e.g., formula/rate changes) that are not significantly different from the original treatment. Based on their professional judgement, RDs can decide whether the expected benefits, risks or side effects to the adjustments they make warrant further consent from the substitute decision-maker.

7. DEPENDING ON THE SITUATION, CONSENT CAN BE IMPLIED, GIVEN VERBALLY OR IN WRITING

The College requires RDs to comply with the HCCA and ensure that they have obtained informed consent for nutritional assessments and treatments.

In this scenario, the physician obtained the initial consent for tube feeding in writing. Consent for a nutrition assessment can often be implied, and in this case, the RD relied on implied consent to conduct her nutrition assessment. She walked into the client's room, introduced herself to the client and his substitute decision-maker and conducted a comprehensive nutrition assessment. The substitute decision-maker openly answered the questions about the client's health and nutrition history. He then asked the RD some detailed questions about the tube feeding regimen and the risks involved for his father. Given the nature of these probing questions, the RD felt that she had to confirm the initial consent obtained from the physician before proceeding with the tube feeding regimen. She answered the questions, made sure that the substitute decision-maker had a clear understanding of the process, the benefits and risks associated with the tube feeding treatment and verbally confirmed the consent to treatment.[1]

8. CLIENTS (OR THEIR SUBSTITUTE DECISION-MAKERS) HAVE THE RIGHT TO REFUSE TREATMENT AND/OR WITHDRAW CONSENT AT ANY TIME

In the scenario, the tube feeding regimen was initiated and the client was tolerating well. Two weeks later the client's daughter visited from overseas and was shocked to find her father on a G-tube. She expressed her concerns to her brother (the substitute decision-maker) and relayed a conversation which had taken place about three years previously, where her father commented that he would never wish to be tube fed.

Section 21 of the HCCA specifies that the person who gives or refuses consent to a treatment on an incapable person's behalf must do so in accordance with the wishes that the incapable person expressed while capable and take into consideration the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable."[1]

The substitute decision-maker asked his sister for more details about the context of their father's comment. Since the comments were made approximately three years before, she could not remember the particulars.

After much deliberation, further discussion with family members, and consultation with the health care team about other feeding options, the substitute decision-maker decided to continue with the tube feeding treatment. Since other feeding options were limited and his father was tolerating treatment well, he did not feel comfortable discontinuing the tube feeding based on a comment made by his father in the past.

9. VERBAL OR WRITTEN CONSENT OR THE WITHDRAWAL OF CONSENT/REFUSAL OF TREATMENT MUST BE DOCUMENTED

There are three key considerations for documenting consent:

i. the legal requirements of the HCCA

ii. professional judgment

iii. organizational policies

Except for implied consent, verbal and written consent should be documented. RDs need to exercise their professional judgment as to when they can rely on implied consent versus when verbal or written consent is required and subsequently documented. This decision will usually involve some assessment of the risk to the client for following or refusing treatment. When documenting consent, RDs should consider organizational policies.

In this scenario, informed consent to treatment was documented by the physician through a signed consent form. The RD documented all follow-up discussions with the substitute decision-maker and, also, that she had obtained additional verbal consent prior to initiating the tube feeding regimen.

ENGAGING CLIENTS

As illustrated in this scenario, obtaining informed consent is not only about filing a checklist to satisfy the law. At the heart of client-centred dietetic services, informed consent involves listening and communicating effectively to engage clients or their substitute decision-makers in the decision-making process.

By law, RDs have the responsibility to effectively communicate information and answer all questions to help clients exercise their right and responsibility to make informed decisions and consent to treatment. RDs with good communication skills will engage clients in the decision-making process, build trust and develop a respectful relationship. This is essential for transmitting the information clients or substitute decision-makers need to make informed decisions about treatment options[3] In the end, it is the responsibility of the client or their substitute decision-maker to make a decision and consent to treatment.

INFORMED CONSENT CAN BE COMPLEX

RDs may face some complex issues affecting how they obtain informed consent in their practice. There may be disagreement between clients and their substitute decision-makers, or the latter with other members in the family. In this scenario, because the sister thought that her father would not agree to the treatment, she objected to it and consent had to be revisited.

There may be issues surrounding end-of-of life decisions or living wills. In our diverse society, there are complex cultural sensitivities around faith, ethnicity, literacy, personal values, beliefs and language barriers, which may also have an impact on a client's ability to give informed consent. The RD is responsible in all cases for ensuring that treatment is not administered without informed consent.

A good knowledge of the *Health Care Consent Act* will help RDs manage the complexities surrounding consent. We encourage RDs to read the Act. It is easy to read and the requirements for consent and substitute decision-making are set out clearly. Based on a respect for client-centred decision-making and care, it articulates the fundamental principles to engage clients in exploring treatment options.

In the next issue of *résumé*, we will explore some of the complex issues surrounding consent including the responsibilities of the substitute decision-maker and the role of the *Consent and Capacity Board* under the HCCA.

If you have questions or examples of complex issues around informed consent that you have encountered, please let us know. We may use them as an example in the next *résumé*.

1 *Health Care Consent Act*. (1996). Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

2 Steinecke and CDO. (2012). Chapter 7: Consent to Treatment, *Jurisprudence Handbook for Dietitians in Ontario*, http://www.cdo.on.ca/en/pdf/Publications/Books/Jurisprudence%20Handbook.pdf

3. Ibid. Chapter 2, p. 11

Previous *résumé* articles about consent:

Winter 2005, *The Circle of Care and Consent to Treatment.*

Winter 2007, *Changes in the Plan of Treatment and Consent.*

Summer 2009, *Documenting Consent.*

Fall 2009, *Managing Conflicts Between RDs & Substitute Decision-Makers.*

Fall 2011, *Consent to Treatment Based on Capacity, Not Age*

Click here to test your knowledge about the informed consent.

Seeking Your Input

Practice Standards for Consent

The College is developing practice standards related to consent to treatment. We are seeking input from RDs on where explicit standards for consent are needed in dietetic practice and we would welcome your input.

Please provide specific examples/questions you may have by contacting us by phone or email:

416-598-1725/1-800-668-4990, ext. 367

practiceadvisor@cdo.on.ca

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Building Capacity for Collaborative Leadership In Knowledge-Creating Teams

Carole Chatalalsingh, PhD, RD
Practice Advisor &
Policy Analyst

In the Fall 2012 *résumé*, the article, "Are you a knowledge-creating team member?", discussed how Registered Dietitians (RDs) have an obligation to make interprofessional collaboration work by actively participating in building effective knowledge-creating teams. RDs can do this effectively by recognizing the team stages of functioning, taking the actions needed to nurture their team at each stage, and taking responsibility for their own roles and functions within the team. This article focuses on collaborative team leadership which enables synergetic relationships and effective working partnerships to achieve the common goal of effective client-centred dietetic services.[1]

WHAT IS COLLABORATIVE TEAM LEADERSHIP?

The concept of "collaborative leadership" is identified as one of the six competency domains in the *National Interprofessional Competency Framework*. The competency statement says, "Learners/practitioners understand and can apply leadership principles that support a collaborative practice model."[1]

For dietitians, the collaborative practice model for health care in Ontario is defined by the IPC Charter developed by HeathForceOntario (2009) to foster a common vision and language for interprofessional client-centred care in Ontario. (also see the back cover for information on the new IPC eTool developed in collaboration with the Federation of Health Regulatory Colleges of Ontario).[2]

Collaborative leaders are expected to be skilled in enabling collaboration, "a process that requires relationships and interactions between health professionals regardless of whether they are members of a formalized team or a less formal or virtual group of health professionals working together to provide comprehensive and continuous care to a patient/client".[3]

Leadership Functions

As collaborative leaders, the role of dietitians is to help the IPC team develop synergy and engage in client-centred practices to ensure that it operates safely within the IPC environment. To do this, a collaborative leader has two functions: task orientation and relationship orientation.[4]

Task Orientation Function

In the task-orientation function, the collaborative leader helps others on the IPC team (interprofessional practitioners, clients, their families, the circle-of-care, other teams and organizations) keep on task in achieving safe outcomes for client care. This could involve tasks, such as, organizing and defining roles, coordinating individual profession's regulatory and professional obligations and setting goals. Other task-oriented responsibilities include:[4, 5]

- helping to maintain the integrity of the team's governance and operating processes;
- helping to achieve client-centred outcomes for quality services;
- establishing continuous monitoring and re-evaluations for mitigating risks; and
- carrying out daily administrative responsibilities, processes, and systems essential to managing the boundaries with the larger organization or with key stakeholders.

Relationship Orientation Function

In the relationship orientation, the leader assists the IPC team to work more effectively. This includes ensuring effective communication among members, providing support, managing conflict, and building productive work relationships.[6] These responsibilities include:[5]

- coaching, in a supportive role, by providing guidance and acting as a sounding board;

- energizing a group into action, which means enabling breakthroughs where possible, being a change agent in holding the team accountable for actions, making unpopular observations;
- facilitating the internal and external coordination of activities among team members as mediator and catalyst, by bringing people together, ensuring integrity in work relationships, and making necessary interventions;
- sharing responsibility for the success of the team;
- actively participating in its activities; and
- nurturing the team's development stages.

COLLABORATIVE SHARED LEADERSHIP

In a shared leadership model, IPC team members will collaborate to determine who will be group leaders in certain situations. Clients may choose to serve as the leader or leadership may move among practitioners to provide opportunities for mentorship in the leadership role. In some cases, there may be two leaders: one for practitioners to keep the work flowing and the other who connects with clients and their families, serving as the link between the IPC team, clients and families.

Within collaborative or shared leadership, dietitians on the knowledge-creating IPC teams support the choice of leader and team decision-making. They will also assume shared accountability for the processes chosen to achieve outcomes. This means that they will take responsibility for their scope of practice, their roles and expertise and will work collaboratively with others to enable continuous quality improvement in work processes for effective client-centred outcomes.[1]

Collaborative leaders and supporters of leaders can enable:

- the coordination of services to ensure that the client is kept appropriately informed;
- the treatment plan is executed by the right people with appropriate continuity and with as little waste as possible;
- interprofessional team learning, synergy and collaboration;
- the integration of professional knowledge, skills and attitudes into team practice;
- support of organizational values that members will need in order to function as a health care teams;
- communication and decision-making;
- clear expectations of the team based on client-centered care;
- the coordination of services to reduce risk to the client;
- negotiation skills to manage conflict, mediation, and facilitate building of partnerships; and
- continuous improvement of the health care system, particularly in the area of client safety by mitigating risks and increasing efficiency.

Over time, collaborative IPC team leaders will help develop knowledge-creating teams with a body of common knowledge and effective team practices and approaches that allow them to function collaboratively in a client-centred environment.

1. *A National Interprofessional Competency Framework,* Canadian Interprofessional Health Collaborative, February 2010.
2. Oandasan. I., Robinson, J., Bosco, C., Carol, A., Casimiro, L., Dorschner, D., Gignac, M. L., McBride, J., Nicholson, I., Rukholm, E., & Schwartz, L. (2009). *Final Report of the IPC Core Competency Working Group to the Interprofessional Care Strategic Implementation Committee.* Toronto: University of Toronto.
3. Canadian Health Services Research Foundation. *Teamwork in Healthcare: Promoting effective teamwork in healthcare in Canada.* www.chsrf.ca.
4. Heineman, G.D., & Zeiss, A.M. (2002). *Team performance in health care: Assessment and development.* New York: Kluwer Academic/Plenum Publishers.
5. Marshall, E. (1995). *Transforming the way we work: The power of the collaborative workplace.* New York: American Management Association.
6. Laiken. M. (1998). *The anatomy of high performing teams: A leader's handbook* (3rd ed.). Toronto, Ontario, Canada: University of Toronto Press.
7. Day, D., Gronn, P., & Salas, E. (2004). "Leadership capacity in teams". *The Leadership Quarterly*, 15, 857-880.
8. Carroll, J. S., & Edmondson, A. C. (2002). "Leading organizational learning in health care." *Quality and Safety in Health Care,* 11, 51-56.

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Professional Liability Insurance

What we learned in 2012

The 2012 renewal marked the second time when 20% of College members were randomly selected to provide proof of liability insurance. Of those selected, we noticed that the following three groups were most likely to be without appropriate insurance coverage:

- **Members who are new to the College** – either new grads or experienced RDs who were moving from another province. All new members are advised of the requirement for insurance when they register, however, it was either misunderstood or missed by some new members.
- **Members who had recently changed employers and had been covered by their previous employer's insurance.** In the transition to the new job, they had forgotten to ensure that they had appropriate insurance coverage, either through the new employer or privately.
- **Members in non-traditional roles.** Some members had assumed that they did not need insurance because they did not have one-on-one clinical roles with their clients. The by-law states that you must have liability insurance if you are practising dietetics. It does not say that the practise must be in a clinical setting. Refer to the College's definition of practising dietetics in the Jurisprudence Handbook for Dietitians in Ontario, p. 41.

WHAT IF I AM ON LEAVE?

The most frequently asked question during this renewal period was whether an RD needed insurance coverage while on leave from a job, either for maternity leave, sick leave or returning to school.

The answer depends on whether you will be doing any dietetic practice while you are on leave from your job. The by-law requires members to have appropriate professional liability insurance while practising dietetics. If you do not practise at all while you are on leave (either paid dietetic work or unpaid dietetic volunteer work), then you do not need to have insurance coverage. If you choose to do any dietetics related volunteer work or part-time/casual work while on leave, then you must have the appropriate liability coverage.

Important Obligation

UPDATE YOUR REGISTER INFORMATION WITHIN 30 DAYS

- when you move and your contact information changes
- when you change your work place
- when you change your position

Not receiving correspondence from the College is not an acceptable excuse for missing a deadline or for not complying with a College requirement.

As regulated health professionals, RDs have a duty to update their profile within 30 days of any change in the information required for the College's Register. Failing to do so is considered professional misconduct. (*Professional Misconduct Regulation,* s. 35.2).

How to Update Your member profile

Within 30 days of a change:

1. Go to www.cdo.on.ca
2. Enter your member ID number and password in the boxes in the upper right hand corner of the home page to access your *Member Home Page*.
3. On the Member Home Page you will see your name at the top. In the left hand navigation, choose *Update My Profile*

Make these changes in writing only and include documents for proof of change:

- Name
- Change in immigration and citizenship status

RDs are responsible for reading all material from the College

All important notices are sent to members in several formats well ahead of deadlines and critical information is communicated in résumé, by email and on our website. It is important to pay attention to College communications and visit the website regularly to be informed of changes in laws and College requirements affecting your practice.

Redesigned SDL Tool More Relevant to RDs

Over 800 RDs completed the survey "Evaluation of the new 2012 SDL Tool"

- 81% felt that the redesigned tool was more relevant to their practice.
- Members spent between 29-50% less time completing their SDL Tool in 2012 vs. 2011.
- 82% felt that no changes were necessary to this new format for 2013.

RDs enjoyed other aspects of the new design as well:

- Ease of Completion - 85%
- Brevity - 65%
- Last Year's Goals Visible - 83%
- Inclusion of Action Plans - 53%
- Sample Goals - 52%

"Tool was much easier to use, more efficient, and helped me make more focused goals - I also appreciated the samples - please continue to use this tool!"

"I liked that I was able to choose the questions most relevant to my practice - made me focus more closely on assessing my areas of expertise."

"It allowed me to focus on specific goals that directly impact my clients and area of practice. I also found the redesigned version much easier to complete, allowing more time to reflect on specific areas that could be improved within my area."

"I work as a department head in a public health unit and much of my work is management. I felt more able to use management-related learning objectives."

"I was able to cater the competencies to my specific area of practice."

Each member is required to keep their SDL tools for 5 years. The College does not have the capacity to store over 3000 SDL tools for multiple years.

Evidence-Based Practice Workshop Summary

- **25% of College members attended the workshop (850 RDs) which is the highest attendance to date.**
- **The workshop was also given to 30 students and interns**

The primary objective of this workshop was to examine the concepts of evidence-based practice (EBP), discuss and illustrate professional and regulatory obligations for EBP and to introduce the College's *Five-Step Evidence-Based Practice Framework*, presented on the next page. This framework can be applied to various scenarios when practising dietetics in any environment.

An online version of this presentation with reflective questions and scenarios is posted on the College website at: www.cdo.on.ca > Resources > Practice Standards and Resouces: Evidence-Based Practice: Regulatory and Professional obligations for RD.

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College of Dietitians of Ontario — Five-Step Evidence-Based Practice Framework

D.L. Sackett, 1997
"[Evidence-based practice] is the conscientious, explicit & judicious use of current best evidence in making decision about the care of individual (clients)."

College of Dietitians of Ontario, 2012
Evidence-based practice refers to using the best evidence in balancing anticipated benefits and risks in supporting decisions for optimizing client-centered dietetic services.

Dietitians of Canada, 2012
"Evidence-based decision-making refers to making decisions that affect client/patient care based on the best available evidence".

STEPS	DIETETIC EVIDENCE-BASED PRACTICE	CLIENT-CENTRED APPROACH
STEP 1 Ask	**Ask focused questions. This involves the translation of uncertainty into answerable questions to clarify information.**	When information seems conflicting or fuzzy, ask "what is happening or what is going on? Use the "PICO" Model to add clarity to the information: • Problem/population/client - Who or What? Describe a group of clients similar to your own. • Intervention/exposure/ maneuver - How? What intervention are you considering? • Comparison - What is the main alternative? (If appropriate). • Outcome - What are you trying to accomplish, measure, improve, effect?
STEP 2 Access	**Find the best evidence, including the client's contributions, to enable knowledgeable and informed decisions.**	Finding the evidence improves the treatment of many clients. Evidenced-based practice recognizes that science alone is not sufficient; it places emphasis on the client's contributions to the body of evidence.
STEP 3 Appraise	**Critically appraise the evidence using the four cornerstones of evidence-based practice and individualize, based on professional expertise and client concerns.**	Critique and synthesize research findings, manage personal assumptions through reflective practice and address bias using the four cornerstones of evidence-based practice.* *Jane F. Gilgun, (2005). "The Four Cornerstones of Evidence-Based Practice in Social Work." *Research on Social Work*. Vol 15 (1); 52-61. 
STEP 4 Act	**Enable clients and team to make "informed" decisions.**	Determine whether the evidence has an impact on practice. When making a decision recognize that research alone is not sufficient to justify a change in practice. The client's preference is part of the decision-making process: • Choose solutions based on information from all four cornerstones of evidence-based practice: research + professional judgement (practice wisdom and personal assumptions) + client's contribution (values). • Ask: Do any of the quadrants outweigh another in this solution? If yes, Why; and is this a benefit or a risk to the client? Is there a bias?
STEP 5 Assess	**Evaluate your own performance.**	Evaluating personal performance allows RDs to modify their practice in the best interests of clients. This involves monitoring and assessing their own performance; monitoring changes in outcomes, supporting positive changes, mitigating risks and emphasizing client-centered benefits.

Certificates of Registration

GENERAL CERTIFICATES OF REGISTRATION

Congratulations to all of our new dietitians registered from October 25, 2012 to January 28, 2013.

Name	Registration ID	Date
Sharona Abramovitch RD	12753	10/01/2013
Jaime Anderson RD	12822	14/01/2013
France Archer RD	3700	07/11/2012
Saloomeh Armin RD	12236	11/01/2013
Gennavieve Armour RD	12825	16/01/2013
Simen Atwal RD	12641	08/01/2013
Chaviva Augenblick RD	12692	08/01/2013
Lauren Baker RD	12730	08/01/2013
Kellie Barber RD	12755	08/01/2013
Shira Becker RD	12729	09/01/2013
Laura Belsito RD	12732	14/01/2013
Julie Bonin RD	12714	09/01/2013
Ashley Boudens RD	12721	11/01/2013
Michelle Bouhuis RD	12809	09/01/2013
Trudy-Ann Breckenridge RD	12680	09/01/2013
Andrea Brennan RD	12751	14/01/2013
Leslie Brooke Brown RD	12443	21/01/2013
Rebecca Brown RD	12704	11/01/2013
Danielle Brubacher RD	12742	10/01/2013
Atheana Buckley RD	12756	09/01/2013
Jenny Bui RD	12793	11/01/2013
Ashleigh Callan RD	12823	21/01/2013
Nadine Campeau RD	12754	09/01/2013
Rachel Capron RD	12708	08/01/2013
Elysia Cartlidge RD	12791	09/01/2013
Julianne Cavanagh RD	12697	09/01/2013
Marion Champagne Cliche RD	12762	14/01/2013
Magdalene Chan RD	12785	09/01/2013
Kristina Chandler RD	12637	14/01/2013
Erika Charette RD	12631	28/01/2013
Deepa Chitaliya RD	12300	15/01/2013
Lisa Cianfrini RD	12648	14/01/2013
Claudia Cloutier RD	12763	10/01/2013
Kaitlin Cobean RD	12771	09/01/2013
Jessica Corner RD	12676	09/01/2013
Theresa Couto RD	12768	10/01/2013
Kelly Coyne RD	12703	09/01/2013
Natalie Diaz RD	12735	09/01/2013
Julia DiCesare RD	12740	14/01/2013
Lisa Dietrich RD	12670	10/01/2013
Jessica Donaldson RD	12675	11/01/2013
Raquel Duchen RD	12824	11/01/2013
Jany Dumont RD	12815	17/01/2013
Stéphanie Duplain RD	12757	21/01/2013
Mélanie Duquette RD	12777	09/01/2013
Emily Elliott RD	12682	11/01/2013
Abbey Sharp Fitzpatrick RD	12687	14/01/2013
Laura Francis RD	12644	11/01/2013
Dany Frechette RD	12827	28/01/2013
Julia Freeman RD	12707	10/01/2013
Yolanda Fung RD	12651	08/01/2013
Mahsa Gharegozlo RD	12786	09/01/2013
Lyndsay Glazier RD	12679	08/01/2013
Rojin Golbaz RD	12512	07/01/2013
Amanda Good RD	12678	08/01/2013
Hailey Goodman RD	12770	10/01/2013
Jacalyn Goodwin RD	12789	08/01/2013
Elizabeth Gullaher RD	12744	09/01/2013
Victoria Hall RD	12736	10/01/2013
Kayla Hamilton RD	12725	09/01/2013
Craig Hamilton RD	12241	10/01/2013
Erin Harlton RD	12650	07/01/2013
Stephanie Hass RD	12795	08/01/2013
Natalie Hastings RD	12807	09/01/2013
Maarika Hiis RD	12727	11/01/2013
Kristen Hipwell RD	12722	14/01/2013
Keren-happuch Ho RD	12718	09/01/2013
Carly Hochman RD	12828	08/01/2013
Breanne Hopkins RD	12879	10/01/2013
Esther Iannucci RD	11259	09/01/2013
Saman Iqbal RD	12857	22/11/2012
Krista Jacky RD	12802	08/01/2013
Aglaée Jacob RD	11099	16/11/2012
Sabrina Janes RD	12804	14/01/2013
Sonia Jaquemet RD	12797	14/01/2013
Nisha Joshi RD	12669	08/01/2013
Lee Kapuscinski RD	12715	14/01/2013
Sarah Kasman RD	12764	09/01/2013
Simon Kember RD	12787	14/01/2013
Shaylin Kemmerling RD	12801	14/01/2013
Laura Kennel RD	12806	08/01/2013
Tara Koyama RD	12691	08/01/2013
Jennifer Laban RD	12881	17/01/2013
Ivy Lam RD	12829	11/01/2013
Lisa Man Ting Lau RD	12662	08/01/2013
Courtney-Brooke Laurie RD	12671	14/01/2013
Emily Laver RD	12766	08/01/2013
Caroline LeBlanc RD	12749	10/01/2013
Sylvie Leblanc RD	12759	08/01/2013
Natalie Lefebvre RD	12778	14/01/2013
Marie-Anne Lefebvre RD	12848	07/12/2012
Sabrina Legault RD	12690	08/01/2013
Tanya Lewis RD	12677	08/01/2013
Kwan Yu Li RD	12688	08/01/2013
Jennifer Libman RD	12728	09/01/2013
Michelle Lim RD	12694	09/01/2013
Kelly Longworth RD	12713	09/01/2013
Anita Lopes RD	12731	08/01/2013
Alissa Lunney RD	12701	08/01/2013
Dorothy Lyons RD	12724	15/01/2013
Kelsey MacKinnon RD	12696	11/01/2013
Blair Makey RD	12799	09/01/2013
Sheri Maltais RD	11051	01/11/2012
Lisa Mannik RD	12739	09/01/2013
Cheryl Martin RD	12555	09/01/2013
Lisa Martin RD	12693	10/01/2013
Alexandra Masliwec RD	12748	07/01/2013

GENERAL CERTIFICATES OF REGISTRATION, CONTINUED

Josianne Massicotte RD	12782	10/01/2013
Kimberley McComb RD	12657	14/01/2013
Dawn McGuffin RD	2616	14/01/2013
Caroline Michon RD	12796	14/01/2013
Véronique Millaire RD	12747	10/01/2013
Catherine Mimeault RD	12808	14/01/2013
Rachel Morgan RD	12621	09/01/2013
Ashley Motran RD	12695	09/01/2013
Bob Moulson RD	12652	14/01/2013
Julie Murray RD	12572	09/01/2013
Zeinab Naser RD	12838	11/01/2013
Stephanie Nishi RD	12810	21/01/2013
Erin O'Reilly RD	12711	10/01/2013
Shefali Obhrai RD	12790	09/01/2013
Emily Opperman RD	12698	08/01/2013
Becky Pang RD	12814	09/01/2013
Elise Pauzé RD	12831	08/01/2013
Andrea Pelle RD	12663	07/01/2013
Mélanie Perreault RD	12758	14/01/2013
Christine Peters RD	12773	11/01/2013
Lauren Peters RD	12649	07/01/2013
Anna Phan RD	12832	16/11/2012
Julia Pilliar RD	12647	10/01/2013
Stephanie Piper RD	12765	10/01/2013
Catherine Plaziac RD	12743	16/01/2013
Jillia Prescott RD	12699	9/01/2013
Sarah Pressey RD	12705	09/01/2013
Joanne Pun RD	12686	08/01/2013
Emily Quenneville RD	12642	07/01/2013
Carrie Regan RD	12835	14/01/2013
Jessica Reingold RD	12794	09/01/2013
Shannon Richter RD	12626	07/01/2013
Kayla Robinson RD	12683	15/01/2013
Erin Rudolph RD	12710	09/01/2013
Tasha Rugless RD	12761	11/01/2013
Amanpreet Sagu RD	12783	15/01/2013
Nayla Salameh RD	12027	10/01/2013
Sarah Schaeffer RD	12779	09/01/2013
Sarah Schrier RD	12712	08/01/2013
Katherine Schwenger RD	12685	11/01/2013
Maxine Silberg RD	12655	14/01/2013
Dina Skaff RD	12774	11/01/2013
Angela Smith RD	12811	09/01/2013
Mark Smith RD	12653	11/01/2013
Deidra Smith RD	12833	09/01/2013
Elena Sobolev RD	12741	08/01/2013
Jennie Soguel RD	12726	09/01/2013
Laurel Splawski RD	12769	11/01/2013
Nicole St-Pierre RD	12720	10/01/2013
Julie Stachiw RD	12674	10/01/2013
Ryan Stallard RD	12672	14/01/2013
Sandra Stirpe RD	12798	07/01/2013
Jaclyn Strohl RD	2767	09/01/2013
Natalie Symons RD	12816	09/01/2013
Marisa Tamasi RD	12733	09/01/2013
Zalika Tjon RD	12781	09/01/2013
Vania Tong RD	12738	08/01/2013
Claire Towns RD	12745	08/01/2013
Kasia Tupta RD	12784	08/01/2013
Deborah Van Dyke RD	12723	10/01/2013
Ashleigh Vance RD	12734	09/01/2013
Laura Vermander RD	12706	11/01/2013
Shirley Walsh RD	12689	09/01/2013
Ping Wang RD	11462	08/01/2013
Caitlin Way RD	12716	08/01/2013
Lucia Weiler RD	10414	11/01/2013
Melissa Williams RD	12681	14/01/2013
Lisa Woodrow RD	12882	16/01/2013

TEMPORARY CERTIFICATES

Mana Bayanzadeh RD	12571	19/12/2012
Alle Choi RD	12887	22/01/2013
Jérémie Courcelles-Alie RD	12856	14/11/2012
Emily Kelly RD	12853	14/11/2012
Sheela Kuttaiya RD	12029	20/12/2012
Christine Lee RD	12877	22/01/2013
Jordan Mak RD	12871	07/01/2013
Renée Racine RD	12884	15/01/2013
Marissa Van Engelen RD	12861	14/12/2012
Margot Viola RD	12860	21/12/2012

PROFESSIONAL CORPORATION

Farough Dietetic Professional Corporation	12855	01/11/2012

SUSPENSION LIFTED/MEMBER REINSTATED

Molly Cleator RD	1946	02/01/2013
Brianne MacKenzie RD	11261	15/01/2013

SUSPENSION

In accordance with the *Regulated Health Professions Act* (1991), *Procedural Code*, Section 24, these *Certificates of Registration* have been suspended for failure to pay the prescribed fees.

Molly Cleator	1946	10/12/2012
Brianne MacKenzie	11261	14/12/2012
Amy Lynn Nichols	11620	10/12/2012

RETIRED

Linda Barton	2803	31/10/2012
Kathleen Butler	1263	31/10/2012
Isabel Clark	2288	31/10/2012
Renée C. Crompton	2372	31/10/2012
Rosemary Goodearle	2413	15/11/2012
Elizabeth Hare	2244	31/10/2012
Linda Hines	1379	31/10/2012
Deborah King	1381	31/10/2012
Janie Sanderson	1346	22/11/2012
Brenda Scheepers	2446	27/11/2012
Lynda Scott-Harper	1382	09/11/2012
Suellen Weaver	1543	31/10/2012

IN MEMORIAM

Carol Ayers	2007	17/12/2012

REVOCATION

A *Certificate of Registration* suspended for failure to pay the prescribed fee is automatically revoked after it has been suspended for 12 months.

Josie Deeks	2725	06/12/2012
Jessica Dooley	12018	06/12/2012
Marie-Andrée Gagnon	12044	06/12/2012
Nancy Lew	1882	06/12/2012
Trupti Parekh	4347	06/12/2012
Lyndall Stanley-Thompson	1670	06/12/2012
Alyson Werger	11223	06/12/2012

RESIGNED

Lindsay Ainsworth	12203	31/10/2012
Leslie Brooke Brown*	12443	07/12/2012

* reapplied to the College and became a member on January 21, 2013

Lynda Chadwick	2539	31/10/2012
Kelly Chung	4271	21/12/2012
Lori Doran	3312	30/10/2012
Marie-Eve English	12495	06/12/2012
Laura Fennell	12017	27/12/2012
Melissa Foley	12202	14/11/2012
Elaine Hammond	3105	01/11/2012
Pamela Lai	12032	27/11/2012
Carolyn Laidley	12673	29/11/2012
Jennifer Macintosh	1371	07/12/2012
Lise-Andreé Massé	12538	05/11/2012
Mira Milburn	3394	03/12/2012
Jennifer Pablo	11289	29/10/2012
Summiya Padela	12562	11/12/2012
Alexandra Picard-Sioui	12554	25/11/2012
Dani Renouf	11793	30/10/2012
Deborah Rushton	2714	31/10/2012
Dayna Joy Saari	4254	06/12/2012
Kelly Sherwood	3985	22/01/2013
David Smith	12218	28/10/2012
Carolyn Y. Tam	3367	31/10/2012
Hue-Diane Wuong	10516	31/10/2012

Available to All Healthcare Professionals

New IPC eTool

Building on the consensus achieved by Colleges in the production of the "Interprofessional Guide on Orders, Directives and Delegation," the *Federation of Health Regulatory Colleges of Ontario* also sponsored this new IPC eTool to assist interprofessional teams to coordinate care within the expanded (and overlapping) scopes and authorities established by the *Regulated Health Professions Statute Law Amendment Act,* 2009.

To access the new IPC eTool, go to http://ipc.fhrco.org

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COLLEGE OF DIETITIANS OF ONTARIO
information@cdo.on.ca
1810-5775 YONGE STREET BOX 30 TORONTO ON M2M 4J1
416-598-1725 / 800-668-4990 / FAX: 416-598-0274