ARN

Competency Model

For

Professional Rehabilitation Nursing

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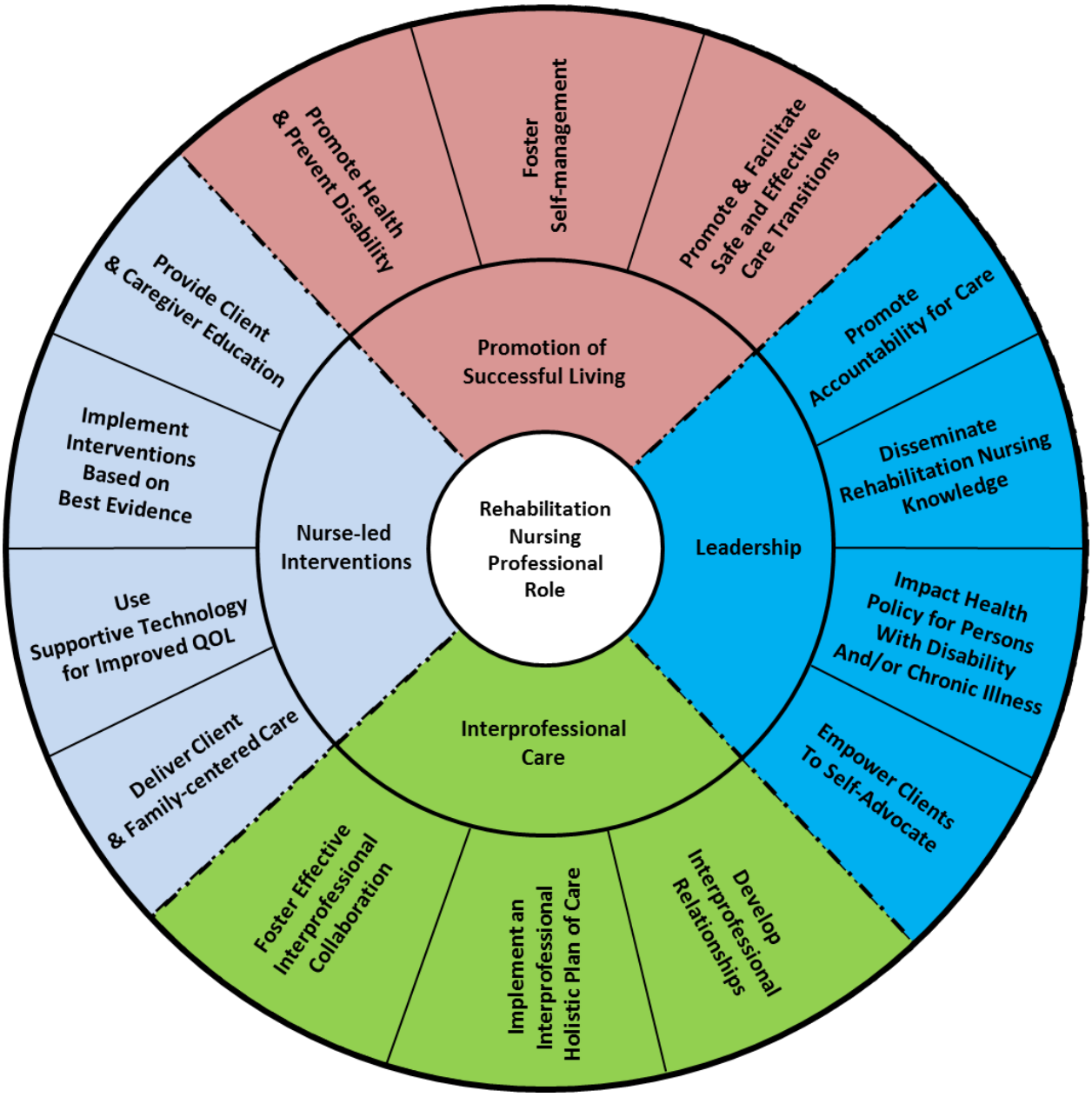
Introduction

The specialty of rehabilitation nursing is practiced in multiple settings along the healthcare continuum; thus, a framework or model for professional rehabilitation nursing needs to encompass domains that reflect all competencies necessary to promote rehabilitation nursing in the current healthcare environment.

An ARN task force comprised of experts representing clinical and academic settings embarked on a journey to develop an evidence-based framework to guide professional rehabilitation nursing practice. Four domains were created that highlighted essential role competencies. The competencies were further defined into three levels of nurse proficiency: beginner (1-2 years); intermediate (3-5 years-CRRN); and advanced (5 years and above in varied roles, including educator, CNS, APRN, etc.).

Additional materials will be developed to enhance rehabilitation nursing courses or be infused into other courses in university curricula and continuing education products, including, but not limited, to the Core Curriculum. The Competency Model for Professional Rehabilitation Nursing is depicted by a circle with the Professional Rehabilitation Nurse Role at the center surrounded by the four domains and various competencies. The broken lines illustrate the crossover of knowledge and skills that are represented in each domain, representing a holistic practice that rehabilitation nurses espouse.

ARN Competency Model for Professional Rehabilitation Nursing



Domains & Competencies

Domain 1: Nurse-led Evidence-based Interventions to Promote Function and Health Management in Persons with Disability and/or Chronic Illness

1.1. Use Supportive Technology for Improving Quality of Life for Persons with Disability
1.2. Implement Nursing and Interprofessional Interventions Based on Best Evidence to Manage the Client's Disability and/or Chronic Illness
1.3. Provide Client & Caregiver Education in Relation to Disability, Chronic Illness, and Health Management (DCIHM)
1.4. Deliver Client and Family-centered Care

Domain 2: Promotion of Health and Successful Living in Persons with Disability or Chronic Illness Across Life-span

2.1. Promote Health & Prevent Disability Across the Life-span
2.2. Foster Self-Management
2.3. Promote and Facilitate Safe and Effective Care Transitions

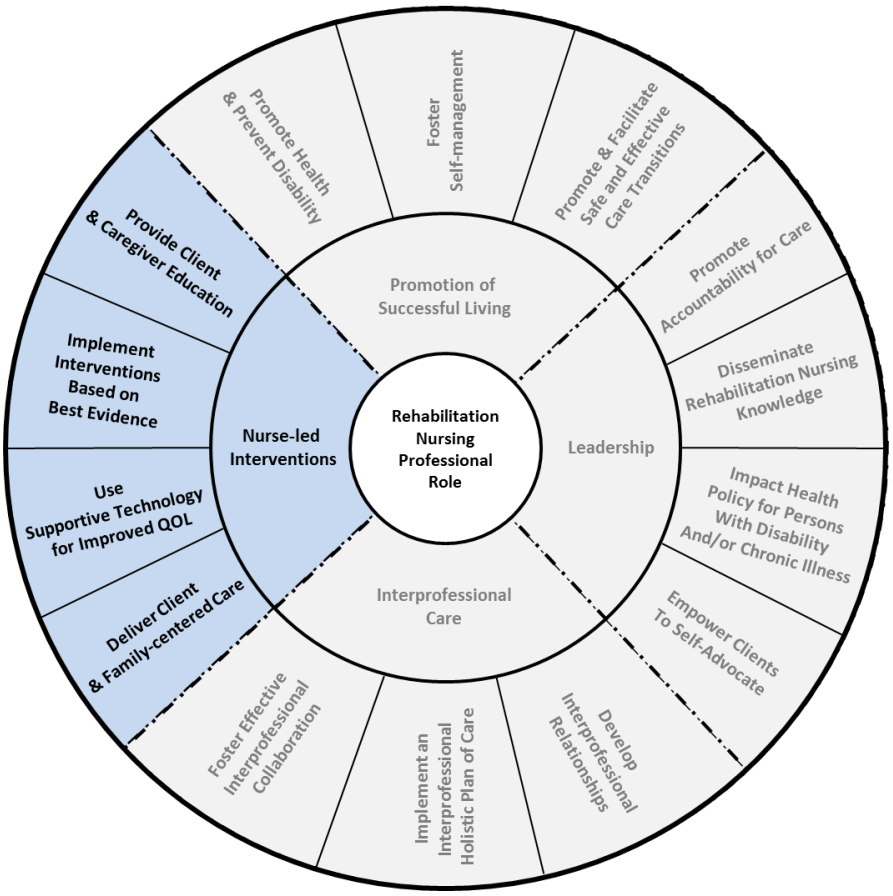
Domain 3: Leadership

3.1. Promote Accountability for Care
3.2. Disseminate Rehabilitation Nursing Knowledge
3.3. Impact Health Policy for Persons with Disability and/or Chronic Illness
3.4. Empower Client Self-Advocacy

Domain 4: Interprofessional Care

4.1. Develop Interprofessional Relationships
4.2. Implement an Interprofessional Holistic Plan of Care
4.3. Foster Effective Interprofessional Collaboration

Domain 1: Nurse-led Evidence-based Interventions to Promote Function and Health Management in Persons with Disability and/or Chronic Illness



The practice of rehabilitation nursing is recognized as the specialty of managing the care of persons with disability and chronic health conditions across all ages. Rehabilitation nurses, whether novice or experienced, use current evidence and supportive technology to deliver the optimum patient and family-centered care. Evidence-based best practices support these nurse-led interventions as well as all of the patient and caregiver education necessary for maximizing the quality of life for those we serve.

Rehabilitation nurses recognize that individuals are part of the family unit, and that families comprise the support structure in each community. They understand these relationships and work collaboratively with other professionals using nurse-led interventions to promote health for individuals, families, and communities.

Competency 1.1: *Use Supportive Technology for Improving Quality of Life for Persons with Disability*

Domain: Nurse-led Evidence-based Interventions to Promote Function and Health Management in Persons with Disability and/or Chronic Illness

Description/Scope: Use of appropriate technology that improves self-management, functional improvement, and quality of life for individuals with disabilities and/or chronic illness. Examples include electronic monitoring, TENS, environment controls, telehealth, etc.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Participates in the process of determining the need for assistive or supportive technology	Assesses for and anticipates the client's need for supportive technology	Recognizes opportunities to implement new technologies for clients with disability and/or chronic illness
Uses basic technology interventions in the plan of care	Establishes goals with the interprofessional team for the use of technology in the plan of care	Recognizes opportunities to incorporate new technologies within the client's financial means
Demonstrates competent use of technology in the care of a client	Tailors technologies to enhance client outcomes	Collaborates with the interprofessional team to develop new technologies to improve client outcomes
Documents the outcome of the technology intervention	Evaluates the effectiveness of technology to improve health outcomes	Incorporates new technology and outcomes measures into the plan of care

Competency 1.2: *Implement Nursing and Interprofessional Interventions Based on Best Evidence to Manage the Client's Disability and/or Chronic Illness*

Domain: Nurse-led Evidence-based Interventions to Promote Function and Health Management in Persons with Disability and/or Chronic Illness

Description/Scope: Use of evidence-based interventions to manage common disabilities and chronic illness, such as TBI, stroke, SCI, amputation, neuromuscular disorders, etc.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Uses established guidelines to assess an individual's function and health management needs	Uses insight and creativity to identify gaps in assessment strategies	Uses insight and creativity to provide expert care, integrating cultural sensitivity and gender preference in consultations for complex clients
Follows an established a plan of care (POC) with the client and family	Collaborates with client, family, and interprofessional team to develop a plan of care with attainable rehabilitation goals	Leads the client, family, and interprofessional team to meet goals for disability and chronic illness health management
Documents responses to standard interventions	Evaluates and documents client responses to interventions; adjusts the POC as needed for best outcomes	Evaluates outcomes for the complex client in relation to life-long function and health management

Competency 1.3: *Provide Client & Caregiver Education in Relation to Disability, Chronic Illness, and Health Management (DCIHM)*

Domain: Nurse-led Evidence-based Interventions to Promote Function and Health Management in Persons with Disability and/or Chronic Illness

Description/Scope: Utilizes the nursing process to provide DCIHM education for individuals, families, interdisciplinary teams and communities. Areas of education include but are not limited to ADL management, mobility, communication, safety, and disease management.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Assesses/determines learning needs and readiness to learn of the client and caregiver for DCIHM "literacy"	Develops an individualized education plan to address DCIHM	Develops and provides the tools that are needed for effective education for DCIHM
Supports established goals for the client and caregiver	Collaboratively establishes goals according to the unique client and caregiver goals	Anticipates long-term learning needs for clients/caregivers related to DCIHM
Utilizes standard rehabilitation education related to DCIHM	Provides tailored and timely education related to DCIHM	Provides consultative rehabilitation education to individuals, families, interprofessional teams, and communities related to DCIHM
Utilizes "teach-back" to evaluate client and family learning	Utilizes "teach-back" and adapts education plan based on client and caregiver performance	Evaluates the effectiveness of the educational outcomes related to DCIHM

Competency 1.4: *Deliver Client and Family-centered Care*

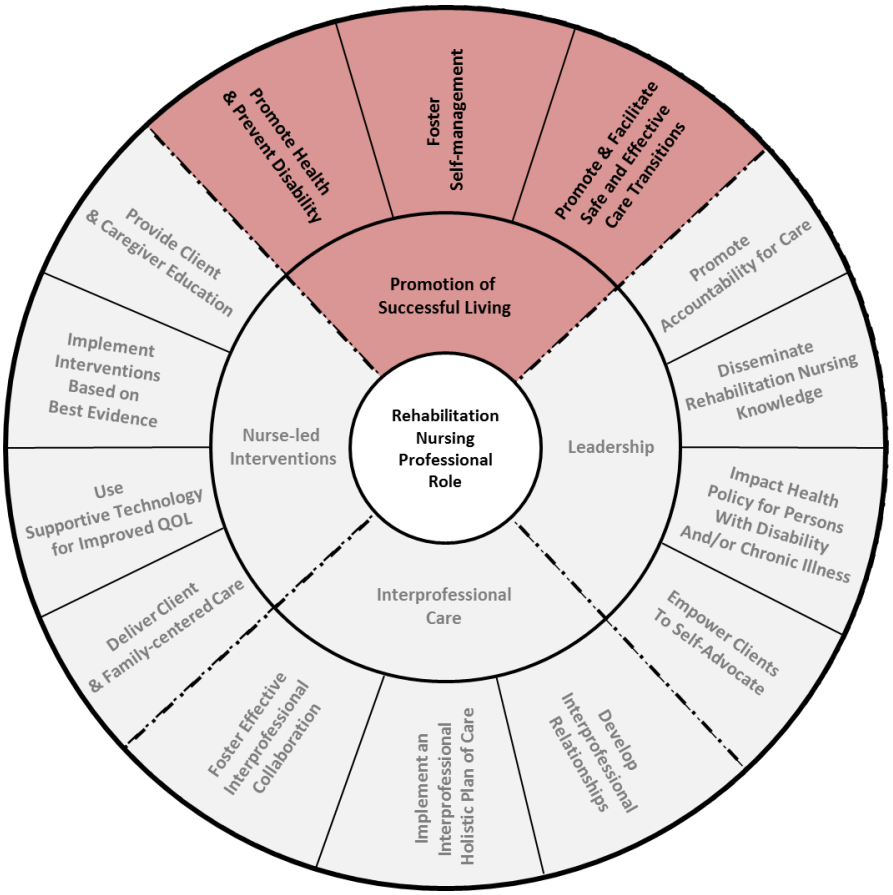
Domain: Nurse-led Evidence-based Interventions to Promote Function and Health Management in Persons with Disability and/or Chronic Illness

Description/Scope: Demonstrates a collaborative approach to planning, delivering, and evaluating care that acknowledges and honors the client's and family's culture, values, beliefs, and care decision-making.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Participates in a holistic assessment of the client and family that includes culture, values, beliefs, and health literacy	Performs a holistic assessment of the client and family and identifies strengths of the client and family that could contribute to a successful plan of care	Synthesizes holistic assessment data to promote optimal rehabilitation outcomes
Supports the development of goal setting that reflects the client's and family's choices including leisure activities	Develops a plan of care in collaboration with the interprofessional team that addresses client and family goals	Advocates for client and family decision making regarding the plan of care goals, modifying as appropriate
Participates in the implementation of the plan of care with the interprofessional team	Coordinates with the interprofessional team to ensure consistent delivery of care that honors the client's and family's values and culture	Serves as a resource to the client, family, and interprofessional team in the implementation of the plan of care
Participates in the care conference that evaluates the client/family-centered plan of care	Modifies the plan of care as needed to incorporate new information evidenced by the client / family response to interventions	Directs the data evaluation process

Domain 2: Promotion of Health and Successful Living in Persons with Disability or Chronic Illness Across Life-span



The rehabilitation nurse provides education and plans for patients to manage disease and disability with maximal independence in the home-living environment. Rehabilitation nurses identify client and caregiver needs and integrate community care services that manage chronic disease and supports health over time.

This domain targets the role that the rehabilitation nurse plays in promoting overall successful living through risk reduction, harm prevention, and maintenance of optimal health.

Competency 2.1: *Promote Health & Prevent Disability Across the Life-span*

Domain: Promotion of Health and Successful Living in Persons with disability and/or Chronic Illness Across Life-span

Description/Scope: The use of risk reduction, harm prevention, and health management promotion strategies, such as helmet safety, transportation services, nutrition education and lifestyle modifications, to promote and encourage wellness.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Assesses for common risks with persons living with DCIHM	Assesses for client risk and readiness to manage potential harm and engages in health promotion	Assesses individual and community needs for risk reduction, harm prevention, and health promotion relating to DCIHM
Establishes goals for RPP (Reducing Risk, Promoting Health, Preventing Disability) following established rehabilitation protocols	Collaborates with the client, family, and interprofessional team to set goals for RPP for individuals with DCIHM	Consults with individuals, communities, and populations to set goals for RPP
Evaluates a person's ability to understand and engage in strategies for RPP	Evaluates individual's health behaviors/ability to engage in RPP, adjusting the plan as needed	Uses data to identify health improvement trends in individuals, communities, and populations

Competency 2.2: *Foster Self-Management*

Domain: Promotion of Health and Successful Living in Persons with disability and/or Chronic Illness Across Life-span

Description/Scope: A collaborative approach that incorporates the client's self-efficacy, past experiences and health literacy to problem solve and make decisions about his/her health care to achieve the highest quality of life while living with a chronic illness and/or disability

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Assesses clients for their readiness to learn and their existing knowledge of their illness or disability	Identifies physical and/or psychosocial barriers to performing self-management	Synthesizes the client and family data and resources needed for optimal self-management of disability and/or chronic illness
Participates in the goal setting and development of the plan of care with the client, family and interprofessional team that includes self-care skills	Identifies appropriate teaching methods to achieve self-management and realistic self-management goals	Adapts the plan of care taking into consideration the client's age, developmental stage, and cultural diversity and generates available strategies for successful self-management
Communicates with the interprofessional team in data collection	Collaborates with the interprofessional team to develop the plan of care and based on best practice and client preferences	Anticipates additional resources to a successful self-management plan and coordinates with the interprofessional team to implement self-management strategies
Participates in the evaluation of the self-management plan of care	Contributes to the modification of the self-management plan of care	Evaluates plan of care, coordinates with referral sources for successful self-management

Competency 2.3: *Promote and Facilitate Safe and Effective Care Transitions*

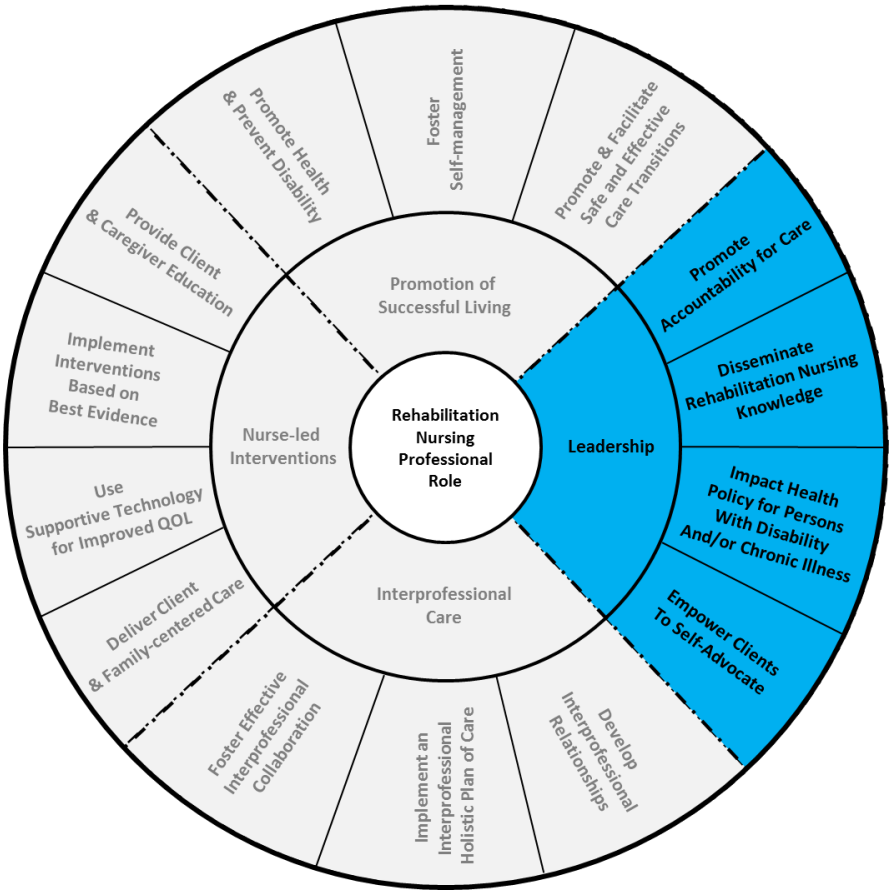
Domain: Promotion of Health and Successful Living in Persons with disability and/or Chronic Illness Across Life-span

Description/Scope: Optimal collaboration and coordination among clients, families and healthcare professionals to promote the safe and timely transition across care settings.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Assesses the client and family regarding cultural values and health literacy as applicable to care transitions	Identifies the barriers that could influence the care transitions	Synthesizes client and family data and resources needed for a seamless care transition
Participates in the development of an interprofessional plan for care transitions	Modifies plan of care based on additional data collection	Coordinates the interprofessional plan for care transition
Contributes to the development and implementation of the goals for care transitions	Coordinates the resources needed for a seamless care transition	Facilitates the interprofessional care transition plan
Participates in the care conference that evaluates the care transition plan	Contributes to the interprofessional evaluation of the client and family care transition plan	Collects program data to evaluate the client and family care transition experience for the purpose of program management and improvement

Domain 3: Leadership



Rehabilitation Nurses at all levels are key in empowering clients and families to be self-advocates. They routinely collaborate with other professionals and organizations and influence health policy to promote optimum care across the continuum for individuals with disability or chronic illness.

The professional rehabilitation nurse is a qualified team leader and a competent key partner in a successful rehabilitation program. Client rehabilitation outcomes are maximized when the rehabilitation nurse takes a leadership role and collaborates with rehabilitation team members.

The Leadership domain highlights competencies which focus on accountability, advocacy, and the sharing of rehabilitation knowledge with clients/families, and other members of the inter-professional team.

Competency 3.1: *Promote Accountability for Care*

Domain: Leadership

Description/Scope: Accountability for care is the continuous, multi-dimensional process that promotes ethical, cost-effective client and family-centered quality outcomes in persons with disability and chronic illness.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Delivers safe, ethical, quality care for the client and family	Identifies factors that influence the provision of quality care and client and family outcomes	Analyzes data from multiple sources that impact the provision of safe and quality care and implements changes as appropriate
Collects unit data that addresses practice issues affecting quality outcomes	Assists in the analysis of unit data that affect quality client-centered outcomes	Synthesizes data from multiple sources and makes recommendations for practice change to promote quality outcomes
Demonstrates awareness of how client/staff variables affect the quality of the processes of the unit	Contributes to unit-based quality improvement activities	Contributes to the evaluation of the environment in monitoring and measuring the efficacy of organizational quality outcomes

Competency 3.2: *Disseminate Rehabilitation Nursing Knowledge*

Domain: Leadership

Description/Scope: The rehabilitation nurse disseminates rehabilitation nursing knowledge in diverse settings such as unit, agency, government, and academia. Dissemination activities include presentations, publications, government advocacy, student instruction, professional organization engagement, etc.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Uses resources to answer clinical questions	Generates innovative strategies for care based on literature	Develops evidence-based guidelines to promote quality care and new knowledge using rigorous research strategies
Participates in unit activities that promote rehabilitation nursing practice	Shares innovative strategies with peers, interprofessional team and professional community	Leads in the dissemination of new rehabilitation nursing knowledge through diverse venues

Competency 3.3: *Impact Health Policy for Persons with Disability and/or Chronic Illness*

Domain: Leadership

Description/Scope: Effectively champions the healthcare policy process in the legislative arena locally, regionally, or nationally. Presents ethical strategies for effective action.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Identifies names and purposes of standard regulatory and accrediting agencies, such as CARF, JC, CMS, and Magnet	Describes the healthcare policy of each body in relation to current rehabilitation nursing practice	Identifies and implements strategies to comply with current/new regulatory and accreditation standards
Demonstrates an awareness of the power of health policy in the provision of care to clients and families living with disability and/or chronic illness	Contributes to a professional organization or other group that influences health policy	Contributes to the development of public policy that improves community services, minimizes environmental barriers, and reduces societal attitudes toward persons with DCIHM

Competency 3.4: *Empower Clients to Self-Advocate*

Domain: Leadership

Description/Scope: Client advocacy is the safeguarding of a client's autonomy, acting on behalf of the client, and empowering the client through education, collaboration, and support for individuals living with chronic illness and/or disability (DCIHM)

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Respects and values client and family autonomy in their health-related choices	Promotes informed and autonomous client and family-centered and shared decision making	Collects and interprets information that is necessary to resolve ethical decisions
Provides information to client and families that they need to make informed decisions about care	Empower the client and families to use information and resources to make informed decisions about care	Fosters the client's independence and the ability to advocate for him/herself utilizing community resources and systems
Demonstrates awareness of developing conflicts on the unit between clients, families, and caregivers.	Mediates discussions to explore resolutions when there are disagreements between clients, families, and caregivers	Serves as an expert witness testifying to the challenges of resource allocations that affect persons with DCIHM

Domain 4: Interprofessional Care

An integral part of the rehabilitation nurse's role is the ability to effectively communicate and collaborate within an interprofessional team. The rehabilitation nurse's role as a member of an effective interprofessional team is instrumental in the development and implementation of a rehabilitation plan of care that uses the best available evidence to promote desired quality outcomes in a diverse client population.

The Interprofessional Care domain explicates the rehabilitation nurse's role on the interprofessional team through relationship development, effective collaboration, and coordinated implementation of the plan of care.

Competency 4.1: *Develop Interprofessional Relationships*

Domain: Interprofessional Care

Description/Scope: The rehabilitation nurse builds and maintains interprofessional team relationships using effective communication and strategies such as client conferences, huddles, etc.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Recognizes the role of the interprofessional team members	Maximizes contributions of each member of the interprofessional team to promote the rehabilitation plan of care	Facilitates effective team function by taking a leadership role in team meetings and communication
Participates in the interprofessional team process	Coordinates the implementation of the interprofessional plan of care	Evaluates the effectiveness of the interprofessional team

Competency 4.2: *Implement an Interprofessional Holistic Plan of Care*

Domain: Interprofessional Care

Description/Scope: The rehabilitation nurse develops a plan of care for diverse clients, which prescribes strategies, alternatives, and interventions to attain desired outcomes.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Identifies client problems that need care planning	Contributes nursing-specific assessment findings to the care planning	Collaborates with the interprofessional team when the POC is altered for economic reasons
Contributes to interprofessional team in establishing client centered goals	Collaborates with the interprofessional team in establishing client-centered goals	Anticipates long-term care needs for individuals, families, and communities
Implements the interventions established in the interprofessional plan of care	Implements the interprofessional plan of care using evidence based best practice	Provides consultation to the interprofessional team to achieve the plan of care
Evaluates effectiveness of nursing interventions in the interprofessional plan of care	Evaluates effectiveness of the interprofessional plan of care	Evaluates aggregate data with the interprofessional team to promote quality client outcomes

Competency 4.3: *Foster Effective Interprofessional Collaboration*

Domain: Interprofessional Care

Description/Scope: The rehabilitation nurse collaborates with the client, family, and other members of the interprofessional team in providing exemplary client care.

Proficiency Levels & Descriptors:

Beginner	Intermediate	Advanced
Represents the discipline of nursing while participating on the interprofessional team	Collaborates with the client, family, and interprofessional team members regarding goals and priorities of the plan of care	Models and coaches the collaborative process while engaging with the interprofessional team to advance rehabilitation
Communicates pertinent information regarding the client to the interprofessional team	Collaborates with the interprofessional team to develop and implement an evidence-based plan of care	Evaluates the plan of care in collaboration with other interprofessional team members
Recognizes and respects diversity and roles within the interprofessional team	Mediates discussions to explore resolutions when conflict arises	Leverages interprofessional team diversity as a strength to synergize team collaboration

