

The Competency Model for Professional Rehabilitation Nursing

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Abstract

Background: Rehabilitation nursing is practiced in various settings along the healthcare continuum. No framework is noted in the literature that defines the necessary competencies of the rehabilitation nurse.

Purpose: To develop a Competency Model for Professional Rehabilitation Nursing and its application to clinical and educational practice.

Method/design: A seven-member Association of Rehabilitation Nurses (ARN) task force was convened; conducted a literature review, reviewed current and historical ARN documents, including the Strategic Plan, and developed a Competency Model for Professional Rehabilitation Nursing practice.

Findings: The Competency Model for Professional Rehabilitation Nursing delineates four domains of rehabilitation nursing practice and essential role competencies.

Conclusion: The Competency Model for Professional Rehabilitation Nursing addresses this diverse specialty practice in the current healthcare arena. This framework can be used to guide nurses practicing at different levels of proficiency in various settings.

Clinical Relevance: The Competency Model can be used as a structure for staff orientation, evaluation tools, clinical ladder components, role descriptions and rehabilitation nursing courses.

Introduction

According to Fawcett and DeSanto Madeya (2013), most disciplines or professions purport a single metaparadigm, which represents the global perspective of the discipline and identifies the discipline's practice. Nursing is no exception, with a metaparadigm that highlights the concepts of person, health, environment, and nursing. The multiple

conceptual models in nursing provide the lens through which nurses view their practice. Rehabilitation nurses, educated in various academic settings and who are at various stages of their professional careers, may already subscribe to a particular conceptual model or framework.

As the nursing profession continues to evolve and become more specialized, there has been a surge in the number of models and frameworks developed to define

specific practice areas (Rimmer & Rowland, 2008). Examples include the Synergy Model for Patient Care developed by the American Association of Critical Care Nurses (1995) and the International Classification of Functioning, Disability, and Health (ICF) Model used by physical therapists and physiatrists as a tool for clinical problem solving (Steiner et al., 2002). Rehabilitation is a specialty practice of nursing and needs its own professional competency model. Rehabilitation is practiced in multiple settings, including but not limited to acute rehabilitation settings, skilled nursing facilities, home health, acute care, long-term acute care, and outpatient settings. Thus, a framework or model for describing professional rehabilitation nursing should encompass domains that reflect competencies necessary in each practice setting.

To that end, an Association of Rehabilitation Nurses (ARN) member task force comprised of seven experts representing clinical and academic settings embarked on a journey in the fall of 2013 to develop an evidence-based (EB) framework to guide professional rehabilitation nursing practice into the future. The seven members of the task force were purposefully selected to represent a cross-section of academe, clinical practice, research, theory development, and experiential backgrounds. Among the members of the task force, four held a PhD and three were Master’s prepared. The group members also represented expertise in a variety of subspecialties or related specialties such as gerontological nursing, and a few were fellows in prominent nursing organizations. In addition, the task force members hailed from different geographic locations in the United States, as well as representing different age groups and levels of experience. Support staff included members of the management organization skilled in education and model development. The process for development of the model is detailed in Table 1.

Before the face-to-face work meeting, the task force connected via e-mail and phone conversations, led by the chair and support staff. The task force reviewed current ARN documents, including the *Standards and Scope of Rehabilitation Nursing Practice*, *The Specialty Practice of Rehabilitation Nursing: The Core Curriculum*, role descriptions, and the entire continuum of available resources on rehabilitation nursing. The group then brainstormed ideas about the goals, activities, and professional roles of the rehabilitation nurse. After comprehensive discussion, four domains were identified that best defined the essential role competencies of the rehabilitation nurse. The competencies included: nurse-led interventions, promotion of health and successful living, leadership, and interprofessional care. The competencies for each domain were delineated into three levels of nurse proficiency: beginner (1–2 years or new to rehabilitation nursing practice); intermediate (3–5 years, CRRN); and advanced (5+ years in varied roles, including, but not limited to an educator or an advanced practice registered nurse (APRN), such as a clinical nurse specialist (CNS) or nurse practitioner (NP). It was also noted that rehabilitation nurses practicing in the current healthcare environment have different levels of proficiency (Table 2). Each level of nurse competency subsumes the previous level; thus, the advanced nurse also demonstrates the competencies identified in the beginner and intermediate levels. Nurses who are experienced in other practice areas, yet new to rehabilitation nursing, will need to acquire a unique body of knowledge related to the specialty (Mauk, 2013).

The Competency Model for Professional Rehabilitation Nursing (Figure 1) is depicted by a circle with the Professional Rehabilitation Nurse Role in the center surrounded by the four domains and competencies for each domain. The broken lines illustrate the transfer of knowledge and

Table 1 Developmental process of the model

Date	Activity
October 2013	ARN Board of Directors solicited experts for Competency Model Task Force (TF)
October 2013	ARN Competency Model TF selected; comprised of academic and clinical experts; met for 2-day work meeting at ARN office; process included review of past and current ARN competencies, the Core Curriculum, and other related documents; and “brainstorming” activity. Four domains and associated competencies were developed; visual depiction of the model (circle) with the professional rehabilitation nurse in the center was developed
November 2013 – February 2014	Conference calls with TF to further develop and “fine tune” each competency and introductions to each section
April 2014	Introduced to the ARN Board of Directors; BOD approved
June 2014	Article in June/July e-News about the Model; solicited comment from membership
October 2014	Presented at ARN Conference in Anaheim, CA by Vaughn

Table 2 Proficiency levels

Beginner	Intermediate	Advanced
1–2 years practice	3–5 years practice CRRN	>5 years practice CRRN CNS, APRN, Educator, Researcher

skills represented in each domain, demonstrating the holistic practice that rehabilitation nurses espouse. This conceptual model defines practice and reflects the paradigm of professional rehabilitation nursing within the metaparadigm of nursing. The purpose of this article is to present each of the domains and their respective competencies and explore potential applications of the model in both educational and clinical practice settings.

Domain 1—Nurse-led Interventions

The practice of rehabilitation nursing is recognized as the specialty of managing the care of people with disabilities

and chronic health conditions across the lifespan. Rehabilitation nurses, whether novice or expert, search for and use current evidence and supportive technology to deliver optimal client and family-centered care. To ascertain the best evidence to answer a clinical question, Pierce (2007) related that nurses may use Evidence-Based Practice or Research Utilization Models to facilitate the process for policy changes, or the development or implementation of new care practices in the rehabilitation client population. Current evidence supports these nurse-led interventions and the client–caregiver education necessary for maximizing the quality of life for people with disabilities and chronic health conditions. Rehabilitation nurses consider individuals as part of a family unit, and that families comprise the support structure for each client.

Use Supportive Technology to Improve Quality of Life

This competency includes rehabilitation nurses seeking out and supporting appropriate technology that improves the self-management, functional improvement, and quality of life for individuals with disability and/or chronic

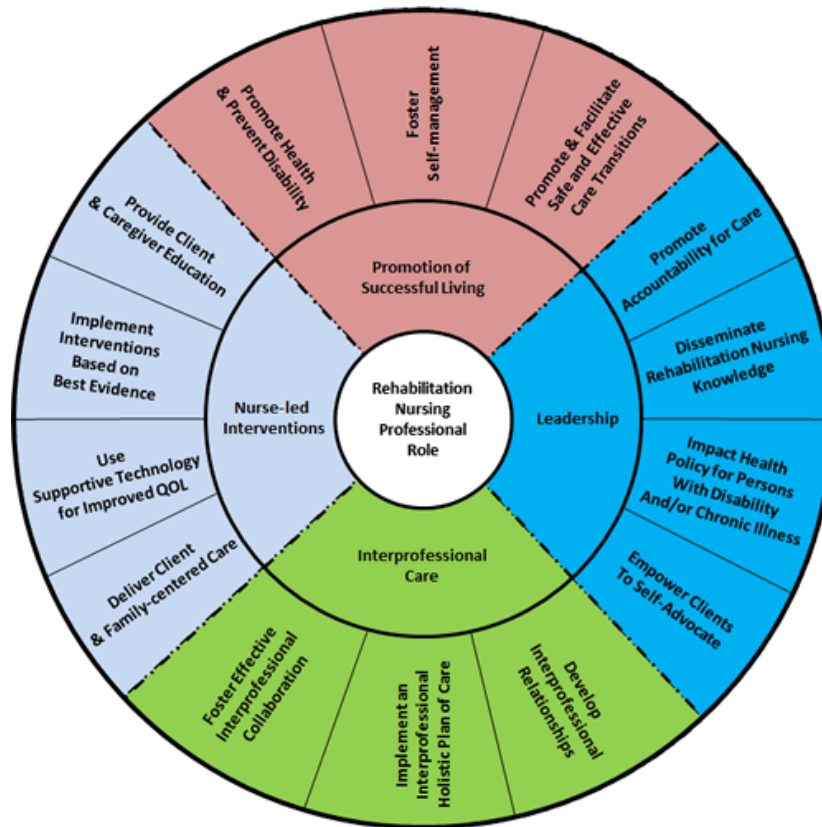


Figure 1 The Competency Model For Professional Rehabilitation Nursing (ARN, 2014a,b).

illness. Examples include electronic monitoring, telehealth, and environmental controls such as smart technology in the home setting (Dreyfuss, 2009). Personalized self-management strategies incorporating user-centered technology in stroke survivors' homes were found to enhance their self-efficacy and ability to meet personal goals (Mawson et al., 2014). In addition, tele-rehabilitation offers the potential for more people to participate in monitored rehabilitation activities post discharge (Munro, Angus, & Leslie, 2013).

The novice nurse participates in the process of determining the need for any assistive or supportive technology, uses the technology in planning and caring for the client, and documents the outcome of the intervention. The intermediate nurse additionally assesses for and anticipates the client's need for such technology, establishes goals with the interprofessional team for the use of technology in the plan of care (POC), tailors technologies to enhance client outcomes, and evaluates the efficacy of technology. The advanced nurse recognizes opportunities to implement cost-effective new technologies for clients with disability and/or chronic illness and collaborates with the interprofessional team to design or develop technologies or make recommendations regarding technology to improve client outcomes, including being able to manage his or her home and the community. Technology, as mentioned above, can influence the discharge plan of individuals and facilitate their ability to return to the community and self-manage their health either independently or with the support of a caregiver. For example, supportive technology that offers web-based stroke caregiver interventions can assist the caregiver with decision-making about his or her personal health and that of the rehabilitation client, which promotes better outcomes. These interventions may also influence caregiver decisions which impact the subsequent use of health services (Pierce, Steiner, Khuder, Govoni, & Horn, 2009).

Implement Nursing and Interprofessional Interventions Based on Best Evidence

Evidence-based interventions to manage common disabilities and chronic illnesses, such as traumatic brain injury (TBI), stroke, spinal cord injury (SCI), amputation, and neuromuscular disorders describe the scope of this competency. Bridging the gap between evidence and practice assists the aforementioned client populations to reach their optimal rehabilitation goals (Bayley et al., 2014). Rehabilitation nurses need to be cognizant of current evi-

dence and integrate appropriate evidence within their proficiency level.

At the novice level, the nurse uses established protocols or practices, such as those described by Miller et al. (2010) on comprehensive nursing and interprofessional stroke care, to assess an individual's function and health management needs, to follow an established POC with the client and family, and document responses to standard interventions. At the intermediate level, the rehabilitation nurse uses creative assessment strategies, identifies gaps in care, and collaborates with the client, family, and interprofessional team to develop a POC with realistic rehabilitation goals. He or she would also evaluate or document client responses to interventions and adjust the POC as needed.

Nurses in advanced practice facilitate nursing knowledge through role modeling, clinical decision-making, and acting as change agents (Gerrish et al., 2011). They use their experience and insight to: provide expert care, integrating cultural sensitivity and gender preference in consultation with complex clients; lead the client, family, and interprofessional team in meeting goals for disability and chronic illness health management; and evaluate the efficacy of the interventions in meeting client outcomes. Examples of creative activities are the development and testing of guidelines to improve client outcomes, such as continence training or poststroke urinary guidelines that impact client safety and quality of care (Grandstaff & Lyons, 2012; Vaughn, 2009). Another example is the implementation of sleep hygiene interventions in people with TBI that facilitate improved functional outcomes in that population (De La Rue-Evans, Nesbitt, & Oka, 2013). Overall, effective nurse management strategies when linked with EB findings, such as clinical guidelines, prompt consistent care and can positively influence client outcomes (Green, Kelloway, Davies-Schinkel, Hill, & Lindsay, 2011).

Provide Client and Caregiver Education in Relation to Disability, Chronic Illness, and Health Management (DCIHM)

Using the nursing process to provide DCIHM education for individuals, families, interprofessional teams, and communities is the focus of this competency. Areas of education include, but are not limited to, activities of daily living management, mobility, communication, safety, and disease management.

The beginner nurse assesses the client and caregiver's learning needs and readiness to learn, supports established

goals for the client and caregiver, uses standard rehabilitation education materials related to DCIHM, and uses “teach-back” to evaluate client and family learning. The intermediate nurse develops an individualized education plan to address DCIHM, collaboratively establishes goals according to the unique needs of the client and caregiver, provides tailored and timely education related to DCIHM, and adapts the education plan based on client and caregiver performance. The advanced nurse develops and provides the tools that are needed for effective education for DCIHM, such as authoring or adapting educational materials, anticipating long-term learning needs related to DCIHM, providing consultative rehabilitation education to individuals, families, interprofessional teams, and communities, and evaluating the efficacy of the educational programs. Examples of effective community and web-based education and caregiver resources available to the rehabilitation community include those from the American Heart/Stroke Association, Stroke Engine, Caring~Web, and the Reeve Foundation for spinal cord injury. ARN also produces “one-click” educational materials for patients and family caregivers including those for bowel, bladder, and brain injury. These are available free for ARN members through the website at www.rehab-nurse.org.

Deliver Client & Family-centered Care

This competency highlights 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. Gill and colleagues noted that their study participants (clients and families) desired frequent interactions with friendly, empathetic team members; regular communication with “senior staff” (case managers, clinical managers, social workers, nurse leaders, etc.); and sought accurate information that was communicated in a timely manner along with intensive rehabilitation services to optimize outcomes (Gill, Dunning, McKinnon, Cook, & Bourke, 2014). The rehabilitation nurse along with the interprofessional team acknowledges and promotes the client and family as active participants in the rehabilitation process and values their input. Gwinn (2008) highlighted the nursing role on the interprofessional team in coordinating and delivering family-centered care to the pediatric client in the rehabilitation setting which included client or family education, the identification of community resources, and activities to promote optimum recovery.

The early career nurse participates in a holistic assessment of the client and family that includes culture, values, beliefs, and health literacy, supports the development of goal setting that reflects the client’s and family’s choices including leisure activities, participates in the implementation of the POC with the interprofessional team, and engages in care conferences that evaluate the plan. Additionally, the nurse practicing at the intermediate level performs a holistic assessment of the client and family, identifies strengths that could contribute to a successful POC, either individually or via a family conference, and develops or adapts and implements the POC in collaboration with the interprofessional team that honors the client’s and family’s values and culture. Inherent in the care planning process is the nurse self-assessment of cultural competence so that he or she is aware of his or her knowledge and biases (Nathenson, 2009). The POC is modified as needed to incorporate new data evidenced by the client or family response to interventions. Visser-Meily and colleagues related that when a family-centered approach is used for stroke care, where family and client strengths are highlighted and incorporated into the POC, better outcomes can be attained (Visser-Meily et al., 2005). The advanced nurse synthesizes holistic assessment data to promote optimal rehabilitation outcomes, advocates for client and family decision-making regarding the goals, modifying as needed, serves as a resource to the client, family, and interprofessional team in the implementation of the POC, and directs the data evaluation process.

Domain 2—Promotion of Health and Successful Living

Although most rehabilitation programs are short term and focus on the client’s acute injury or illness, it is essential that the rehabilitation nurse collaborates with clients and the interprofessional team to assist clients to promote health and prevent further disability, as well as manage his or her disease and disability with optimal independence in the home-living environment and community. Rehabilitation nurses identify client and caregiver health and wellness needs, including facilitators and barriers to health improvement, and integrate community care services that manage chronic disease and support health over time (Smeltzer, 2010). This domain targets the rehabilitation nurse’s role in promoting overall successful living through risk reduction, harm prevention, and maintenance of optimal health.

Promote Health and Prevent Disability

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 is included in the scope of this competency. Health promotion through primary prevention, as well as preventing complications for those with existing disabilities is essential to the role of the rehabilitation nurse (ARN, 2014a, b).

Assessing common risks, establishing goals for reducing risk, promoting health, and preventing disability (RPP) following established rehabilitation protocols with people living with DCIHM, and evaluation of a person's ability to understand and engage in strategies for RPP are envisioned as role functions of a beginner nurse. The intermediate-level nurse assesses the client for risk and readiness to manage potential harm, and engages in health promotion, collaborating with the client, family, and interprofessional team in setting goals for RPP for individuals, as well as evaluating the individual's health behaviors or abilities to participate in RPP. The nurse practicing at an advanced level assesses the client's needs, but also the community resources for risk and health promotion related to DCIHM, consults with individuals, communities, and populations to set goals for RPP, and uses data to identify health improvement trends in individuals, communities, and populations. An example of a program that demonstrated positive sustainable health behaviors in the stroke population was highlighted by Nathenson, Nathenson, and Divito (2014) who incorporated a wellness tool and coaching into the POC.

Foster Self-management

This competency stresses the importance of using a collaborative approach that incorporates the client's abilities; past experiences and health literacy to solve problems; and make decisions about his or her healthcare to foster achievement of a high quality of life. A metasynthesis by Schulman-Green et al. (2012) revealed several areas in which nurses and an interprofessional team through communication could enhance client self-management. These researchers noted the coordination of activities, recognition of self-management processes, such as learning about his or her condition, health promotion activities, resources, and support that all helped the client or family find meaning of the condition.

The novice nurse assesses the client's readiness to learn and his or her existing knowledge of illness or disability, and participates in the goal setting and development of the POC with the client, family, and interprofessional team. The novice nurse participates in data collection and evaluates the client's ability to manage self-care. The intermediate nurse identifies the client's physical and/or psychosocial barriers that obstruct the ability for self-management and collaborates with the interprofessional team to develop and implement the POC. Collaboration with the interprofessional team, using the best evidence and client preferences, and the modification of the self-management plan, are all perceived as role functions of the advanced nurse. Theorists such as Dorothea Orem suggested that nurses have a responsibility to promote self-care among patients and thus promote health and healing (Orem, 1995). The researchers have validated the above descriptors of this competency in patients with SCI, noting that participation of the individual must be fostered or facilitated by the rehabilitation nurse and the interprofessional team. The POC should be tailored for the individual based on his or her preferences and needs to promote optimal self-management to facilitate a successful discharge (Lindberg, Kreuter, Taft, & Person, 2013).

Promote and Facilitate Safe and Effective Care Transitions

Optimal collaboration and coordination among clients, families, and healthcare professionals to promote the safe and timely transition across care settings are the focus of this competency. Even though clients and families may perceive transition decision-making as daunting, support from rehabilitation nurses and other rehabilitation professionals can enhance the transition experience by including them in decision-making regarding postacute discharge destination (Körner, Ehrhardt, & Steger, 2013). ARN's white paper on essential care transitions supports the premise that rehabilitation nurses are the ideal team members to help with postacute care transitions because of their unique knowledge and skill set that encompasses diverse care settings (Camicia et al., 2014). An example of successful care transitions was noted by Wissel, Olver, and Stibrant Sunnerhagen (2013), who found that optimal care transitions fostered greater rehabilitation goal achievement in stroke survivors along the care continuum.

Assessing the client and family's cultural values and health literacy as applicable to care transitions, participating in the development and implementation of an inter-

professional plan for care transitions, and contributing to the care transition plan are all within the purview of the beginner nurse. The rehabilitation nurse practicing at the intermediate level identifies barriers that could influence the care transition, modifies and implements the POC based on data collection, coordinates the resources needed for a seamless care transition, and contributes to the interprofessional evaluation of the client and family care transition plan. Synthesis of client and family data and resources needed for a seamless care transition, coordination of the interprofessional team, and collection and interpretation of evaluation data about the client and family transition and experience are role functions of the advanced rehabilitation nurse. Family or caregiver roles in care transitions need to be supported and enhanced through education and resources. Giosa and researchers purported that care transitions currently are unsupportive of the family caregiver (Giosa, Stolee, Dupuis, Mock, & Santi, 2014). Bakas et al. (2014) explicated current evidence regarding caregiver interventions and noted that a multifaceted approach was effective in promoting improved client and caregiver outcomes when individualized inpatient education, home follow-up, and psychosocial skill building were included. Additional interventions such as web-based programs for caregivers and telephone follow-up were also found beneficial for both client and caregiver (Bakas et al., 2009; Pierce et al., 2009).

Domain 3—Leadership

In the third domain of the model, the rehabilitation nurse focuses on accountability, advocacy, and sharing nursing knowledge with clients, families, and other team members. Building leadership skills among rehabilitation nurses is essential as they are considered key members of the interprofessional team and use leadership skills within the team to promote optimal care of clients and families. Laskowski-Jones (2012) stated that advocacy on behalf of rehabilitation clients strengthen the foundation of caring. Pryor and Buzio's (2010) findings related that practice development initiatives (PDI) among rehabilitation nurses fostered leadership and influenced the culture of the rehabilitation unit including team collaboration. The leadership domain is comprised of four major competencies.

Promote Accountability for Care

The scope of this competency is to promote ethical, cost-effective quality outcomes for clients and families. The

American Nurses Association (ANA) Code of Ethics for Nurses requires that nurses be accountable for themselves and their actions (ANA, 2014). Beginning rehabilitation nurses provide safe, ethical care and are aware of the quality processes in their employment settings. Intermediate-level rehabilitation nurses identify factors related to quality of care, assist in collection of unit data related to quality outcomes, and contribute to quality activities on the unit.

The advanced rehabilitation nurse takes a leadership role in analyzing and synthesizing data related to safety and quality outcomes, and monitors and measures the efficiency of the quality plan at an organizational level. For example, safe client handling has been an emphasis in rehabilitation care. The specialty of rehabilitation nursing has brought these concepts to the forefront of all health-care through the support and dissemination of the work of experts such as Audrey Nelson and her client safety team (Nelson & Baptiste, 2004; Nelson, Harwood, Tracey, & Dunn, 2008).

Disseminate Rehabilitation Nursing Knowledge

All rehabilitation nurses are expected to help disseminate rehabilitation nursing knowledge. This is accomplished in a variety of settings such as the clinical area, academe, and government. Strategies for dissemination include scholarly publications of research findings, presentations at conferences, service on national committees, teaching students, or sharing expertise within a professional organization.

A novice rehabilitation nurse demonstrates competency in this area by participating in unit activities that promote rehabilitation nursing practice and asking questions related to clinical practice. All beginning rehabilitation nurses should be able to use resources to answer clinical questions. The intermediate nurse uses EB literature to develop innovative strategies to improve practice, and shares these strategies with the interprofessional team and larger community. Nurses with certification in rehabilitation nursing often share their knowledge by involvement at the chapter level, presentations at conferences, and serving on committees in professional associations. The expert nurse leads the team in identifying, developing, and publishing findings that improve rehabilitation nursing practice. These activities might include participation in the development of clinical practice guidelines or serving on a content expert panel or work group. For instance, nurse experts in ARN collaborated with the

American Association of Neuroscience Nurses (AANN) in the development of clinical practice guidelines on mild traumatic brain injury and also with the International Organization of Multiple Sclerosis Nurses on practice guidelines for nurses working with clients with multiple sclerosis (ARN, AANN, IOMSN, 2011). Many current ARN members serve on major national and international advisory committees, expert panels, and task forces to represent the interests of patients cared for by rehabilitation nurses.

Impact of Health Policy for People with Disability and/or Chronic Illness

This competency emphasizes the role of the rehabilitation nurse in helping shape healthcare policy. Rehabilitation nurses are champions for disability legislation and advocate politically for causes related to clients requiring rehabilitation. According to Miller (2010), one of the key roles of the rehabilitation nurse is to assist clients, families, and each other to advocate for accessible coordinated quality healthcare. ARN has a standing health policy committee and a professional lobbyist who represents the interests of the population served as well as our membership. ARN has actively advocated for rehabilitation nurses to serve on expert committees at the local and national levels such as the ARN Policy Committee. Currently, the ARN website has 13 position statements and policy papers posted.

Nurses at a beginning level of this competency should keep abreast of current healthcare issues through ARN Legislation Action Center, the ARN Health Policy Digest, and participation in the Nurse in Washington Internship (NIWI) program. They should also recognize the major accrediting and political bodies related to rehabilitation (such as CARF, JC, CMS, etc.) and endorse the necessity for political activism in promoting quality care for clients and families through contact with their local legislators and/or their congressional representative. A more experienced rehabilitation nurse would take an active role in influencing health policy within the professional organization as well as being a resource to policymakers, such as local congressmen, and have an in-depth knowledge of the relationship between the professional bodies mentioned above and rehabilitation nursing practice. The expert rehabilitation nurse takes the lead in implementing strategies related to current accreditation standards and helps to develop and shape public policy to positively influence care for those with chronic illness and disabili-

ties. For example, rehabilitation nurses at this level may serve at the national level on larger advisory committees related to public health, pursue doctoral-level education in health policy, and/or be employed by organizations such as CMS or JC.

Empower Client Self-advocacy

Nurses who are competent in this area use their leadership skills to advocate for and empower clients and families through education, collaboration, and support. Rehabilitation nurses play a key role in the recovery of clients (Kirkevold, 2010). The novice rehabilitation nurse respects and supports client autonomy, provides information to clients and families for informed decision-making, and is aware of potential conflicts that may arise in this area. The intermediate nurse empowers the client and family for shared decision-making and employs conflict resolution strategies to mediate issues of disagreement between clients, families, and healthcare professionals. Lastly, the expert rehabilitation nurse collects and interprets information necessary to resolve ethical decisions, fosters client independence and self-advocacy through additional resources, and may serve as an expert witness testifying to the challenges of resource allocation that affect people with DCIHM. Expert rehabilitation nurses within ARN provide leadership on the Health Policy Committee to advocate for people with disability. In addition, the Board of Directors of ARN makes visits to Washington, DC each year to meet with policymakers and congressional officials to discuss issues related to rehabilitation. The ARN website (www.rehabnurse.org) provides resources for nurses, such as updates on healthcare reform to help nurses navigate the Affordable Healthcare Act. ARN also posts regular updates on Med-Pac, the independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program (ARN, 2015).

Domain 4—Interprofessional Care

The domain of interprofessional care encompasses three competencies. In this domain, the rehabilitation nurse maintains interprofessional relationships through effective communication skill and strategies such as team conferences, huddles, and the like. Trust and respect are important elements not only in client–nurse interaction but also among the interprofessional team members as they

establish the team–client partnership and develop a POC that reflects client preferences and EB interventions (Körner et al., 2013). Care provided by interprofessional teams of experts has been shown to promote positive outcomes in rehabilitation patients (Jacelon, 2011).

Develop Interprofessional Relationships

A survey by White et al. (2013) emphasized the importance of communication and collaboration in promoting an effective rehabilitation team that enhances client outcomes. The new rehabilitation nurse participates in the team process and understands the roles of the team members. This includes attending regular team conferences. The intermediate nurse maximizes the roles of team members in providing quality client care and helps to coordinate the interprofessional POC through huddles and client care conferences. The expert nurse is integral in educating about and promoting IP communication in various venues, and facilitating conflict resolution among team members (Körner et al., 2012). Nurses at this level facilitate an effective team through leadership and evaluation. Effective working relationships and the understanding of each discipline’s role and contribution provide the foundation for an effective interprofessional team (Rice et al., 2010; White et al., 2013).

Implement an Interprofessional Holistic POC

Nurses meeting this competency develop and implement POCs to meet the needs of diverse clients and prescribe strategies, alternatives, and interventions to achieve desired outcomes. For the novice nurse, this means the ability to identify problems, establish mutual goals with the patient and team implement interventions with the interprofessional team, and evaluate the effectiveness of nursing interventions in the interprofessional POC. The intermediate rehabilitation nurse additionally contributes EB nursing practice strategies to the interprofessional POC and is able to implement and evaluate them within the interprofessional POC. The nurse at the intermediate level collaborates with the team to establish client-centered goals. The expert rehabilitation nurse collaborates with the interprofessional team when the POC is altered for economic reasons, and anticipates long-term care needs for individuals, families, and communities. Such nurse experts also provide consultation to the interprofessional team to achieve the POC and evaluate aggregate data with the interprofessional team to promote quality

client outcomes. Nathenson (2012) demonstrated that “components of holistic nursing are compatible and even synergistic with rehabilitation nursing principles and practice” (p. 114). He provided examples of rehabilitation nurses using holistic components such as a healing environment, intention, self-care, and intuition. These elements are often included in an interprofessional holistic POC.

Foster Effective Interprofessional Collaboration

Rehabilitation nurses collaborate with the client, family, and members of the interprofessional team to provide quality care. The Institute of Medicine lists interprofessional team cooperation as one of the five core competencies for healthcare professionals (White et al., 2013). The novice nurse represents nursing within the interprofessional team, collaborates with other team members, and appreciates their diverse contributions and roles. The intermediate nurse takes a more active role and collaborates with the client, family, and interprofessional team members regarding goals and priorities of the POC, collaborates with the interprofessional team to develop and implement an EB POC, and mediates discussion to explore resolutions when conflict arises. The expert nurse role models and coaches the collaborative process while engaging with the interprofessional team to advance rehabilitation, evaluates the POC in collaboration with other interprofessional team members, and leverages interprofessional team diversity as a strength to synergize team collaboration. In addition, the intermediate and advanced nurse can mentor novice nurses in their interactions with members of the interprofessional team. Collaboration among team members regarding client issues is needed to promote best outcomes. An example of an effective collaboration is that of the speech therapist, dietitian, and nurse in managing a client with dysphagia, preventing complications, and meeting hydration and nutrition needs (Perry, Hamilton, Williams, & Jones, 2012).

Application of the Model into Practice

In 2015, ARN will begin integrating the Model into ARN’s current educational products as well as new materials, such as the revised Core Curriculum, the Professional Rehabilitation Nursing (PRN) course, and the Clinical Practice Guidelines. Additionally, opportunities to discuss the Model and its application to practice and/or education will be afforded

to the membership through local ARN Chapter and regional conferences or meetings. During a presentation of the Competency Model for Professional Rehabilitation Nursing at the 40th Annual ARN Educational Conference, the audience had the opportunity to share their perceptions regarding the Model and its application. Common ideas and themes included:

- The model can be used as a framework for recruitment materials to highlight rehabilitation nursing's holistic approach to care.
- It promotes awareness of the specialty practice of rehabilitation among nurse colleagues in healthcare organizations.
- A template for nursing position (role) descriptions can be developed from the four domains.
- Staff orientation programs can be built around the four domains and the associated competencies.
- The model can assist rehabilitation nurses to delineate their role on the interprofessional team while fostering collaboration, communication, and consultation with other healthcare disciplines.
- Domains can be integrated into performance evaluation or self-evaluation tools. Nurses can also develop their annual professional goals using the model's language.
- Educators can use model domains to construct an assessment tool to determine educational needs of rehabilitation nurses.
- The model provides a "road map" for clinical and educational practice and can be integrated into or used as a framework for clinical ladder programs (based on proficiency levels) in organizations.
- It may be threaded through educational curricula or used to develop a "stand alone" rehabilitation nursing course in an academic setting.

Conclusion

In summary, ARN has represented the specialty practice of rehabilitation nursing for over 40 years. Rehabilitation nursing has evolved and grown to include nurses who practice in various settings and roles across the healthcare continuum. To provide more clarity and role definition, a Competency Model for Professional Rehabilitation Nursing was developed explicating the various roles and the proficiency levels of the rehabilitation nurse. The tenets of rehabilitation nursing practice depicted in the Model join us together as rehabilitation nurses who impact client and family or caregiver outcomes daily. The four domains that comprise the Model and the corresponding compe-

Key Practice Points

- Principles of rehabilitation nursing are integrated into multiple practice settings across the healthcare continuum.
- The Competency Model for Professional Rehabilitation Nursing can be used as a guide for nurses practicing at different levels of proficiency in these various settings.
- The Competency Model for Professional Rehabilitation Nursing can be used as a structure for staff orientation, evaluation tools, clinical ladder, and role descriptions.
- The Competency Model for Professional Rehabilitation Nursing can be used as a framework for developing rehabilitation nursing courses in clinical or academic settings.

tencies reflect our current practice and will serve as a framework to support future growth and advancement of rehabilitation nursing.

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