2020 Updated Competency Model for Professional Rehabilitation Nursing- Application to Practice

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Learning Outcomes:

- Describe the four domains of the ARN Competency Model for Professional Rehabilitation Nursing
- Discuss the competencies for each of the four domains
- Identify the levels of proficiency and the descriptors for each of the competencies
- Demonstrate application of competencies in exemplars

Key Topics:

- An overview: A framework for professional rehabilitation nursing
- Domains and associated competencies and exemplars

INTRODUCTION

The practice of rehabilitation nursing is recognized as the specialty of managing and promoting the care of persons with disability and chronic health conditions across the continuum of care, through special knowledge and expertise, for all ages (ARN, 2014). The ARN Competency Model for Professional Rehabilitation Nursing model is depicted by concentric circles, created to represent the essential role competencies of the rehabilitation nurse (Figure 1). The center most circle represents the "Rehabilitation Nursing Professional Role", with the next circles representing the four domains of the professional role of the rehabilitation nurse, and the applicable competencies for each domain that are observable and integrate rehabilitation nursing knowledge, skills, and core values and beliefs in their practice.. The four domains of the nurses' role are: "Nurse-Led Interventions", "Promotion of Successful Living", "Leadership" and "/Intraprofessional/Interprofessional Care". Three levels of competency proficiencies are identified in the model, starting with the beginner level nurse (1-2 years of rehabilitation experience), the intermediate nurse (3-5 years of experience/Certified Rehabilitation Registered Nurse [CRRN]) and the advanced rehabilitation nurse who is an expert in rehabilitation nursing with greater than 5 years in one or more roles, including, but not limited to, case manager, clinical educator, and staff nurse who has achieved Clinical III or IV on the organization's Clinical Ladder (if applicable). The

advanced rehabilitation nurse may also be an advanced practice registered nurse (APRN) [nurse practitioner, clinical nurse specialist] educator and researcher who practices in the rehabilitation setting (Vaughn et al., 2016).

The revisions to the Model include the addition of a competency to Domain one which focuses on the understanding of the worldview of individuals who are culturally different. This new competency reflects rehabilitation nursing's multicultural approach and global reach. ARN through its mission and strategic plan purport that rehabilitation nursing care be inclusive, non-biased, and culturally sensitive. In that accord, the definition of family throughout the model includes any person or persons who provide support and care to the patient. Rehabilitation nurses are strong advocates for the patient-family and acknowledge the social conditions that may influence the patient's ability to access care and ensure that optimum care in the right setting is received. Another revision is the addition of the word intraprofessional to the Domain four title which reflects the peer collaboration and feedback process integral to professional nursing practice in the rehabilitation setting. All of these aforementioned values and concepts are integrated into the context of care throughout the revised ARN Model

DOMAINS and COMPETENCIES

Domain One (1)

Domain One of the Competency Model for Professional Rehabilitation Nursing is identified as "Nurse-Led Interventions for family-centered care to promote function and health management in persons with disability and/or chronic illness." Rehabilitation nurses, whether novice or experienced, are expected to utilize the most current evidence available and supportive technology to deliver optimum patient-family (blood relative, significant other, neighbor, friend, or support person) centered care. Nurse-led interventions and patient-family education should be supported by evidence-based best practices. This model represents the holistic nature of rehabilitation nursing practice, with collaborative relationships with other professionals, such as occupational therapists, physical therapists, and case managers, to

promote the health of the patient, the family unit, and the community. There are four competencies for Domain one.

Competency 1.1. *Use supportive technology for improving quality of life for persons with disability, chronic illness, and health management (DCIHM).* Technology may be used to enhance and encourage the person with a disability and/or chronic conditions along with family members, as appropriate to improve self-management, quality, and function through the use of environmental controls, electronic monitoring, robotic nursing assistance, remote patient monitoring or telehealth, and pain control, such as transcutaneous electrical nerve stimulation (TENS).

At the beginner level of proficiency (1-2 years of experience), the rehabilitation nurse may not be aware of many support technologies but can participate in assessing the patient's needs for the device, be able to use simple technology and to document the care and the patient's use of the technology intervention. As an intermediate level rehabilitation nurse (3-5 years of experience), the nurse should be competent to creatively assess the patient's need for technological solutions, develop goals in collaboration with other professionals, the patient-family, identify gaps and personalize the care needed, and evaluate the effectiveness and patient-family response to the technology. The advanced practice rehabilitation nurse serves in many roles, such as an expert, role model, and decision-making leader especially in the care of the complex disabled and chronically ill patient. The advanced practice nurse (greater than 5 years' experience) may collaborate with other experts to develop or improve technology that integrates the unique needs and preferences of this patient population. The three proficiency levels for Competency 1.1 (beginner, intermediate and advanced) are represented in the Proficiency Levels and Descriptors table below (Table 1.1).

Table 1.1. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Participates in the process of determining the need for assistive or supportive technology	Assesses for and anticipates the patient-family's need for supportive technology	Recognizes and advocates for opportunities to implement new technologies for patients with disability and/or chronic illness and family carers
Uses basic technology interventions in the plan of care (POC)	Establishes goals with the interprofessional team for the use of technology in the POC	Recognizes opportunities to incorporate new technologies within the patient-family's financial means
Demonstrates competent use of technology in the care of a patient-family	Tailors technologies to enhance patient-family outcomes	Collaborates with the interprofessional team to develop new technologies to improve patient-family outcomes

Competency 1.2. *Implement nursing and interprofessional interventions based on best evidence to manage the client's disability and/or chronic illnesses.* As rehabilitation nurses develop strategies for care, at their proficiency level, only the best available evidence should be integrated. The nurse intervenes to manage the care of common disabilities and/or chronic conditions, commonly seen in the rehabilitation setting, such as traumatic brain injury (TBI), stroke, spinal cord injury (SCI), amputation, neuromuscular disorders, post stroke, pain and cancers, etc. (Eberhard et al., 2018; Lutz & Young, 2010). As a novice or beginner, the nurse will seek out and utilize appropriate evidence-based practice guidelines and protocols based within valid and reliable research. Then, centered on the patient-family's assessed needs, the nurse will follow established plans of care (POC). The intermediate level nurse, using creative strategies, collaborates with other professionals along with the patient-family to develop an individualized

interprofessional POC and set attainable goals. Interventions are evaluated and re-adjusted, as needed, for the best outcomes and documented, which helps to develop the evidence in rehabilitation nursing practice. Advanced practice rehabilitation nurses use their expertise to integrate the complex and unique needs of the disabled and chronically ill patients, integrating cultural, spiritual, and gender preferences in conjunction with the interprofessional team and patient-family. Developing evidence-based guidelines/bundles to manage certain conditions and conducting quality improvement activities are also included in the advanced practice role. Outcomes for long-term function and management are evaluated. Table 1.2 represent three proficiency levels for Competency 1.2 (beginner, intermediate and advanced) presented in the Proficiency Levels and Descriptors table below.

Table 1.2. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Uses established guidelines to assess an individual-family's function and health management needs Performs baseline assessment of patient's current abilities and impact of illness.	Performs more in-depth assessment to determine less apparent needs for patient-family 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 patient-family context
Follows an established POC with the patient-family Administers medications and performs treatments as ordered by provider and determined by intra and interprofessional POC	Collaborates with patient-family, intra and interprofessional team to develop a POC with attainable rehabilitation goals Shares assessments and insights with team (patient-family) for verification/buy in.	Leads the patient-family, intra and interprofessional team to meet goals for disability and chronic illness health management Serves as resource for patient-family and interprofessional team; offers insight.

Evaluates and documents patient-family responses to standard interventions in a specific progress note	Evaluates and documents patient-family responses to interventions; collaboratively adjusts the POC with team as needed for best outcomes	Evaluates outcomes for the complex patient-family in relation to life-long function and health management Discusses next steps to continue progress and connects patient-family to support services.

Competency 1.3: *Provides patient-family education in relation to DCIHM.* Pedagogy is the art and science of teaching. Providing education to the patient-family is a major role function of the rehabilitation nurse to promote safety and independent living, enhance mobility, function, improve communication, and disease management. Yet, often times, patient-family education is not recognized as such or appreciated. Therefore, it is important that nurses utilize strategies clearly communicating their role as teacher and second thoroughly documenting the education that is provided (Wagner et al., 2018).

In providing education for the patient-family for DCIHM, the nurse must assess and integrate the effect of ethnicity, spirituality, age, growth and development, culture, as well consider the health literacy level when developing and evaluating the educational plan. Applying the three learning domains: cognitive, affective, and psychomotor improves client health management (Mayset al., 2014). The novice rehabilitation nurse begins by assessing the patient-family for educational needs and their readiness to learn, ensuring that materials are presented to them in accordance with their preferred method to learn and level of literacy. Assessment of the learner, patient-family member, must include the learner's developmental stage, learning needs and skills, health literacy, readiness to learn, ability to learn and learning style (Burnett & Miller, 2015). Health literacy refers to the individual's "ability to obtain, process, and understand basic health information and services" in order to make appropriate health decisions (Burnett & Miller, 2015, p. 119). The nurse utilizes established rehabilitation education information and materials that support the expected outcomes and goals of the patient-family. The

beginner level nurse utilizes the “teach-back” or “show me” communication technique, in which the nurse asks the patient-family to explain or demonstrate what they need to know, which confirms whether the patient-family understands what is being explained or taught to them. An education plan that is individualized to the patient-family is developed by the intermediate nurse while also collaborating with other members of the team and the patient-family to develop specific goals that address DCIHM. The teaching plan must be deliberately and purposefully communicated. This method of teaching values the patient-family’s past experiences, knowledge, and acknowledges their motivation to learn. The advanced nurse is able to utilize expert knowledge and experience to create, evaluate the efficacy, and adapt educational materials and methods, provide consultative services, and develop education resources and programs. The expert rehabilitation nurse is aware of the patient-family’s learning styles, capabilities, and needs (Burnett & Miller, 2015). The three proficiency levels for Competency 1.3 (beginner, intermediate and advanced) are represented in the Proficiency Levels and Descriptors table below.

Table 1.3. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Assesses/determines learning needs and readiness to learn of the patient-family for DCIHM “literacy” such as new medications/treatments and asks “what are we doing that you don’t understand”	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 patient-family Provides education with each interaction	Collaboratively establishes goals according to the unique patient-family’s goals	Anticipates long-term learning needs for patient-family related to DCIHM

Communicates progress with education to intra/interprofessional teams.		
Utilizes standard rehabilitation education related to DCIHM	Provides tailored and timely education related to DCIHM	Provides consultative rehabilitation education to patient-family, intra/ interprofessional teams, and communities related to DCIHM
Utilizes "teach-back" to evaluate patient-family learning	Utilizes "teach-back" and adapts education plan based on patient-family performance Builds on and makes connections to previous learning to deepen the patient-family's understanding of concepts.	Evaluates the effectiveness of the educational outcomes related to DCIHM Assists intra/ interprofessional teams develop skills with patient-family education.

Competency 1.4. *Understand the worldview of individuals who are culturally different.* There is no doubt that the 'face' of the United States will continue to evolve in terms of diversity, inclusion, and equity in the coming years. Although a multicultural approach to rehabilitation nursing care has been part of any POC for some time, it is of the utmost importance to continue and expand that approach in the foreseeable future. Patient-family members need to feel included, respected, and free from discrimination based on national origin/ethnicity, race, religion, beliefs, age, gender, socio-economic status, sexual orientation, gender identity or disability. Beginning rehabilitation nurses are aware of their emotional reactions and any tendency to view ethnic, racial, or any other oppressed group of people in ways that may negatively impact service delivery and effective rehabilitation interventions. They are also aware of how stereotypic attitudes and preconceived ideas affect other ethnic and racial group's acceptance. Intermediate rehabilitation nurses possess specific knowledge and understand sociopolitical systems (i.e.,

oppression, racism, discrimination, and stereotyping) operating in the United States and how these systems impact them personally and their patients. Expert or advanced rehabilitation nurses constantly seek to understand themselves as cultural and racial beings and are actively seeking a nonracial identity. Further they familiarize themselves with relevant, valid, and reliable research that affects various underrepresented groups of people. The three proficiency levels for Competency 1.4 (beginner, intermediate and advanced) are represented in the Proficiency Levels and Descriptors table below (Table 1.4).

Table 1.4. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Participates in the process to become aware of emotional reactions and any tendency to view ethnic, racial, or any other oppressed groups in ways that may negatively impact nursing care	Recognizes and understands how culture, ethnicity, and race may impact rehabilitation care approaches and outcomes	Advocates and becomes actively involved with ethnically and racially diverse patient-families or any oppressed groups in and out of the workplace
Demonstrates caring competence in showing an awareness of how stereotypic attitudes and preconceived ideas affect any oppressed group	Seeks further knowledge, including relevant research evidence, for ways to adapt personal views to reflect greater respect for the worldviews of persons from other cultures in caring for patients-families	Applies current relevant valid and reliable research evidence that affects various underrepresented groups when designing or providing and evaluating care

Competency 1.5. *Deliver patient-family-centered care.* A family-centered model of care allows the patient-family to be active, rather than passive participants in the patient's care, strengthening shared decision-making and responsibility. Planning and delivering care to the patient, the role of the family as

caregiver unit as an active participant in that care, optimizes the patient's goal attainment. The rehabilitation nurse must integrate the patient-family's familial mores, cultural considerations, ethnic influences, and spiritual preferences in order to create an individualized POC that meets the needs of the patient-family own environment (Camicia et al., 2018). Family-centered care approach throughout the life-span of the patient, with the support of interprofessional collaborative care and community resource identification promotes optimum recovery. The beginner nurse participates in the assessment of the patient-family unit, emphasizing cultural, spiritual, and ethical values, plus health literacy; directly participates in the POC, and supports goal setting with the interprofessional team by participating in team conferences and evaluation of the POC. The intermediate nurse is culturally competent and conducts a holistic family-centered assessment in order to develop an individualized POC, specific to the patient-family's cultural needs. The intermediate nurse coordinates the family centered care plan, evaluates, and modifies the POC that values the strengths of the patient-family for optimal goal attainment. The nurse also collaborates with the interprofessional team for consistent interventions that meets the patient-family needs, paying attention to support the caregiver as well as the patient, for the benefit of both. The advanced nurse serves as an advocate and resource to the patient-family and the interprofessional team and directs the evaluation process. The experienced nurse synthesizes the evidence and assessment data and assumes the role of directing the evaluation process. The three proficiency levels for Competency 1.4 (beginner, intermediate and advanced) are represented in the Proficiency Levels and Descriptors table below (Table 1.5).

Table 1.5. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Determines patient's role in family unit. Participates in a holistic assessment of the patient-family that includes culture,	Performs a holistic assessment of the patient-family and identifies strengths of the patient-	Synthesizes holistic assessment data to promote optimal rehabilitation outcomes

values, beliefs, and health literacy	family that could contribute to a successful POC Identifies how current condition impacts patient's role in family unit.	
Supports the development of goal setting that reflects the patient-family's choices including leisure activities	Develops a POC in collaboration with the interprofessional team that addresses patient-family goals	Advocates for patient-family decision making regarding the POC goals, modifying as appropriate
Participates in the implementation of the POC with the intra/ interprofessional teams	Coordinates with the intra/interprofessional team members to ensure consistent delivery of care that honors the patient-family's values and culture Considers additional resources to assist in honoring client and family culture and values Provides support through role changes	Serves as a resource to the patient-family, intra/ interprofessional team members in the implementation of the POC
Participates in the care conference that evaluates the patient-family-centered POC	Modifies the POC as needed to incorporate new information evidenced by the patient-family response to interventions	Directs the data evaluation process

Domain Two (2)

Domain Two of the Rehabilitation Nursing Competency Model is identified as "Promotion of Health and Successful Living in Persons with Disability or Chronic Illness Across Life-span." Patients and families often have to traverse a complicated healthcare delivery system with limited guidance. Less than optimal communication between the patient/family and the healthcare team can lead to adverse outcomes during care transitions (Camicia et al., 2014). Knowledgeable intra- and inter-professional team members who advocate for and effectively communicate with the patient and family are key factors for a safe discharge to the community. Providing care and teaching with the patient and family to "promote maximum independence, prevent complications and enhance the client's health status" is a central function and competency for the rehabilitation nurse (Burnett & Miller, 2015, p.115). This domain and its competencies support rehabilitation nursing goals in multiple ways. With the acute care lengths of stay shorter, it is important to begin rehabilitation as early as possible, and teach skills of health maintenance, care management, and injury prevention to patient-family who are affected by chronic illness and physical disability. This domain emphasizes the promotion of and restoration of optimal health throughout the patient's lifespan, including addressing all of actual or potential problems of functional ability and lifestyle so to attain optimal quality of life. There are three competencies for Domain Two: Promote Health and Prevent Disability Across the Life-Span (2.1), Foster Self-Management (2.2), and Promote and Facilitate Safe and Effective Care (2.3).

Competency 2.1: *Promote Health and Prevent Disability Across the Life-Span*. This competency identifies the role of the rehabilitation nurse in primary, secondary, and tertiary health and wellness promotion strategies for those living with disability and chronic conditions from birth, aged, to death.

Primary prevention for those with disability is the promotion of a healthy state of wellness and prevention of complications, including preventing exposures to hazards that can cause disease or injury (e.g. smoking, chemical substance abuse) and altering unhealthy or high risk behaviors (e.g. not wearing a helmet, vehicle seat belt, or a protective face covering). Secondary prevention strategies reduce the impact of injury that has occurred, such as treatment protocols/guidelines for stroke, rescue protocols for

spinal cord injury, and routine health screenings, such as mammograms and prostrate checks. Tertiary prevention strategies include those for long-term management, such as support groups, programs for specific chronic disease states, and vocational re-training that matches the abilities of the disabled patient's new "normal."

Pursuant to the nursing process, the beginner nurse starts with an assessment of common risks, such as fall risk, promotion of health, and prevention of further disability. Potential risks in the home setting should also be identified by the nurse (e.g. throw rugs, stairs, and clutter). This is followed by the implementation of established protocols and standards with identified individualized patient goals for the care of disability, chronic illness, and health management (DCIHM). The determination of the patient and family's readiness and ability to learn the strategies needed is initiated by the nurse at this practice level. The beginner nurse also implements patient/family teaching which may include a teach-back scenario. Mentorship of the beginner nurse by an intermediate or advanced rehabilitation nurse regarding these above strategies may be needed. Mentoring the beginner nurse allows the nurse to grow and become more confident in the new role as a rehabilitation nurse. The intermediate nurse, usually with the certified rehabilitation registered nurse designation (CRRN), builds upon the assessment of the patient family's readiness for self-management of health promotion strategies and identification of harm, in collaboration with the intra- and inter-professional teams. The intermediate nurse may pose the question, "What do you do to stay healthy" to learn more about the patient's wellness behaviors. The patient-family's health promotion and secondary prevention practices are evaluated and adjusted as needed. The experienced nurse practicing at the advanced level, serves as a consultant, and assesses not only the needs of the individual and family, but those of the community-at-large for strategies and the resources with which the patient and family can use to reduce risk, prevent harm, and promote health management. Through examination of health improvement trends and the use of current evidence, the advanced rehabilitation nurse advocates for the patient-family to set realistic individual goals, for the community, and for the population with disabilities and chronic illnesses. In addition, both the intermediate and advanced rehabilitation nurses should mentor the beginner nurse regarding risk assessment, goal setting, and

readiness to learn to augment the beginner nurse's knowledge and skill set. The three proficiency levels for Competency 2.1 (beginner, intermediate and advanced) are represented in the Proficiency Levels and Descriptors Table below (Table 2.1).

Table 2.1. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Assesses for common risks with persons living with DCIHM (e.g. fall risk; are chronic conditions being managed?)	Assesses for patient risk and patient/family 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
Identifies potential goals for Reducing Risk, Promoting Health, Preventing Disability (RRPHPD) following established rehabilitation protocols	Collaborates with the patient, family, intra/ interprofessional team members to set goals for RRPHPD for individuals with DCIHM	Consults with individuals, communities, and populations to set goals for RRPHPD
Contributes to determination of patient/family readiness to learn and engage in strategies for RRPHPD	Evaluates individual's health behaviors/ability to engage in RRPHPD, adjusting the plan as needed Mentors the beginner nurse regarding risk assessment, goal setting, and readiness to learn	Analyzes data to determine health improvement trends in individuals, communities, and populations Mentors the beginner and intermediate nurse regarding risk assessment, goal setting, and readiness to learn

Competency 2.2*: Foster Self-management*, describes the promotion and empowerment of the patient to utilize all of his/her abilities, self-efficacy, health literacy, collaborative relationships and past experiences to enhance decision-making to achieve the highest quality of life.

The beginner rehabilitation nurse would perform the initial assessment for existing disability, illness and injury and readiness to learn new information. The family unit is assessed for readiness to participate in goal-setting and participation in developing a plan of care (POC) which includes a safe discharge to the community). Identification of necessary equipment along with intra/ interprofessional teams to sustain self-management in the community is also an important role of the beginner nurse In addition, the beginner nurse will provide instruction and solicit teach back regarding the management of patient's illness or injury, including medications and the safe use of the equipment. In consultation with the advanced nurse, the intermediate nurse anticipates and describes barriers to self-care management by the patient and family; and identifies any physiological or psychosocial facilitators of self-management. Collaborating with both the intra/interprofessional teams and patient-family about meaningful realistic goals for managing one's care is also an essential function of the intermediate nurse in addition to coordinating the medical/adaptive equipment and community resources. The advanced nurse's role is to examine patient/family data, such as culture, developmental level, preferences, best practices supported by evidence, and community resources. In addition the advanced nurse will establish a collaborative advocative relationship with patient-family, and individualize the POC to promote optimal self-management strategies to live with chronic illness and/or disability. Self-care management promotion strategies may include providing resources for supplies, respite care, transportation, and support groups information. The three proficiency levels for Competency 2.2 (beginner, intermediate and advanced) are represented in the Proficiency Levels and Descriptors Table below (Table 2.2).

Table 2.2. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Assesses patients for readiness to learn and current knowledge of their illness or disability using a	Consults with the advanced nurse and describes physical and/or psychosocial barriers to performing self-management (e.g., not	Examines the patient- family information and resources needed for optimal self-management of disability

standardized assessment and/or tool	wanting to perform self-catheterization)	and/or chronic illness in the community
Participates in the goal setting and development of the POC with the patient-family, intra and inter-professional team that includes self-care skills	Collaborates with intra/ interprofessional team members and patient-family regarding realistic self-management goals for the POC	Adapts the POC as needed taking into consideration the patient's age, developmental stage, and cultural diversity and generates appropriate evidence-based strategies for successful self-management
Communicates with the intra- and inter-professional teams in data collection	Collaborates with the intra/inter-professional teams to develop the POC based on best practice and patient-family preferences	Anticipates additional resources for a successful self-management plan and coordinates with the intra/ interprofessional team members to implement self-management strategies
Demonstrates to the patient and family the safe use of equipment (e.g. Insulin administration, self - catheterization, application of brace/splint) to sustain self-management in community; provide teach back opportunity Participates in the evaluation of the self- management POC	Coordinates medical/adaptive equipment/community resources and follow-up care Contributes to the modification of the self-management POC	Advocates for medical/adaptive equipment/community resources and follow-up care that is individualized to patient-family Evaluates the POC, coordinates with referral sources for successful self-management to the community

Competency 2.3: *Promote and Facilitate Safe and Effective Care Transitions* for the rehabilitation patient and family, is a unique competency for the rehabilitation nurse.

Rehabilitation transition from the acute setting to rehabilitation care to home care has been highlighted in recent literature. It has been noted as the rehabilitation lengths of stay have shortened, medical acuity of rehabilitation patients has increased. Families are typically unfamiliar with community resources and are unable to navigate such successfully post-discharge from care settings to home and community. Assisting the patient-family to transition across many diverse care settings requires a professional with a unique skill set and knowledge of a variety of settings; along with the capacity to collaborate with multiple disciplines. Strong and Bettin (2015) describe a discharge concept used in a rehabilitation facility to promote and provide a smooth transition across the continuum of care and improve patient satisfaction scores. Successful transition can also be crucial in decreasing hospital re-admission rates and increasing patient/family satisfaction.

The beginner nurse participates in the development of a POC, utilizing the patient and family assessment information for cultural considerations and health literacy. The beginner rehabilitation nurse also participates in the team care conference, collaborating with other members of the professional team to establish goals and evidence-based interventions for a safe and successful care transition. In collaboration with the advanced nurse, the intermediate nurse acknowledges and describes actual and potential barriers that could impact a safe care transition plan, makes modifications to the care plan, coordinates resources needed for transition to the community, and participates in evaluation of the plan with the patient and family throughout the process. Improving care transition processes are within the purview of the rehabilitation nurse and the interprofessional team. The intermediate nurse may collect data that will contribute to improved processes in the organization for safe transition. The advanced nurse synthesizes data related to the patient and family and their resources that are needed for a safe care transition. This nurse also coordinates and facilitates strategies for safe and effective transition across care settings in addition to analyzing data for to determine the efficacy of the organization's care transition processes. Patient and family experiences with care transitions are key to the improvement of the

transition program. To promote a successful transition plan from the rehabilitation setting to the community, good communication is essential among all members of the intra/interprofessional teams as well as with the patient and family (Camicia, 2015). The three proficiency levels for Competency 2.3 (beginner, intermediate and advanced) are represented in the Proficiency Levels and Descriptors Table below (Table 2.3).

Table 2.3. Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Assesses the patient and family's cultural values and health literacy as applicable to safe care transitions	In consultation with the advanced nurse describes the barriers that could influence safe care transitions, including cultural, physical, psychosocial, and health literacy issues	Synthesizes patient and family data and resources needed for a seamless safe care transition
Participates in the development of an interprofessional plan for safe care transitions	Assesses the POC to determine the appropriate setting for transition; modifies POC based on additional data collection (e.g. are further services needed such as mental health, nutrition, home modification for safety)	In collaboration with the intermediate nurse and the inter-professional team, advocates for the services and equipment needed and coordinates the POC for safe care transition
Contributes to the development and implementation of the goals for safe care transitions	Coordinates the resources needed for a seamless safe care transition; consults the advanced nurse and intra and inter-professional team members as indicated	In collaboration with the intermediate nurse and intra/interprofessional team members, facilitates the care transition plan

Participates in the care conference that evaluates the care transition plan	Contributes to the inter-professional evaluation of the patient and family care transition plan including quality improvement data collection	Analyzes quality improvement program data with the purpose of improved and safe care transition including the evaluation of the patient and family care transition experience

Domain Three (3)

Domain Three of the Rehabilitation Nursing Competency Model is identified as "Leadership" to empower the patient-family advocacy. Rehabilitation nurses have an important leadership role regardless of the setting. The goal of rehabilitation nursing is to assist individuals with disability and/or chronic illness in restoring, maintaining, and promoting maximal health (ARN 2015). This involves not only providing care, but also information regarding health management and risks, function, resources and adaptation to acute and chronic illness or disability in order to empower patients/families and support persons to advocate for themselves in making life and healthcare choices. In addition, rehabilitation nurse leaders recognize that persons with disabilities are globally marginalized and understand the importance of political engagement to resolve health inequities, (Frier et al., 2018)

Because rehabilitation patients can have a plethora of needs an intra/ interprofessional (IP) team approach is used. The rehabilitation nurse leader is an effective team member who promotes collaboration among care providers across the continuum of care as well as within each team. The complexity of the patient's care needs requires nurses to foster this collaborative work with the team, so that patient-family-centered, culturally sensitive, unbiased, safe, and value-based care is delivered by all. Through the sharing of essential communication with the IP team the rehabilitation nurse leader will ensure coordination of care, promote smooth transition across teams

and ensure the medical, functional and patient/family- centered goals are communicated, understood, and protected, according to the policies and procedures of the organization or agency. Domain 3 is comprised of four competencies.

Competency 3.1 *Promote accountability for care to promote ethical, cost-effective, patient/family-centered quality outcomes in the disabled* is exemplified in *The American Nurses Association (ANA) Code of Ethics* that requires that nurses be accountable for their actions with a commitment to their patients/families. Nurses face ethical dilemmas daily. Examples of ethical issues include: A family requests that information be withheld from the rehabilitation patient. What should a rehabilitation nurse do? What is the rehabilitation nurse's responsibility when working with patients who do not have the coverage or funds they need for equipment? How do rehabilitation nurses work with patients and families who disagree with the approach to care or discharge plan advocated by the IP team? What is the rehabilitation nurse's role in ethical dilemmas such as these? Ultimately, it is the patient/family who has the right to make decisions. The rehabilitation nurse provides support to the patient-family who may be advocating for their own needs for the first time (Lindsay et al., 2018).It is the responsibility of the rehabilitation nurse and IP team to inform the patient and family of all aspects of the plan including the potential issues the IP team perceive as barriers to a safe discharge

Ethical dilemmas such as those above must be addressed although there may be no absolute right or wrong. To address ethical dilemmas with patients and families, nurses must approach each situation with empathy, respect for human rights and unconditional acceptance of a person (Bates 2000). Unbiased education needs to be presented regarding the issue, possible choices, and consequences of choices. As addressed in Competency 1.3, consideration must be given to readiness to learn, learning needs, age, health literacy, cultural or religion and safety. According to Lindsay et al. (2018), the timing of the transition preparation and the readiness is influenced by age-related supports, many of which for the younger patient end at age 18. Accountability for care is also influenced by culture and diversity of the patient/family and their supporters as well as the IP team.

All involved in the decision-making process should be included, clear information presented, and questions answered, so patients and families can come to their own conclusions. If a nurse is uncomfortable with the process, assistance should be sought from resources such as a nurse supervisor, case manager, or the clinical educator (an intermediate or an advanced rehabilitation nurse), advanced practice nurse, or consultant. Depending on the issue and the employer, there may be policy and procedures that need to be followed.

Patient-family-centered quality outcomes set by the IP team in collaboration with the patient-family support unbiased, and culturally sensitive value-based care. Indicators are identified and used to monitor the effectiveness of nursing care. The patient-family is assisted in considering appropriate and available resources which might include equipment, attendant care, transportation, and community services. Outcomes of a plan are individualized to the patient and may be related to their function, pain control, health management, self-advocacy, or educational goals. Unmet patient goals should be evaluated by the rehabilitation nurse and the team and alternative strategies or interventions developed to foster desired health outcomes. Nurse leaders' responsibility and ethical commitment in patient care prompts the collaboration with the patient-family (Murcia et al., 2016). Rehabilitation nurses and the IP team need to consider the cost efficacy of proposed interventions and equipment, insurance coverage and other potential challenges as they develop and implement the POC.

The rehabilitation nurse and the intra/interprofessional team should be creative in developing strategies that promote the patient's successful transition to the community taking into consideration patient-family preferences, and resources. It is imperative to educate the patient and family regarding the rehabilitation process and foster realistic expectations and goal setting.

A beginner level rehabilitation nurse (1-2 years of experience) will provide safe and ethical care to patients. They have a basic knowledge of the social conditions that may affect care, including the patient-family access to care and public safety. The beginner and intermediate nurses are also

knowledgeable of evidence-based best practices to enhance coordination of care and patient outcomes. These can be practices for safe medication administration or guidelines for patient-family education to facilitate transition to the next level of care. The beginner nurse will begin the process of collecting data. An intermediate level rehabilitation nurse identifies factors that are related to quality of care such as staffing issues, nurse knowledge, cultural implications that may influence individuals' reactions to diagnoses, or patient/family perceptions to treatment plan. The identification of these factors may actually lead to a performance improvement project which would involve collection and analysis of data. Results may contribute to a practice change on the unit. The advanced level rehabilitation nurse assumes a leadership role in these activities synthesizing and interpreting the data that could be used to change nursing practice and policies to improve care. As a leader in the rehabilitation setting the advanced rehabilitation nurse must strategically address unit and organizational issues that promotes inclusion and embrace diversity in the work setting through clinical practice and education and research initiatives. Advanced accountability to care must include planning for interventions that are culturally relevant and sustainable for families (Jarvis, et al., 2019).

Table 3.1: Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Delivers safe, ethical, quality care for the patient and family Learns about the influence of social determinants that affect care	Identifies factors including social conditions, that influence the provision of quality care and patient and the achievement of quality 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 patient/staff variables affect the quality of the processes of the unit	Contributes to unit-based quality improvement activities	Evaluates the environment and social conditions while monitoring and measuring quality outcomes and organizational efficacy Strategically promotes inclusion and embraces diversity in the work setting through clinical practice and education and research initiatives

3.2 Dissemination of Rehabilitation Nursing Knowledge is an essential behavior of rehabilitation nurses. The implementation of evidence based practice (EBP) is imperative. All rehabilitation nurses are expected to identify, create, and disseminate rehabilitation nursing knowledge. Information may be shared at the unit level, in publications, at professional conferences or in public forums. Rehabilitation nurses may teach patients/families, nursing students or nurses new to rehabilitation. They may ask practice questions, or present at their own organization's meetings or interprofessional conferences to disseminate information regarding rehabilitation nursing practice and innovations. The beginner nurse demonstrates this competency by asking patient-family related questions in unit activities that promote optimum rehabilitation nursing practice, by participating or serving on committees, and attending local and national rehabilitation related webinars/conferences to learn

about meeting standards or approaches to patient care. The beginner nurse should know where to find resources to answer clinical practice questions, which may include consultation with the intermediate and advanced rehabilitation nurses.

The intermediate nurse uses evidence-based literature to innovate and improve care. The use of critical appraisal to glean the best evidence in the development of new strategies is an essential in promoting quality outcomes. These nurses share these strategies with the IP team as well as with other rehabilitation communities as appropriate. CRRNs or those aspiring to be a CRRN present information to the intra/interprofessional teams on the unit, as well as to ARN chapter meetings, and conferences. They also may serve on local and national committees in professional organizations. The advance nurse is a role model for nursing practice and is often a leader of the team who strives to improve rehabilitation nursing practice by evaluating available health information and leading the development of evidenced-based practice guidelines or serving as a content expert on panels or committees, both nationally and internationally. Advanced nursing leaders must embrace, role model, and support EBP (Melnyk, et al, 2019).

Table 3.2: Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Uses resources to answer clinical questions	Generates innovative strategies for care based on best evidence	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, intra/interprofessional teams and professional community.	Leads in the dissemination of new rehabilitation nursing knowledge through varied venues

		Establishes a sustainable culture for EBP that engages all levels of the IP team.

3.3 Impact of Health Policy for People with Disability and/or Chronic Illness; knowledge of health policy and regulations, such as the ADA, is a key role competency for rehabilitation nurses at all levels of proficiency. Rehabilitation nurses advocate for patients/families, by participating in legislative causes that affect patients. They also assist their patients-families and communities to advocate for accessible health care and the ability to initiate innovative access to rehabilitation (Turk & Mudumbi, 2013). Rehabilitation nurses serve on expert committees and panels at local, national, and international levels. They review and provide feedback on proposed changes in rules for healthcare coverage, and advocate for the allocation of resources for the care of patients, support of families, and to fund research in pursuit of new knowledge. It is the responsibility of the rehabilitation nurse to educate and make rehabilitation resonate with political leaders (Cieza, 2019). ARN has long been involved in health policy and has a standing committee as well as a lobbyist in Washington DC who monitors legislative activities, apprises its membership and considers the interests of the population rehabilitation nurses serve. A scholarship for the Nurse in Washington Internship (NIWI) is offered to ARN members annually to learn about advocacy through legislative and regulatory processes. Although rehabilitation nurses play a role in advocacy efforts, persons who can provide personal experiences can be particularly persuasive in advocacy efforts. Different types of advocacy messages can accompany evidence, but messages should be tailored to the advocacy target (Farrer et al. 2015).

The beginner nurse acknowledges the Americans with Disabilities Act (ADA) and maintains social awareness of current health care issues by accessing the Legislative Action Center and Advocacy tool kit and reviewing ARN's health policy updates. They should recognize the major accrediting

bodies and promote quality care for patients by endorsing political activism. The intermediate nurse may actively influence health policy through participation in professional organizations and serving as a resource to policy makers. The intermediate and advanced rehabilitation nurses recognize that persons with disability are globally marginalized and understand the importance of political engagement (Frier et al., 2018). The relationship between the regulatory and accrediting bodies and nursing practice must be recognized. Shaping public policy that improves accessibility to rehabilitation care is an advanced nurse descriptor. The advanced rehabilitation nurse works to resolve health inequities impacting persons with disability, (Frier et al., 2018). Lastly, all rehabilitation nurses must communicate the importance of finding and using the best evidence when providing rehabilitation care to colleagues and policy makers, (Melnyk et al.,, 2019). Overall, rehabilitation nurse leaders should address areas for evaluation and assessment, for providing information and resources, and for professional advocacy on a broader scale in policy, practice, and raising societal awareness (Sheppard-Jones, et. al. 2013).

Table 3.3: Proficiency Levels & Descriptors:

Beginner	**Intermediate**	**Advanced**
Knowledgeable of ADA rights; identifies names and purposes of standard regulatory and accrediting agencies, such as CARF, JC, CMS, and Magnet Demonstrates an awareness of the importance of health policy in the provision of care to patients and families living with disability and/or chronic illness	Recognizes that social conditions of health impact health status Describes regulations that impact current rehabilitation nursing practice Contributes to a professional organizations or regulatory bodies that influence health and rehabilitation practice	Identifies and implements strategies to comply with current/new regulatory and accreditation standards. Works to resolve health inequities related to social conditions and contributes to the development of public policy to improve community services, minimize environmental barriers, and reduces societal attitudes toward persons with DCIHM Uses EBP, rehabilitation expertise, and lived experiences to reduce disability, improve productivity, and impact economies.

Competency 3.4: Empower Patient Self-advocacy safeguards a patient's autonomy, acting on his/her behalf, and, empowering the client through education, collaboration, and support. Autonomy can be described as an individual's right to develop their own perspectives about life and health and make health related decisions. The individual patient's actions should be independent of the will of others (Schmidt, 2015). Rehabilitation nurses can empower the patient and family through collaboration, education, and directing them to resources that will assist in making informed decisions while in the rehabilitation setting. This collaboration may result in a patient-family conference with the intra/IP

team where the POC is reviewed and recommendations are made. If needed, the rehabilitation nurse and intra/IP team may consult the ethics committee for guidance regarding conflicts that arise between the team and client/family about the plan. The patient's values and autonomy will be respected and an unbiased review of information and time for questions will be provided so that care decisions can be made that promotes self-advocacy. Fostering greater intra and interprofessional collaboration in addition to advocating for patient-family may contribute to social justice (Williams et. al., 2017).The beginner rehabilitation nurse helps patients to express wants, desires, and goals. The intermediate proficient rehabilitation nurse teaches patients how to use the ADA to request reasonable accommodations (Lee, et al, 2019). The advanced rehabilitation nurse acknowledges that participation and policy and regulation development such as serving as an expert witness for a government panel promotes active citizenship and empowers patients to also engage in and influence health policy (Maclachian, M., et al, 2018, p. 454).

Table 3.4: Proficiency Levels & Descriptors:

Beginner	**Intermediate**	**Advanced**
Respects and values client and family autonomy in their health-related choices	Promotes informed and autonomous patient-family-centered and shared decision making	Collects and interprets information that is necessary to resolve ethical decisions
Provides information to patient-family that they need to make informed decisions about care	Empower the patient-family to use information and resources to make informed decisions about care	Fosters the patient's independence and the ability to advocate for self-using available resources

Demonstrates awareness of developing conflicts on the unit between patients-~~patients~~, family	Mediates discussions to explore resolutions when there are disagreements between patients-family	Serves as an expert witness testifying to the challenges of resource allocations that affect persons with DCIHM

Domain Four (4)

Patients in rehabilitation often have complex needs that require a team of professionals from several disciplines to reach their individual goals. It is important for the rehabilitation nurse to understand the role of each team member to develop the plan of care (POC). While composition of these teams may vary depending on the needs of the patient, family or healthcare setting, the patient is always the center of the team (Vaughn et al., 2016). Interprofessional teams communicate, collaborate and coordinate complex patient care efficiently to improve patient outcomes and help reduce the cost of care (Giuliante et al., 2018).

The Intra/Interprofessional Team is the focus of Domain four. Coordination of patient care in the context of interprofessional teams is an effective strategy for patients with chronic diseases or acquired disability. Critical components of healthcare teams include communication in the intraprofessional as well as interprofessional teams. Intraprofessional communication refers to the process of communicating information within distinct disciplines such as nurses, physical therapists, occupational therapists, speech therapists and other ancillary team members. Each discipline has their own intraprofessional communication style. These intraprofessional communication styles often inform how professionals communicate with their interprofessional colleagues (Shoham et al., 2016). Highly effective interprofessional teams rely on their role awareness, knowledge of other discipline's skills, trust between team members, and the belief

that collaboration between disciplines improve patient care and outcomes (Bookey-Bassett et al., 2016).

Rehabilitation nurses have a unique communication style and collaboration techniques that may differ from other disciplines (Shoham et al., 2016). Rehabilitation nurses implement the nursing POC as well as integrate rehabilitation techniques and goals from other disciplines. These strategies may include skills such as transfers, use of adaptive equipment or memory strategies. As rehabilitation nurses gain experience and knowledge in rehabilitation, they are better able to work effectively in interprofessional teams. Three competencies comprise Domain four.

Competency 4.1 *Develop Intraprofessional/Interprofessional Relationships.* Intraprofessional and interprofessional relationships can be actualized by the rehabilitation nurse through interacting with a network of peers. Team members discuss their patient assessment findings which prompts collaboration within the intraprofessional and interprofessional teams. Characteristics of an effective team include; active listening and discussion regarding patient care and treatment. Developing intraprofessional and interprofessional relationships improves patient safety, care planning and outcomes (Shoham et al., 2016). Communication and feedback can occur formally during team meetings or huddles; or it may occur 1:1 with individual team members. The novice nurse will recognize their role as a rehabilitation nurse on the team and the role of each of the team members. It may take time for a team to accept and respect the information and recommendations of a new team member, in addition new nurses will need to establish themselves by sharing accurate information and knowledge with the team. The intermediate nurse will facilitate the contributions of each of the team members and evaluate the implementation of the POC to ensure a successful outcome. This involves understanding the role

of each team member and the contributions toward the plan, interventions, and goals. The expert nurse will take a leadership role in educating and promoting intra/interprofessional communication. These communication styles identify and maximize creative evidence-based interventions that will foster positive health outcomes. , as well as coordinate and implement innovative strategies to solve complex patient problems to maximize patient independence.

Table 4.1: Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Recognizes the role of the intra/interprofessional team members	Facilitates contributions of each member of the intra/interprofessional team to promote the rehabilitation plan of care	Maximizes effective team function by taking a leadership role in team meetings and communication
Participates in the intra/ interprofessional team process	Promotes collaboration of the intra/interprofessional plan of care	Coordinates the intra/interprofessional teams to create and implement strategies for system outcomes

Competency 4.2 *Implement an intra/interprofessional holistic plan of care* is an essential function of the IP team. The rehabilitation nurse develops a plan of care (POC) for diverse patients, which prescribes strategies, alternatives, and interventions to attain desired outcomes.

The POC is patient-family centered starting with an assessment of status, health literacy and learning needs and resources. The plan is individualized and developed with the client/family and team and reflects of complexity of care across the continuum, promoting independence in function, active decision making and self-advocacy. Goals are agreed upon by patients/families and the team, including target dates. These goals reflect current standards and evidence-based practice (EBP) (ARN 2014). Understanding the importance of implementing an intra/interprofessional holistic plan of care is essential to best rehabilitation nursing practice (Steinbach & Mauk 2015).

The beginner nurse will identify problems from initial and ongoing assessments and share this information with the team, contributing to the intra/interprofessional plan of care. Understanding the plan and coordinating care, interventions will be implemented and the effectiveness of the plan of care (POC) will be evaluated. The intermediate nurse contributes to rehabilitation nursing practice through the use of EBP strategies and is able to implement and evaluate the efficacy of such interventions. Further, the intermediate nurse is more fully engaged in the evaluation of the overall IP plan of care. The advanced nurse builds on the competencies of the intermediate nurse but also strategizes with the team when there are changes in the plan of care related to various factors including the availability of resources. Long-term care needs will be anticipated, and the advanced nurse will act as a consultant to mobilize the team to achieve goals for the altered plan. The client's values and beliefs will be shared with the team and incorporated into the strategies for the long-term plan. The advanced nurse is also poised to synthesize aggregate data to recommend quality improvement methods.

Table 4.2: Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**

Identifies patient problems that need care planning	Contributes nursing-specific assessment findings to intra/interprofessional care planning	Strategizes with the intra/interprofessional teams when the POC is altered for internal or external reasons
Contributes to intra/interprofessional teams in establishing client centered goals	Collaborates with the intra/interprofessional teams in establishing patient-centered goals	Anticipates long-term care needs for individuals, families, and communities
Implements the interventions established in the intra/interprofessional plan of care	Implements and evaluates the intra/interprofessional plan of care	Mobilizes the intra/interprofessional teams using evidence-based practice achieve the plan of care
Evaluates effectiveness of nursing interventions in the intra/interprofessional plan of care	Evaluates effectiveness of the intra/interprofessional plan of care	Synthesizes the aggregate data with the intra/interprofessional team to recommend quality improvement initiatives

Competency 4.3 *Foster effective intra/ interprofessional collaboration* is integral to the success of the team. In order to provide the highest quality of care rehabilitation nurses will work with the patient/family and intra/interprofessional team. Assessment data are shared with the team and incorporated into the POC. Teams work best when there is common interest in collaboration and there are perceived opportunities to improve quality of care (Supper et al, 2015). It is important that the rehabilitation nurse share information with the team that could

affect the POC. The team can form or alter the POC in order to meet both medical and rehabilitative needs as well as include other team members in the plan. The entire team must work together for the best patient outcomes; the nurse will promote collaboration by sharing information that may lead to alterations in care. Having shared information and recognizing alterations the nurse can then provide feedback about effectiveness of the POC.

The beginner nurse provides basic nursing information to the team and collaborates with other team members, recognizing the diversity of roles and each member's contribution to the team and the POC. The intermediate nurse is more active in the collaboration, engaging with the entire team regarding goals and priorities of the POC and the use of EBP knowledge for the plan. The advanced nurse acts as a role model and coach, engages the team in the collaborative process to improve rehabilitation, and design and evaluate the POC. Team diversity will be recognized and used to foster creative collaboration in finding appropriate solutions to identified challenges to the plan of care. Both intermediate and advanced nurses mentor beginner nurses in order to foster the development of intra/interprofessional collaboration and a holistic plan of care.

Table 4.3*:* Proficiency Levels & Descriptors

Beginner	**Intermediate**	**Advanced**
Represents the discipline of nursing while participating on the intra/interprofessional teams	Collaborates with the patient, family, along with the intra/interprofessional team members regarding goals and priorities of the plan of care	Models and coaches the collaborative process while engaging with the intra/interprofessional teams to advance rehabilitation

Communicates pertinent information regarding the patient to the intra/interprofessional teams	Collaborates with the intra/interprofessional teams to develop and implement an appropriate POC.	Designs and evaluates the evidence-based plan of care in collaboration with other intra/interprofessional team members
Recognizes and respects diversity and roles within the intra/interprofessional teams	Engages in discussions to explore resolutions when conflict arises	Leverages intra/interprofessional team diversity as a strength to synergize team collaboration

In summary, the Competency Model for Professional Rehabilitation Nursing provides a framework in which rehabilitation nurses practice at various levels of proficiency in different settings along the healthcare continuum, from the emergency room to home health. The Model explicates the many roles of a rehabilitation nurse and offers insight into the specialty practice through the four domains and the associated competencies.

Other Competency Frameworks similar to the ARN's Competency Model for Professional Rehabilitation Nursing have been developed to provide structure for rehabilitation practice in organizations. One example is The Rehabilitation Competency Framework (RCF) developed by World Health Organization's (WHO) technical working group in 2019-2020 which included ARN members; it was developed to be setting-neutral and have broad application and relevance. The goals of this global model are similar to the ARN Model: to foster communication among professions; demonstrate rehabilitation competencies; and facilitate

workforce planning. Countries and/or organizations without structured rehabilitation programs can adopt and adapt the WHO Model and modify it for application into local context.

The revisions to the ARN Model included a reference to the global marginalization of persons with DCIHM and the need for rehabilitation nurses to advocate for regulations/policies that promote access to evidence-based quality rehabilitation care for all persons acknowledging the social conditions that influence persons' ability to procure unbiased and inclusive care. Implications for Model utilization include integration into the ARN educational materials such as the *Core Curriculum*, webinars, and other educational materials. Members have offered ideas for model implementation in their organizations including staff orientation (onboarding) as well as integration into an annual skills day. It can be used to explicate the rehabilitation nurse role on the intra/interprofessional teams while fostering collaboration and consultation with other healthcare professions in the development and implementation of a holistic plan of care for the patient-family. Role descriptions, including clinical ladder programs based on the proficiency levels, can also be grounded in the ARN Model.

Rehabilitation nursing practice has evolved and encompasses nursing in various settings across the healthcare continuum. The domains and the associated competencies of the ARN Model unite the global rehabilitation nurse community through the clarification of the nursing roles at the different proficiency levels; is a reflection of current practice and supports the advancement of the specialty practice of rehabilitation nursing.

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Figure 1

The Competency Model for Professional Rehabilitation Nursing

Make the following changes:

Domain 1 add Competency #4: Understand Worldview of Culturally Different Individuals and change the previously competency #4 to #5 in the listing below

Domain 4 to read – Intra- and Interprofessional Care