

# Updated Competency Model for Professional Rehabilitation Nursing: Practice Applications

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## Abstract

**Background:** The Competency Model for Professional Rehabilitation Nursing is a lens through which nurses can view their practice; the four domains provide a template that guides that practice.

**Purpose:** The aim of this study was to describe a task force's review procedures and share the updated model.

**Appraisal Process:** A rehabilitation nursing task force appraised the model over the course of 1 year.

**Revision Outcomes:** The original four domains remain, with wording changes for content and clarity throughout. Notable changes include (1) new competency for Domain 1 that focuses on the understanding of the worldview of individuals who are culturally different and (2) case stories for each domain related to nurses' proficiency (beginner, intermediate, and expert).

**Clinical Relevance:** This updated model can be used to explicate the rehabilitation nurses' role on intra/interprofessional teams, as well as provide a framework for education and staff orientation/performance evaluation.

**Conclusion:** This competency model reflects the current practice and advances of the specialty practice of rehabilitation nursing.

**Keywords:** Rehabilitation nursing practice; model; competency.

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 (Association of Rehabilitation Nurses [ARN], n.d.). Nursing models provide a lens through which nurses can view their practice

and are templates or designs that guide that practice (Miller & Pierce, 2019). The Competency Model for Professional Rehabilitation Nursing, developed in 2014, provides an organized structure for rehabilitation nursing and fosters best practices through its application. This model encompasses four domains that reflect competencies needed for practicing rehabilitation nurses across the healthcare continuum. The domains include: (1) nurse-led interventions, (2) promotion of successful living, (3) leadership, and (4) interprofessional care (Burnett et al., 2019; Vaughn et al., 2016).

In 2020, the authors, an eight-member task force of the ARN, were purposively selected to represent different geographic locations in the United States, clinical specialties, and academic settings. These rehabilitation nursing experts reviewed and revised the original competency model to reflect the current rehabilitation nursing practice. The aim of this article is to share the appraisal process and those revision outcomes that ensure the model remains relevant into the second decade of the 21st century.

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## Competency Model for Professional Rehabilitation Nursing Transformation

### Appraisal Process

The eight task force members came together in 2020 over Zoom to review the competency model at 1- to 2-month

### Cite this article as:

Vaughn, S., Rye, J., Allen, A., Bok, A., Mauk, K., Park, L., & Wintersgill Holler, W., (2021). Updated competency model for professional rehabilitation nursing: Practice applications. *Rehabilitation Nursing*, 00(00), 00–00. doi: 10.1097/RN.0000000000000350

intervals throughout that year. After an initial review of the four domains and their related competencies by all members, two-person task force member groups were assigned to one of the four domains and its competencies for appraisal. Each group also wrote a case story to illustrate a “real-life” situation that demonstrates the principles for each domain. All updated domains with competencies and case stories were presented to and discussed by task force members as a whole. Once the initial revisions were agreed upon, each group was assigned to another domain for continued in-depth appraisal. The task force reconvened, and domains with competencies and case stories were discussed until final consensus for the updated competency model was reached.

### Revision Outcomes

Words do matter. Throughout the model, the word “client” was changed to “patient” to be more inclusive, as people with disability need healthcare and treatment intervention in partnership with professionals. The definition of family was also modified to include any person or persons who

provide support and care to the patient (e.g., blood relative, significant other, neighbor, friend, or support person). Rehabilitation nurses are strong advocates for the patient–family and acknowledge social conditions (determinants) that may influence the patient’s ability to access care and ensure that optimum care in the right setting is received.

Notable model revisions include the addition of Competency 1.4 to Domain 1, which focuses on the understanding of the worldview of individuals who are culturally different, reflecting rehabilitation nursing’s multicultural approach and global reach. The ARN, through its mission and strategic plan (see Strategic Plan/ARN at [rehabnurse.org](http://rehabnurse.org) for more information), purports that rehabilitation nursing care be inclusive, nonbiased, and culturally sensitive, and this concept was threaded across the domains and their competencies. Another revision was the addition of the word “intraprofessional” throughout the model and to the Domain 4 title, which reflects the nursing peer collaboration and feedback process with other disciplines integral to professional nursing practice in the rehabilitation setting.

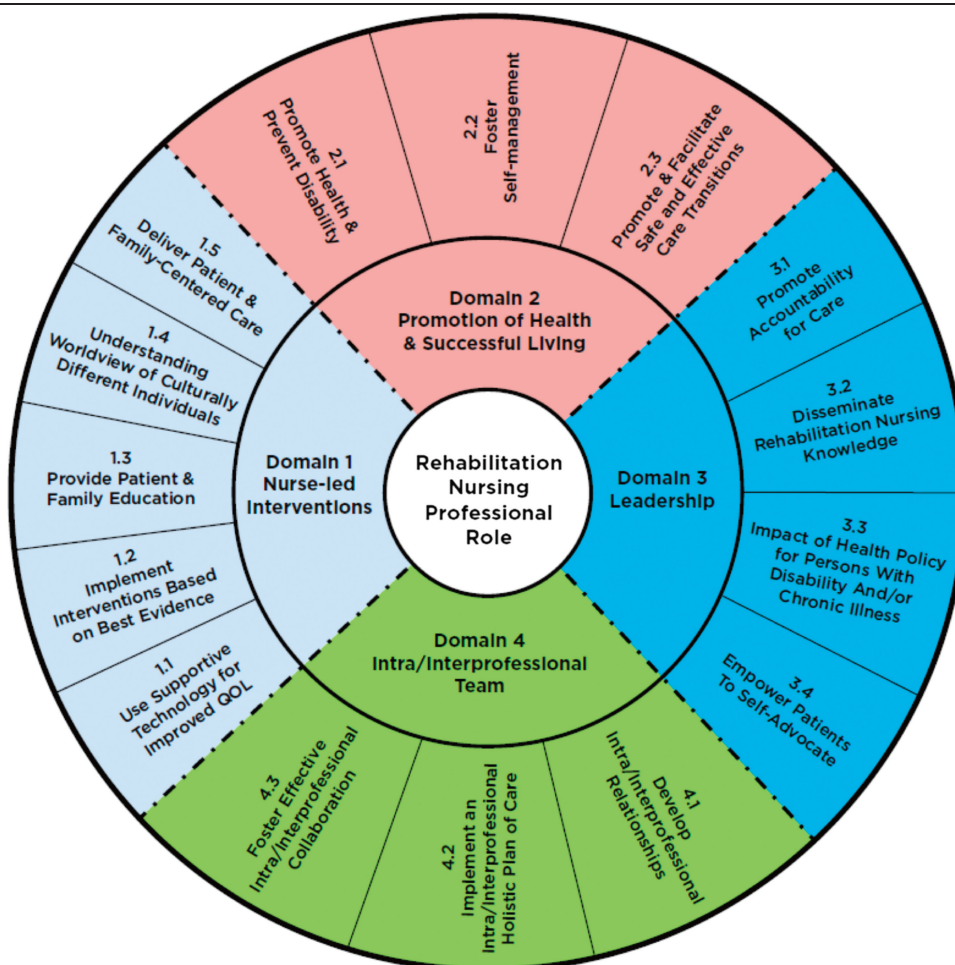


Figure 1. Update competency model for professional rehabilitation nursing.

## Updated Model Domains and Competencies

All of these aforementioned values and concepts are integrated into the context of care throughout the updated competency model and its visual depiction of colorful concentric circles that highlight the domains and their associated competencies (see Figure 1). The presence of broken lines between the domains illustrates the crossover of skills and knowledge and the demonstration of holistic practice that rehabilitation nurses espouse. Each competency model domain is explained through case stories in practice applications.

### Domain 1: Nurse-Led Interventions

Nurse-led interventions for family-centered care promote function and health management in persons with disability and/or chronic illness. Rehabilitation nurses, whether novice or more experienced, are expected to utilize the most current evidence and supportive technology available to deliver optimum patient-family-centered care. Nurse-led interventions, including patient-family education, should be supported by evidence-based best practices (Melnik & Fineout-Overholt, 2018). This competency model represents the culturally sensitive and holistic nature of rehabilitation nursing practice, with collaborative relationships with other professionals, such as physicians, occupational and physical therapists, and case managers, to promote the health of the patient, the family unit, and the community. There are four competencies for Domain 1. In Text Box 1, a case story captures this domain's essence.

#### Text Box 1

Domain 1: Nurse-led interventions—Application to practice story.

A 65-year-old Hispanic patient with a history of neurogenic bowel has extended illness related to stroke. Before hospitalization, she lived independently in an apartment. She shared that her Catholic faith “keeps me safe and well.” In recovery, she developed diarrhea/incontinence because of antibiotics. The diarrhea began to subside, and a bowel program could be established prior to discharge home with her daughter. However, the patient cannot safely sit on a bedside commode because of poor balance/strength. The rehabilitation nurse with 1 year of experience collaborated with the nurse practitioner expert to determine medications to help bulk stool. She then collaborated with the patient-daughter to determine an appropriate time for the bowel program to occur based on previous bowel patterns and positioning for evacuation of the bowel. The nurse sought out the unit manager, an intermediate-level rehabilitation nurse, to evaluate the proposed bowel program and then documented the plan of care (POC) in the patient's chart.

Over the next week, the beginning rehabilitation nurse continued collaboration with the unit manager and nurse

practitioner (CRRNs) to review medications because of an occasional loose stool and balance issues. Discussions occurred during shift hand-off between the patient-daughter and beginning and intermediate rehabilitation nurses about progress toward bowel management, modifications to the bowel program, and the desire to return to the home setting rather than an assisted living facility. The daughter insisted that her mother will now live with her family, stating “we and God take care of our own.” Discussion among these rehabilitation nurses with the patient-daughter continued regarding progress because the patient was unable to sit safely on a bedside commode. Based on this discussion, occupational/physical therapy staff were queried regarding safe sitting and how to accommodate the bowel program. Teach-back education for the patient-family ensued where they demonstrated safe sitting posture. Based on current evidence, a CRRN case manager made discharge arrangements with the patient-family to purchase a medical alert sensor for the mother to wear, alerting the daughter if she fell. The case manager also provided a list of online support groups and confirmed the patient's follow-up telemedicine appointment with her primary care provider and an in-person appointment for a physical therapy evaluation.

### Competency 1.1: Use Supportive Technology for Improved Quality of Life

Supportive technology, for example, environmental controls, electronic monitoring, robotic nursing assistance, remote patient monitoring or telehealth, and pain control, such as transcutaneous electrical nerve stimulation, is used for potentially improving quality of life for persons with disability and chronic illness for health management in any culturally all-inclusive environment, along with family members, as appropriate, to improve self-management, quality, and function. At the beginner level of proficiency (1–2 years of nursing experience), the rehabilitation nurse may not be aware of many support technologies but participates in assessing the patient's needs for the device and is 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 nursing experience and usually with the certified rehabilitation registered nurse [CRRN] designation), the nurse is competent to creatively assess the patient's need for technological solutions, develop goals in collaboration with other professionals and the patient-family, identify gaps and personalize the care needed, and evaluate the effectiveness and the patient-family response to the technology. The expert rehabilitation nurse (more than 5 years of nursing experience and typically a CRRN) serves in many positions, such as a skilled role model and a decision-making leader, especially in the care of the complex disabled and chronically ill patient. This expert nurse may collaborate with other advanced providers to develop or improve the technology that integrates the unique needs and preferences of this patient population.

### **Competency 1.2: Implement Interventions Based on Best Evidence**

As rehabilitation nurses develop strategies for care, at their proficiency level, only the best available evidence should be integrated to manage the patient's disability and/or chronic illnesses commonly seen in the rehabilitation setting, such as traumatic brain injury, stroke, spinal cord injury, amputation, neuromuscular disorders, poststroke, pain, and cancer. As a beginner, the nurse will seek out and utilize culturally sensitive appropriate evidence-based practice (EBP) guidelines and protocols based on valid and reliable research. Then, centered on the patient–family's assessed needs, this nurse follows established plans of care (POCs). 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 readjusted, as needed, for the best outcomes and documented, which help to develop the evidence in rehabilitation nursing practice. Expert rehabilitation nurses use their expertise to integrate the complex and unique needs of disabled and chronically ill patients, integrating cultural, spiritual, and gender preferences, in conjunction with the interprofessional team and the patient–family. Developing EBP guidelines/bundles to manage certain conditions and conducting quality improvement activities are also included in the expert practice role where outcomes for long-term function and management are evaluated.

### **Competency 1.3: Provide Patient and Family Education**

Providing education to the patient–family is a major role function of the rehabilitation nurse to promote safety and independent living, enhance mobility and function, improve communication, and implement disease management. In providing education for the patient–family with disability and chronic illness, the nurse assesses and integrates the effect of ethnicity, spirituality, age, growth and development, and culture, as well as considers the health literacy level when developing and evaluating the educational plan. The beginner rehabilitation nurse starts by assessing the patient–family for educational needs and their readiness to learn, ensuring that materials are presented to them in accordance with their cultural heritage, preferred method to learn, and level of literacy. The nurse utilizes established rehabilitation education information and materials that support the expected outcomes and goals of the patient–family. The beginner-level nurse uses the “teach-back” or “show me” communication technique, in which the nurse asks the patient–family to explain or demonstrate what they 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 disability and/or chronic illness. The teaching plan is deliberately and purposefully communicated. The expert nurse is able to utilize advanced knowledge and experience to create, evaluate the efficacy, 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.

### **Competency 1.4: Understanding the Worldview of Culturally Different Individuals**

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 (Peterson & Smith, 1996), this competency was added to the model as 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, socioeconomic 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 oppressed group of people in ways that may negatively impact service delivery and effective rehabilitation interventions. They are also mindful of how stereotypical 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 their patients and themselves personally. Expert rehabilitation nurses constantly seek to understand themselves as cultural and racial beings and are actively seeking a nonracial identity. Furthermore, they familiarize themselves with relevant, valid, and reliable research that affects various underrepresented groups of people.

### **Competency 1.5: Deliver Patient- and 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 a caregiver unit and 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’s own environment. The 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 as well as evaluates and modifies the POC that values the strengths of the patient–family for optimal goal attainment. The nurse also collaborates with the intra/interprofessional teams for consistent interventions that meet the patient–family’s needs, paying attention to support the caregiver as well as the patient, for the benefit of both. The expert nurse serves as an advocate and resource to the patient–family and the intra/interprofessional teams and directs the evaluation process. The expert nurse synthesizes the evidence and assessment data and assumes the role of directing the evaluation process.

## **Domain 2: Promotion of Health and Successful Living**

Patients–families often have to traverse a complicated health-care delivery system with limited guidance to achieve promotion of health and successful living with disability or chronic illness across the life span. A stronger emphasis in the updated model is placed on knowledgeable interprofessional (other disciplines)/intraprofessional (nurses) team members. This team advocates for and effectively communicates with the patient–family in a culturally inclusive manner, which are key factors for a safe discharge to the community. Providing patient–family care and teaching to “promote maximum independence, prevent complications and enhance the client’s health status” (Burnett & Miller, 2015, p.115) is a central function and competency for the rehabilitation nurse. With acute care lengths of stay becoming shorter, it is important to begin rehabilitation as early as possible and teach skills of health maintenance,

care management, and injury prevention to the patient–family who are affected by chronic illness and physical disability. This domain emphasizes the promotion and restoration of optimal health throughout the patient’s life span, including addressing all of actual or potential problems of functional ability and lifestyle to attain an optimal quality of life. There are three competencies for

baby in 3 weeks. On the day of admission, the beginner rehabilitation nurse assesses his baseline condition and identifies his physical, mental, spiritual, cultural, and educational needs, as well as those of his wife. This nurse also assesses the patient–family’s readiness to learn and their existing knowledge of his condition and disability to participate in the care planning process. The patient is queried about his goals, which he states, “to be able to hold my newborn daughter safely and be strong and independent enough to not be a burden to my wife.” The beginner nurse communicates this goal to the intra/interprofessional team during a meeting. This nurse also reminds the wife that a caregiver readiness assessment survey will be sent to her. The patient–wife is strongly encouraged to attend SCI classes offered throughout the week to foster self-management in preparation for discharge to the home and community. The class on how to manage the complications associated with SCI is taught by an intermediate CRRN rehabilitation nurse. This intermediate nurse teaches the patient–wife tips and tricks for how to manage potential harm and engage in health promotion, including how to access community resources such as support groups. This nurse instills hope and encouragement to class participants. The beginner nurse implements a teach-back scenario to determine his ability to perform intermittent catheterization (IC). When he was successful with teach back, the nurse moves forward to teach the patient–wife the clean method of IC. However, during the demonstration of the clean technique, the nurse feels resistance from the catheter with insertion. The nurse retracts and stops advancing the catheter and seeks assistance from an intermediate-level nurse. After the intermediate nurse reviewed the patient’s medical record and performs a hands-on assessment, the nurse identifies that the patient’s enlarged prostate could be the reason for resistance.

The intermediate nurse then recommends to the beginner rehabilitation nurse to reattempt IC with a coude catheter. As the coude catheter advances without problems, the intermediate rehabilitation nurse modifies his catheter equipment order to coude catheters, ensuring the proper equipment would arrive at home prior to discharge.

The unit manager CRRN and expert case manager nurses consult with the patient–wife for weekly goals and the POC. These nurses assess the patient–family’s needs and adapt the POC throughout their stay, considering their age, developmental stage, and cultural background. Intermediate and expert nurses collaborate to develop individualized evidence-based strategies to promote successful self-management. The expert nurse reviews and advocates for medical/adaptive equipment to be sent home with him, keeping in mind that he has “a newborn on the way.” This expert nurse also coordinates with the occupational therapist in searching for wheelchair-accessible cribs, strollers, and adaptations for the wheelchair to enhance how to manage the complications associated with SCI. Knowing not all equipment will be approved by insurance, this expert nurse continues to advocate for the patient–family to lobby their insurance company for necessary benefits.

### **Text Box 2**

Domain 2: Promotion of health and successful living—Application to practice story.

A 34-year-old male individual sustained a motor vehicle accident resulting in an incomplete thoracic spinal cord injury (SCI). He presents with paraplegia, urinary retention, and a history of enlarged prostate. He and his wife are expecting a

nance, care management, and injury prevention to the patient–family who are affected by chronic illness and physical disability. This domain emphasizes the promotion and restoration of optimal health throughout the patient’s life span, including addressing all of actual or potential problems of functional ability and lifestyle to attain an optimal quality of life. There are three competencies for

Domain 2. In Text Box 2, a case story demonstrates components for Domain 2.

### **Competency 2.1: Promote Health and Prevent Disability**

This competency identifies the role of the rehabilitation nurse in primary, secondary, and tertiary health and wellness promotion strategies where diversity is recognized and appreciated for those living with disability and chronic conditions from birth 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 (i.e., smoking and chemical substance abuse) and altering unhealthy or high-risk behaviors, such as not wearing a helmet, a vehicle seat belt, or a protective face covering. Secondary prevention strategies reduce the impact of injury, such as treatment protocols/guidelines for stroke, rescue protocols for spinal cord injury, and routine health screenings, such as mammograms and prostate checks. Tertiary prevention strategies include those for long-term management, such as support groups, programs for specific chronic disease states, and vocational retraining 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. This is followed by the implementation of established protocols and standards with identified individualized patient goals to manage health, disability, and/or chronic illness. The determination of the patient–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 expert rehabilitation nurse regarding these strategies may be needed. Mentoring the beginner nurse allows the nurse to become more confident in the new role as a rehabilitation nurse.

The intermediate nurse 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/interprofessional teams. The patient–family's health promotion and secondary prevention practices are evaluated and adjusted as needed. The expert nurse serves as a mentor to beginner nurses, acts as a consultant, and assesses not only the needs of the individual and family but also those of the community-at-large for strategies and the resources that the patient–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 as a whole.

### **Competency 2.2: Foster Self-Management**

Promotion and empowerment of patients to utilize all of their abilities, self-efficacy, health literacy, collaborative relationships, and past experiences to enhance decision-making to achieve the highest quality of life defines fostering self-management in a culturally responsive environment. The beginner rehabilitation nurse performs 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 in developing a POC, which includes a safe discharge or transition to the community. Collaboration with the intra/interprofessional team to identify needed equipment and devices to sustain self-management in the community is also an important role of the beginner nurse. In addition, the beginner nurse provides instruction and solicits teach back regarding the management of the patient's illness or injury, including medications and the safe use of the equipment. In consultation with the expert nurse, the intermediate nurse anticipates and describes barriers to self-care management by the patient–family and identifies any physiological or psychosocial facilitators of self-management. The collaboration with both the intra/interprofessional team and the patient–family regarding realistic goals for home management is also an essential function of the intermediate nurse, along with the coordination of the medical/adaptive equipment and community resources. The expert nurse's role is to examine patient–family data, such as culture, social conditions, developmental level, patient–family preferences, and community resources. The expert nurse establishes a collaborative advocative relationship with the patient–family and further individualizes the POC to promote optimal self-management strategies for the patient with chronic illness and/or disability. Self-care management promotion strategies may include providing resources for supplies, respite care, transportation, and support group information.

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

As rehabilitation lengths of stay have shortened and medical acuity of rehabilitation patients has increased, transition from the acute setting to rehabilitation (postacute) care to home care is the norm. Families are typically unfamiliar with community resources and are often unable to navigate those postdischarge. Assisting the patient–family to transition across the healthcare continuum requires a professional with a unique skill set and knowledge of

the various settings, along with the capacity to collaborate with multiple disciplines. The beginner nurse participates in the development of a POC, utilizing the patient and family assessment information for cultural considerations and health literacy. This beginner rehabilitation nurse also participates in the team care conference, collaborating with other members of the professional team to establish goals and EBP interventions for a safe and successful care transition.

In collaboration with the expert 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 the evaluation of the plan with the patient–family throughout the process. Improving care transition processes is within the purview of the rehabilitation nurse and the intra/interprofessional team. The intermediate nurse collects data that will contribute to improved processes in the organization for safe transition. The expert nurse synthesizes data related to the patient–family and their resources that are needed for a safe care transition. This nurse also coordinates and facilitates strategies for a safe and effective transition across care settings, in addition to analyzing data to determine the efficacy of the organization’s care transition processes. Patient–family experiences with care transitions are key to the improvement of the transition program.

### Text Box 3

Domain 3: Leadership—Application to practice story.

A 72-year-old African American female individual transferred to a subacute rehabilitation unit from acute care on postop Day 3 of a right total hip replacement. Prior to surgery, the patient had a history of falls, urinary tract infections, and periods of forgetfulness. She was a former smoker with no known drug allergies. Her comorbidities include osteoporosis, hypertension, chronic obstructive pulmonary disease, hypothyroidism, and depression and are controlled with medications. After her husband’s death, 6 months ago, she lives alone in a private inner-city residence. She has four children; three live out of state. One son lives 12 miles away and has not been involved in her care. Upon admission, the beginner rehabilitation nurse noticed the patient lived alone and had not involved her family in her recent health concerns. During the care planning process, this nurse decides to include the following in her problem list: lack of resources to meet daily needs, limited access to social services, and limited to no support system, along with memory loss and high risk for falls. As the nurse proceeds to establish an intervention for some of the goals, she only identifies areas in which she can find resources to address her patient’s need. After attending the intra/interprofessional team meeting, she discovers that the patient expressed concerns of “feeling lost” to the physical therapist. After the patient agrees to include her son–wife in her POC, the intermediate nurse begins to inform

them of his mother’s recent health status. Several proposed interventions address the patient–family’s needs, such as (1) increasing the patient–family’s knowledge of memory loss, (2) encouraging them to attend physical therapy sessions to help identify ways to decrease falls, and (3) addressing the emotional support needs because of the recent loss of the patient’s spouse. The beginner nurse intervenes by responding to the patient’s discomfort in her right hip and high blood pressure. She realizes that after her son left, the patient’s pain level and blood pressure increased. Though this nurse was able to manage and monitor her complications with medication, she spoke with the intermediate nurse and reviewed the social worker’s notes where they discovered the son expressed disinterest in caring for his mother and thought she was not doing “enough” in therapy. The intermediate nurse shares what she has learned with the team leader, an expert nurse, and a CRRN. Together, they visit the patient in her room. The beginner nurse is there and reports that the patient’s blood pressure is 150/92, her heart rate is 104, and her pain has not improved even after her standing order for an analgesic was given almost an hour ago. The intermediate nurse asks the patient to rate her pain on an analog scale, 0–10. She responds slowly, “I think it’s still a seven.” The beginner nurse says, “I will get her an oral NSAID,” and exits the room. The expert nurse is concerned about the patient’s ability to cope and asks, “Tell me about your visit with your family today” The patient responds, “It’s quiet and seconds go by,” and the expert nurse adds, “What can we do to help?” The patient says, “I just want to go home” with a tremor in her voice. The expert nurse asks her if she has ever used aromatherapy (AT), explaining that it is the use of scents that might help her to feel better. The patient responds, “not that I know of.” The intermediate nurse chimes in, “are you sensitive to any odors or scents?” The patient’s response is the same, “not that I know of.” The intermediate nurse does a focused respiratory assessment that is within defined limits and tells the patient, “I am going to get you a lavender sniffer. Lavender may help you to feel less anxious and may also help with your pain.” The beginner nurse returns to administer the NSAID, asking for her name and date of birth. The intermediate nurse comes back with the lavender, instructs the patient on its use, and then gives the lavender sniffer to the patient who then holds it in front of her nose and correctly takes two to three inhalations. The patient smiles up at her nurses and says, “that’s really nice.” The intermediate nurse documents that patient denies scent allergies; respiratory system is within defined limits; AT is initiated with lavender; teach back is positive, as patient returned demonstration of proper use after several attempts; and patient response is positive. The expert nurse continues, “Going home is important to you; we just want to help you plan for a safe discharge. We will be back to check on you within the hour.” After leaving the patient’s room, the expert nurse engages her colleagues and notes that a nursing organization composed a position statement on the use of complementary therapies, specifically AT. She will make that paper available for the team. One hour later, the beginner nurse checks the patient and realizes that her pain and blood pressure have decreased and is prepared to discuss discharge planning with her family.

### Domain 3: Leadership

Rehabilitation nurses have an important leadership role regardless of the setting to empower patient–family advocacy. This involves providing not only care but also information regarding health management and risks, function,

resources, and adaptation to acute and chronic illness and/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 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 team, the rehabilitation nurse leader ensures coordination of care; promotes smooth transition across teams; and makes sure 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 composed of four competencies. A story that links Domain 3 to rehabilitation nursing practice is provided in Text Box 3.

### **Competency 3.1: Promote Accountability for Care**

Accountability to promote ethical, cost-effective, patient–family-centered quality outcomes in the disabled is exemplified in the American Nurses Association (2015) Code of Ethics that requires that nurses be accountable for their actions with a commitment to their patients–families. Nurses face ethical dilemmas daily. What is the rehabilitation nurse's role in ethical dilemmas? Ultimately, it is the patient and/or their family, as appropriate, who has the right to make decisions. However, the rehabilitation nurse provides support to the patient–family who may be advocating for their own needs for the first time. It is the responsibility of the rehabilitation nurse and the team to inform the patient–family of all aspects of the plan, including the potential issues the team perceives as barriers to a safe discharge. A beginner-level rehabilitation nurse provides safe and ethical care to patients. These nurses have a basic knowledge of the social conditions that may affect care, including the patient–family access to health care and public safety. The beginner and intermediate nurses are also knowledgeable of best EBPs 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 begins 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 the 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 expert 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, this expert nurse must strategically address unit and organizational issues that promote inclusion and embrace diversity in the work setting through clinical practice and education and research initiatives.

### **Competency 3.2: Dissemination of Rehabilitation Nursing Knowledge**

The implementation of EBP is an essential behavior of rehabilitation nurses and imperative for rehabilitation nursing practice. 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 and present rehabilitation topics at their own organization's meetings or interprofessional conferences to disseminate information regarding rehabilitation nursing and innovations. The beginner nurse demonstrates this competency by asking patient–family-related questions in unit activities that promote optimum rehabilitation nursing practice, participating or serving on committees, and attending local and national rehabilitation-related webinars/conferences to learn about standards or approaches to holistic patient care. The beginner nurse knows where to find resources to answer clinical practice questions, which may include consultation with the intermediate and expert 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 part of promoting quality outcomes. These nurses share these strategies with the intra/interprofessional teams as well as with other rehabilitation communities, as appropriate. Beginning nurses, with assistance of intermediate and expert nurses, present information to the intra/interprofessional teams on the unit, as well as at ARN chapter meetings and regional and national conferences. They also serve on local and national committees in professional organizations. The expert nurse is also 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 EBP guidelines or serving as a content expert on panels or committees, both nationally and internationally.

### Competency 3.3: Impact of Health Policy for People With Disability and/or Chronic Illness

Knowledge of health policy and regulations is a key role competency for rehabilitation nurses at all levels of proficiency. ARN has a health policy committee and a professional lobbyist who advocate for persons with disability and/or chronic illness, as well as for rehabilitation nursing. The beginner nurse acknowledges the Americans With Disabilities Act (U.S. Department of Justice Civil Rights Division, 2021) and maintains social awareness of current healthcare issues by accessing the Legislative Action Center and Advocacy tool kit and reviewing ARN's health policy and advocacy updates (ARN, 2021). These nurses recognize the major accrediting bodies and promote quality care for patients by endorsing political activism. The intermediate nurse actively influences health policy through participation in professional organizations and serves as a resource to policy makers. The intermediate and expert rehabilitation nurses recognize that persons with disability are globally marginalized and understand the importance of political engagement. Lastly, all rehabilitation nurses must communicate the importance of finding and using the best evidence to colleagues and policy makers. Overall, intermediate and expert levels of rehabilitation nurses 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.

### Competency 3.4: Empower Patients to Self-Advocate

Self-advocacy or acting on one's behalf safeguards a patient's autonomy and empowers the patient through education, collaboration, and support. Rehabilitation nurses empower patients and their families through collaboration, education, and directing them to resources that will enhance their informed decision-making while in the rehabilitation setting. This collaboration may result in a patient-family conference with the intra/interprofessional team where the POC is reviewed and recommendations

#### Text Box 4

Domain 4: Intra/interprofessional teams—application to practice.

A 35-year-old single, female accountant fell 8 feet from a ladder while trimming a tree branch in her yard. She sustained an unstable burst fracture at T7, a left pulmonary contusion, and three left rib fractures. She underwent a

T5–T9 reduction and stabilization. She has no medical or surgical history and jogged 3–4 days per week prior to her injury. Her mother is staying with her and will assist with discharge planning. The patient's condition is classified on the American Spinal Injury Association Impairment Scale as grade A, SCI with neurogenic bowel and bladder. She is to wear a thoraco-lumbo-sacral orthosis brace when up; her back incisions are healing with staples in place. An indwelling Foley catheter is in place draining clear urine. She is admitted to a rehab facility after 6 days on the orthopedic/trauma unit. She begins working with physical therapy on slide board transfers and requires maximum assistance because of poor sitting balance. With fatigue and safety concerns, all nurses are using a mechanical lift in the room for transfers at the end of the day.

On Day 2 in acute rehabilitation, the indwelling Foley catheter is discontinued and intermittent catheterization (IC) begins. One of the immediate nursing goals is to begin a bladder management program. The beginner nurse discusses the IC process with the patient. The patient replies that she would like the catheter to remain in for at least another week, because she is just not ready for it to be removed. This nurse explains the catheter may cause an infection as well as weaken bladder muscles, and it is important to remove it. The nurse then shows her an IC video. Later in the day, the beginner nurse performs the IC while she is in bed. The intermediate nurse sits down with the patient, discusses in detail the IC process, and asks how she feels about learning to IC. The nurse then allows time for the patient to ask questions, provides written materials and online resources, and tests her knowledge by asking her to explain the IC process in her own words. The intermediate nurse also identifies that she should begin to perform IC while on the toilet, but this nurse identifies safety concerns with transfers to the toilet from the wheelchair because of poor sitting balance and consults with physical therapy and expert nurse colleagues.

The expert nurse discusses the IC process with the patient-family. The nurse provides written materials on the IC process and brings in a variety of catheter types to determine what may work best. This nurse explains in language that the patient-family understands the reason why she does not have the ability to urinate on her own because of her SCI and allows time for them to express their feelings. The expert nurse explains autonomic dysreflexia and the importance of managing her bladder volumes to avoid an episode of autonomic dysreflexia. The expert nurse then consults with occupational therapy to assist with implementing techniques to adjust clothing prior to IC. The nurse also consults with physical therapy to ensure transfers to the toilet are safe and solicits suggestions to share with the nursing staff.

are made. If needed, the rehabilitation nurse and the team may consult the ethics committee for guidance regarding conflicts that arise between the team and patient-family about the plan. The beginner rehabilitation nurse helps patients to express their concerns, desires, and goals. The intermediate rehabilitation nurse teaches patients how to use the Americans With Disabilities Act and community resources to request reasonable accommodations. The expert 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.

#### **Domain 4: Intra/Interprofessional Teams**

Patients in rehabilitation often have complex needs that require a team of professionals from several disciplines to help them reach their individual goals. Coordination of patient care in the context of an intra/interprofessional team is an effective strategy for patients with chronic diseases or acquired disability. It is important for the rehabilitation nurse to understand the role of each team member to develop the rehabilitation POC. Although 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). Intra/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). As nurses gain experience and knowledge in rehabilitation, they are better able to work effectively in both intra/interprofessional teams. Three competencies comprise Domain 4. An application to practice story for Domain 4 is displayed in Text Box 4.

##### **Competency 4.1: Develop Intra/Interprofessional Relationships**

Intra/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 that team and consistent approaches to care. Characteristics of an effective team include active listening and discussion regarding patient care and treatment. Developing intra/interprofessional relationships improves patient safety, care planning, and patient outcomes. Communication and feedback occur formally during team meetings or huddles, or they may occur 1:1 with individual team members. Beginning nurses start to recognize their new role 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 less experienced team member, as new nurses need to establish themselves by sharing accurate and current information and knowledge with the team. The intermediate nurse facilitates the contributions of each team member and evaluates 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 advanced/expert nurse takes a leadership role in educating and promoting effective intra/interprofessional communication. Effective communication maximizes the implementation of innovative evidence-based interventions that foster

positive health outcomes and solve complex patient problems promoting patient independence.

##### **Competency 4.2: Implement an Intra/Interprofessional Holistic POC**

The rehabilitation nurse develops a collaborative holistic POC for diverse patients that is culturally sensitive and prescribes strategies, alternatives, and interventions to attain desired outcomes. The POC is individualized and patient–family centered, beginning with an assessment that includes health literacy, learning needs, and resources, which reflects care across the continuum, including the promotion of independence, active decision-making, and self-advocacy. Goals are agreed upon by patients–families and the team, including target dates to accomplish each goal. The beginner nurse identifies problems from initial and ongoing assessments and shares this information with the team, contributing to the intra/interprofessional POC. When the plan is understood and care is coordinated, interventions are implemented and the effectiveness of the POC is evaluated. The intermediate nurse contributes to rehabilitation nursing practice through the use of EBP strategies and implements and evaluates the efficacy of such interventions. Furthermore, the intermediate nurse is engaged in the evaluation of the overall POC. The expert nurse adds to the POC and modifies, as indicated, through collaboration with the intra/interprofessional teams regarding complex health conditions and barriers to a safe transition to the community, including limited access to resources. Long-term care needs are anticipated, and the advanced nurse then may act as a consultant to mobilize the team to achieve goals for the altered plan. The patient–family's values and beliefs are shared with the team and incorporated into the long-term plan. The expert nurse is also poised to analyze and synthesize aggregate data to recommend practice changes using a quality improvement process.

##### **Competency 4.3: Foster Effective Intra/Interprofessional Collaboration**

In order to provide the highest quality of care, rehabilitation nurses work with the patient–family and intra/interprofessional teams. 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. It is important that the rehabilitation nurse shares information with the team that could affect the POC. The team forms or alters the POC in order to meet both the patient's medical and rehabilitative needs. The entire team works together for the best possible patient outcomes.

The nurse shares salient information with the team that may lead to alterations in the POC. Beginner nurses

## Key Practice Points

- Competency models provide a lens through which professional nurses can view their practice in multiple settings across the healthcare continuum.
- The 2021 updated Competency Model for Professional Rehabilitation Nursing from the Association of Rehabilitation Nurses (ARN) includes four updated domains with competencies, plus new text boxes for practice application stories, and provides a template that drives performance.
- The ARN, through its mission and strategic plan, purports that rehabilitation nursing care be inclusive, nonbiased, and culturally sensitive, and this concept is threaded across all domains.
- This model provides a guide for nurses practicing at different levels of proficiency, beginner, intermediate, or expert, in various locations.
- The Competency Model for Professional Rehabilitation Nursing can be used to explain the nurses' role on intra/interprofessional teams, as well as provide a structure for clinical or academic education and staff role descriptions, orientation, and performance evaluation.

provide basic nursing information to the team and collaborate with other team members, recognizing the diversity of roles and each member's contribution to the team and the patient's POC. The intermediate nurse is more active in the collaboration process, engaging with the entire team regarding goals and priorities of the POC and the implementation of best practices. The expert nurse acts as a role model and coach, engages the team in the collaborative process to improve rehabilitation, and designs and evaluates the POC, including a safe transition of care. Team diversity is recognized and assists in understanding cultural differences and fostering innovative approaches to patient care that address identified barriers to a safe transition to the community. Both intermediate and expert nurses mentor beginner nurses in order to foster the development of a holistic POC.

### Clinical Relevance

The Competency Model for Professional Rehabilitation Nursing provides a unique structure in which rehabilitation nurses practice at various levels of proficiency in different settings along the healthcare continuum, from the emergency room to home care. The model delineates the many roles of a rehabilitation nurse and offers insight into the specialty practice throughout the four domains and the associated competencies. Application for model utilization includes a map for educational and clinical practice, that is, a construct assessment tool to determine rehabilitation nurses' educational needs; a framework for academic, staff orientation, or continuing education courses

or clinical ladder programs based on proficiency levels; a template for recruitment; and/or explicit job/role descriptions and role delineation on intra/interprofessional teams. The competency model can be integrated into the ARN educational materials, such as the core curriculum, webinars, and other conferences and/or publications. Furthermore, the rehabilitation competency framework (RCF; see <https://apps.who.int/iris/rest/bitstreams/1328010/retrieve>) developed by the World Health Organization technical working group in 2019–2020 included input from ARN leaders who were integral in the creation of the original Competency Model for Professional Rehabilitation Nursing. The RCF is setting-neutral and has broad application and relevance. The goals of this global RCF are similar to the updated competency 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 World Health Organization model and modify it for application into local context.

### Conclusion

Rehabilitation nursing practice has evolved and encompasses nursing in various settings across the healthcare continuum. The domains and the associated competencies of the updated Competency Model for Professional Rehabilitation Nursing unite the global rehabilitation nurse community through the clarification of the nursing roles at the different proficiency levels, reflection of current practice, and advancement of the specialty practice of rehabilitation nursing.

### Conflict of Interest

The authors declare no conflict of interest.

### Funding

None.

### Acknowledgment

The authors thank the Association of Rehabilitation Nurses for the opportunity to participate in the 2020 Competency Model Task Force.

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