Inside Looking Out: Updated Competency Model for Professional Rehabilitation Nursing Practice

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Abstract

Background: The original Association of Rehabilitation Nurses (ARN) Competency Model for Professional Rehabilitation Nursing published in 2016, and updated in 2020, provides a framework for rehabilitation nursing practice.

Aim: This companion, but stand-alone, article to a 2022 publication further explicates and informs the updated Competency Model from inside looking out toward an increasing application for evidence-based practice (EBP).

Approach: An eight-member 2020 ARN Task Force used an iterative process to review the original four domains and related competencies and came to consensus for the updated model.

Outcome: This model provides revised competency role descriptors or behaviors that guide nurses practicing at different proficiency levels in various settings.

Clinical Relevance: The Competency Model for Professional Rehabilitation Nursing is a premier resource that can advance professional rehabilitation nursing and guide EBP, including evaluation, quality improvement, and research. The model describes the nurse's role on the intra/interprofessional team and fosters collaboration with other healthcare professionals to enhance the quality of life for those affected by disability and chronic illness.

Conclusion: The domains and associated competencies of this model clarify nursing roles at different proficiency levels, and role descriptors reflect current practice, supporting advancement of the specialty practice of rehabilitation nursing well into the 21st century.

Keywords: Rehabilitation; nursing practice; model; competency.

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Cite this article as:
Vaughn, S., Rye, J., Allen, A., Bok, A., Mauk, K., Park, L., Pierce, L., & Holler, W. (2023). Inside looking out: Updated competency model for professional rehabilitation nursing practice. *Rehabilitation Nursing, 48*(1), 23–38. doi: 10.1097/RNJ.0000000000000397

The practice of rehabilitation nursing is recognized as the specialty of managing and promoting the care of persons with disabilities and chronic health conditions across the continuum of care and for all ages through special knowledge and expertise (Association of Rehabilitation Nurses [ARN], 2014). Nursing models provide a framework for clinical practice and research (Miller & Pierce, 2019). The Task Force (TF) of rehabilitation nurse leaders who developed the original ARN Competency Model for Professional Rehabilitation Nursing (hereafter also referred to as the "Competency Model" or "the model") in 2013 could only predict how this model would be viewed and used. Those leaders charged with the model creation used an iterative process grounded in current literature, which included ARN materials such as the *Standards and Scope of Rehabilitation Nursing Practice* (ARN, 2014), along with Benner's (2001) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* and Bloom's

Taxonomy (Armstrong, 2010), to develop the four domains and the associated competencies and the levels of proficiency. The 2013 ARN TF gave the model its "wings" through dissemination at the Annual 2014 ARN Education Conference and the initial article published by Vaughn et al. (2016) in the *Rehabilitation Nursing* journal. The model has since been integrated into ARN publications and educational offerings, journal articles, research projects, new nurse orientation, annual competencies, and evaluation tools. It was also used to inform the international interprofessional technical working group that developed the World Health Organization Rehabilitation Competency Framework. These many activities reflect how rehabilitation nurses have used the ARN Competency Model to promote the specialty practice. A timeline for the model's development, along with revision processes, is displayed in Table 1.

Background

Review Process

In 2020, the ARN Board of Directors requested that the Competency Model for Professional Rehabilitation Nursing be reviewed and revised as needed. An eight-member 2020 ARN TF was purposefully selected to reflect clinical and academic practice, different subspecialties, and geographic regions of the country. Because of the COVID-19 pandemic, the 2020 TF met virtually using a similar iterative process as the original ARN TF to review the four domains and related competencies. Over a 13-month period, this 2020 TF came to consensus for the updated model. The review process included (1) orientation of the review process by the four continuing group members from the original TF and (2) division into teams of two members, pairing a clinical expert and an academic, where each team took one of the four domains for review.

After each team's review, the teams presented their revisions to the entire 2020 TF. Next, each team chose another domain and continued to review, revise, and present revisions to the entire TF. During this process, all TF members contributed their expertise to the suggested revisions until an agreement for the updated 2020 Competency Model was achieved. This updated model was presented virtually at the ARN annual education conference in 2021; attendees' responses were positive, and there were no substantive changes suggested. The model was placed on the ARN website in late 2021, and an initial article was published by Vaughn et al. (2022).

A recap of these revisions, published by Vaughn et al. (2022), to this updated ARN Competency Model

Table 1 Timeline: Competency Model Development and Revision Process

October 2013	The original Association of Rehabilitation Nurses (ARN) Competency Model for Professional Rehabilitation Nursing Practice developed by a 2013 ARN Task Force (TF) composed of seven rehabilitation nursing experts from academia and the clinical setting in a 2-day intensive workshop.
November 2013 to February 2014	The 2013 ARN TF refined the model domains, competencies, and role descriptors via teleconference and email communication.
June 2014	The Competency Model was highlighted in the June/July edition of the ARN e-news, and comments were solicited from the ARN membership.
October 2014	The model was presented at the ARN Annual Education Conference in Anaheim, CA; additional feedback and suggestions from the attendees were solicited.
January to June 2015	The ARN Competency Model was finalized and placed on the ARN website.
January 2016	An article was published in *Rehabilitation Nursing* (*RNJ*; Vaughn et al., 2016) describing the model and recommendations for utilization.
June 2020 to June 2021	2020 ARN TF was formed and was composed of four 2013 ARN TF members and four new members representing various regions of the United States and practice areas. Similar to the 2013 ARN TF, this 2020 TF of rehabilitation nurse leaders were from academia and clinical practice. Because of the pandemic, the 2020 ARN TF met virtually throughout a 13-month period reviewing and revising the model to reflect current rehabilitation nursing practice.
July to November 2021	(1) The 2020 ARN Competency Model was presented virtually at the ARN Annual Education Conference, and positive comments were received from attendees with no substantive changes suggested. (2) The Competency Model was introduced with materials on the ARN website reviewed and updated.
January 2022	An article was published in *RNJ* (Vaughn et al., 2022) highlighting the updated/revised Competency Model and its application to clinical practice via case stories for each domain.
2023	A companion article is published in *RNJ* that highlights the model development process and the revised role descriptors with behaviors for each competency specific to the nurse's level of proficiency. This encourages rehabilitation nurses to view the updated model from the inside out toward evidence-based practice.

includes four domains and essential competencies with role descriptors (key behaviors) matched to nurses' level of proficiency. Updated domains include the following: (1) nurse-led interventions, (2) promotion of health and successful living, (3) leadership, and (4) intra/interprofessional team. Throughout this model, domain and competency words were changed to reflect current practice: (1) "client" was changed to "patient" to be more inclusive, as persons with disabilities need healthcare plus appropriate treatment interventions in partnership with professionals; (2) definition of "family" was changed to include anyone who supports and cares for the patient; and (3) the term "intraprofessional" was adopted to depict the collaboration that occurs among nursing peers (Vaughn et al., 2022).

This updated ARN Competency Model by Vaughn et al. (2022) continues to guide rehabilitation nurses at different levels of proficiency: beginner, intermediate, and expert. Beginner nurses may be recent graduates or new to rehabilitation practice with 1–2 years of rehabilitation experience. Intermediate rehabilitation nurses have 3–5 years of experience or are certified rehabilitation registered nurses. Expert rehabilitation nurses have greater than 5 years of experience in various roles, for example, staff, manager, educator, researcher/nurse scientist, advanced practice registered nurses, and so forth. Rehabilitation nurses practice in a variety of settings, including but not limited to acute and long-term care, home health and community-based care, outpatient settings, and academia (Vaughn et al., 2016, 2022).

The overarching aim of this companion article to the 2022 Vaughn and colleagues' publication is to do a deeper dive into the components of the updated Competency Model that explicates and informs the initial publication from 2022 (Vaughn et al., 2022). Specifically, the purpose of this article is to provide an innovative view of professional rehabilitation nurses' proficiency levels and the competency role descriptors as a way of looking from the inside of the updated 2020 ARN Competency Model for Professional Rehabilitation Nursing Practice outward toward a broader application for evidence-based practice (EBP).

Updated ARN Competency Model for Professional Rehabilitation Nursing

The newly updated figure for the ARN Competency Model for Professional Rehabilitation Nursing is depicted by concentric circles, created to represent the essential role competencies of the professional rehabilitation nurse (see Figure 1). The centermost circle represents the "Rehabilitation Nursing Professional Role." The next circles represent the four "domains" of the professional rehabilitation nurses' role. Applicable "competencies" for each domain are observable and incorporate rehabilitation nursing knowledge, skills, core values, and beliefs. Nurses' proficiency levels and competency role descriptors are integrated for EBP care (Vaughn et al., 2016, 2022).

Domains and Competencies

Domains and competencies are intertwined with rehabilitation nurses' level of proficiency from beginner to expert, along with professional nurses' role descriptors. The role descriptors are (1) expressed in terms of key phrases or behaviors that provide in-depth characteristics for each component and (2) key to effective performance within rehabilitation nursing roles at the different proficiency levels (Burnett et al., 2019; Vaughn et al., 2016). The revised professional role descriptors form the basis of the discipline of rehabilitation nursing inside the model looking out to EBP and build a foundation for career-long development.

Domain 1: Nurse-Led Interventions

Domain 1 of the Competency Model for Professional Rehabilitation Nursing is focused on nurse-led interventions for family-centered care in a variety of settings that promote optimum function and health management in persons with disability and/or chronic illness. This domain represents the holistic nature of rehabilitation nursing practice, with collaborative relationships with other members of the interprofessional team to promote the health of the patient and family unit, and the community (Burnett et al., 2019; Vaughn et al., 2022). One new competency was added to this domain: "Understanding Worldview of Culturally Different Individuals." There are now five reordered competencies for Domain 1, with professional nurses' proficiency levels, along with revised role descriptors, displayed in Table 2.

Competency 1.1: Use Supportive Technology for Improved Quality of Life

Technology may be used to enhance and encourage the person with a disability and/or chronic condition, along with family members, as appropriate. Technology tends to improve self-management, quality of life, and function (Burnett et al., 2019; Vaughn et al., 2016, 2022).

At the beginner level of proficiency, professional nurses may not be familiar with various types of advanced rehabilitation support technologies. However, they can participate as a collaborative team member in assessing the patient's needs for such, be able to use the basic technology while learning about advanced technology, and document care involving the application of a support technology. Intermediate-level rehabilitation nurses assess the patient's need for technological solutions, develop goals

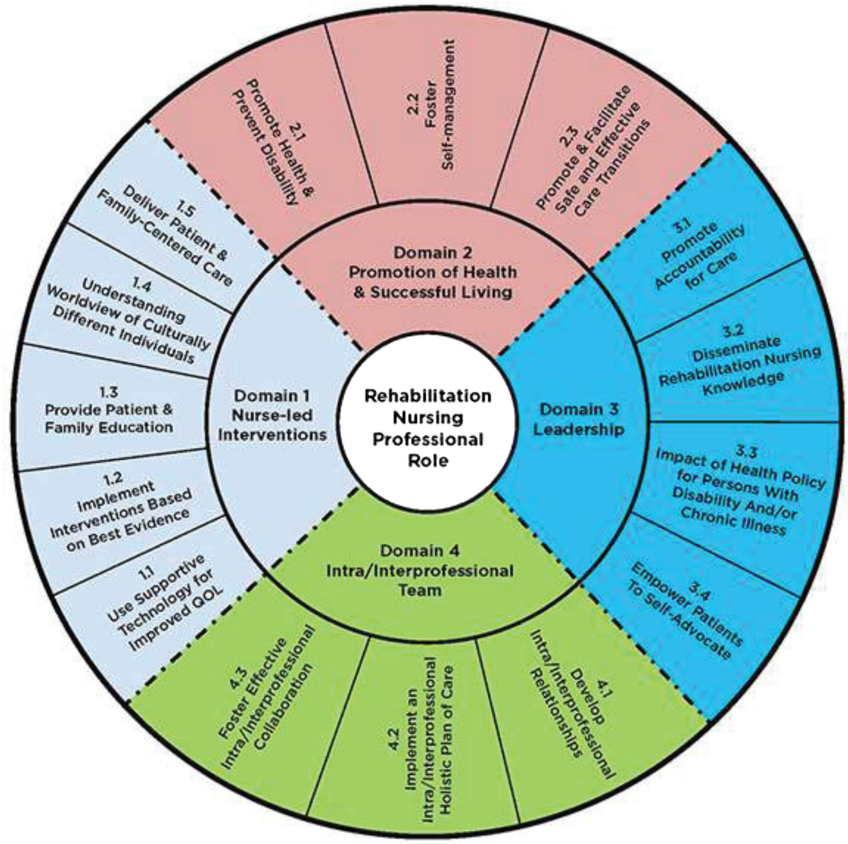

Figure 1. Updated Competency Model for Professional Rehabilitation Nursing Practice.

in collaboration with other professionals and the patient's family, identify gaps and personalize the care required, and evaluate the effectiveness of the patient and family response to the technology. Expert rehabilitation nurses serve in many roles, such as role model, mentor, and the clinical decision-making leader, especially in the management of complex patients and those with chronic illness. Expert nurses may collaborate with other advanced practitioners to develop or improve technology, such as an application for a smartphone, that integrates the patient and family's specific needs (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Competency 1.2: Implement Interventions Based on Best Evidence

In developing the rehabilitation plan of care (POC) at their level of proficiency, rehabilitation nurses seek out and use the best available research evidence. Nurses intervene to assist patients and families to manage disability, chronic illness, and health management commonly seen in the rehabilitation setting (Burnett et al., 2016; Vaughn et al., 2016, 2022). Educators in academic settings foster inquiry in students early in undergraduate nursing programs and introduce the concept of EBP. Albarqouni et al. (2018) identified core EBP competencies that reinforce the need for nurses at all levels to be knowledgeable of EBP.

Beginner nurses will use EBP guidelines and protocols that are grounded in research. These nurses will also assess the patient and family's needs and create and/or adhere to established POCs. Intermediate-level nurses assist beginner nurses in communicating with other team members, along with the patient and family, to develop an individualized POC with attainable goals. Interventions are evaluated and modified as needed to foster optimum patient and family outcomes; this helps to develop the evidence in rehabilitation nursing practice. Expert rehabilitation nurses creatively address the complex needs of the patient and family, which include cultural, spiritual, psychosocial/emotional, and physical needs, and implement innovative care strategies. In addition, expert nurses use EBP to develop policy and practice.

The development and implementation of evidence-based guidelines/bundles to manage certain conditions, such as poststroke incontinence or spinal cord injury neurogenic bowel, and conduct falls or pressure injury quality improvement projects are within the purview of the expert nurse. Expert nurses also manage and evaluate patients with long-term chronic conditions (Burnett et al., 2016; Vaughn et al., 2016, 2022).

Table 2 Domain 1: Nurse-Led Interventions—Proficiency Levels and Revised Competency Role Descriptors

Proficiency Levels		
Beginner Nurse (1–2 Years Rehabilitation Experience)	Intermediate Nurse (3–5 Years Rehabilitation Experience or CRRN)	Expert Nurse (5+ Years Rehabilitation Experience)
Competency 1.1: Use Supportive Technology for Improved Quality of Life		
Participates in the process of determining the need for assistive or supportive technology	Assesses for and anticipates the patient and 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 caregivers
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 and family's financial means
Demonstrates competent use of technology in the care of a patient and family	Tailors technologies to enhance patient and family outcomes	Collaborates with the interprofessional team to develop new technologies to improve patient–family outcomes
Documents outcomes of technology interventions	Evaluates effectiveness of technology to improve health outcomes	Incorporates new technology and outcomes measures into POC
Competency 1.2: Implement Interventions Based on Best Evidence		
Uses established guidelines to assess an individual and their family's function and health management needs	Uses insight and creativity to identify gaps in assessment strategies	Uses insight and creativity to provide expert care, integrating cultural sensitivity and gender preference in consultations for complex patient and family context
Performs baseline assessment of the patient's current abilities and impact of illness	Performs in-depth assessment to determine less apparent needs for the patient	Performs more in-depth assessment to determine less apparent needs for the patient and family
Follows an established POC with the patient and family	Collaborates with the patient–family and intra/interprofessional team to develop a POC with attainable rehabilitation goals	Leads the patient–family and intra/interprofessional team to meet goals for disability and chronic illness health management
Administers medications and performs treatments as ordered by the provider and determined by the intra/interprofessional POC	Shares assessments and insights with the team (patient and family) for verification/buy-in	Serves as resource for the patient–family and intra/interprofessional team; offers insight
Evaluates and documents patient–family responses to standard interventions in a specific progress note	Evaluates and documents patient and family responses to interventions; collaboratively adjusts the POC with the team as needed for best outcomes	Evaluates outcomes for the complex patient and family in relation to life-long function and health management Discusses next steps to continue progress and connects the patient and family to support services
Competency 1.3: Provide Patient and Family Education		
Assesses/determines learning needs and readiness to learn of the patient and family for disability, chronic illness, and health management "literacy" such as new medications/treatments and asks "What are we doing that you don't understand?"	Develops an individualized education plan to address disability, chronic illness, and health management	Develops and provides the tools that are needed for effective education for disability, chronic illness, and health management

(continues)

Table 2 Domain 1: Nurse-Led Interventions—Proficiency Levels and Revised Competency Role Descriptors, Continued

Proficiency Levels		
Beginner Nurse (1–2 Years Rehabilitation Experience)	Intermediate Nurse (3–5 Years Rehabilitation Experience or CRRN)	Expert Nurse (5+ Years Rehabilitation Experience)
Supports established goals for the patient and family, provides education with each interaction, and communicates progress with education to intra/interprofessional teams	Collaboratively establishes goals/objectives according to unique patient and family's goals	Anticipates long-term learning needs for patient and family related to disability, chronic illness, and health management
Utilizes standard rehabilitation education related to disability, chronic illness, and health management	Provides tailored and timely education related to disability, chronic illness, and health management	Provides consultative rehabilitation education to patient–family and intra/interprofessional teams, and communities related to disability, chronic illness, and health management
Utilizes "teach-back" to evaluate patient and family learning	Utilizes "teach-back" and adapts education plan based on patient and family performance Builds on and makes connections to previous learning to deepen the patient and family's understanding of concepts	Evaluates the effectiveness of the educational outcomes related to disability, chronic illness, and health management Assists intra/interprofessional teams develop skills with patient and family education
Competency 1.4: Understanding Worldview of Culturally Different Individuals		
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 patients–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- and Family-Centered Care		
Determines patient's role in family unit and participates in a holistic assessment of the patient and family that includes culture, values, beliefs, and health literacy	Performs a holistic assessment of the patient and family and identifies strengths of the patient and family that could contribute to a successful POC and identifies how current condition impacts patient's role in family unit	Synthesizes holistic assessment data to promote optimal rehabilitation outcomes
Supports the development of goal setting that reflects the patient and family's choices including leisure activities	Develops a POC in collaboration with the interprofessional team that addresses patient and family goals	Advocates for patient and 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 and family's values and culture, considers additional resources to assist in honoring client and family culture and values, and provides support through role changes	Serves as a resource to the patient and family, and intra/interprofessional team members in the implementation of the POC
Participates in the care conference that evaluates the patient- and family-centered POC	Modifies the POC as needed to incorporate new information evidenced by the patient and family response to interventions	Directs the data evaluation process

Note. Adapted and revised text from Burnett et al. (2019). CRRN = certified rehabilitation registered nurse.

Competency 1.3: Provide Patient and Family Education

The effect of ethnicity, spirituality, age, growth and development, culture, as well as the patient and family's health literacy levels must be addressed when developing and evaluating the educational plan. Examples of education may include topics such as bowel and bladder retraining, mobility, fall prevention, and the safe execution of activities of daily living (Vaughn et al., 2016, 2022). Evidence-based caregiver assessment tools such as PATH allow the rehabilitation nurse to ascertain caregiver readiness and information needed to develop an individualized culturally sensitive POC (Camicia et al., 2019).

Beginner rehabilitation nurses start by assessing the patient and family for educational needs and their readiness to learn, ensuring that education materials are presented to them in a method congruent with their learning style and literacy level. The assessment components must include the learners' developmental stage, learning needs and skills, level of health literacy, readiness to learn, ability to learn, and learning style. Early-career nurses use established rehabilitation education information and materials that support the expected outcomes and goals of the patient and family. An evidence-based teaching technique used to evaluate the patient and family's understanding of information and/or a procedure is the "teach-back" or "show me" method.

The intermediate nurse develops an individualized patient and family education plan, in addition to mentoring the beginner nurse in the education process, which includes collaboration with intra/interprofessional team members. This education plan must incorporate the patient and family's preferences and knowledge and acknowledge their motivation to learn and be purposefully communicated. In addition to having proficiency in the beginner and intermediate competencies, expert rehabilitation nurses also address the patient and family's learning styles, capabilities, and educational and cultural needs when consulting, creating, adapting, and evaluating educational resources for the patient and family and for specific patient populations, such as stroke survivors (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Competency 1.4: Understanding Worldview of Culturally Different Individuals

This competency was added to the updated model, as it is important to continue and expand a multicultural approach to rehabilitation care. To actualize this competency, nurses must promote inclusivity of the patient and family. Patient and family members need to feel they are respected and free from discrimination based on national origin/ethnicity, race, religion, beliefs, age, gender, socioeconomic status, sexual orientation, gender identity, or disability (Vaughn et al., 2022).

Beginning rehabilitation nurses are expected to be cognizant of their emotional responses to any ethnic, racial, or any other oppressed group of people in ways that may negatively influence service delivery and effective rehabilitation care. These nurses should also be aware of the effect of stereotypic attitudes and preconceived ideas on ethnic and racial group's acceptance. Intermediate rehabilitation nurses are knowledgeable of and demonstrate an understanding of sociopolitical systems (i.e., oppression, racism, discrimination, and stereotyping). They are also cognizant of how these systems impact their patients and them personally. Expert rehabilitation nurses constantly seek to understand themselves—their unconscious biases—and actively seek an integrated identity that is not based on race. This group also familiarizes themselves with relevant, valid, and reliable research that impacts various underrepresented and/or oppressed groups of people to ensure that care is planned and delivered in an inclusive, equitable, and respectful manner (Vaughn et al., 2022).

Competency 1.5: Deliver Patient- and Family-Centered Care

Patient- and family-centered care encourages persons to be active, rather than passive, participants in the care, which strengthens shared decision-making and responsibility. It is imperative that rehabilitation nurses and the intra/interprofessional team integrate the patient–family unit's values, culture, ethnic influences, and spiritual preferences into the individualized POC that meets the needs of the patient and family environment and promotes recovery (Camicia et al., 2019; Vaughn et al., 2016, 2022).

Beginner nurses participate in the assessment of the patient–family unit, emphasizing cultural, spiritual, and ethical values, plus health literacy. These nurses also directly participate in developing and implementing the POC and support goal setting with the interprofessional team by participating in team conferences as well as the evaluation of the individualized rehabilitation POC. Culture informs human behavior, including health behavior (Camicia et al., 2021). To develop a culturally sensitive individualized POC, nurses at the intermediate level are culturally competent and conduct a holistic family-centered assessment. These nurses mentor beginner nurses as they coordinate the family-centered plan and evaluate and modify the POC to ensure that patient and family are empowered and their strengths are valued and that shared decision-making is encouraged. This also fosters optimal goal attainment. Intermediate-level nurses also collaborate with the intra/interprofessional team for consistent interventions that meet the patient and family needs, paying attention to support the caregiver and/or family as well as the patient, which reduces the potential of role strain. Expert nurses serve as an advocate and resource to the patient

and family and the interprofessional team and direct the evaluation process. These experienced nurses direct the evaluation process through synthesis of the evidence and assessment data (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Domain 2: Promotion of Health and Successful Living

Domain 2 of the ARN Competency Model is identified as "Promotion of Health and Successful Living." This domain emphasizes the promotion and restoration of optimal health throughout the patient's life span, including addressing all actual or potential problems of functional ability and lifestyle to attain the best quality of life. Providing patient and family care and education promotes independence and safety, prevents complications, and enhances their health status (Burnett & Miller, 2016; Vaughn et al., 2022). There are three competencies for Domain 2 with professional nurses' proficiency levels and revised role descriptors displayed in Table 3.

Competency 2.1: Promote Health and Prevent Disability

This competency identifies the health promotion role of professional rehabilitation nurses, which includes the implementation of primary, secondary, and tertiary health and wellness promotion strategies for those living with disability and chronic conditions along the life span. Rehabilitation nurses promote primary prevention in their patients by employing wellness strategies and the prevention of complications, which includes altering unhealthy or high-risk behaviors. Secondary prevention interventions reduce the impact of the injury that has occurred. Tertiary prevention includes creative strategies for patient and family in managing disability and chronic conditions long term (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Using the nursing process, beginner nurses assess common risks, such as falls; they then follow established protocols or evidence-based guidelines to assist the patient in meeting their rehabilitation goals. The determination of the patient and family's readiness and ability to learn the necessary strategies is initiated by nurses at this proficiency level. Beginner nurses also implement patient and family education, which may include a "teach-back" or "show me" scenario. Intermediate nurses build upon the assessment of the patient and family's readiness for self-management of health promotion strategies and identification of harm, in collaboration with intra/interprofessional teams. The intermediate nurse may pose the question, "What do you do to stay healthy?" to learn more about the patient's wellness behaviors. After an evaluation of the patient and family's health promotion and secondary prevention practices, the intermediate nurse may collaborate with the patient and family and recommend modifications as needed.

Experienced nurses practicing at the expert level serve as consultants and assess the needs of not only the patient and family but also those of the community at large reflected in global problem-solving. As a result, strategies are implemented that can reduce or alter risk, prevent harm, and promote optimum management of their disability and/or chronic condition. Through the examination of current health improvement trends and valid evidence, expert rehabilitation nurses advocate for and assist the patient and family to set realistic goals for their recovery. The expert nurse also disseminates health promotion information to the community, including populations with disabilities and chronic illnesses. In addition, both intermediate and expert rehabilitation nurses provide mentorship to the beginner rehabilitation nurses regarding risk assessment, goal setting, and readiness to learn to augment their knowledge and skill set (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Competency 2.2: Foster Self-Management

Empowered patients use their abilities, self-efficacy, health literacy, collaborative relationships, and past experiences to enhance their decision-making to achieve the highest quality of life (Burnett et al., 2019; Vaughn et al., 2022).

Performing the initial assessment for an existing disability or chronic condition and their readiness to learn new information is within the role of the beginner professional rehabilitation nurse. The family unit is also assessed for their readiness to participate in goal setting, which may include 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 nursing role. In addition, beginner nurses educate the patient and family on how to manage the patient's illness or injury, including medications and the safe use of the equipment.

In consultation with expert nurses, the intermediate nurse anticipates and identifies potential and/or actual barriers to self-care management by the patient and family and discusses strategies to facilitate self-management. Collaborating with both the intra/interprofessional team and patient and family about meaningful realistic goals for managing one's care is also an essential function of intermediate nurses, in addition to coordinating the medical/adaptive equipment and community resources. The expert nurses' role is to examine patient and family data, such as culture, developmental level, preferences, best practices supported by evidence, and community resources. In addition, expert nurses will establish a collaborative advocative relationship with the patient and family and individualize the POC to promote optimal

Table 3 Domain 2: Promotion of Health and Successful Living—Proficiency Levels and Revised Competency Role Descriptors

Proficiency Levels		
Beginner Nurse (1–2 Years Rehabilitation Experience)	Intermediate Nurse (3–5 Years Rehabilitation Experience or CRRN)	Expert Nurse (5+ Years Rehabilitation Experience)
Competency 2.1: Promote Health and Prevent Disability		
Assesses for common risks with persons living with disability, chronic illness, and health management (e.g., fall risk; are chronic conditions being managed?)	Assesses for patient risk and patient–family readiness to manage potential harm and engage in health promotion	Assesses individual and community needs for risk reduction, harm prevention, and health promotion relating to disability, chronic illness, and health management
Identifies potential goals for reducing risk, promoting health, and preventing disability following established rehabilitation protocols	Collaborates with the patient and family, and intra/interprofessional team members to set goals for reducing risk; promoting health; preventing disability for individuals with disability and chronic illness; and health management	Consults with individuals, communities, and populations to set goals for reducing risk, promoting health, and preventing disability
Contributes to determination of patient and family readiness to learn and engage in strategies for reducing risk, promoting health, and preventing disability	Evaluates individual's health behaviors/ability to engage in reducing risk, promoting health, preventing disability, and adjusting the plan of care (POC) as needed and 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 and mentors beginner and intermediate nurses regarding risk assessment, goal setting, and readiness to learn
Competency 2.2: Foster Self-Management		
Assesses patients for readiness to learn and current knowledge of their illness or disability using a standardized assessment and/or tool	Consults with expert nurses and describes physical and/or psychosocial barriers to performing self-management (e.g., not wanting to perform self-catheterization)	Examines the patient and family information and resources needed for optimal self-management of disability and/or chronic illness in the community
Participates in the goal setting and development of the POC with the patient and family, and intra/interprofessional team that includes self-care skills	Collaborates with intra/interprofessional team members and patient and 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/interprofessional teams in data collection	Collaborates with the intra/interprofessional teams to develop the POC based on best practice and patient and 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; provides "teach-back" opportunity	Coordinates medical/adaptive equipment/community resources and follow-up care	Advocates for medical/adaptive equipment/community resources and follow-up care that is individualized to patient and family
Participates in the evaluation of the self-management POC	Contributes to the modification of the self-management POC	Evaluates the POC and coordinates with referral sources for successful self-management to the community
Competency 2.3: Promote and Facilitate Safe and Effective Care Transitions		
Assesses the patient and family's cultural values and health literacy as applicable to safe care transitions	In consultation with expert nurses, 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

(continues)

Table 3 Domain 2: Promotion of Health and Successful Living—Proficiency Levels and Revised Competency Role Descriptors, Continued

Proficiency Levels		
Beginner Nurse (1–2 Years Rehabilitation Experience)	Intermediate Nurse (3–5 Years Rehabilitation Experience or CRRN)	Expert Nurse (5+ Years Rehabilitation Experience)
Participates in the development of an interprofessional plan for safe care transitions	Assesses the POC to determine the appropriate setting for transition and 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 intermediate nurses and the intra/interprofessional 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 and consults expert nurses and intra/interprofessional team members as indicated	In collaboration with intermediate nurses and intra/interprofessional team members, facilitates the care transition plan
Participates in the care conference that evaluates the care transition plan	Contributes to the interprofessional evaluation of the patient and family care transition plan, including quality improvement data collection	Collects/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

Note. Adapted and revised text from Burnett et al. (2019). CRRN = certified rehabilitation registered nurse.

self-management strategies to live with chronic illness and/or disability. These strategies may include providing community resources for supplies, respite care, transportation, and support groups (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Competency 2.3: Promote and Facilitate Safe and Effective Care Transitions

Lengths of stay in the acute and rehabilitation settings have shortened; however, the medical acuity of rehabilitation patients has increased. Patients are often discharged home with poorer functional status requiring a higher level of care from family caregivers. Unfamiliar with community resources, families often are unable to navigate them successfully after discharge from care settings to home and community. Assisting the patient and 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 (Burnett et al., 2019; Camicia et al., 2021; Vaughn et al., 2016, 2022).

The role of beginner rehabilitation nurses includes participating in the development of a POC that incorporates patient and family assessment information for cultural considerations and health literacy. Participating in team care conferences and collaborating with other interprofessional team members to establish goals and evidence-based interventions for a safe and successful care transition is also within the beginner nurse's scope.

Intermediate nurses, in collaboration with expert nurses, acknowledge and describe potential and actual impediments or barriers that could impact a safe care transition plan, modify the care plan as needed, coordinate resources for transition to the community, and participate in the evaluation of the plan with the patient and family input throughout the process. Improving care transition processes are within the purview of the rehabilitation nurse and the interprofessional team. Intermediate nurses may participate in the quality improvement activity through data collection and collaboration with the expert nurses that contribute to improved processes regarding safe care transitions in the organization.

Expert nurses synthesize these data related to safe care transitions. Based on the data analysis of the efficacy of the organization's care transition processes, expert nurses also coordinate and facilitate evidence-based strategies for safe and effective transitions across care settings. Positive patient and family experiences with smooth care transitions are the result of good communication among all members of the intra/interprofessional team and with the patient and family (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Domain 3: Leadership

Domain 3 is identified as "Leadership" to empower patient and family self-advocacy. The rehabilitation nurse leader is an effective team member who promotes collaboration among providers across the continuum of care, as well as within each team. Communicating essential information regarding the patient and family needs with the intra/interprofessional team, the rehabilitation nurse leader ensures coordination of care, and

Table 4 Domain 3: Leadership—Proficiency Levels and Revised Competency Role Descriptors

Proficiency Levels		
Beginner Nurse (1–2 Years Rehabilitation Experience)	Intermediate Nurse (3–5 Years Rehabilitation Experience or CRRN)	Expert Nurse (5+ Years Rehabilitation Experience)
Competency 3.1: Promote Accountability for Care		
Delivers safe, ethical, quality care for the patient and family and learns about the influence of social determinants that affect care	Identifies factors, including social conditions, that influence the provision of quality care and the achievement of quality outcomes	Collects/analyzes data from multiple sources that impact the provision of safe and quality care and implements changes as appropriate
Collects unit data that address practice issues affecting quality outcomes	Assists in the analysis of unit data that affect quality patient-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 and strategically promotes inclusion and embraces diversity in the work setting through clinical practice and education and research initiatives
Competency 3.2: Disseminate Rehabilitation Nursing Knowledge		
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 and establishes a sustainable culture for EBP that engages all levels of the inter/intraprofessional team
Competency 3.3: Impact of Health Policy for Persons With Disability and/or Chronic Illness		
Knowledgeable of ADA rights; identifies names and purposes of standard regulatory and accrediting agencies, such as Commission on Accreditation of Rehabilitation Facilities, Joint Commission, Centers for Medicare & Medicaid Services, and MAGNET	Recognizes that social conditions of health impact health status Describes regulations that impact current rehabilitation nursing practice	Identifies and implements strategies to comply with current/new regulatory and accreditation standards.
Demonstrates an awareness of the importance and power of health policy in the provision of care to patients–families living with disability and/or chronic illness	Contributes to a professional organizations or regulatory bodies that influence health and rehabilitation practice	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 disability, chronic illness, and health management issues; uses EBP, rehabilitation expertise, and lived experiences to reduce disability, improve productivity, and impact economies
Competency 3.4: Empower Patients to Self-Advocate		
Respects and values patient and family autonomy in their health-related choices	Promotes informed and autonomous patient- and family-centered and shared decision-making	Collects and interprets information that is necessary to resolve ethical decisions
Provides information to patient and family that they need to make informed decisions about care	Empower the patient and 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 patient and family and other caregivers	Mediates discussions to explore resolutions when there are disagreements between patient and family and other caregivers	Serves as an expert witness testifying to the challenges of resource allocations that affect persons with disability, chronic illness, and health management

Note. Adapted and revised text from Burnett et al. (2019). CRRN = certified rehabilitation registered nurse; EBP = evidence-based practice; ADA = Americans with Disabilities Act.

promotes smooth transition across teams. The nurse leader also makes certain that the medical, functional, and patient- and family-centered goals are communicated clearly, understood, and protected according to the policies and procedures of the organization or agency (Burnett et al., 2019; Vaughn et al., 2022). Domain 3 is composed of four competencies with professional nurses' proficiency levels and revised role descriptors shown in Table 4.

Competency 3.1: Promote Accountability for Care

Promoting accountability for care is exemplified in *the American Nurses Association (ANA) Code of Ethics* (see https://www.nursingworld.org/coe-view-only). This code requires that nurses be accountable for their actions with a commitment to their patients and families. Although it is ultimately the patient and family who have the right to make decisions, it is the responsibility of the rehabilitation nurse and intra/interprofessional team to inform the patient and family of all aspects of the POC, including the potential issues that the team perceives as barriers or impediments to a safe discharge (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Beginner-level rehabilitation nurses provide safe and ethical care to patients and have a basic working knowledge of the social conditions that may affect outcomes, including access to care and public safety. Knowledgeable of current evidence-based best practices to enhance coordination of care and patient outcomes, beginner and intermediate nurses provide competent rehabilitation care, including patient and family education to facilitate transition to the next level of care. Early career nurses begin the process of collecting data. Intermediate-level rehabilitation nurses identify factors that are related to quality of care, for example, staffing issues or patient and family perceptions to the treatment plan. The identification of these factors may actually lead to a quality improvement project for nurses at all levels of proficiency, which would involve collection and analysis of data.

As rehabilitation nurse leaders, expert nurses synthesize and interpret the data that could be used to facilitate a nursing practice or policy change to improve care. Expert nurses must strategically address organizational issues and advocate for policies that promote inclusion and embrace diversity in the work setting through clinical practice, education, and research initiatives (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Competency 3.2: Disseminate Rehabilitation Nursing Knowledge

All rehabilitation nurses at their level of proficiency are expected to identify, create, and disseminate rehabilitation nursing knowledge, as implementation of EBP is imperative. Information may be shared in multiple venues, such as clinical settings, professional nursing conferences, publications, or even in public forums, such as through AARP or the local YMCA. Rehabilitation nurses may provide rehabilitation information to patients and families, nursing students, or beginner rehabilitation nurses as part of their role (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Beginner nurses demonstrate this competency by asking questions related to the patient and family in team conference, by participating or serving on committees, and by attending local and national rehabilitation related webinars/conferences on nursing standards and evidence-based approaches to patient and family care. These nurses should know where to find and how to access evidence-based resources to answer clinical questions. This may include consultation with intermediate and expert rehabilitation nurses. Intermediate nurses use evidence-based literature to innovate and/or improve care. These nurses share these evidence-based strategies with the intra/interprofessional team as well as with other rehabilitation communities as appropriate. They also may serve on local and national committees in professional organizations. Expert nurses are role models for practice and are often leaders of the team who strive to improve rehabilitation nursing practice by evaluating available health information and leading the development of EBP guidelines. Expert nurses may also serve as content experts on national and international panels or committees (Burnett et al., 2019; Vaughn et al., 2016, 2022).

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

Knowledge of health policy and regulations, such as the Americans with Disabilities Act (see https://beta.ada.gov/topics/intro-to-ada/#top), is a key role competency for rehabilitation nurses at all levels of proficiency. ARN has a long-standing health policy committee as well as a lobbyist in Washington, DC, who monitors legislative activities, appraises its membership, and considers the interests and needs of the populations rehabilitation nurses serve. The committee, along with the lobbyist, regularly provides the members with information about current legislation and regulatory processes and how to advocate for issues that impact the rehabilitation population and nursing community (Burnett et al., 2019). Currently, rehabilitation nurses are encouraged to learn more about health policy, advocacy, and how to make their voices heard through ARN's evolving programs. For example, nurses can view ARN's Health Policy Agenda and correspondence and even track legislation related to rehabilitation nursing at https://rehabnurse.org/about/health-policy-advocacy.

Beginner rehabilitation nurses are encouraged to become members of professional organizations such as ARN. These nurses are aware of the tenets of the Americans with Disabilities Act and maintain social awareness of current healthcare issues by accessing ARN's Health Policy and Advocacy webpage (see https://rehabnurse.org/about/health-policy-advocacy) the Health Policy Tool Kit (see https://rehabnurse.org/about/advocacy/advocacy-toolkit) and reviewing ARN's Health Policy Digest (see https://rehabnurse.org/health-policy-advocacy/categories/health-policy-advocacy). Beginner and intermediate rehabilitation nurses recognize the major accrediting bodies and promote high-quality care for patients by endorsing political activism. Intermediate nurses may actively influence health policy through participation in ARN or other professional organizations and serve as a resource to policy makers. Intermediate and expert rehabilitation nurses acknowledge that persons with disability are globally marginalized and understand the importance of political engagement to resolve health inequities, such as access to services that impact persons with disability. The importance of using the best evidence when providing rehabilitation care must be communicated to colleagues and policy makers by all rehabilitation nurses at their level of proficiency (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Competency 3.4: Empower Patients to Self-Advocate

Protecting and advocating for patients' autonomy, acting on their behalf, and empowering them through education, collaboration, and support are this competency's focus. Rehabilitation nurses can empower the patient and family through communication and education and direct them to resources that will help them make informed decisions while in the rehabilitation setting and in the community (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Beginner rehabilitation nurses advocate for patients and assist them in expressing their needs, desires, and goals. These nurses respect and support patient autonomy and provide information for informed decision-making but are also aware of potential conflicts that may arise. Intermediate-level nurses empower patients, foster shared decision-making, and employ conflict resolution strategies as needed to mediate potential or actual issues of disagreement.

Expert rehabilitation nurses collect, analyze, and interpret information necessary to resolve issues and promote patient independency and self-advocacy, providing resources as needed. They may also serve as expert witnesses for government, technical, and/or advisory panels. These activities promote active citizenship and can empower patients to engage in and influence health policy. In addition, to advocate for patients with disability, expert nurses provide leadership on the ARN Health Policy Committee (Vaughn et al., 2016, 2022).

Domain 4: Intra/Interprofessional Team

Domain 4 focuses on the "Intra/Interprofessional Team," as patient and family needs in rehabilitation are often complex. Their needs often require a team of professionals from several disciplines that collaborate to assist patients and families reach their individual goals. Rehabilitation nurses, through sharing essential communication with the team, ensure coordination of care; promote a smooth transition of care across teams; and make certain that medical, nursing, functional, and patient- and family-centered goals are communicated, understood, and protected according to policies and procedures of the organization (Burnett et al., 2019; Vaughn et al., 2022). Three competencies comprise Domain 4 with professional nurses' proficiency levels and revised role descriptors included in Table 5.

Competency 4.1: Develop Intra/Interprofessional Relationships

Rehabilitation nurses networking with a group of peers can foster intra/interprofessional relationships. Collaboration within the intra/interprofessional team is often prompted by team members' discussion of patient assessment findings. An effective intra/inter professional team must employ active listening and respectful discussion regarding patient care and treatment. Developing an effective intra/interprofessional team that is collaborative and respectful of all member's contributions improves patient safety, care planning, and outcomes. Communication and feedback can occur formally during team meetings or huddles, or it may occur 1:1 with individual team members (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Nurses new to the rehabilitation setting may recognize their role as well as the role of each of the other interprofessional team members. They are also aware that it takes time to acclimate to the team and for a team to accept and respect the information and recommendations they offer as a new team member. Beginner rehabilitation nurses will need to establish themselves by sharing accurate patient information and recommending evidence-based interventions as appropriate. Intermediate nurses facilitate the various team member contributions and evaluate the implementation of the POC to ensure a successful patient and family outcome. This involves understanding the unique role of each team member and their contributions toward the plan, the interventions, and the goals. As a rehabilitation nursing leader, expert nurses educate and promote effective intra/interprofessional communication. Optimizing communication assists the expert nurses in the identification and enhancement of creative evidence-based interventions that foster positive

Table 5 Domain 4: Intra/Interprofessional Team—Proficiency Levels and Revised Competency Role Descriptors

Proficiency Levels		
Beginner Nurse (1–2 Years Rehabilitation Experience)	Intermediate Nurse (3–5 Years Rehabilitation Experience or CRRN)	Expert Nurse (5+ Years Rehabilitation Experience)
Competency 4.1: Develop Intra/Interprofessional Relationships		
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 (POC)	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 POC	Coordinates/evaluates the intra/interprofessional teams to create and implement strategies for system outcomes
Competency 4.2: Implement an Intra/Interprofessional Holistic POC		
Identifies patient and family 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 patient and family centered goals	Collaborates with the intra/interprofessional teams in establishing patient- and family-centered goals	Anticipates long-term care needs for individuals, families, and communities
Implements interventions established in the intra/interprofessional POC	Implements and evaluates the intra/interprofessional POC using evidence-based best practice	Mobilizes the intra/interprofessional teams using research evidence to achieve the POC
Evaluates effectiveness of nursing interventions in the intra/interprofessional POC	Evaluates effectiveness of the intra/interprofessional POC	Synthesizes the aggregate data with the intra/interprofessional team to recommend quality improvement or research initiatives
Competency 4.3: Foster Effective Intra/Interprofessional Collaboration		
Represents the discipline of nursing while participating on the intra/interprofessional teams	Collaborates with the patient and family, along with the intra/interprofessional team members, regarding goals and priorities of the POC	Models and coaches the collaborative process while engaging with the intra/interprofessional teams to advance rehabilitation
Communicates pertinent information regarding the patient and family to the intra/interprofessional teams	Collaborates with the intra/interprofessional teams to develop and implement an appropriate POC based on evidence	Designs and evaluates the evidence-based POC 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

Note. Adapted and revised text from Burnett et al. (2019). CRRN = certified rehabilitation registered nurse.

health outcomes. Communication is essential to coordinate innovative evidence-based strategies to solve complex problems and maximize patient independence and quality of life (Burnett et al., 2019; Vaughn et al., 2022).

Competency 4.2: Implement an Intra/Interprofessional Holistic POC

Rehabilitation nurses develop holistic care plans for diverse patients, which prescribe culturally sensitive strategies, alternatives, and interventions to attain desired outcomes. The POC is patient- and family-centered starting with an assessment of health status, health literacy, and learning needs and resources. The plan is individualized and developed with the patient and family and team and reflects the complexity of care across the continuum, promoting independence in function, informed decision-making, and self-agency. Mutually agreed-upon goals, including target dates for achievement, are developed in collaboration with the patient and family (Burnett et al., 2019; Vaughn et al., 2022).

The initial and ongoing patient assessments performed by the beginner rehabilitation nurse provide integral information to the team about patient issues, which are used to develop the intra/interprofessional POC. Being knowledgeable of the plan and coordinating care, interventions are implemented, and the efficacy of the POC is evaluated. Intermediate nurses contribute to rehabilitation nursing practice through the use of EBP strategies and evaluate

the efficacy of the interventions in achieving the patient rehabilitation goals. Furthermore, intermediate nurses are more fully engaged in the evaluation of the overall POC. Expert nurses build on the competencies of intermediate nurses but also strategize with the team when there are changes in the POC related to various factors such as the availability of resources. Expert nurses anticipate the patient and family's long-term care needs and consult with the team to facilitate goal achievement for the altered plan. It is important that patients' values and beliefs are acknowledged and addressed with the team and incorporated into the strategies for the long-term plan. Expert nurses are also poised to synthesize aggregate data to recommend quality improvement opportunities (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Competency 4.3: Foster Effective Intra/Interprofessional Collaboration

To provide optimum quality of care, rehabilitation nurses work with the patient and family and intra/interprofessional team members. Patient and family assessment data are shared with the team and integrated into the POC. Burnett et al. (2019) and Vaughn et al. (2022) noted that the entire team must work together for the best patient and family outcomes while respecting individual contributions and acknowledging different views. Nurses promote collaboration by sharing information that may precipitate modifications in the care plan.

Although beginner rehabilitation nurses are new to the role, they provide valuable basic nursing information to the team and recognize the diversity of roles and each members' contribution to the team and the plan. Intermediate nurses engage in more active collaboration with the entire team regarding goals and priorities of the POC and the use of their knowledge of EBP for the plan. The expert nurse acts as a role model, a coach, and a consultant while engaging the team in the collaborative process to improve rehabilitation through the evaluation of the POC and quality improvement activities. Team diversity is recognized, valued, and used to foster creative collaboration in finding appropriate solutions to identified challenges to the POC. Both intermediate and expert nurses actively engage in mentoring beginner nurses to foster the development of intra/interprofessional collaboration and a holistic POC (Burnett et al., 2019; Vaughn et al., 2016, 2022).

Conclusion

Although this discussion has focused on rehabilitation nursing practiced in clinical settings, rehabilitation nurses in academic and researcher/nurse scientist roles may also apply this Competency Model to their respective settings.

Key Practice Points

- The Association of Rehabilitation Nurses (ARN) updated Competency Model for Professional Rehabilitation Nursing provides a framework for nurses practicing at different levels of proficiency (beginner, intermediate, or expert) in different settings along the healthcare continuum, from emergency room, acute care, in-patient rehabilitation to home health and community-based care.
- The model's four domains and associated competencies provide role descriptors specific to nurses' level of proficiency that are a way of viewing professional rehabilitation nursing practice from the inside looking outward toward an evidence-based practice.
- Rehabilitation nurses, as well as other members of the team, may employ this Competency Model in orientation, evaluation, education, and research processes.
- Countries and/or organizations without structured rehabilitation programs can adopt and/or adapt the ARN Competency Model for application into local context.

This model's domains and competencies are congruent with the revised accreditation standards (American Association of Colleges of Nursing, 2021), which are integrated throughout nursing curricula. Competencies are mapped and inform the content of various courses, such as Competency 1.2, implement the best available evidence, which is introduced early in nursing programs and integrated throughout as students develop their skills and knowledge and, ultimately, their professional practice. Graduate students grounded in EBP knowledge embark on faculty-mentored quality improvement or small research studies designed to improve care and/or processes. As a nurse researcher/scientist, the model may be used as a framework to investigate the effectiveness of a nursing intervention, such as an evidence-based sleep hygiene program. It also may be used to explore nurse role behaviors in various settings in which rehabilitation is practiced, or to create an innovative application to assist the patient and family in managing their chronic health condition in the home setting. Nursing research contributes to the growing body of evidence used by rehabilitation nurses globally to improve patient and family outcomes. ARN promotes research and quality improvement projects that can impact rehabilitation nursing practice in all settings as "best practice becomes better practice" (Miller & Pierce, 2019; Reigel & Vaughn, 2019).

In summary, equipped with ARN materials, such as *Standards and Scope of Rehabilitation Nursing Practice* (ARN, 2014), Benner's (2001) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, and Bloom's Taxonomy (Armstrong, 2010), the original TF of rehabilitation nurse leaders created an innovative Competency Model for Professional Rehabilitation Nursing Practice.

Seven years later, in 2020, the Competency Model TF reviewed and revised the model, adding a new competency (1.4) and clarified and added language throughout to reflect current practice and social values. An initial article published in 2022 by the 2020 ARN TF focused on the clinical application of the model depicted in case stories and exemplars of how the model is integrated into healthcare organizations (Vaughn et al., 2022). As a companion to the earlier publication, this article provides a comprehensive overview of the model revisions, including the role descriptions for each competency from inside the model looking outward toward an EBP.

The goal of the 2020 ARN TF of rehabilitation nurse leaders was to ensure that the model could be sustained and embraced by the global community to advance rehabilitation nursing practice. The ARN Competency Model for Professional Rehabilitation Nursing will continue to evolve with EBP well into the 21st century.

Conflict of Interest

The authors declare no conflict of interest.

Funding

The authors declare that there is no funding associated with this article.

Acknowledgment

The authors thank the 2014 Task Force of the original Competency Model for Professional Rehabilitation Nursing Practice for their work.

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