The Rehabilitation Nurse in the Skilled Nursing Setting
Role Description

Definition of skilled nursing
Skilled nursing is a Medicare covered service and is health care that is provided when skilled nursing or rehabilitative services are needed to manage, observe and evaluate the care an individual receives. Medicare skilled services are provided for a short period of time (e.g. 100 days or less).

Skilled nursing facilities are licensed by each State’s Department of Health and Human Services and are certified by CMS for the provision of Medicare services.

The skilled nursing setting provides intense skilled nursing care aimed at helping an individual regain or maintain their independence and level of functioning, to the extent possible, or to provide comfort and support for the end of life. Skilled nursing is not custodial care.

Nursing in the skilled setting tends to serve older/elderly individuals who
• Have experienced a decline in condition
• Need assistance with activities of daily living
• Are sick with multiple co-morbidities
• May or may not have a disability
• May be recovering from surgery and are in need of rehabilitative services in a skilled nursing facility/unit
• May or may not have support systems to assist them with their recovery care needs

The focus of care in the skilled nursing setting is to provide skilled nursing services (e.g. wound care, tube feedings, IV therapy, respiratory care, dialysis, anticoagulant therapy, insulin administration) and rehabilitative services.

Admission to a skilled nursing setting requires medical necessity and often follows hospitalization or is related to a decline in functioning. The individual may be
• Recovering from surgery (e.g. hip replacement, fracture, amputation, tracheostomy placement, colostomy placement)
• Experiencing an exacerbation of an illness/chronic condition (e.g. COPD, CHF, kidney failure, pneumonia, thrombosis, CVA, UTI), a progressive disease (e.g. Parkinson’s, Alzheimer’s, Huntington’s), a terminal illness (e.g. cancer)
• Unable to care for him/herself.

Admission to a skilled nursing setting may be for a short stay admission (e.g. less than 100 days) for skilled services or for a long-term care admission for custodial care. The provision of skilled nursing services is for a short period of time and usually follows a qualifying hospital stay.

Culture and Education
The need for skilled nursing and rehabilitative services has no cultural or educational boundaries. As noted in the Standards and Scope of Rehabilitation Nursing Practice, rehabilitation nursing care must be individualized to meet each person’s individual needs and situation. Consideration must be given to the cultural diversity/differences, values, beliefs and goals of each individual served or his/her guardian/Power of Attorney. The client and his/her family/guardian/Power of Attorney goals and wishes are central to the care planning process and to the goals and provision of care.
Goal
The goal of care and services provided by the Rehabilitation Nurse in the skilled nursing setting is to promote health and wellness and to assist the individual in regaining or maintaining his/her optimal level of functioning in accordance with the goals of the individual.

Although not always possible, the goal for the individual is to return home to a prior level of functioning. Promoting health and wellness, and independence may not be possible or may not be the goal of the individual or his/her family. In these cases, the rehabilitation nurse in the skilled nursing setting must transition the focus of nursing care to custodial care or to providing comfort and support for the end of life.

Settings
The skilled nursing setting is often found within the nursing home (long-term care) setting. This may be a free-standing nursing home with designated skilled nursing beds throughout the facility, a distinct part of a nursing home, a skilled part of an acute care hospital, or a distinct part of a care continuum environment that includes services from independent living through long-term care.

The skilled nursing setting may be part of a chain of facilities, may be for profit or not-for profit, may be privately owned or a governmental entity.

Standards
The practice of nursing in the skilled setting requires specialized knowledge, skills, abilities and independent decision making aimed at meeting the special and unique needs of each individual served. The American Nurses Association identifies the nursing process as including assessment, diagnosis, outcomes/planning, implementation, and evaluation. When putting the nursing process into action and further defining each step of the process, the standards of care for the practice of nursing for the rehabilitation nurse in the skilled nursing setting become evident. The rehabilitation nurse is a registered nurse who leads the team and coordinates the care of the individual receiving care in the skilled nursing setting.

Role of the Rehabilitation Nurse in the Skilled Nursing Setting
The majority population of a skilled nursing facility/unit (SNF) or long-term care (LTC) facility continues to be the elderly. However, there is an increase in clients requiring short-term rehabilitation in a SNF. The rehabilitation registered nurse has many important roles in both settings. They might be employed by the SNF or LTC organization, work for a physician or physician group, or an insurance company. Following are the roles of the rehabilitation nurse in a long-term care or skilled nursing facility/unit.

Practitioner
- Assists with assessment, management, goal-setting, and evaluation of clients’ acute and chronic care illnesses
- Monitors client change of condition/treatment to decrease rehospitalization
- Utilizes critical thinking skills in the care of the clients
- Serves as a liaison with the physician, SNF/LTC facilities, and third-party payers
- May oversee clients in multiple facilities within an organization, physician contract, or with insurance management of clients
- May serve in a management role in a SNF/LTC organization (Director of Nursing, Regional Clinical Nurse, Director of Clinical Support, Chief Nursing Officer)
- Provides education to clients, families, and staff
- Promotes quality of life for clients and families
- Promotes evidence-based practice
Care Coordinator/Manager
- Is a member of the interdisciplinary team
- Promotes quality of life for clients and families
- Utilizes leadership skills to effectively guide and develop the staff
- Is knowledgeable of state and federal regulations, managed care, and reimbursement
- Is knowledgeable of quality assurance and quality measures/quality improvement
- Practices client-centered care
- Utilizes critical thinking skills in the leadership role
- Monitors client change of condition/treatment to decrease rehospitalization

Advocate
- Is an advocate for clients and families
- Supports the rights of the client with care decisions
- Supports the rights of the client with end-of-life decisions

Educator
- Provides education to clients and families
- Provides education for staff (orientation, acute and chronic illnesses, incontinence/UTI management, pressure ulcer prevention/management, infection control, restraint-free, anti-psychotropic medication/management, pain management)
- Provides staff education on an on-going basis
- Is a mentor to staff, students, and the interdisciplinary team
- Maintains on-going self-education to advance knowledge of rehabilitation knowledge

Direct Care Provider
- Manages care of clients with acute and chronic care needs
- Serves as staff nurse/ supervisor/charge nurse/unit manager for staff on a designated unit/hallway or for a determined number of clients
- Is a mentor to staff, students, and the interdisciplinary team
- Provides education to staff related to care of the clients/safety
- Maintains infection control and safety measures within the environment
- Is knowledgeable of acute and chronic illnesses of the elderly
- Utilizes critical thinking skills and leadership skills with the scope of the role

Functions
The skilled nursing facility rehabilitation nurse utilizes the principles of rehabilitation nursing as defined by the Association of Rehabilitation Nurses in their Standards and Scope of Rehabilitation Nursing Practice. The functions of this specialized practitioner have been classified into categories and are summarized below.

Assessment
- Focusing on the health care needs of the client, collects and analyzes data employing a systematic and ongoing approach, and includes the resident, family/significant other and members of the interdisciplinary team in the data collection as indicated.
- Utilizes a variety of evidence-based assessment tools/techniques to ascertain relevant data related to the client’s health status including but not limited to mobility, self-care, elimination, comfort, safety, nutrition, skin integrity, coping skills, knowledge of health status, cognition/communication, and psychosocial status.
- Assesses the client’s functional health status and skilled needs, diagnoses, prognosis and plan of care.
- Identifies the client’s learning needs and rehabilitation potential related to his/her functional impairment, medical diagnoses and psychosocial adjustment.
- Documents assessment data that can be retrieved for the formulation of nursing diagnoses and a plan of care specific to the client’s health care needs.
Data analysis and formulation of nursing diagnoses

- Identifies current and potential health issues in the form of nursing diagnoses based on an analysis of the assessment data and validates these with the client, family/significant other and the health care team.
- Identifies potential challenges/complications/difficulties in the client’s physical and/or psychosocial functioning that may impact his/her being successfully discharged home or to an alternate level of care.
- Identifies the learning needs of the client and the client’s family/significant other for a successful discharge to home or to an alternate level of care.
- Documents individualized nursing diagnoses specific to the client’s health care needs.

Establishment of goals and plan of care

- Creates realistic, measurable goals in collaboration with the client, the family/significant other and the health care team in order to prevent further disability and achieve optimal outcomes that include health and wellness across the lifespan.
- Establishes a plan of care based on the identified health care needs, goals and outcomes, communicating the plan of care with the client, the family and the health care team.
- Creates an individualized plan of care, defining goals that considers the client’s values/beliefs, ethical considerations, environment and situation.
- Develops goals with realistic target dates that are attainable in relation to the resources available to the client.
- Revises goals based on an evaluation of the changes in the client’s health status.
- Documents client-specific goals and plan of care that address the client’s health care needs.

Implementation

- Utilizing rehabilitation standards of care, implements evidence-based interventions/treatments that are aligned with the client’s plan of care taking into consideration age-specific needs and established goals.
- Provides interventions that promote client independence including appropriate community/systems resources.
- Provides interventions that address the educational needs of the client and their family/significant other related to adjustment to chronic illness/disability, self-care and functional skills, health promotion and maintenance, safety, communication, and cognition.
- Collaborates with the client, the family/significant other and the health care team to facilitate timely discharge planning to home or an alternate level of care.
- Assists in the coordination of the discharge plan with the client, the family/significant other and the health care team.
- Documents interventions delivered to the client including their effectiveness, and any changes or omissions to the plan of care, with ongoing revisions as indicated in order to prevent rehospitalization and to promote wellness.
- Evaluates the client’s response to the care provided and the planned interventions.
- Provides support and care related to decisions for comfort care or Hospice.
- Assists with transitions of care to other settings within or outside the community.

Collaboration

- Provides ongoing, effective communication with the client, family/significant other and the health care team regarding the client’s current plan of care.
- Collects and communicates data to assure an integrated interdisciplinary treatment plan of care for the client.
- Collaborates with the client, family/significant other and the health care team in the creation of client-centered goals and plan of care.
- Collaborates with the health care team to assure the provision of optimal client care by participating in interdisciplinary team meetings, and incorporates the team’s recommendations into the client’s plan of care.
• Documents collaborative discussions, communications, plans and rationale for care plan changes.

Reference

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