

Utilizing the ARN Competency Model for Professional Rehabilitation Nursing in Long Term Care



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Objectives

- List the four domains of the ARN Competency Model for rehabilitation nursing
- Define the competencies for each domain
- Discuss the utilization of the model to practice in a LTC setting
- Describe the three levels of nurse proficiency



Why a Competency Model?

- ❑ Rehabilitation nursing principles are practiced in **multiple settings** along healthcare continuum
 - ❑ Thus, a framework or model for professional rehabilitation nursing should encompass domains that reflect **ALL** competencies needed to promote rehabilitation nursing in current healthcare environment
- ❑ ARN task force comprised of experts representing clinical and academic settings worked to develop an evidence-based framework to:
 - ❑ Guide professional rehabilitation nursing practice in various settings.

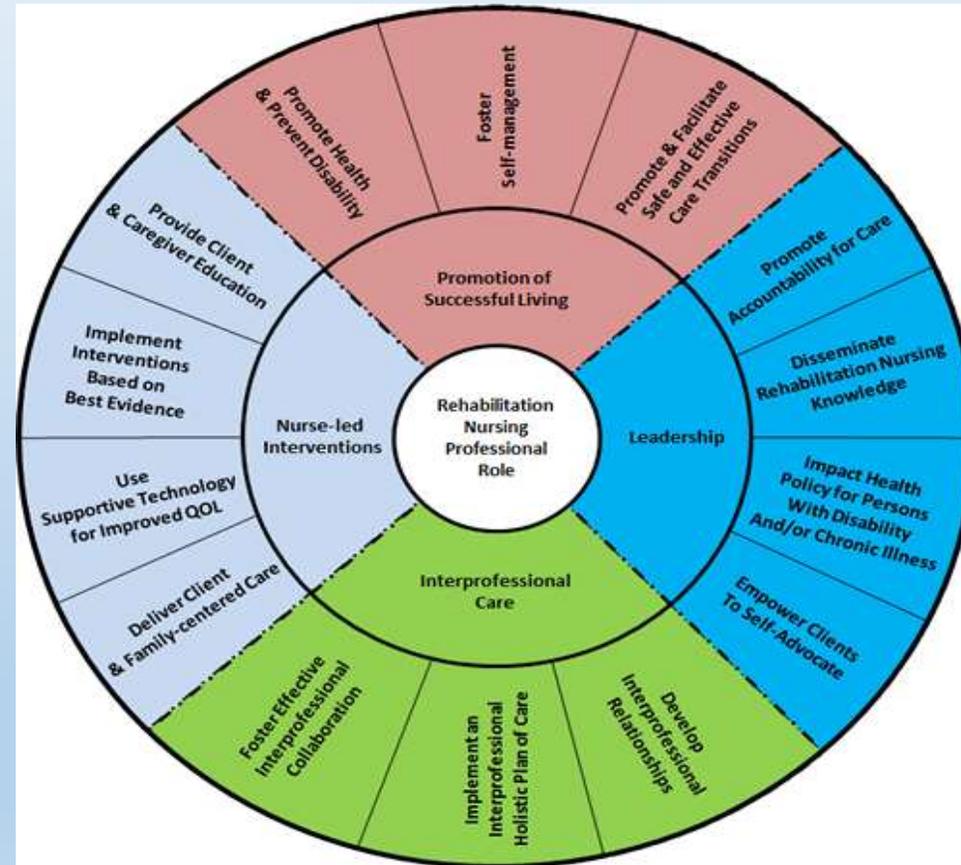


Results

- ❑ Four domains were created that highlighted essential role competencies:
 - ❑ Nurse-led evidence-based interventions to promote function & health management in persons with disability &/or chronic illness
 - ❑ Promotion of health & successful living in persons with disability &/or chronic illness
 - ❑ Leadership
 - ❑ Interprofessional care

- ❑ competencies were further defined into three levels of nurse proficiency:
 - ❑ beginner (1-2 years)
 - ❑ intermediate (3-5 years-CRRN);
 - ❑ advanced (5 years and above in varied roles, including educator, APRN, etc.).

ARN Competency Model for Professional Rehabilitation Nursing





Competencies

- ❑ For each competency there is a description/scope
- ❑ Domain 1- Nurse led interventions
 1. Use support technology for improving quality of life
 2. Implement nursing & interprofessional interventions based on best evidence to manage the client's disability and/or chronic illness
 3. Provide client/caregiver education
 4. Deliver client & family-centered care



Competencies (cont.)

- ❑ Domain 2 – Promotion of successful living
 1. Promote Health & Prevent Disability Across the Life-span
 2. Foster Self-Management
 3. Promote and Facilitate Safe and Effective Care Transitions



Competencies (cont.)

Domain 3 - Leadership

1. Promote Accountability for Care
2. Disseminate Rehabilitation Nursing Knowledge
3. Impact Health Policy for Persons with Disability and/or Chronic Illness
4. Empower Client Self-Advocacy



Competencies (cont.)

□ Domain 4 – Interprofessional Care

1. Develop Interprofessional Relationships
2. Implement an Interprofessional Holistic Plan of Care
3. Foster Effective Interprofessional Collaboration



Competencies (cont.)

- ❑ Model application in education and practice
 - ❑ Promotes **awareness of the specialty practice** of rehabilitation among nurse colleagues in healthcare organizations in various settings, including **LTC**
 - ❑ Assists rehabilitation nurses to delineate their **role** on the **interprofessional team** while fostering collaboration, communication, and consultation with other healthcare disciplines
 - ❑ Can be **integrated** into education curricula or used to develop a “stand alone” rehabilitation nursing course in an academic setting
 - ❑ Provides a “**road map**” for **clinical and educational practice** and can be integrated into or used as a framework for clinical ladder programs (based on proficiency levels) in organizations

- ❑ Various teaching scenarios are available of the ARN Website – rehabnurse.org

Competency 1.1

Use Supportive Technology for Improving Quality of Life for Persons with Disability



Description/Scope: Use of appropriate technology that improves self-management in Persons with Disability and/or Chronic Illness

**Beginner Proficiency Level
Descriptors**



Participates in the process of determining the need for assistive or supportive technology

Uses basic technology interventions in the plan of care

Demonstrates competent use of technology in the care of a client

Documents the outcome of the technology intervention



Behavioral Scenario

A nurse enters a resident's room to administer medications and quickly notices that the patient is in distress. Due to tremor, the patient requires an assistive high technology spoon to eat.

She is having difficulty placing the spoon securely in her hand. The nurse watches the resident repeatedly pick up the spoon, try to place it in her hand and then drop it to the tray. The resident is clearly frustrated.





Proficient

The nurse continues to watch out of the corner of her eye as she prepares medications. She approaches the resident and follows the rights of medication administration. Then, she administers the medications. The nurse walks back to her cart and quickly documents the medication pass. She pauses for a moment and states, “You are really having trouble with that spoon. May I help?” The resident looks up with tears in her eyes and says, “Yes, please. The therapist showed me how but I can’t make it work.” The nurse states, “Ok, I am not really familiar with this particular supportive technology so I’d like **you** to tell **me** what you know about it.” The resident states that the therapist also left some information about how the spoon stabilizes tremor and a link to a short video for her.



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Proficient

The nurse pulls a chair near the resident so she can sit at her level and says, “Let’s look at the information, pull up the video and see if we can figure this out.” Once they have discovered how to use the assistive technology, they briefly discuss the resident’s care plan and all other needs the resident has for that shift. At the end of the conversation, the nurse states she will check in regularly and leaves to document the outcome of the nurse led intervention using assistive technology.



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Proficient Observations & Outcomes



1. The nurse is exhibiting the use of technology in the plan of care, is demonstrating competent use of technology in the care of a resident and is documenting the outcomes of using a supportive technology nurse-led intervention.
2. Positive outcomes include meeting the patient's dietary needs and assistance in the use of supportive technology. The resident is also recognized as a unique and caring individual, is able to participate in the care plan and may feel empowered. The nurse is more aware of how to best care for the resident.
3. In order to increase proficiency levels, the nurse should continue to assess and anticipate the resident's needs for supportive technology, establish goals with the interprofessional team for the use of technology in the plan of care, tailor the technology to the needs of the resident, and continue to evaluate the effectiveness of the supportive technology.





What did you observe?

Proficient Nurse

- Looked beyond the obvious in order to meet the needs of the resident
- Embraced technology
- Communicated uses and benefits to the resident



Takeaways

1. **The new nurse should embrace technology for the benefit of the resident.** This will impact the resident by meeting her needs. It will also impact the team as important information is shared with other nurses and team members so that optimal care is provided.
2. **The resident may require additional assistance in using supportive technology.** Supporting her may result in a more positive healing experience and increased likelihood that the resident will continue to use the supportive technology while at the facility.
3. **Transition of care may be better facilitated** when everyone on the care team is aware of resident needs and preferences.



Competency 1.4: Deliver Client and Family-Centered Care

Description/Scope: Demonstrates a collaborative approach to planning, delivering, and evaluating care that acknowledges and honors the client and family culture, values, beliefs and care decision making

**Beginner
Proficiency Level
Descriptors**



Participates in a holistic assessment of the client and family that includes culture, values, beliefs and health literacy

Supports the development of goal setting that reflects the client's and family choices including leisure activities

Participates in the implementation of the plan of care with the interdisciplinary team

Participates in the care conference that evaluates the client/family-centered plan of care



Behavioral Scenario

- ❑ Mrs. Parson is a 64 year old widow who lives alone in a two story home in the city. She has 6 children and 14 grandchildren. Mrs. Parson is a retired elementary school aide and currently enjoys cooking food for family and friends. She has a medical history of hypertension (HTN) and breast cancer.
- ❑ She is admitted to the SNF following a period of uncontrolled HTN resulting in a stroke with left sided weakness. Report from the acute care unit in the hospital indicates that she is not eating well and has lost 20 pounds.





Behavioral Scenario

- ❑ The nurse giving report states that family members are always present and can be bossy. The resident is reported to be withdrawn and quiet as evidenced by her not making eye contact and not wanting to get out of bed.

- ❑ The RN arrives in Mrs. Parson's room to complete the initial assessment.





Proficient

The nurse comes into the room to complete the initial assessment. Based on the report from acute care, the nurse is aware that the family is very involved and interested in the resident's care. He asks Mrs. Parson if she would like her family to stay in the room during the assessment. Mrs. Parsons is visibly relieved that the nurse will allow them to stay. The nurse learns that the resident was living independently prior to coming to the facility, and has several children in the area. The nurse assesses the family involvement, asking questions related to their proximity and ability to assist their mother if she needed help when and if discharged home. The family and resident all indicate a strong family support system and would really like to see Mrs. Parsons return home as she gets stronger. The nurse learns that the resident is deeply religious and that her faith and church members are very important to her. The nurse notes that he will need to find a chaplain or service for Sunday morning.





Proficient

The nurse asks Mrs. Parson about medications and learns that she was on a beta blocker and a diuretic. She also has a primary care physician (PCP). The nurse asks if she took her meds everyday, recalling that the report indicated Mrs. Parson was admitted with uncontrolled HTN. He learns that the resident only took the beta blocker when she had a headache and she had not seen her PCP for over a year because she really did not trust her. When she tells the nurse that she did not like the hospital food, the nurse further explores with Mrs. Parson and her family what kind of food she does like and discusses the possibility of them bringing in some food items from home. The nurse notices a small bottle of black liquid in a baby food jar next to the bed. He asks Mrs. Parson what it is, and she tells him it is a home remedy that she finds helpful. The family confirms this and describes it as a strong tea.





Proficient

The family is pleased to hear that they can bring in food from home; they share with the nurse that their mother has never been in a SNF before and is very frightened. The nurse explores with Mrs. Parson and her family what would help her be less afraid. They feel that having her daughter stay over the first night in the new facility will be helpful. Mrs. Parson is determined to overcome her mobility, self care, urgency incontinence, and nutritional/weight loss concerns as well as her knowledge deficits re: her health maintenance. Her goal is to return to her if possible.



Proficient

The nurse gives Mrs. Parson an informational booklet. Concerned with her overall level of health literacy, the nurse also brings in a DVD player and shows her and her family a video about the facility's restorative nursing program and reinforces the information in the booklet.

The nurse shares with the interprofessional team the importance of the resident's family, faith and church visitors. He shares that the resident will be less withdrawn with her family around her and encourages liberal visitation. The nurse contacts the chaplain and also asks the dietician to see Mrs. Parsons. The nurse shares with the OT the patient's goal of returning home and even to doing some cooking in the kitchen. Building of trust between the health care team and the resident will be important for ongoing education and care.



Proficient Observations & Outcomes

1. The proficient nurse completes an initial assessment that is holistic and includes consideration of the resident's culture, values, beliefs and health literacy. Drawing upon cultural competence and sensitivity, the nurse explores Mrs. Parson's health practices related to the taking of medication, her trust in the health care system, and the use of home remedies to address health needs. The nurse considers the resident's prior dietary practices to address the current hospitalization weight loss. The nurse further demonstrates respect for the high value Mrs. Parson places on her faith and church and seeks to communicate this to the team.
2. Rather than viewing the family as "bossy", as the nurse is told in report, he further assesses their level of support and moves to integrate them into the plan of the care. The nurse recognizes the significant family support system in place and the resident's central role as the grandmother.
3. Because the nurse is proficient, he is able to implement a plan of care for Mrs. Parson in a way that is personalized and respectful of her unique situation. The experience for the resident and family will be heightened and satisfaction will be higher. By individualizing the plan of care there is a greater likelihood of the attainment of meaningful goals for the resident.



Proficient Observations & Outcomes



4. The nurse can increase his proficiency in delivering resident and family-centered care by further developing knowledge and application of cultural competency and assessment skills. The nurse can increase opportunities to identify strengths in the resident and family and increase collaboration and partnership with the team to identify and meet her goals. The nurse can increase his advocacy of resident and family decision making, and further develop skills as a resource to others in the development and implementation of a plan of care which is resident and family centered. As the nurse further advances, he will increase his evaluation of goal attainment skills as evidenced by his ability to assess and modify goals and provide overall leadership through the process.

Proficient Nurse



- Drew upon cultural competence to look beyond basic assessment
- Integrated the resident's culture, values, beliefs, and health literacy into the Plan of Care
- Involved the family in the assessment and goal development



Takeaways

It is critical that the new nurse understand the significance of delivering resident and family-centered care.

- ❑ **Personalized care will positively impact** the resident and family.
- ❑ **Resident outcomes will be more meaningful** and the likelihood of attaining goals will be greater.
- ❑ **Transitions of care will be facilitated with greater ease** for the resident, family and health care team when we more fully know our patient.
- ❑ **The power to make a difference** in our nursing care is greatly expanded when it is resident and family-focused.

Competency 2.2: Disseminate Rehabilitation Nursing Knowledge



Description/Scope: The rehabilitation nurse disseminates rehabilitation nursing knowledge in diverse settings such as unit, agency, government, and academia. Dissemination activities include presentations, publications, government advocacy, student instruction, professional organization engagement, etc.

**Beginner
Proficiency
Level
Descriptors**



Uses resources to
answer clinical
questions

Participates in unit
activities that promote
rehabilitation nursing
practice



Behavioral Scenario

- ❑ An RN with a BSN and 2 years of experience on an acute neuro floor has recently been hired to work in a large free-standing Long Term Care facility. After finishing orientation and completing 3 months of work on her assigned unit, she is asked to allow a student nurse to shadow her for a few hours.

- ❑ The nurse agrees because the student must complete this clinical observation with a bachelor's prepared nurse, and she is one of the few who meets this qualification during the required hours for the student experience. During the student observation period, they care for a resident with left hemiplegia. The student asks why the chart shows that the resident is at high risk for falls.





Path 2 - Proficient

The nurse says, “We use the Hendrich II Fall Risk Assessment Tool to quantify resident risk, and this resident had a high risk score. I will get you a copy of the tool so you can look at it. Also, residents with left hemiplegia (right brain damage) typically have a more impulsive behavior style with poorer judgment, making them more prone to falls. There is an interesting team meeting today where the speech therapist will talk more about this, and I will also share a new strategy for fall prevention with the nurses. Also, before you leave today, let’s look at the resources on the ARN website where you can get further information on fall risk in stroke survivors.” In addition, the nurse shares with the student that she presented at the ARN national conference a poster on fall prevention for stroke survivors and would be happy to share the handout on that topic with her.



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Proficient Observations & Outcomes

1. The proficient nurse shared specific knowledge about right brain injury with the student. She also provided information on a useful tool and a poster presentation about reducing fall risk.
2. Rather than just answering the student's question generally, the proficient nurse demonstrated leadership in a specific area by mentoring the student nurse, providing resources for the student, promoting interprofessional problem solving at the unit meeting, and presenting a poster at a national ARN conference.

Proficient Nurse



- Took time to share specific information, resources, and tools with a nursing student
- Disseminated rehabilitation nursing knowledge on a one-to-one, unit, and national level
- Used various strategies for disseminating knowledge including mentoring, sharing innovations with the interprofessional team, and presenting at a national conference



Takeaways

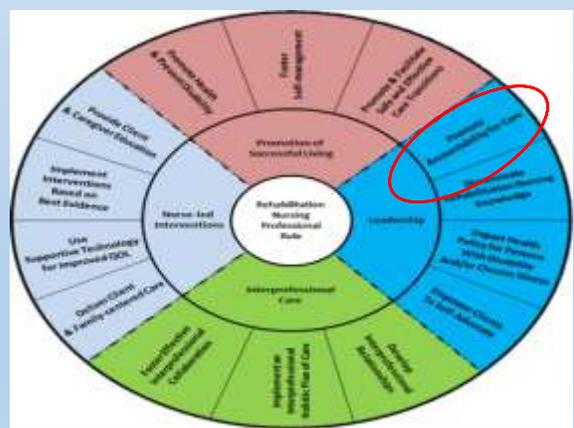
1. **Disseminating rehabilitation nursing knowledge** can take a variety of forms and venues.
2. **Nurses wishing to become proficient** in this competency should actively engage in mentoring newer nurses, participate in unit activities, volunteer at the chapter and national level in specialty organizations, and be actively engaged in evidenced-based practice and development of innovations to solve clinical problems.
3. **Advanced practice nurses** would additionally be expected to find and or develop clinical practice guidelines, conduct and disseminate research findings related to rehabilitation nursing, and use knowledge to advocate at the policy level for persons with disabilities and chronic illness.



Competency 3.1

Promote Accountability for Care

- Description & Scope: Accountability for care is the continuous, multi-dimensional process that promotes ethical, cost-effective client and family-centered quality outcomes in persons with disability and chronic illness.



Beginner Proficient Level Descriptors

Delivers safe, ethical, quality care for the client and family

Collects unit data that addresses practice issues affecting quality outcomes

Demonstrates awareness of how client/staff variables affect the quality of the processes of the unit



Behavioral Scenario

- Mr. Cantarez is 68 years of age and was admitted to the SNF yesterday afternoon after a stroke. He speaks little English. When approached by the nurse he speaks rapidly and loudly. Mr. Cantarez has a reddened area at the base of his spine and his right elbow. He has mild right sided weakness and is complaining of right sided shoulder pain.
- The nurse caring for Mr. Cantarez is a novice who has been on the unit for six months. He knows the routine and the importance of therapy and restorative activities. He took report, passed his morning medications and is ready to get his residents to the rehab gym per their schedule.

Proficient



The charge nurse learns from two other nurses that gait belts are missing from resident rooms. She takes the initiative to check every room and replaces each missing belt. She sends a message to the Quality Team and asks to be placed on the agenda for their meeting next week stating that the purpose of her request is to talk about the missing gait belts and propose doing a weekly monitor to ensure that staff have the proper equipment at the point of care.

Later, she sees Mr. Cantarez who is now very tired. She asks his nurse to help her put Mr. Cantarez in his bed. She sees that the whiteboard isn't updated and calls the language line to perform a mobility assessment. The novice nurse says, "He's a gait belt assist." The charge nurse says, look at him, and proceeds to do a new mobility assessment. Mr. Cantarez is too tired to participate. Together, they safely transfer Mr. Cantarez back to bed using a chair sling lift. Once Mr. Cantarez is safe in his bed the charge nurse takes the novice nurse aside and reminds him that Mr. Cantarez had received pain medication, and spent the last hour being evaluated by PT & OT. She also adds that stroke itself causes fatigue while the body is working to restore itself. After summarizing the changes in Mr. Cantarez, she finishes with, "Always re-assess when there is a change in your resident's condition." The charge nurse updates the white board to read, *Use Transfer Sling when Fatigued.*



Proficient Observations & Outcomes



1. The proficient nurse gathers and shares his/her analysis of unit data that affects the quality of resident –centered care and takes ownership of the path forward for change and improvement.
2. The proficient nurse leader stops what he/she is doing and re-prioritizes to meet the resident’s needs and to support his/her peers.
3. The proficient nurse identifies factors that influence the provision of quality care and resident and family outcomes.





What did you observe?

Proficient Nurse

- Puts the resident first
- Demonstrates proficient assessment according to the standards and scope of practice
- Provides constructive feedback to support the professional growth and development of her novice partner
- Initiates an environmental analysis, implements changes as appropriate that impact the provision of safe and quality care



Takeaways

1. **It is critical that** nurses recognize their own limitations.
2. **Accountability for care** can take a variety of forms and venues.
3. **Nurses wishing to become proficient** in this competency should actively identify factors that influence the provision of quality care and resident and family centered outcomes; also, contribute to unit-based quality improvement activities including the analysis of unit data that affect quality resident-centered outcomes.
4. **Advanced practice nurses** would additionally be expected to analyze data from multiple sources that impact the provision of safe and quality care and implements changes as appropriate; as well as to contribute to the evaluation of the environment in monitoring and measuring the efficacy of organizational quality outcomes.



Summary

- ❑ The Model can **inform** care of residents in a LTC setting through the identification and implementation of the applicable competencies within the four domains. Rehabilitation nurses in these settings incorporate the competencies to manage residents' care across the continuum.



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Question and Answer

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