Restorative Nursing Program

Provided by:
Post-Acute Support Center
(502) 541-1051

Restorative Nursing Manual
Table of Contents

Restorative Nursing Philosophy ………… 3
Levels of Restorative ………… 4
Setting up the Program ………… 6
Documentation ………… 8
Care Planning ………… 9
Quality Assurance ………… 11
Education ………… 13
Job Descriptions ………… 14
- **Restorative Nurse** ………… 15
- **Restorative CNA** ………… 17

Policies and Procedures ………… 19
- **Flow Sheet Policy** ………… 20
- **Master List Policy** ………… 21
- **Moving from Level to Level** ………… 22
- **Level Change** ………… 23
- **Ambulation Policy** ………… 24
- **Gait Belt Policy** ………… 26
- **Range of Motion Policy** ………… 27
- **ADL Policy** ………… 29
- **Continence Management Policy** ………… 31
- **QA Tool** ………… 35

A Restorative Nursing Philosophy –

Restorative nursing is a philosophy of nursing that involves the entire facility. All staff should be participants in restorative nursing. Restorative nursing is a planned systematic program that builds on positive goals from impairment deficits.

Restorative nursing involves staff being focused on the things that residents can do for themselves rather than what staff needs to do for the resident. It involves encouraging the residents to do for themselves rather than doing things for them.

Restorative nursing is based on small steps and progress, such as being able to brush the right side of the hair five strokes, as well as larger goals, such as being able to ambulate independently or improve that allows a resident to discharge home.

In short, we do restorative nursing for three reasons:

1. To help the residents maintain their current level of function;
2. To improve the resident's level of function;
3. If we cannot maintain or improve, we do restorative to slow the decline.

The RAI Process's MDS 3.0 User's Manual explains that a Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

Restorative Nursing Services

The following criteria must be met in order to code O0500 on the MDS 3.0 assessment:

1. Two or more restorative nursing services (a – i) received 6 or more days for at least 15 minutes during a 24-hour period.
   a. **Urinary toileting program (H0200C) and/or bowel toileting program (H0500)
   b. **Passive (O0500A) and/or active (O0500B) range of motion
   c. Splint or brace assistance (O0500C)
   d. **Bed mobility (HO0500D) and/or walking (HO0500F) training
   e. Transfer training (HO0500E)
   f. Dressing and/or grooming training (O0500G)
   g. Eating and/or swallowing training (O0500H)
   h. Amputation/prostheses care (O0500I)
   i. Communication training (O0500J)
   **Count as one service even if both provided
2. Each restorative nursing service provided must be coded independently and meet the 15 minutes or more during a 24-hour period (12:01 a.m. – 11:59 p.m.).
3. When coding Section H Items H0200 Toileting Program or Trial it is required that the required timeframes be confirmed. Toileting Program (Urine or Bowel) must have occurred 4 or times throughout the assessment reference date and a Toileting Trial must have been conducted for a least a 3 days (72 hours) period during the assessment reference date.
4. Measureable objectives and interventions must be documented in the care plan and in the medical record. If a restorative program is in place where care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
5. Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
6. Nursing assistance/aides must be trained in the techniques that promote resident involvement in the activity.
7. A registered nurse or licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation

professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing programs. The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

Service Levels – Skilled, Restorative and Maintenance

1. **Skilled Therapy**
    i. **Provided by licensed therapist and certified therapy aides**
    ii. **Physician-ordered**
    iii. **Reimbursed by the Federal Medicare program**
    iv. **Includes Physical, Occupational and Speech therapy services**
2. **Restorative Nursing**
    i. **Can be recommended and directed by a licensed therapist**
    ii. **Provided under the direction of a licensed nurse**
    iii. **Does not require a physician order**

A Restorative Nursing Program consists of a designated restorative nurse and may include other staff trained in restorative services. The services provided are those tasks delegated, taught, and supervised by therapy or licensed restorative nurse. Some of these restorative nursing measures may be more difficult or time-consuming to provide while others may be repetitive and routine in nature. Restorative measures are provided to maintain a function or attain a higher level of function.

A Restorative Nursing Program include the following techniques: passive and active range of motion; splint or brace assistance, and training and skill practice in bed mobility, transfer, walking, dressing and/or grooming, eating and/or swallowing, amputation/prostheses care and communication. Restorative services works with the resident daily until the resident has achieved set goal(s) of the program. If the resident is not ready to be discharged home, they should maintain achieved status and abilities while they remain in the facility. The resident may have program adjustments made to maintain the achieved status and abilities commonly referred to as restorative nursing maintenance programming.

As previously mentioned a restorative nursing program sometimes functions in conjunction with skilled therapy but often functions alone. An example of this would be the resident receiving skilled physical therapy but who is having incontinent episodes and is picked up by restorative nursing services for bladder retraining.

Listed are some reasons for providing restorative care:

- Shows initiative towards compliance with Federal regulation and standards of care
- Enhance a residents Quality of Life through dignity and self-worth (it does not feel good to lose function)
- Minimize or decreased functional loss by promoting feelings of independence and adequacy.
- Increased staff morale - staff that are responsible for helping residents regain and maintain function feel good about themselves. An added benefit is that as residents become more functional, fewer staff hours are needed.

Setting Up a System of Restorative Programs

1. Decide who should be your core restorative committee.
    a. Medical Director
    b. Director of Nursing Services
    c. Therapy Representative
    d. Restorative Nurse and Aides
2. Develop philosophy for the restorative program.
3. Adopt Policy and Procedures of the Restorative Nursing Program
4. Develop restorative nursing program job descriptions and staff duties
5. Develop a budget and allocate funds
6. Assign a restorative nursing program supervisor
7. Decide on facility's restorative programs and criteria
8. Approve documentation guidelines and forms for each restorative program
9. Identify and obtain tools and supplies needed for each restorative program
10. Provide mandatory education/training for all staff.
    a. Develop on-going restorative education calendar
11. Decide on Restorative Nursing Program implementation date
12. Assess and identify residents for the program
13. Develop and utilize a QA measurement tool to track the Restorative Nursing programs resident outcomes

Example of Restorative Philosophy

"It is our philosophy that in this facility, each individual has the right to be involved in his own care and have the services available to reach his highest possible, practicable, functional level if he so chooses. We believe that dignity and self-worth are enhanced by remaining independent for as long as possible."

Your philosophy should be communicated at every training session you provide for your staff.

Fine-Tuning the Program

- Regular and periodic reviews of workloads are conducted

- Regularly scheduled nurse rounds are made to observe techniques and provide staff with one-on-one training as needed
- Implement 'back-up coverage plan' for restorative staff to ensure appropriate coverage
- Review quality indicators at least once a month.
- Regularly review restorative job descriptions, policy and procedures for completeness and revise as necessary
- Develop orientation program for new staff
- Conduct formal audit of the program on a regular basis (QA)

Add restorative training to new employee orientation. Do a formal audit of your program on a regular basis, make it part of your QA. Include resident outcomes.

Documentation

1. Restorative Needs Assessment
2. A developed restorative plan of care
3. Written evidence that plan is being implemented
    a. Written evidence of efforts taken for refusals to participate
4. Written evidence that decline was unavoidable, or progress is being made
5. Written, periodic evaluation of the plan of care
    a. Review of program goal(s); was it met or new approaches/interventions added
    b. Daily session, weekly notes, and monthly summary

In Summary, documentation for restorative nursing services is no different than documenting other nursing care that was provided. Whenever you assess or document restorative nursing care be sure to include the level of participation by the resident, ability to follow directions, the resident's progress towards goals along with attitude and motivation towards restorative.

There should be written evidence that the restorative program is being carried out. If the resident is refusing, you must document efforts that were made to address the refusal. Should a resident physically decline written evidence that the decline was unavoidable must be in the medical record. Showing everything provided by restorative nursing through documentation in effort to avoid the physical decline but the decline occurred anyway is paramount.

If the resident is not meeting goals, revise the plan of care!

Care Planning

Care planning is essential to an effective restorative nursing program. There are four basic steps to care planning:

1. Assessment - An assessment of the resident to identify strengths and problems or needs.
2. Problem/Needs Identification – Writing problem statements based on the identified needs of the resident and developing goals and interventions or approaches to help the resident meet those goals.
3. Implementation - The staff provides care and services according to the care plan.
4. Evaluation - This step is necessary to determine if goals are being met and to determine the reason if they are not.

Components of the Care Plan

1. Problem Statement – This is the statement of the resident's problem or need that has been identified through assessment.

2. Goals- Goals are the desired resident-based outcome for a specific problem or need. When you are planning restorative care, the goals should be measurable. For example, "resident will continue to be able to raise left arm to shoulder level". Goals should be reasonable and attainable. They can be short-term and long-term, so while the long-term goal may be for the resident to be completely independent and be discharged home, smaller short-term goals need to be met first.

   Some principles for developing and writing goals:

   a. Goals must address the assessed problem.

   b. Goals must be written in resident terms. The subject of the goal statement is always the resident.

   c. Goals must be measurable. Evidenced by observing the resident to see if he/she accomplished or completed the activity, by observing resident physical functioning over a period of time, or by performing procedures or tests that lead to specific data or outcomes. For example: The Resident will ambulate 50 feet 4 days out of 6. This goal is easily measured through observation and recording of actual feet performed each day.

   d. Each goal must have a time frame. This is the amount of time that we expect it will take to accomplish the goal and the time that we should evaluate to see if the resident met the goal.

   Problems may have more than one goal. Goals are reviewed and revised as a resident accomplishes a goal and requires a new goal or when there has been a significant change in the resident's condition, at least on a quarterly basis.

3. Approaches - Approaches are written instructions for specific measures that each discipline is responsible in performing to help the residents meet their goals. Approaches must be realistic and written in specific terms. The staff person performing the approach should have no doubts about what she is supposed to do.

4. Strength - A positive aspect of the resident's physical or psychosocial functioning that enhances her quality of life. Identified strengths along with specific team interventions and approaches developed to help the resident maintain that strength should be incorporated into the plan of care.

Quality Assurance

The purpose of doing Quality Assurance is simply to look at a system, using objective tools to review all aspects of the system, and to answer this question: “Are we accomplishing what we planned to accomplish, and is there a way to improve the system?”

When identified areas that need improvement the following steps should be taken:

1. Further define the problem.
2. Investigate and problem-solve to find the root cause of the problem.
3. Start the improvement cycle by developing an action plan that is specific to the root cause.
4. Implement the plan of action.
5. Monitor and follow up to determine the effectiveness of the plan.
6. If the plan is effective, continue the plan. If the plan is not effective, perform further evaluation and modify the plan.

There are several ways to identify areas that need improvement. Performing a formal audit of the program by taking a sampling of the area you are looking at and applying a QA tool or questionnaire to each sample, is one way.

Investigating a resident or family complaint often turns up aspects of a system that needs improvement.

Collecting data on specified indicators is another way to keep up with what is happening in a department or in a system. Indicators are quantitative measures that can be used as a guide to monitor and evaluate the quality of resident care and facility services. Quality Indicators are not a direct measure of quality but merely a warning, indicating that certain areas may need more analysis. For example, the quality indicators may show an increase in incontinent residents or an increase in late loss ADLs. These would be areas that would need to be investigated through the QA process to determine if there is an area that needs improvement.

Implementation Steps to Follow

1. Decide how often a formal audit of your program should be conducted and which tools and methods should be used.
2. Break down sections of the audit and involve regular staff in the evaluation. This should help reinforce expectations of the program and help staff feel more involved.
3. Once areas for improvement have been identified, meet with staff, and identify causes.
4. Once causes have been identified, develop, and implement an action plan.
5. Set a follow-up date and determine how the plan is working.
6. If the plan is not working, re-evaluate to discover why and make adjustments to the plan.
7. Keep staff informed of the outcomes of the process and give positive feedback on their performance.

Important Points

1. The ultimate judges of the quality of your care and services are your customers.
2. While all employees should be involved in quality improvement, the ultimate responsibility for creating an environment which promotes continuous quality improvement rests with Administration.
3. An effective quality improvement program encourages staff to take pride and ownership in their work, improves staff morale, and improves provision of quality care and services.

Education

Orientation

Many facilities have a comprehensive education program in place but neglect to thoroughly orient new staff to restorative nursing.

The initial orientation for restorative nursing should include the philosophy of restorative nursing and a review of the regulations governing restorative care and staff roles and responsibilities. This should be incorporated into the orientation for all newly hired staff.

For direct care staff, the orientation for restorative should continue on the units. Facilities should utilize a skills check-off list and have employees demonstrate skills to ensure proficiency.

Staff on the units providing orientation should be a select group chosen because of their skills, abilities, and professional conduct.

Ongoing Education

The following topics should be included in the facility's annual training program;

1. Restorative philosophy - *all staff*
2. OBRA regulations related to restorative nursing - *interdisciplinary team*
3. Staff roles and responsibilities in relation to levels of restorative - *interdisciplinary team*
4. Basic techniques and practices to include ROM, ambulation, ADLs, restorative dining, and assistive feeding devices- *Nurses, CNAs, other disciplines as appropriate*
5. Continence management- *Nurses, CNAs*
6. How to supervise and monitor the program- *Charge nurses*
7. Annual skills check-off for basic techniques- *CNAs, charge nurses*

Classes should be mandatory and given at various times to allow all staff to attend.

Restorative Nursing
Job Description Samples

Job Description: Nursing Service

Job Title: Restorative Nurse

Job Summary: Responsible for the development, implementation, monitoring and supervision of the restorative nursing program for the facility. The restorative nurse functions as the liaison between formalized therapy and Nursing and promotes the restorative nursing philosophy among all facility departments.

Supervision: Reports to and is supervised by the Director of Nursing. Directly supervises Restorative aides and works closely with charge nurses and nursing assistance in seeing that nursing staff are performing the approaches necessary to keep residents at their highest possible functional level.

Functions:

1. Works with unit managers in maintaining a current master list of residents on the restorative nursing program on each unit. The Restorative Nurse is directly responsible for keeping the restorative programming lists current.

2. Sets up documentation flow sheets for daily documentation of restorative nursing measures for each resident on a restorative program and initiates restorative nursing flow sheets.

3. Makes a minimum of one assessment note per week and a monthly summary on residents in restorative programs. Documents more often if a resident is not progressing or has a change of condition. Reviews documentation done by other staff and provides direction and guidance, as necessary.

4. Ensures that restorative nursing measures are reflected on the care plan as an approach for the problem or need for which they are being done. Ensures that problems are clearly stated and that goals are reasonable, measurable, and attainable.

5. Makes regular rounds to oversee and monitor restorative nursing measures being provided and provides one-to-one instruction as needed.

6. Makes restorative rounds on all shifts as necessary to monitor program functional status.

7. Works with the facility's various committees and therapy disciplines in setting up restorative nursing programs such as dining and ambulation programs.

8. Works with the nursing staff in selecting candidates to be on a bladder retraining program, in setting up the program and in overseeing to make sure staff are following through.

9. Attends care planning conferences and makes recommendations and/or reports on progress of restorative nursing measures for those residents on restorative programs as needed or directed.

10. Ensures that residents receive their restorative nursing program as planned and that all necessary assistive devices are obtained and used as recommended. Works with departments to develop a system for ensuring that these assistive devices are consistently available for resident use and are addressed on the care plan.

11. Serves as chairperson for the Restorative Committee.

12. Completes QA forms as directed and utilizes this information to problem-solve.

13. Meets with Supervisor on a planned basis, keeping him/her informed of the program.

14. Works closely with formalized therapy. Ensures that specific recommendations are carried out.

15. Provides direct care as needed.

16. Participates in orientation and staff development in relation to roles, responsibilities and principles and practices of restorative nursing.

17. Participates with nursing Administration in review and development of restorative nursing policies, procedures and systems and completion of time studies.

18. Other duties as assigned.

Qualifications:

1. Is a licensed nurse with education and/or restorative programming experience.
2. Understands the philosophy, principles, and techniques of restorative nursing.
3. Has the skill to perform techniques and practices of restorative nursing.
4. Has a minimum of two year's experience in geriatric nursing.
5. Has management experience, preferably.
6. Has the ability to work as a team member.

Job Description: Nursing Service

Job Title: Restorative Nursing Assistant

Job Summary: Responsible to work with residents needing restorative nursing measures to gain or to maintain their highest possible practicable, functional level. Responsible for providing consistency between therapist's work and carry over by nursing on a daily basis.

Supervision: Reports to and is supervised by the Restorative Nurse Coordinator. Physical Therapy should be responsible for teaching the Restorative aides and providing direct supervision for only those items that are beyond the scope of restorative nursing and are delegated to the Restorative aides from Physical Therapy after he/she has received appropriate training to perform the task. Directly supervises no one but provides one-to-one and serves as a resource in restorative nursing aides measures to other nursing assistants.

Functions:

1. Provides direct restorative care and delegated formalized therapy tasks, as assigned, completing work accurately, safely and in a timely manner. Specific care to include passive and active ROM, ambulation, special positioning techniques, splints, assistive feeding devices/adaptive equipment, ADL training, bowel and bladder management, restorative dining, bladder retraining.
2. Receives specific instruction from nursing on restorative nursing techniques through nursing orders.
3. Receives specific instructions from formalized therapies when the functions are beyond basic restorative nursing scope and receives supervision for these tasks from the indicated formalized therapy discipline.
4. Works with other disciplines, as appropriate, in setting up grooming, exercise, sensory stimulation classes, etc.
5. Participates in the restorative dining program and works with OT and other nursing staff in accomplishing this.
6. Coaches and assists other staff members in positioning, ROM, ambulation, ADLs, cones/splints/contracture care.
7. Coaches and assists to make sure residents have their recommended assistive feeding devices in the dining room.
8. Follows protocols and procedures for restorative nursing care as set by nursing administration.
9. Attends care planning conference and provides input into development of individualized plan of restorative care.
10. Informs charge nurse of suggestions for changes that he/she perceives as necessary for improving resident care.
11. Reports lack of functioning equipment and lack of adequate supplies to supervisor.
12. Assists with bladder retraining and works with staff in seeing that the program is properly carried out.

13. Documents progress of residents by completing flow sheets daily to signify that the specified restorative nursing measure was done. Makes a weekly observation, progression/regression note in narrative format.
14. Notifies charge nurse and supervisor when a resident is progressing/regressing or refusing to participate in the program so that an assessment can be done by nurses, with changes in the program and care plan made as indicated.
15. Assists with orientation and staff development in principles and practices of restorative nursing as directed.
16. Informs the charge nurse and/or supervisor when restorative nursing services are declined or not being performed as directed.
17. Informs the restorative nurse of suspected resident decline.
18. Assists in keeping restorative approaches current and updated.
19. Serves as a resource and teammate to other nursing assistants, working with them to provide the specific restorative nursing care for each resident.
20. Meets routinely or as necessary with the Restorative Nurse.
21. Other duties as assigned.

Training and Qualifications:

1. Must be a certified nursing assistant.
2. Must have knowledge and skills in basic restorative nursing principles and practices.
3. Has training and demonstrates ability in techniques and practices of restorative nursing.
4. Must be conscientious with ability to work as a team member.
5. Must have prior experience as a CNA, with consistently good evaluations of job performance.

Restorative Nursing
Policies and Procedures Samples

Flow Sheets for Restorative Care

Policy:

All restorative nursing measures should be documented on a flow sheet in the eMR.

Procedure:

1. When residents are started on a restorative program a flow sheet should be started. The prescription for restorative care and the goal should be written on the flow sheet. Prescribed programs should be specific, and goals should be measurable.

2. The staff providing the service should initial all restorative care services each day as they are completed. The staff should record the time, in minutes, that it took to provide the care

3. Narrative notes should be made on the flow sheet.

4. If a resident does not perform or complete the restorative function for two consecutive days, the nursing staff or nursing assistant should document and notify the Restorative Nurse.

5. Flow sheets should be kept in an organized format in a Restorative Nursing Program Notebook along with the master lists of the restorative programs and residents.

6. At the end of each month, the completed flow sheets should be placed on the clinical record and new flow sheets should be placed in the notebook.

Master List Development

Policy:

A master list of all residents and their restorative nursing prescriptions should be kept. These lists should be current and reflect residents that are in the restorative program and what restorative services residents are receiving.

Procedure:

1. The restorative nurse should add the names and restorative nursing prescriptions to the master list as programs are started and should delete names and make the necessary changes as they occur to assure that the list is current.

2. A copy of the master list should be kept in a Restorative Nursing Program notebook with the flow sheets.

3. The master lists are to be used by the nurse to monitor and supervise restorative nursing care and to orient new staff to the residents and their restorative care needs.

4. When a resident is discharged from the Restorative Nursing Program the resident flow sheet will be placed in the medical record.

5. Restorative nursing flow sheets are to be considered part of the resident medical record.

Restorative Nursing – Program Services

Policy:

In effort to maintain and promote the highest practicable level of resident functioning residents being discharged from skilled therapy services will be assessed for needs of a Restorative Nursing Program to assure continued optimal level of physical function within recognized pathology and the normal aging process.

Procedure:

1. When formal therapy staff is discharging a resident to they should complete a **Restorative Nursing Referral/Request** form and complete the following:

    a. Document previous therapy program and goal(s) achieved
    b. Recommend specific instructions or desired restorative care program.
    c. Indicate adaptive equipment or techniques to be used
    d. Other pertinent resident or program requests

2. Formal therapy staff should work with the restorative nurse and/or staff by demonstrating and providing instructions to involved staff.

3. The restorative nurse will assess the resident and as assessment indicates will –

    a. Add the resident's name and prescription for care to the master list
    b. Develop and implement a restorative nursing program plan of care
    c. Initiate the necessary flow sheet(s)
    d. Add to staff assignment sheet

4. Each professional should make corresponding notes in the clinical record in their designated areas as to the change process being started, when it is completed and the results.

6. Restorative forms should be a part of the resident clinical record and should be maintained according to medical records policy.

Ambulation Policy and Procedure
(Bed Mobility/Transfer Skills/Walking)

Policy

The facility will offer a restorative nursing program for ambulation based on the comprehensive assessment. A restorative ambulation program will be developed based on the individual resident's ambulation status and needs. This program should be reflected on the interdisciplinary care plan and consistently carried out by staff.

Physical Therapy should work closely with the nursing staff in communicating goals and recommending approaches to assure continuity of the plan of care and restorative nature of the resident.

Procedure

1. Upon admission to the facility but not later than the 7th day of stay if the resident is not receiving physical therapy services the resident will be assessed for restorative nursing programming needs including ambulation.
2. When a related care area trigger such as #5 ADL Functional/Rehabilitation Potential if not already evaluated and receiving skilled therapy services a restorative nursing assessment needs should be performed.
3. Residents who are in wheelchairs, who are having ambulation or mobility difficulty or who remain in bed for extended periods of time should be assessed for restorative nursing ambulation programming needs.
4. The restorative nurse should develop, based on assessment, a restorative ambulation/mobility plan of care where restorative ambulation needs are identified, the restorative nurse should oversee the implementation of the plan.
5. Once the restorative ambulation program is determined, the resident is then added to the designated restorative master list, goals and approaches should be communicated and the care plan and a restorative nursing flow sheet implemented.
6. The ambulation program should be carried out daily but no less than 6 out of 7 days within an MDS 3.0 assessments assessment reference date observation period. The restorative nurse should monitor the MDS 3.0 calendar and flow sheets to assure daily services are documented.
7. The restorative nurse along with appropriate physical therapy staff should communicate with involved nursing staff about the specifics of ambulation approaches and goals so that the program can be carried out as planned.
8. When assisting with out of bed ambulation, adhere to the following:

    a. Assist resident to a sitting position.

    b. Be sure resident has proper fitting, non-skid footwear.

c. Apply braces, as indicated, and have assistive ambulation devices ready for use.
d. Assist resident to a standing position and allow resident time to stand until balance is established.
e. Ask resident to place his/her arm on your arm and hold hand for support.
f. Use gait belt according to facility's gait belt usage policy and procedure.
g. Stand at the resident's affected side.
h. Use a second person to provide additional support, as indicated.
i. Encourage use of guard rail for additional support when initiating the program.
j. Have an extra person follow closely behind with a wheelchair for additional security when unsure of tolerance or as indicated.
k. Observe endurance, distance, and resident motivation throughout session.
l. Provide positive feedback and comments about efforts and achievements.
m. Encourage resident to walk the distance to meet planned goals, but do not push beyond his/her capabilities or endurance.
n. Return resident to bed or chair and express thanks and praise of their efforts and success during the session.

9. Bed Mobility includes educating the resident on the importance to shift body weight from one position to another in order to prevent skin problems such as pressure ulcers. Have the resident shift position using rails and techniques to safely move the body without sheering or bumping.
10. Transfer Skills require supervision and cueing but can also include hands-on physical assistance and weight bearing of the resident. Many residents fear transfer due to a history of falling or other mishap and building a relationship of trust is important. A step-by-step instruction is also very important during transfer skills training.
11. Document session on flow sheet. Complete flow sheet thoroughly. Include signature, distance/minutes, etc. on flow sheet.
12. If a resident refuses to ambulate, or for some other reason is unable to work with staff on ambulation, indicate on the flow sheet and document specifics in the comments section.
13. If a resident refuses or is unavailable for two or more days notify the charge nurse or restorative nurse.
14. Weekly progress notes are recommended, and this can be done by bedside care staff or the restorative nurse.

Gait Belt Policy and Procedure

Policy

Nursing staff should use gait belts on residents needing one or more person assist in transferring and ambulation unless the use is contraindicated. A gait belt provides a firm, grasping surface for staff, protects the resident from accidental trauma to the skin and provides a sense of security for the resident.

Procedure

1. Once the resident is in a sitting position, apply the gait belt over the resident's clothing, around the waist.
2. Make sure the belt is snugly in place, remembering that the belt should loosen when the resident stands. You should be able to insert two fingers between the belt and the resident's clothing.
3. Stand in front of the resident with your feet approximately twelve inches apart and alternating your feet with the resident's.
4. Grasp the gait belt with one hand at each side of the resident's waist. Have the resident place his/her hands on your arms or waist, never around your neck.
5. Maintaining good body mechanics, bring the resident to a standing position.
6. When the resident begins to ambulate, stand slightly behind the resident on the weaker side, grasping the belt with an underhand grip from the back.
7. If the resident begins to fall during ambulation, pull the resident close to your body with the gait belt and slowly lower the resident to the floor.
8. Contraindications for gait belt usage are the following:
    a. Recent abdominal surgery
    b. Severe respiratory problems
    c. Recent chest or back surgery
    d. Severe cardiac conditions
    e. Fragile skin
    f. Other care planned reason for non-gait belt usage

Passive/Active Range of Motion
Policy and Procedure

Policy

The facility will offer a restorative nursing program for range of motion based on the comprehensive assessment. A restorative range of motion program will be developed based on the individual resident's physical status and needs. This program should be reflected on the interdisciplinary care plan and consistently carried out by staff.

Physical Therapy should work closely with the nursing staff in communicating goals and recommending approaches to assure continuity of the plan of care and restorative nature of the resident.

Active and passive range of motion education is part of basic nurse and nurse assistant training and can be performed by all nurse staff including nursing assistants. Resistive and isometric exercises are not a part of basic staff knowledge and training should be provided by trained therapist or therapy assistants. Only staff that has completed education and demonstrated competency in resistive and isometric exercises and restorative range of motion procedures should perform these services.

The Restorative Nursing Programs primary responsibility is to preserve the resident's current ROM. The Physical Therapist's role is concerned with building muscle strength and restoring as much ROM as possible and in this case would be treating the resident based on therapy evaluation in an active physical therapy program ordered by a physician.

Procedure

1. Upon admission to the facility but not later than the 7th day of stay if the resident is not receiving physical therapy services the resident will be assessed for restorative nursing programming needs including range of motion.
2. When a related care area trigger such as #5 ADL Functional/Rehabilitation Potential and if not already evaluated and receiving skilled therapy services a restorative nursing assessment needs should be performed.
3. When contracture risk or actual decrease in ROM is identified further assessment should be completed and part of the comprehensive assessment process with pertinent information added to triggered Care area assessment summaries.
4. The restorative nurse should review the admission nursing assessment along with other review of the medical record and work with involved nursing staff including therapy disciplines to assure that specific risk factors are identified for potential range of motion decline or contractures.
5. When a resident is identified as at risk and there is no indication for formalized therapy, the resident's name and restorative services should be added to the designated restorative master list, goals and approaches should be determined and care planned and a restorative nursing flow sheet implemented.

6. The Restorative nurse along with the therapy department as needed should communicate with involved nursing staff about the specifics of range of motion approaches and goals so that the program can be implemented as planned.

7. When splints or other devices are part of the plan, the respective therapy discipline should instruct nursing staff on their use and recommend a schedule for application and removal of the device and incorporate these into the restorative nursing plan of care.

8. Unless contraindicated, part of contracture care can be to soak the affected limb in warm water for twenty minutes daily to encourage increased range of motion.

9. When performing ROM exercises, adhere to the following:

    a. Exercise only the joints specified in the plan.

    b. Work from top to bottom, exercising upper extremities first.

    c. Support the extremity being exercised at the joint.

    d. Perform each motion slowly, smoothly, and gently.

    e. Do not move joints past the point of resistance or when pain is present.

    f. Pause at the end of each movement.

    g. Never exercise a painful, swollen or reddened joint.

10. Encourage the resident to assist with exercises, if possible.

11. Document session on flow sheet. Complete flow sheet thoroughly. Include signature, indicate services provided during session.

12. If a resident refuses session, or for some other reason is unable to work with staff, indicate on the flow sheet and document specifics in the comments section.

13. If a resident refuses or is unavailable for two or more days notify the charge nurse or restorative nurse.

14. Weekly progress notes are recommended, and this can be done by care staff or the restorative nurse.

Activities of Daily Living
Dressing/Personal Hygiene, Bathing and Dining/Eating Services
Policy and Procedure

Policy

The facility will offer a restorative nursing program for activities of daily living skills based on the comprehensive assessment. A restorative program for activities of daily living skills will be developed based on the individual resident's physical status and needs. This program should be reflected on the interdisciplinary care plan and consistently carried out by staff.

The respective therapy discipline should work closely with the restorative nursing and other nursing staff in communicating goals and recommending approaches to assure continuity of the plan of care and restorative nature of the resident.

Education regarding ADLs is part of basic nurse and nurse assistant training and can be performed by all nurse staff including nursing assistants. Restorative ADL services are not a part of basic staff knowledge and training should be provided by trained therapist or therapy assistants. Only staff that has completed education and demonstrated competency in restorative services and restorative ADL procedures should perform these services.

***This policy and procedure can be used in developing restorative programs related to eating, dressing/personal hygiene, and bathing.**

Procedure

1. Upon admission to the facility but not later than the 7th day of stay if the resident is not receiving physical therapy services the resident will be assessed for restorative nursing programming needs activities of daily living skills.

2. When a related care area trigger such as #5 ADL Functional/Rehabilitation Potential and if not already evaluated and receiving skilled therapy services a restorative nursing assessment needs should be performed.

3. Should the resident have identified a need for restorative ADL program/service further assessment should be completed and be made part of the comprehensive assessment process with pertinent information added to triggered care area assessment summaries.

4. The restorative nurse should review the admission nursing assessment along with other review of the medical record and work with involved nursing staff including therapy disciplines to assure that specific risk factors are identified for potential ADL decline.

5. When a resident is identified as at risk and there is no indication for formalized therapy, the resident's name and restorative services should be added to the designated restorative master list, goals and approaches should be determined and care planned and a restorative nursing flow sheet implemented.

6. The outcome of the functional assessment should be to determine if the resident is a candidate for restorative dining, dressing, grooming, or bathing programs.

7. Once the level and restorative prescription is determined, the resident's name and prescription should be added to the designated restorative master list, goals and approaches should be determined and care planned, and a restorative nursing flow sheet implemented.

8. The use of assistive devices should be considered as a part of the nursing functional assessment with a therapy screen performed by to ascertain the need for adaptive equipment.

9. Direct care staff will assure assistive devices are available and in working condition during the ADL restorative program. Staff will report equipment issues to the restorative nurse.

10. If a resident refuses the restorative ADL session, or is unable to participate for any reason, document specifics on the restorative flow sheet.

11. If a resident refuses or is unavailable for two or more days notify the charge nurse or restorative nurse.

12. Weekly progress notes are recommended, and this can be done by care staff or the restorative nurse.

Programing Considerations

Eating/Dining

- The MDS 3.0 User's Manual v1.10.4 (4/12) defines eating as how the resident eats and drinks and includes intake of nourishment by other means including tube feeding, total parenteral nutrition and IV fluids administered for nutrition and hydration.
- Group programming of 4 or less during the lunch meal is customary as a restorative dining program
- When adaptive equipment is first introduced individual dining sessions may be more appropriate than group dining to ensure resident focus, dignity, and success
- Proper posture and seating is important to successful dining and in the eating process
- Atmosphere is important! Lighting, sound levels and décor should all be considered whether its a group or an individual restorative program
- Occupational and speech therapy disciplines are excellent information resources when developing restorative eating and dining programs and creating dining/eating education modules and competency evaluations

Dressing/Personal Hygiene

- The MDS 3.0 User's Manual v1.10.4 (4/12) defines dressing as how the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses.
- The MDS 3.0 User's Manual v1.10.4 defines personal hygiene as how a resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands but excludes baths and showers.
- Some restorative grooming programs can be conducted as a group program but generally grooming and dressing is conducted as an individual restorative session.

- Adaptive equipment is often important to successful grooming/dressing and in improving an individual's level of grooming and dressing skills.
- Initial input with an occupational therapist in development of a grooming/dressing restorative program is vital.
- A quick audit of clothing for proper fit and adjustments can ward off potential resident failure and frustration. Use of Velcro closures instead of buttons or snaps is an example of a minor adjustment that promotes success.

Bathing

- An individual restorative program that requires constant attention in promotion of dignity and respect. Taking time to customize the bathing experience with a personal touch assist in the resident's comfort to the process.
- The MDS 3.0 User's Manual v1.10.4 (4/12) defines a bath as a full bath (tub or whirlpool), sponge bath (in bed, chair or at sink) or shower and a restorative session can occur during any type of bath and includes transfer in/out of tub/shower but excludes washing of back and hair.
- Making use of privacy signage "IN USE" promotes dignity and confidence.
- Like other restorative programs adaptive equipment is important to success and in improving an individual's level independence in bathing skills.
- Initial input from therapist is helpful when developing a restorative bathing program by identifying adaptive equipment and a practical bathing process.
- The SPA experience is the new standard in a cultural change methodology from the traditional bathing practice. The SPA experience incorporates décor including equipment, atmosphere, and temperature of the environment as well as the water in setting a relaxing mood state. The SPA experience is a start to finish process often beginning with the resident choosing music to listen while in the SPA and includes gentle massage of warmed lotion to hands and feet and finishes with a drink of fresh juice or cool water once dressed.

Bladder and/or Bowel Restorative Programs
Policy and Procedure

Policy

The facility will offer a restorative nursing programs related to bladder and bowel continence based on the comprehensive assessment. These programs are bladder retraining, scheduled toileting, and bowel management. A restorative program will be developed based on the individual resident's physical status and incontinence needs. The program(s) should be reflected on the interdisciplinary care plan and consistently carried out by staff.

Therapy disciplines should work closely with the nursing staff in communicating goals and recommending approaches to assure continuity of the plan of care and restorative nature of the resident.

Bladder and Bowel continence care education is part of basic nurse and nurse assistant training and can be performed by all nurse staff including nursing assistants. However restorative bladder and bowel restorative services are not a part of basic staff knowledge and training should be provided by licensed nurses and other medical professionals. Only staff that has completed education and demonstrated competency in bladder and bowel restorative procedures should perform these services.

Bladder and Bowel Restorative Programs will focus primarily on a 12-hour daytime schedule. Once an individual resident is successful in daytime continence then a nocturnal restorative program will be implemented as assessed necessary and is resident accepted and practicable.

Furthermore, the CMS MDS 3.0 User's Manual Chapter 3 page H-3 states that restorative bladder and bowel programs scheduled during daytime hours are the often successful for residents; the manual does not state or define restorative bladder or bowel programs to be required as a 24-hour program nor are service hours a requirement dictated through federal regulation. However, a restorative bladder, prompted voiding and habit training programs needs to be provided 4 days out of 7 for it to be assessed as a program and for 3 days to be considered a toileting program trial on the MDS 3.0 assessment.

The MDS 3.0 User's Manual v1.10.4 (4/12) defines the various options of restorative bladder and bowel services in Chapter 3 as follows:

BLADDER REHABILITATION/ BLADDER RETRAINING is defined as a behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

PROMPTED VOIDING Prompted voiding includes (1) regular monitoring with encouragement to report continence status, (2) using a schedule and prompting the resident to toilet, and (3) praise and positive feedback when the resident is continent and attempts to toilet. Prompted voiding can be used to treat either bladder or bowel incontinence.

HABIT TRAINING/ SCHEDULED VOIDING is defined as a behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs. Prompted voiding can be used to treat either bladder and or bowel incontinence.

CHECK AND CHANGE Involves checking the resident's continent status at regular intervals and using incontinence devices and products.

Procedure
Bladder Retraining

1. Upon admission to the facility but not later than the 7th day of stay if the resident is not receiving physical therapy services the resident will be assessed for restorative nursing programming needs related to achieving bladder continence.

2. When a related care area trigger such as #6 Urinary Incontinence/Indwelling Catheter and if not already evaluated and receiving skilled therapy services a restorative nursing assessment needs should be performed.

3. Should the resident have identified a need for a restorative bladder program further assessment should be completed and be made part of the comprehensive assessment process with pertinent information added to triggered care area assessment summaries.

4. The restorative nurse should review the admission nursing assessment along with other review of the medical record and work with involved licensed healthcare professionals, nursing staff and therapy disciplines to assure that specific risk factors or medical reasons are identified that may be contributing to the incontinence bladder status.

5. When a resident is identified as at risk and there is no indication for formalized therapy, the resident's name and restorative services should be added to the designated restorative master list, goals and approaches should be determined and care planned and a restorative nursing flow sheet implemented.

6. The outcome of the restorative functional assessment should be to determine if the resident is a candidate for a restorative bladder retraining program. If a bladder retraining program is assessed not indicated conduct additional restorative assessment to determine whether a habit retraining/scheduled voiding program is an alternative.

7. Once the level and restorative prescription is determined, the resident's name and prescription should be added to the designated restorative master list, goals and approaches should be determined and care planned, and a restorative nursing flow sheet implemented.

8. The use of assistive devices should be considered as a part of the restorative functional assessment with a therapy screen performed by to ascertain the need for adaptive equipment.

9. Direct care staff will assure assistive devices are available and in working condition during the bladder restorative program. Staff will report equipment issues to the restorative nurse.

10. If a resident refuses the restorative bladder retraining session, or is unable to participate for any reason, document specifics on the restorative flow sheet.

11. If a resident refuses or is unavailable for two or more days notify the charge nurse or restorative nurse.

12. Staff should follow the plan as specified and report when instructions cannot be completed as directed to the restorative nurse.

13. A 72-hour voiding pattern worksheet should be initiated by the restorative nurse. Direct care staff is responsible for checking and toileting the resident every hour, documenting on the flow sheet whether the resident was wet or dry and if the resident eliminated when toileted. This should be done for 72 hours to establish a voiding pattern.
14. A schedule for delayed voiding should be established by the restorative nurse and a bladder retraining flow sheet initiated. Times should be set for 15 minutes after the established voiding times.
15. Staff should work with resident to consciously resist the urge to void, so they can delay voiding until the scheduled time.
16. Staff should continue to work with the resident until he/she is capable of voiding independently or notifying staff when he/she needs to go to the bathroom and routinely has continent episodes.
17. Weekly documentation should be done by the restorative nurse to show progress, regress, adjustments to the plan and final outcome.
18. Licensed nurse staff is accountable to see that the restorative bladder retraining daily plan is followed and documented accordingly.
19. If a resident regresses after the program is completed, the restorative nurse should be notified, and a re-evaluation should be done.
20. If the program is not successful, alternative bladder retraining techniques and interventions should be tried.

Habit Training/Scheduled Voiding (Bladder or Bowel)

1. Upon admission to the facility but not later than the 7th day of stay if the resident is not receiving physical therapy services the resident will be assessed for restorative nursing programming needs related to achieving bladder or bowel continence.
2. When a related care area trigger such as #6 Urinary Incontinence/Indwelling Catheter and if not already evaluated and receiving skilled therapy services a restorative nursing assessment needs should be performed.
3. Should the resident have identified a need for a restorative habit training program further assessment should be completed and be made part of the comprehensive assessment process with pertinent information added to triggered care area assessment summaries.
4. The restorative nurse should review the admission nursing assessment along with other review of the medical record and work with involved licensed healthcare professionals, nursing staff and therapy disciplines to assure that specific risk factors or medical reasons are identified that may be contributing to the incontinence status.

5. When a resident is identified as at risk and there is no indication for formalized therapy, the resident will be assessed by the restorative nurse using the restorative functional assessment.

6. The outcome of the restorative functional assessment should be to determine if the resident is a candidate for a restorative habit retraining/scheduled voiding program.

7. Once the level and restorative prescription is determined, the resident's name and prescription should be added to the designated restorative master list, goals and approaches should be determined and care planned, and a restorative nursing flow sheet implemented by the restorative nurse.

8. The use of assistive devices should be considered as a part of the restorative functional assessment with a therapy screen performed by to ascertain the need for adaptive equipment.

9. Direct care staff will assure assistive devices are available and in working condition during the habit retraining program. Staff will report equipment issues to the restorative nurse.

10. If a resident refuses the restorative habit training session, or is unable to participate for any reason, document specifics on the restorative flow sheet.

11. If a resident refuses or is unavailable for two or more days notify the charge nurse or restorative nurse.

12. Staff should follow the plan as specified and report when instructions cannot be completed as directed to the restorative nurse.

13. If the program is not successful, alternative habit training techniques and interventions should be tried.

14. A 72-hour voiding pattern worksheet should be initiated by the charge nurse or restorative nurse, and CNAs are responsible for checking and toileting the resident every hour, documenting on the flow sheet whether the resident was wet or dry, and if the resident eliminated when toileted. This should be done for 72 hours to establish a voiding pattern. Bladder and bowel are to be recorded individually.

15. Once a voiding pattern is established, a planned schedule for toileting the resident should be developed by the charge nurse or restorative nurse. The times are set ten to fifteen minutes before the established pattern so the staff can toilet the resident before he/she is incontinent.

16. If a resident has difficulty starting his urine stream when being toileted, try the following techniques: Running water, have resident blow through a straw, exert manual pressure over the bladder. To assist with complete emptying of the bladder, have the resident lean forward. Document recommended and used techniques of each session on flow sheet.

17. If a resident complains or shows signs and symptoms of constipation notify the appropriate nurse staff. Document these items on the flow sheet.

18. CNAs are responsible for following the schedule and reporting to the charge nurse when the results of following the schedule are not as planned, so that adjustments to the schedule can be made.
19. Once a habit training/scheduled voiding pattern is established and effective it becomes part of the daily care routine.
20. Weekly progress notes should be made until the program is effectively established. Monthly summary notes should be written by the charge nurse thereafter.
21. Charge nurses are accountable to see that the daily plan is followed and documented by the CNAs.

Restorative Bowel Management Considerations

1. The goal of bowel management program is to avoid negative consequences that accompany bowel incontinence including but not limited to skin problems and reduced social interaction.

2. Bowel habit are often patterns established over a long period of time and because of this bowel patterns are schedules that a person can articulate and identify that can be used as a baseline when attempting to effectively implement a successful bowel management program.

3. As part of the bladder and bowel assessment conducting a resident interview relative to these established patterns should be a normal part of the functional restorative nursing assessment. Utilizing this information can be the foundation to a successfully resident centered restorative program.

4. A bowel toileting or habit training program is similar to a bladder habit training/scheduled voiding program in that it is set around an established schedule.

5. The nursing staff should identify elimination patterns by observing and recording all bowel movements on the pattern assessment flow sheet.

6. A bowel management schedule should be established based on the resident's recorded pattern.

7. Once the schedule is established, the results of each scheduled toileting should be recorded on the flow sheet along with any unscheduled bowel movements. Adjustments to the plan should be made, as necessary.

8. Daily services are recorded on the flow sheet and progress notes should be made until a successful plan has been established.

9. Monthly progress notes should be completed after a successful plan has been established for as long as a program continues.

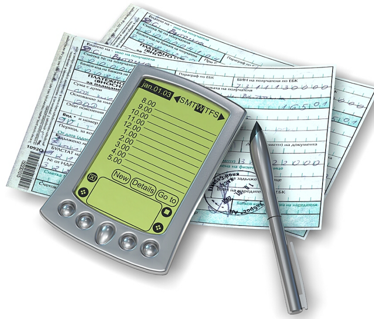
Incontinence products and toileting adaptive equipment

1. Routine use of incontinence products are discouraged except when their use can promote participation in facility and community functions and when individuals are so debilitated that they are incapable of toileting, after all other treatment options and modalities have been attempted and failed.

2. When incontinence products are required for regular use less is best! For example, if someone dribbles use of incontinence pads or liners would be more appropriate than use of a full cut brief.

3. The medical record should show rationale for adult incontinence products, which should be care planned as an approach to the problem for which they are being used. The restorative nurse should make a monthly summary statement about the resident's response to their use when a resident is an active participant in a bladder or bowel restorative program.

4. Raised toilet seat, slide board for transferring, toilet rails and long handled grabbers are examples of adaptive equipment commonly used to enhance the skill level of a resident. Occupational or physical therapy departments should be used as a resource when residents are experiencing difficulty completing the toileting process.



Restorative Nursing
Forms

KEY
X = Satisfactory
O = Unsatisfactory

Restorative Nursing QA Tool

Page 1

Date:	MEDICAL RECORD NUMBER:	1	2	3	4	Comments
	REVIEWER:					
Restorative Nursing	Residents are receiving care and services to attain or maintain the highest practical, physical, mental, and psychosocial well-being in accordance with assessment and plan of care.					
	Residents' abilities in ADLs have not diminished unless unavoidable in areas of:					
	Bathing, Dressing, Grooming					
	Transferring and ambulation with specific program as indicated					
	Toileting					
	Eating					
	Communication					
	Residents are given the appropriate treatment and services to maintain or improve specific abilities.					
Ambulation	Ambulation needs identified according to resident's ability to increase function or plan of care needed to maintain function.					
	Goals and approaches are care planned specific to ambulation needs of the resident					
	The prescription for ambulation is specific on the care plan and documented on the flow sheet and staff is observed to be following through consistently.					
	Staff uses gait belts consistently and appropriately.					
	PT is involved as indicated					
	ADL needs identified according to resident's ability to increase function or plan of care needed to maintain function.					
	Goals and approaches are care planned specific to what resident can do and what staff need to do to assist the resident for ADL program					
	The prescription is documented on the flow sheet and staff are observed to be following through consistently					

Restorative Nursing QA Tool
Page 2

KEY
√ = Satisfactory
0 = Unsatisfactory

Date:	*Medical Record Number*	*1*	*2*	*3*	*4*	Comments
	Reviewer :					
Restorative Dining	OT and speech involved as indicated					
	Assistive devices that are indicated are care planned and being used.					
	Staff verbalizes and demonstrates knowledge of goals and approaches for residents they are working with in restorative dining.					
	Restorative dining takes place 3 meals/day, 7days/week					
	Residents in restorative dining program meet the criteria for restorative dining.					
Range of Motion	A resident who enters the facility without a limited ROM does not experience reduction in ROM unless clinically unavoidable. F-317					
	A resident with limited ROM receives appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM. F-318					
	Residents at risk for contractures or further contractures are identified by assessment.					
	ROM approach on the care plan identifies the type, how often and by which discipline on which shift.					
	The prescription for ROM is on the flow sheet and staff is observed to be following through consistently.					
	Hand rolls/cones/braces/splints are in place as indicated on the care plan.					
	OT/PT involved as indicated.					
Communication	Communication problems or risks for communication problems are identified.					
	Goals and approaches specific to the communication needs are care planned.					

Restorative Nursing QA Tool
Page 3

KEY
X = Satisfactory
O = Unsatisfactory

Date:	*Medical Record Number:*	*1*	*2*	*3*	*4*	Comments
	Reviewer :					
Continence Management	Residents who enter the facility without an indwelling catheter are not catheterized unless the clinical condition demonstrates that it was necessary. F-315.					
	Residents who are incontinent of bladder receive appropriate treatment and services to prevent UTI and to restore as much normal bladder function as possible. F-316.					
	There are valid justifications for Foley catheters.					
	Evaluations as to continued appropriateness are done periodically.					
	All incontinent residents have an evaluation to determine if bladder retraining is an appropriate approach and to attempt to determine the cause.					
	Incontinence is addressed on the care plan with bladder retraining, scheduled toileting, or other approaches to demonstrate a system for managing incontinence is in place.					
	Potential for infection is identified as a problem on care plan for those residents who are incontinent of urine or who have a catheter.					
	Staff is following through with the steps and procedures for bladder retraining and for toileting programs.					
Organization	MDS and additional assessments accurately reflect the resident's status.					
	Master lists are current and available on all units.					
	All restorative care that is care planned is on a flow sheet. Flow sheets are filled out including minutes. Minutes observed are accurate.					
	Care plan goals and progress or regression are evaluated and documented appropriately					
	CNAs and nurses understand their roles and are consistently following through.					