RESTORATIVE NURSING NEEDS IDENTIFICATION

Directions: Complete in conjunction with Admission, Quarterly, Annual and Significant Change in Status assessments. Answer all items in the Resident Function column then check the amount of supervision or assistance needed in the Restorative Programs column. 0 = Independent; 1 = Supervision (cueing, oversight, encouragement); 2 = Limited Assistance (resident highly involved, staff provide maneuvering of limbs or non-weight-bearing assist); 3 = Extensive Assistance (resident involved - staff provide weight-bearing assist); 4 = Total Dependence (staff perform 100%). Complete the evaluation by checking the RP (Restorative Program) box if the resident could benefit from that Restorative Program. This will be a combination of answers in the Resident Function area as well as Supervision (1) to Extensive Assistance (3) needed. Record additional comments/notes on the reverse side including action taken for the items for which a restorative program is indicated.

RESTORATIVE PROGRAMS	RESIDENT FUNCTION
RANGE OF MOTION/ROM (Active & Passive) ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Functional limitations ❍ No ❍ Yes LUE ❍ No ❍ Yes Joint(s) involved: ❑ Shoulder ❑ Elbow ❑ Wrist ❑ Hand RUE ❍ No ❍ Yes Joint(s) involved: ❑ Shoulder ❑ Elbow ❑ Wrist ❑ Hand LLE ❍ No ❍ Yes Joint(s) involved: ❑ Hip ❑ Knee ❑ Ankle ❑ Foot RLE ❍ No ❍ Yes Joint(s) involved: ❑ Hip ❑ Knee ❑ Ankle ❑ Foot
SPLINT/BRACE ASSISTANCE ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Uses brace or splint ❍ No ❍ Yes Able to remove ❍ No ❍ Yes Able to apply ❍ No ❍ Yes Able to care for the device ❍ No ❍ Yes
BED MOBILITY ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Moves to and from a lying position ❍ No ❍ Yes Turns from side to side ❍ No ❍ Yes Positions self in bed ❍ No ❍ Yes
TRANSFER ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Able to move from bed to chair ❍ No ❍ Yes From chair back to bed ❍ No ❍ Yes Move to a standing position ❍ No ❍ Yes
AMBULATION ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Able to walk ❍ No ❍ Yes Requires assistive device(s) to walk ❍ No ❍ Yes If Yes, device(s) used: ❑ Cane ❑ Crutches ❑ Walker ❑ Other_____ Does resident require assistance to walk ❍ No ❍ Yes If Yes, type of assistance: ❑ Guided maneuvering ❑ Weight-bearing support
DRESSING/GROOMING ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Locates, selects, obtains clothing ❍ No ❍ Yes Uses snaps ❍ No ❍ Yes Uses buttons ❍ No ❍ Yes Uses zippers ❍ No ❍ Yes Puts on upper body clothing ❍ No ❍ Yes Removes upper body clothing ❍ No ❍ Yes Puts on lower body clothing ❍ No ❍ Yes Removes lower body clothing ❍ No ❍ Yes Shoes: Puts on ❍ No ❍ Yes Takes off ❍ No ❍ Yes Socks: Puts on ❍ No ❍ Yes Takes off ❍ No ❍ Yes Support stockings ❍ No ❍ Yes Puts on ❍ No ❍ Yes Takes off ❍ No ❍ Yes Able to brush teeth/clean dentures ❍ No ❍ Yes Comb/brush hair ❍ No ❍ Yes Shave ❍ No ❍ Yes ❍ NA Able to wash/dry face ❍ No ❍ Yes Clean fingernails ❍ No ❍ Yes Apply makeup ❍ No ❍ Yes ❍ NA
EATING/SWALLOWING ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Hold and use utensils ❍ No ❍ Yes Get food from plate to mouth ❍ No ❍ Yes Able to scoop food onto utensil effectively ❍ No ❍ Yes Swallowing problem ❍ No ❍ Yes Chewing problem ❍ No ❍ Yes Hand tremors ❍ No ❍ Yes Able to hold a glass ❍ No ❍ Yes Cup ❍ No ❍ Yes Drink without spilling ❍ No ❍ Yes Uses fingers to eat ❍ No ❍ Yes
COMMUNICATION ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Speech: Clear ❍ No ❍ Yes If No, slurred or mumbled words ❍ No ❍ Yes Unable to speak ❍ No ❍ Yes Another way to communicate ❍ No ❍ Yes If Yes: ❑ Communication board ❑ Gestures ❑ Sign language ❑ Writing ❑ Other_____
AMPUTATION/PROSTHESIS CARE ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❑ **RP**	Has prosthesis ❍ No ❍ Yes Type: ❑ Limb ❑ Eye ❑ Other_____ If limb, identify the body part_____
FACTORS CURRENTLY IMPACTING RESIDENT'S ABILITY TO PERFORM ADLs ❑ **RP**	Medical: Decline in medical status ❍ No ❍ Yes Unstable or acute conditions ❍ No ❍ Yes On psychoactive medications ❍ No ❍ Yes Pain present ❍ No ❍ Yes Behavior: Daily behavior problems ❍ No ❍ Yes Little or minimal response to intervention ❍ No ❍ Yes Mood: Persistent mood problems ❍ No ❍ Yes Cognitive: Decision making ability impaired ❍ No ❍ Yes Has the ability to learn ❍ No ❍ Yes Sensory: Vision deficits ❍ No ❍ Yes Hearing deficits ❍ No ❍ Yes
TASK SEGMENTATION ❑ **RP**	Would task segmentation be beneficial for this resident ❍ No ❍ Yes

Clinician Signature/Title:_____ Date:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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NOTES

Clinician Signature/Title:_____ Date:_____

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