Month/Year_____ **RESTORATIVE NURSING CARE FLOW RECORD**

Functional Improvement Area:_____

Goal:_____

Program:_____

_____ Program Start Date:_____

CNAs: When "R" or "W" is marked on the daily column, also write in the Weekly Narrative Notes the reason for each. Observed concerns during resident's program must also be included in the Weekly Narrative Notes. Report these items to a nurse, according to facility policy and include name/title of nurse reported to. A Nurse will complete the monthly progress note.

NURSES: To ensure reimbursement is maximized, a facility must show evidence of periodic evaluation by a licensed nurse. Recommended: Weekly notes x 4 when program is initiated; monthly as program continues, progresses and adjustments being made; quarterly when no more improvement is expected, resident is maintaining and program stable.

WEEK 1 (R = Refused W = Withheld)								WEEKLY NARRATIVE NOTES
Day of Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	
Time/Initials								
Minutes								
Time/Initials								
Minutes								
Time/Initials								
Minutes								
Total Daily Minutes								

WEEK 2 (R = Refused W = Withheld)								WEEKLY NARRATIVE NOTES
Day of Month	**8**	**9**	**10**	**11**	**12**	**13**	**14**	
Time/Initials								
Minutes								
Time/Initials								
Minutes								
Time/Initials								
Minutes								
Total Daily Minutes								

WEEK 3 (R = Refused W = Withheld)								WEEKLY NARRATIVE NOTES
Day of Month	**15**	**16**	**17**	**18**	**19**	**20**	**21**	
Time/Initials								
Minutes								
Time/Initials								
Minutes								
Time/Initials								
Minutes								
Total Daily Minutes								

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

RESTORATIVE NURSING CARE FLOW RECORD

WEEK 4 (R = Refused W = Withheld)							WEEKLY NARRATIVE NOTES
Day of Month	**22**	**23**	**24**	**25**	**26**	**27**	
Time/Initials							
Minutes							
Time/Initials							
Minutes							
Time/Initials							
Minutes							
Total Daily Minutes							

WEEK 5 (R = Refused W = Withheld)							WEEKLY NARRATIVE NOTES
Day of Month	**28**	**29**	**30**	**31**			
Time/Initials							
Minutes							
Time/Initials							
Minutes							
Time/Initials							
Minutes							
Total Daily Minutes							

INITIALS	SIGNATURE	INITIALS	SIGNATURE

MONTHLY SUMMARY EVALUATION NOTE

_____

_____

_____

_____

_____

_____

_____

❑ Continue Program ❑ Discontinue Program ❑ Revise Program

Revisions, if indicated:_____

_____

Nurse Signature:_____ **Date/Time:**_____