Overview

- Restorative Nursing is not a new concept
- Techniques have been taught in nursing school and CNA training programs for decades.
- Restorative measures are not a separate entity, but should be integrated into routine nursing care
- Restorative Nursing is based on a belief in the dignity and worth of each individual, moving away from stereotyping or labeling a person by injury, age or diagnosis.
Restorative Program

“Program” – is defined as “a specific approach that is organized, planned, documented, monitored and evaluated.

Goals

- To return or maintain an individual to their highest practicable physical, mental and psychological functional level and well being.
- Utilizing the skills and expertise of each discipline to plan, implement and facilitate all pathways for the best individual outcomes.
- For some residents this means being discharged home or maintaining as much independence as possible.
Restorative

- Instituting an individualized, effective program means a program will be implemented to assure an individual will not deteriorate or diminish unless circumstances, such as a progressive deteriorating condition, makes the decline unavoidable.

Criteria

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by a licensed nurse must be present in the clinical record.
- Certified nurse assistants must be trained in the task and in the techniques that promote resident involvement in the activity.
Criteria

- This category does not include exercise groups with more than four residents per care giver.
- These activities are carried out or supervised by members of the nursing staff.
- Restorative Nursing can be working in conjunction with formalized therapy, when preparing a resident for discharge from therapy services, or working independently when formalized services are not indicated.

Why Rehabilitation?

- Hazards of Immobility – Historical Perspectives
  - Hippocrates:
    - Exercise strengths
    - Inactivity weakens
  - “Rest until healed” philosophy popular from 1863 until WWII
  - Space research led to belief in benefits of early mobilization
Hazards of Immobility

- Immobility effects everybody system:
  - Musculoskeletal System:
    - Osteopenia (bone loss) leads to fractures with minimal movement and exercise
    - Prevention
      - Early mobilization
  - Cardiovascular System
    - System wide problems
      - Redistribution of body fluids
      - Postural hypotension
      - Thromboembolus
    - Prevention
      - Early mobilization
    - Correction
      - Gradual reconditioning
Hazards of Immobility

- Immobility effects every body system:
  - Integumentary System (Skin)
    - Pressure ulcers
      - Just 2 hours of pressure may result in tissue damage for an individual with impaired sensation
    - Prevention
      - Identification of those at high risk
      - Early mobilization
  - Respiratory System
    - Pneumonia
      - Caused by decreased airway clearance
      - Caused by pooling of secretions
    - Prevention
      - Early mobilization
Hazards of Immobility

- Immobility effects every body system:
  - Genitourinary System
    - Calculi
      - Caused by absorption of calcium (as bone loss occurs)
    - Urinary tract infections
      - Inadequate bladder emptying, inadequate hydration associated with immobility
  - Prevention
    - Early mobilization

Hazards of Immobility

- Immobility effects every body system:
  - Gastrointestinal System
    - Anorexia
      - Caused by decreased metabolism
    - Constipation
    - Prevention
      - Early mobilization
Hazards of Immobility

- Immobility effects every body system:
  - Central Nervous System
    - Hallucinations and disorientation
    - Prevention
      - Early mobilization

Immobility and Dependence

- Loss of mobility
  - Directly linked with a need for assistance
  - Directly linked with a need to rely on others for daily care
  - Directly linked with a loss of independence

One of the most common fears of older adults is the fear of loss of independence.
Impact of Increased Dependence

- Fear of dependence causes anxiety
  - Loss of function and role
  - Loss of purpose and self worth
  - Loss of privacy
  - Loss of home and community

Defining Nursing Rehabilitation

- Components of a Restorative Nursing Program are:
  - Restore to original status or improve the level of independence post-decline of an ADL skill
  - Stabilize the primary problem
  - Prevent secondary complications (incontinence, decreased)
  - Maintain or improve a resident’s functional abilities in Activities of Daily Living (ADLs)
  - Promote resident ability and wellness and where possible, preventing decline or loss of independence
  - Enable residents to achieve and/or maintain their highest practicable level of functioning
Why Restorative Nursing?

- Maintain or improve a resident’s functional abilities in Activities of Daily Living (ADLs)
- Promote resident ability and wellness and where possible, preventing decline or loss of independence
- Enable residents to achieve and/or maintain their highest practicable level of functioning

It’s our responsibility to promote wellness, self-determination and independence in the lives of the people under our care and influence!!

Why Restorative Nursing?

- Restorative Nursing is not a new concept
- Techniques have been taught in nursing school and CNA training programs for decades.
- Restorative measures are not a separate entity, but should be integrated into routine nursing care
- Restorative Nursing is based on a belief in the dignity and worth of each individual, moving away from stereotyping or labeling a person by injury, age or diagnosis
Restorative Nursing Program Timing

- A resident is re-admitted or admitted to the center and is not a candidate for skilled therapy
- A resident who is receiving a skilled therapy service or a resident who is identified for a need of a restorative nursing program by an IDT team member
- When a resident is close to discharge from a skilled therapy program, the therapist would be communicating the need for a restorative program and to begin a discussion with the IDT to establish goals and approaches to ensure continuity of care

Restorative Nursing Program

**Level I:** Transition from therapy; involves the licensed nurse and nursing assistants. The services provided at this level are those tasks established, delegated, taught and supervised by therapy and nursing.

**Level II:** Involves the trained nurses and nursing assistants. Restorative nursing measures are provided to maintain a function, or attain a higher level of functioning.

**Level III:** Functional maintenance; becomes part of the every day way we care for the resident.
Restorative Nursing Drivers

Other drivers of restorative nursing practices are:

- Federal regulations,
- QI/QM,
- 24 Hour Report process
- 5 Star Quality Rating System
- Survey Results
- Resident Quality of Care

Restorative Nursing Program

- Nursing care delivered with the purpose of improving a person’s ability to participate in daily living activities such as bathing, dressing, transfer & ambulation, grooming, eating, toileting and joint range of motion
- Provided to any resident who shows potential.
- Provided by all nursing personnel
- Provided for at least 15 minutes during a 24 hour period (does not have to be 15 consecutive minutes)
- May be provided to reinforce direct therapy plans
- Accomplished during routine care activities 24 hours a day; 7 days a week
- A program developed by the IDT including input from a therapist. The therapy department works closely with the nursing staff in communicating goals and recommending approaches to assure continuity of the plan of care and continued progression of the resident
Restorative Nursing Program (Cont)

- Managed by the nursing management team in partnership with therapy as applicable
- Limited to no more than 90 days based on IDT evaluation of individual resident goals and accomplishments. If the resident would benefit from further restorative programming the resident individual goals must be changed to reflect the new/updated programming
- Self-limiting based on the resident’s abilities and it progresses to a functional maintenance program which becomes “the way we care for our residents”

Restorative Nursing is NOT!

- A continuation of direct therapy activities
- Relegated to 15 minute blocks of time
- Mandated by or managed by a therapist alone
- An unending program
- Provided solely by a specialist (e.g., Restorative Aide) although individual centers may deploy personnel for that purpose
- Extra duty
Restorative Nursing Implementation

-APIE

- Assess
- Plan
- Implement
- Evaluate

Restorative Nursing Program

- The program relies on evidence-based treatment protocols and standards of practice and focuses on three aspects of care. They are to:

  - Maintain or improve a resident’s functional abilities in Activities of Daily Living (ADLs).
  - Promote resident ability and wellness and where possible, preventing decline or loss of independence.
  - Enable residents to achieve and/or maintain their highest practicable level of functioning.
Identifying a Resident for Restorative Nursing

- **PreAdmission Screening**
  - Whether or not the resident is a direct therapy candidate, the team should begin thinking about the restorative possibilities for the resident.

Upon Admission

- The Interdisciplinary Team (IDT) assesses/evaluates the resident using the assessments and evaluation tools from RCMS, MDS & RAI protocols.
- When admitted with restorative needs, but is not a candidate for skilled therapy.
- During and after skilled therapy.
- When a need arises during the course of his/her stay.
- The IDT assessments / evaluations along with resident and family interviews presents a snapshot of the residents past and current status.
Comprehensive Assessment

- Comprehensive assessment / evaluation data is utilized to assist the IDT to more effectively determine if a resident is more suited to active restorative care or, depending on circumstances, more suited to a functional maintenance program.

- The difference between the two programs is:
  - A restorative program is geared toward improving or reinforcing functional abilities (Levels I and II).
  - A functional maintenance program focuses on keeping current abilities from declining (Level III).

Determine Individual Interventions

- Many times a resident can benefit from participating in more than one restorative program at the same time. These programs can and should be implemented in a complimentary fashion – a.k.a. companion programs - that means in pairs.
  - For example; a resident whose restorative plan includes toileting and ambulation should certainly be walked to the bathroom.
Case Study

- Let’s say you’re worried about Mary...
  - She has had a recent fall due to new onset of urinary incontinence. During the root cause analysis, she was slightly weaker when walking and now needs more assistance with toileting

- We would consider the following programs:
  - Restorative ambulation
  - Restorative bowel and bladder

Case Study - Answer

- Restorative Ambulation / Walking Program
- Restorative Bowel and Bladder/ Transfer Training
- Refer to handouts
Writing the Restorative Plan

- Once the decision has been made regarding the suitability of a resident for restorative nursing, it’s time for care planning.
- Restorative interventions should be activity based – that means they should occur during the residents normal daily care activities

Example

- A resident has been discharged from therapy and is able to walk 200 feet with a walker and supervision. For the purposes of restorative care planning, we will consider that ability as just that, his ability.
- If the resident is able to walk 200 feet, then he should certainly have the potential to or be able to walk 20 feet 10 times. His goal may be as simple as walking to and from the bed or chair to the bathroom several times during the day.
- The nursing staff is not required to schedule a time for the resident to ambulate. We would not limit the ambulation to just the bathroom, we would build ambulating opportunities into the care plan based on his abilities
Care Plan Goals

1. “Mr. Jones will walk to and from the bathroom with a walker and supervision.”
2. “Mr. Jones will walk in the corridor from his room to the dining room for breakfast and lunch with a walker and supervision.”

Keys For Developing A Successful Care Plan

- Keep it simple
- Focus on the resident’s ability to participate
- Make it realistic
- Construct it as part of the resident’s daily care routine
- Keep to a timeframe
Responsibility

- The collaboration of the IDT and the therapy manager will assist with the development of the residents individualized restorative program(s). The licensed nurse is responsible for communication to the primary care physician and writing the restorative program, development of the individualized care plan and the C.N.A. care card, and notification of the responsible party.

Program Implementation

- We must fit the restorative interventions into the care routine where it will do the resident the most good and makes sense (work smarter not harder).
- Restorative programs have been broken down into five categories of daily activities
Program Implementation

- Suggested daily care activities that can be associated with the Restorative Programs include:
  - A.M. Care
  - P.M. Care
  - Meals & Dining
  - Hygiene pre & post meals, between meals
  - Shower/ Tub/Bed Bath

Nursing Assistant Care Sheet

<table>
<thead>
<tr>
<th>Nursing Assistant Work Sheet</th>
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<tbody>
<tr>
<td>Date:</td>
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</table>
Documentation

- All restorative nursing must meet the following criteria:
  - There are two programs outlined for the resident based on individual clinical needs
  - There are measurable objectives and interventions documented in the care plan and medical record.
  - There is periodic evaluation documented by a licensed nurse.
  - The nursing assistants are trained in restorative interventions and training is documented.
  - The programs are carried out/supervised by nursing staff
Restorative Nursing Implementation

- The Restorative Nursing Program Flow Sheet and the Care Plan should outline the specific goals and interventions.
- The care appropriate for each resident is evaluated, care planned and delivered.

Documentation

- The Restorative Nursing Program Documentation should address:
  - Track the daily minutes (and feet, if applicable)
  - Monitor weekly progress
  - Summarize overall achievements monthly.
Documentation

- **Restorative Minutes** are documented 24/7 during programming. The minutes equal the amount of time spent with a resident trying to have the resident accomplish a particular task and are not the measure of success – just the time spent. Time spent is individual and will vary based on each resident’s abilities. Minutes are documented each shift and must be equal to or greater than 15 minutes over a 24 hour period to qualify as restorative programming for regulatory purposes.

Documentation Case Study

- **Example 1:** One of Fred’s restorative goals is to ambulate to the bathroom. He does this at least twice a shift and it takes approximately 9 minutes each time. He is on an ambulation restorative program and a bowel and bladder (prompted voiding) program. That adds up to 54 minutes in a 24 hour period.

- **Example 2:** You spend 10 minutes cueing Ethel to feed herself, and you spend 20 minutes feeding her, that adds up to 30 minutes.
Case Study

The **Weekly Note** may be written by a NURSING ASSISTANT if it is signed by a licensed nurse and should describe general progress or setbacks based on the time spent.

- Example:
  - *The Weekly Note may be written by a NURSING ASSISTANT if it is signed by a licensed nurse and should describe general progress or setbacks based on the time spent.*

Documentation

- **Monthly Note**
  - Is completed by a licensed nurse and should summarize the overall status of the resident progress toward the goals in the programs.
  - Example:
    - *Ethel has been successful this month in increasing the amount of time that she can feed herself with the adaptive devices. She has progressed from an average of 5 minutes to about 12 minutes feeding her self per meal. Although she tires at supper time and cries out of frustration, she is getting stronger. Last week we spent time talking with her prior to supper and she seems less frustrated.*
Documentation

- Documentation of restorative minutes, weekly notes, and monthly summary, stops when the resident is no longer on a restorative program.
  - NOTE: Remember, just because the restorative documentation ends, the care does not. The restorative interventions simply become “the way we care for that resident”.

Restorative Nursing Program Evaluation

- The duration of restorative programs should be, by design, an individualized matter. The IDT evaluates each resident on a weekly/monthly basis. The quarterly IDT care plan review is a check point for the IDT to ask the following questions:
  - Has there been progress?
  - Can the resident do more?
  - Can we do more?
  - Have we reached the goals or an impasse and is it time to stop?
  - Do we discontinue the programs?
Evaluation

The IDT evaluates the resident’s restorative care plan during the quarterly care plan meeting to determine if the resident’s goal was met, exceeded or not met. The IDT will determine whether further progress is possible, or if additional restorative programs/goals/revisions are appropriate.

Evaluation

The resident’s care plan is then:

- Updated to continue with current programs, or
- Revised for additional restorative interventions, or
- Finalized and the interventions become “the way we care for that resident” moving forward.
Making Restorative Nursing Program Work

- Nursing Assistants need education and training as well as positive reinforcement so that they can integrate restorative into “the way we care for our residents”
- Charge Nurses must understand which restorative programs have been implemented so that they can monitor and coach both the Nursing Assistants and residents alike
- The Unit Managers work with the IDT to ensure that the restorative plans are realistic. They must also serve as champions of the program and provide constructive reinforcement to the floor staff
- The ADNS/designee spearheads the process. It will take consistency and perseverance to implement and develop effective restorative programming
- Therapists need to collaborate with nursing to establish restorative goals and approaches to achieve the desired outcome for the restorative program
- Administrator and department managers to teach and train on the “Hey Therapy” approach to resident advocacy

Implementation Plan

- Review residents in your center using the restorative programming tools.
- Determine which residents would benefit from restorative programming or therapy.
- Institute a daily process through the Morning Clinical Meeting
Restorative Program

✎ TARGET IS DEPENDENT ON YOUR RESIDENTS’ NEEDS

- Generally at least 10 - 15% of the center’s residents require restorative programming

Restorative Program

SAMPLE FLOOR PLAN
Structure Nursing Assistant assignments based on the ADL scores of the residents

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<tr>
<th>B</th>
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<th>B</th>
<th>SHOWER</th>
<th>SOILED UTILITY</th>
<th>COMMON ROOM</th>
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<tbody>
<tr>
<td>A</td>
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<td>A</td>
<td>119</td>
<td>117</td>
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<td>A</td>
<td>113</td>
<td>111</td>
<td>110</td>
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</table>

1. Place the ADL code for each resident.
2. Evaluate the work load based on the care needs of the residents.
## Restorative Dining – Adaptive Eating Utensils

<table>
<thead>
<tr>
<th>UTENSIL</th>
<th>RESTORATIVE USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angled/Curved spoon or fork</td>
<td>Utensils made with the spoon or fork bent toward the resident making it easier to reach the mouth</td>
</tr>
<tr>
<td>Built-up spoon, fork or knife</td>
<td>Utensils with larger handles that helps residents with limited ROM to hold onto a knife, fork or spoon</td>
</tr>
<tr>
<td>Double handle cup</td>
<td>A cup with 2 handles so that a resident can grasp both handles to stabilize the cup when drinking</td>
</tr>
<tr>
<td>Noisy cup</td>
<td>A cup or glass, with a section cut away, making it easier for a resident with limited neck mobility to drink liquids</td>
</tr>
<tr>
<td>Plate Guard</td>
<td>A rim that fits on the edge of a plate that helps the resident, with limited ROM to eat by pushing food against the guard and onto a fork or spoon</td>
</tr>
<tr>
<td>Rocking Knife</td>
<td>A knife with a special curved blade that helps a resident cut food by rocking the blade back and forth</td>
</tr>
<tr>
<td>Scoop Dish</td>
<td>A plate with a rounded edge that allows a resident with limited ROM to push food against the plate edge onto a spoon or fork</td>
</tr>
<tr>
<td>Sippy cup or Straw Holder</td>
<td>Cup with a cover with a tip that allows a person to sip fluids. A straw holder does the same thing but uses a straw in place of a covered container</td>
</tr>
<tr>
<td>Weighted cup</td>
<td>A cup with a weighted bottom to assist a person with hand tremors</td>
</tr>
<tr>
<td>Weighted utensils</td>
<td>Knives, spoon, forks with a little extra weight on the handles to provide stability for a person with hand tremors</td>
</tr>
</tbody>
</table>

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## Restorative Nursing – ADL Assistive Devices

<table>
<thead>
<tr>
<th>DEVICE</th>
<th>RESTORATIVE USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Button hook – zipper pull</td>
<td>A tool that helps the resident, with limited ROM to dress himself/herself by securing buttons and/or pulling a zipper</td>
</tr>
<tr>
<td>Long handled sponges, combs/brushes</td>
<td>Sponges, combs or brushes with extended handles that allows a person with limited ROM to bathe him/herself</td>
</tr>
<tr>
<td>Long shoe horn</td>
<td>A shoe horn with an extended handle that allows a resident with limited ROM to put shoes on</td>
</tr>
<tr>
<td>Raised toilet seat</td>
<td>A device, usually of molded plastic that allows a resident with limited ROM to sit on the toilet</td>
</tr>
<tr>
<td>Reacher</td>
<td>A tool that helps the resident, with limited ROM to reach or pick up items</td>
</tr>
<tr>
<td>Resting hand splint</td>
<td>A device that is hard or soft cloth covered plastic that holds a resident’s hand in a neutral position and is used to prevent the fingers from curling into a fist (contracture)</td>
</tr>
<tr>
<td>Rolling walker</td>
<td>A walker with wheels on it that allows a resident with limited ROM push the walker along as opposed to picking it up and moving it</td>
</tr>
<tr>
<td>Shower chairs</td>
<td>A chair with or without a back, or with an extended seat that allows a resident with limited ROM or balance to sit in a shower or bathtub,</td>
</tr>
<tr>
<td>Sock aid</td>
<td>A device that helps a resident with limited ROM to dress himself/herself by pulling on socks</td>
</tr>
</tbody>
</table>
Adaptive Devices

ANGLED UTENSILS

DOUBLE HANDLED CUP

DRESSING STICKS

BUTTON HOOK WITH ZIPPER-PULL

Question and Answer

Tell me how you are using devices?
Types of Restorative Programs

- **Range of Motion (Passive)** - resident takes no part in the activity-moving the body part around a fixed point or joint thru the resident’s available ROM. Must be planned, scheduled and documented.

- **Range of Motion (Active)** - exercises performed by resident with cueing and supervision by staff that are planned, scheduled and documented.

- **These count as one service even if both are documented.**

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Types of Restorative Programs

- **Eating or Swallowing** - activity used to **improve** or maintain self-performance in feeding one’s self food and fluids, or activities used to improve or maintain resident’s ability to ingest nutrition and hydration by mouth.

- **Communication** - activity used to **improve** or maintain self-performance in newly acquired functional communication skills or assisting in using residual communication and adaptive services.
Types of Restorative Programs

- **Amputation/Prosthesis Care** - activity used to **improve** or **maintain** in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body. (e.g., stump or eye socket)

- **Dentures are not considered in this coding.**

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Types of Restorative Programs

- **Schedule toileting program and/or bladder retraining program** - count as one service. This is usually placed on the ADL flow sheet and documented on each time the schedule is completed and the resident’s response to the modality. The exact description of the plan must be documented including frequency, reason, and response.
Schedule toileting cont.

- The plan must be periodically evaluated and revised as necessary, which would include documentation of the resident’s response to the plan.
- This does not include routine changing of resident’s incontinent briefs, pads, or linens when wet, where there is no participation in the plan by the resident.

Types of Restorative Programs

- **Splint or Brace Assistance**—can be of 2 types: 1) where staff provides verbal and physical guidance and direction that teaches the resident how to apply, manipulate and care for the brace/splint or 2) staff have a scheduled program of applying and removing a splint/brace, observing the resident’s skin and circulation under the device and correct position of the limb. These activities again must be planned, scheduled and documented.
Types of Restorative Programs

- **Other**-any other activities used to improve or maintain the resident’s self performance in functioning. (e.g., teaching self-care for diabetic management, self-administration of medications, ostomy care, cardiac rehabilitation. These must be planned, scheduled and documented. Remember a periodic evaluation by the licensed nurse has to be done.

MDS End Splits

- Any 2 or more nursing rehab services as stated in the previous slides for at least 15 minutes each on 6 of last 7 days of the assessment period will effect low rehab, impaired cognition, behavior and reduced physical function categories on the MDS.
Quality Care and Reimbursement, too

- Under the prospective payment system, restorative nursing provided in conjunction with skilled rehabilitation therapy can place a resident in the low Resource Utilization Group (RUG) category.
- "The lower 18 RUGs are all broken down as to whether the resident receives restorative nursing services or not, which affects the skilled nursing facility's [SNF] payment."
- Restorative care can also help residents maintain the functioning they achieve by participating in skilled rehab therapy. "In such a case, the rehab therapists set up the program as a step down."

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Quality Care and Reimbursement, too

- Therapists can help set up a restorative care program that's just nursing-and they get reimbursed under Part B for setting up the program if it's due to a decline in condition and is a medically necessary service. "Rehab therapy could pick up the resident for Part B service for a short period of time and train the CNAs [certified nursing assistants] in restorative care as part of the plan of care,"
Medicare PPS Criteria

- SNFs have to meet very specific criteria before Medicare Part A will cover restorative nursing care. "You have to provide two restorative programs equal to or more than 15 minutes in a 24-hour period, six out of seven days—that's 30 minutes or more per day."
- Your program must be supervised by a licensed nurse and provided by people who are trained to do the program, although there are no specifications as to how much training or what types of staff can do it. The facility can have activities staff or even trained volunteers do restorative programs.
  - "The restorative program also has to be an integral part of the resident's plan of care with clearly measurable goals and interventions and periodically evaluated by a licensed nurse." "The goal for the resident does not have to be progress—it can be to maintain functioning."

Documentation

- "The documentation on the MDS that triggers the RUG must be accurate and complete, if the MDS is not coded accurately, even if the facility provided the services, it won't get paid."
- The clinical record and other documentation must substantiate the MDS coding of the restorative minutes, services, and days. The clinical record must also show evidence that the restorative program is being evaluated periodically by the licensed nurse. Boyer suggests using a documentation tool such as a flowsheet, which has the times restorative nursing staff have provided treatments. "The 15 minutes per program can be broken up throughout the 24-hour day—it doesn't have to be all at one time," she says.
How Restorative Nursing Affect Resident Quality of Life

- Restorative nursing programs affect resident quality of life by allowing the resident to be as independent as possible. Restorative nursing programs also affect reimbursement, survey, and resident/family facility choice. These programs are vital to your facility’s success.
- Functional decline, on the other hand, can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers. Functional decline has been described as the “main determinant of quality of life, cost of care, and vital prognosis” (Baztan, 2009). The OBRA legislation and Medicare recognized the importance of preventing decline and created both a legislative and financial incentive to provide restorative nursing programs in skilled nursing facilities.

Measures That Affect Restorative Nursing Programs

- In March of 2011, the National Quality Forum released 21 measures for public reporting and quality improvement that will be used at the Nursing Home Compare website. Both short-stay and long-term residents are included in this data. The measures that affect restorative nursing programs are:
  - Percentage of residents who need increased help with activities of daily living.
  - Physical therapy or restorative nursing for long-stay residents with a new balance problem.
  - Percentage of long-term residents experiencing one or more falls with major injury.
  - Percentage of low-risk residents who lose control of their bowels or bladder.
  - Percentage of long-term residents who have a catheter inserted and left in the bladder.
How Restorative Care Affects Quality of Life

Restorative nursing is basically person-centered, whole-person nursing care; the kind of nursing that we practice every time we care for a resident. The difference in a formalized restorative nursing program is that activities of daily living are considered therapeutic modalities.

Nursing assistants are trained to instruct, encourage, guide, and assist residents to perform self-care skills with as much independence as possible. Quality of life is a natural outcome of restorative care.

Restorative Nursing Case Mix

A restorative nursing program must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Defined as during the observation period.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff.
- This category does not include groups with more than four residents per supervising helper or caregiver.
**REHABILITATION (4 Categories)**

In the last 7 days were:
- 45 minutes or more combined total of therapy provided AND
- At least 3 days of any combination of the 3 disciplines AND
- 2 or more Restorative Nursing Services* received each for at least 15 minutes, each administered for 6 or more days, including urinary toileting program or bowel training program

**Case Mix**

- IB2 Impaired Cognition / Restorative Nursing Services (2 or more services)  ADL 6-10
- IB1 Impaired Cognition / Restorative Nursing Services (0 or 1 service)  ADL 6-10
- IA2 Impaired Cognition / Restorative Nursing Services (2 or more services)  ADL 4-5
- IA1 Impaired Cognition / Restorative Nursing Services (0 or 1 service)  ADL 4-5
### Case Mix

- BB2 Impaired Cognition / Restorative Nursing Services (2 or more services) ADL 6-10
- BB1 Impaired Cognition / Restorative Nursing Services (0 or 1 service) ADL 6-10
- BA2 Impaired Cognition / Restorative Nursing Services (2 or more services) ADL 4-5
- BA1 Impaired Cognition / Restorative Nursing Services (0 or 1 service) ADL 4-5

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### Case-Mix

**Reduced Physical Function**

- ADL 16-18: Restorative PE1 → PE2
  - ADL 11-15: Restorative PD1 → PD2
  - ADL 9-10: Restorative PC1 → PC2
  - ADL 6-8: Restorative PB1 → PB2
  - ADL 4-5: Restorative PA1 → PA2
**Restorative Nursing Case-Mix**

**Reduced Physical Functioning**

- PE2 Physical Function / Restorative Nursing Services (2 or more services)
  - ADL 16-18
- PE1 Physical Function / Restorative Nursing Services (0 or 1 service)
  - ADL 16-18
- PD2 Physical Function / Restorative Nursing Services (2 or more services)
  - ADL 11-15
- PD1 Physical Function / Restorative Nursing Services (0 or 1 service)
  - ADL 11-15
- PC2 Physical Function / Restorative Nursing Services (2 or more services)
  - ADL 9-10
- PC1 Physical Function / Restorative Nursing Services (0 or 1 service)
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- PA2 Physical Function / Restorative Nursing Services (2 or more services)
  - ADL 4-5
- PA1 Physical Function / Restorative Nursing Services (0 or 1 service)
  - ADL 4-5

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**Implementation**

- An effective Restorative Care Program requires organization and all staff knowing what their duties and responsibilities are.
- This program is under the supervision of the nursing department.
  - The information is relayed to the RCNA/CNA on ADL flow sheets.
Implementation

- ALL CNA’S involved with restorative programs will be trained in delivery of those services. This may be done by therapists while resident is still receiving formalized therapy or by the trained restorative nurse supervising the program.
- Specific individual needs must be relayed to the certified nursing assistant and they are to be trained on those needs.

Restorative Nursing Program

- Divided into three levels
  - Level I – Formalized Therapy (PT, OT, ST) – Low rehab with 2 restorative programs 6 days per week – carried out by RCNA or CNA
  - Rehab Nursing Category
  - Last 7 days
    - 45 minutes or more (total) of therapy
    - And at least 3 days of any combination of the 3 disciplines
    - And 2 or more nursing rehab each 15 minutes / day 6 or more days/week
    - Must be documented in the record on a daily basis
Restorative Nursing Program

- **Level II**
  - Specified Restorative Staff – RCNA and Supervising Nurse.
  - Usually discharged from therapy to this level
  - Therapy may recommend after screening
  - In most cases residents are transferred from level II to Level III when their program has stabilized

- **Level III**
  - Involves regular CNAs and nurses on the floor
  - Restorative Dining is usually on Level II and Level III to provide coverage for 3 meals/day/7 days a week
  - Bladder retraining and toileting is done by Level III on all 3 shifts
Care Planning

- Care planning is essential to an effective Restorative program
- Serves as an outline for the care provided
- Restorative is not the problem, the reason for the restorative program is the problem
- Goal is the task or function the program helps the resident to maintain
- Approach is the specific restorative program

Documentation

- Documentation tracks progress or regression
- Document toward the care plan. Charting to goals and approaches
- Care plan should be updated as resident status changes
- A baseline assessment should be done with the initiation of the restorative program so that goals and objectives can be measureable
**Documentation**

- **Narrative notes should include**
  - Identify Restorative needs
  - Specific restorative program provided
  - Date program started
  - Resident response
  - If the resident is not responding as expected
  - Changes in goals and approaches
  - When a program is discontinued

---

**Documentation**

- **Charting**
  - CNA charts daily on flow sheet
  - Designated nurse charts monthly (periodic) summary
  - CNA circles the day if a resident does not participate and writes the reason on the back of the flow sheet
  - 2nd day a resident refuses the CNA circles writes a note on the back of the flow sheet and notifies the Nurse
Documentation

- Nurse documents an assessment as to why the resident did not participate and makes changes in the program as indicated
- If your computer software will allow you to code all residents to a specific code for restorative then you can generate a master list that can be reviewed as necessary.
- A good approach is to review weekly in your therapy meeting.

Criteria for Restorative

- Measurable goals and interventions must be documented in the care plan
- Must have periodic evaluation
- CNA must be trained
- Supervised by nursing staff
- Group restorative-no more that four residents in a group
- Obtain a Physician’s order for all levels for tracking purposes
Procedure

- The modalities need to be recorded separately on a flow sheet.
- The activity/modality must be recorded for a total of 15 minutes during the 24 hour period.
- The time provided for Items P3a-k must be coded separately in time blocks of 15 minutes or more.
  - For example, 15 minutes can be totaled across a 24-hour period (e.g., 10 minutes on the day shift and 5 minutes on the evening shift) however, 15 minute time increments cannot be obtained by combining P3a-P3c.

Restorative Program

- There may be situations where nursing staff request assistance from a licensed therapist to evaluate the restorative nursing aides or to recommend changes to a restorative nursing program. Consultation with nursing staff and staff training are certainly good clinical practice. This would not be coded as skilled therapy in Item P3.
Restorative Program

- Restorative nursing techniques can help prevent falls and fractures by keeping people’s bones and muscles as strong as possible.
- It gives resident’s motivation and a sense of well-being.
- The morale of the staff assisting with the restorative program need to be motivated and upbeat with a direction and goal in mind.

Restorative Program

- “Think outside the box”-be creative with different ways to get the resident’s to exercise.
- Ex. Energizing music, Wii, bingo with wrist weights, games involving groups of four, peg boards, puzzles, painting etc.
- “Be proactive-not reactive to their needs”
Types of Restorative Programs

- **Walking**: activity to **improve** or **maintain** self-performance in walking with or without assistive devices.

- **Walking/bed mobility count** as one service even if both is provided.

- **Dressing or Grooming**: activity used to **improve** or **maintain** the resident’s self-performance in dressing/undressing, bathing and washing, and other personal hygiene tasks.

---

Types of Restorative Programs

- **Eating or Swallowing**: activity used to **improve** or **maintain** self-performance in feeding one’s self food and fluids, or activities used to improve or maintain resident’s ability to ingest nutrition and hydration by mouth.

- **Communication**: activity used to **improve** or **maintain** self-performance in newly acquired functional communication skills or assisting in using residual communication and adaptive services.
Types of Restorative Programs-Training and Skill Practice

- **Bed Mobility**—activity used to improve or maintain the resident’s self-performance in moving to and from a lying position, turning from side to side and positioning self in bed.

- **Transfer**—activity to improve or maintain the resident’s self-performance in moving between surfaces either with or without assistive devices.

---

Defining Nursing Rehabilitation

- Components of a Restorative Nursing Program are:
  - Restore to original status or improve the level of independence post-decline of a ADL skill
  - Stabilize the primary problem
  - Prevent secondary complications (incontinence, decreased)
  - Maintain or improve a resident’s functional abilities in Activities of Daily Living (ADLs)
  - Promote resident ability and wellness and where possible, preventing decline or loss of independence
  - Enable residents to achieve and/or maintain their highest practicable level of functioning.
Nuts and Bolts of Restorative Nursing

- Regulations drive reimbursement, a fact of life in long-term care. Reimbursement dictates the amount of resources available for resident care and services.
- A well-managed restorative nursing program can bring profit to the facility’s bottom line. This is one of the ways that good care creates resources for more good care – a positive cycle.

MDS 3.0 Focus

- Many of the changes in emphasis that occurred with the MDS 3.0 directly or indirectly relate to restorative nursing. The MDS 3.0 focuses on toileting programs, nutrition (which relates to feeding and swallowing programs), and balance (which can be affected by transfer training and ambulation programs).
- For the program to be profitable, attention to, and support for, the restorative nursing must come from the top. The facility administrator, director of nurses, and therapy director must be on board. A facility-wide culture of restorative nursing must be present. If not, the “helpful” housekeeper who does a task for the resident instead of with the resident will undermine the program.
Nurses Roll Regarding Restorative Programs

- Nurses, not physicians or therapists, order restorative nursing programs. Therapists work with nurses as consultants. However, restorative nursing is not rehabilitation therapy. Rehab and restorative nursing are complements to one another, but not the same. Residents work to keep the skills they learned in therapy in restorative nursing programs, so there is some crossover. Therapy is based more on the medical model, while restorative nursing programs are, by definition, based on the nursing model.

- Therapy is faster-paced, and significant progress must be made in a fairly short time. Restorative nursing, on the other hand, focuses on maintaining function in a long-term, ongoing process. Improvement is hoped for but not required.

Nuts and Bolts (cont’d)

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- The need for rehabilitation is generally triggered by an acute illness or injury. Restorative nursing bases treatment on restoring or compensating for skills lost through chronic disease, disuse, or other physiological factors. There is usually not an acute episode that drives the restorative nursing process. Restorative nursing programs are most often begun when a resident is discharged from skilled physical, occupational, or speech therapy. But the reality is that most residents, by the very nature of their needing nursing home care, are restorative nursing candidates. CMS believes strongly that restorative nursing programs are appropriate for almost every resident. Quoting from the RAI Manual:

  - Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.
Reassessment and Documentation

- Reassessment and documentation for long-term care residents must be done quarterly. The quarterly assessment is a detailed overview of the resident’s abilities and current status. Progress over the quarter should be noted, using objective data from the beginning and end of the quarter. This is the time to analyze the resident’s condition. Did she progress? If not, why? If an approach is not working, replace it with another approach to try for better results.
- The RAI manual states “Nursing assistants/aides must be skilled in the techniques that promote resident involvement in the activity”. Training is an important part of any restorative nursing program. Nursing Assistant programs in schools often do not cover restorative nursing in great depth. Most facilities have a training program for restorative nursing. Nursing assistants may be compensated for completing training and passing competency tests so they can become restorative nursing assistants (RNAs).

Survey

- Thinking like a surveyor can help in identifying risk factors, decline as it starts, and possible restorative nursing programs for the resident. When a surveyor evaluates a resident, she will first look for baseline status. Then she will check for diagnoses, and consider the normal progression of these diagnozes. Is the resident worse or better than would be expected of a person with these medical problems or injuries? Have risk factors been identified and documented? Are thorough, complete assessments in the resident’s record?
- The surveyor will then turn to the care plan to assess if appropriate plans with measurable objectives are present, and if the resident and responsible parties, as well as nursing assistants, have been involved in giving input for the care plan. Reassessment and revision of the care plan should be well documented. Any resident or family teaching, counseling, or alternatives for care should also be documented.
Restorative Nursing /Regulatory

F310: A resident’s abilities in ADLs do not diminish unless circumstances of the resident’s condition demonstrate that it was unavoidable
  - Bathing, dressing & grooming
  - Transfer & Ambulation
  - Toileting
  - Eating
  - Communication

F-Tag Restorative Correlation

F311: A resident is given the appropriate treatment & services to maintain or improve his or her abilities in ADLs
Regulatory Cross References

- **F309**: Each resident must receive, and the center must provide, the necessary care & services to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care.
- **F312**: A resident is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene
- **F315**: Catheters - medical reason
- **F316**: Incontinence - restore bladder function as much as possible
- **F317**: Resident does not lose ROM unless unavoidable
- **F318**: Resident with limited ROM receives appropriate services
- **F319**: Resident psychosocial adjustment difficulty receives appropriate services
- **F320**: Resident who does not display psychosocial adjustment difficulty does not develop a pattern unless unavoidable (e.g. untreated depression)
- **F324**: Adequate supervision & assistive devices to prevent accidents
- **F325**: Maintains adequate parameters of nutritional status
- **F328**: Special needs - Resident receives proper care and treatment for special services (e.g. prosthesis)
- **F353**: Center must have sufficient staff to provide nursing and related services to maintain highest level of resident function

F-tags

- F-tags that address restorative nursing include F-309 (highest practical quality of life) and F-297 (development of a comprehensive care plan). F-309 could be described as the essence of restorative nursing: the highest practical quality of life for the resident. Highest: because nurses always aspire for the best. Practical: because we work within the limitations of the person’s physical and emotional resources.
- Other F-tags that impact restorative nursing are:
  - **F241**: dignity
  - **F272**: comprehensive assessments
  - **F279**: comprehensive care plans
  - **F310**: ensuring ADLs do not decline unless the decline is unavoidable
  - **F311**: providing appropriate care and services to maintain or improve resident abilities
  - **F312**: dependent resident receiving necessary/appropriate services
  - **F315**: incontinence programs – resident not catheterized unless unavoidable
  - **F317**: maintain range of motion unless unavoidable
  - **F318**: range of motion treatment
  - **F325**: nutritional status maintained
F-tags (cont’d)

- F155, refusal of care, can be called into play with a resident who has many documented instances of refusing restorative nursing treatments. The surveyor will look for documentation that staff attempted to determine the reason for ongoing refusal, as well as attempts to assist the resident with pain medication, adaptive equipment, seeking the family’s assistance, or other creative problem-solving activities.
- With the advent of extensive resident interviewing, the issue of resident (and family) understanding of restorative nursing programs has become very important. Some surveyors have found during interviews that the resident had no idea he was in a restorative nursing program. Even when prompted with the care plan goals, the resident denied working with staff on those goals. Some auditors even found that staff had no idea there was a restorative nursing program for particular residents. A few staff told surveyors that restorative nursing services were only given “when I have time.” This would trigger F282 – failure to follow the care plan. Good documentation and communication with the resident, family, and staff is important to assure that the surveyor hears the same information from all concerned.

F-tags that restorative nursing can help you avoid

**F-tag #300 (quality of care).** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

**F-tag #310 (decline in ADLs).** A resident’s abilities in activities of daily living do not diminish unless circumstances of the individual’s clinical condition demonstrate that diminution was unavoidable. This includes the resident’s ability to:
- Bathe, dress, and groom
- Transfer and ambulate
- Toilet
- Eat
- Use speech, language, or other functional communication Systems

**F-tag #311 (appropriate treatment to improve/maintain ADLs).** A resident is given the appropriate treatment and services to maintain or improve his or her abilities (in activities of daily living).

**F-tag #315 (urinary incontinence).** Based on the resident’s comprehensive assessment, the facility must ensure that:
- A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary
- A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible

**F-tag #317 (no reduction in range of motion unless unavoidable).** A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident’s clinical condition demonstrates that a reduction in range of motion is unavoidable.

**F-tag #318 (range of motion treatment to increase ROM and/or prevent further decline).** A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
Regulation Cross-Walk

The Regulation

Range of Motion (ROM)
Activity. Exercise performed by a resident, with or without assistance of physical or occupational therapist, that includes range of motion exercises or passive movement. The resident’s ability to perform activities of daily living (ADLs) will be determined by the resident’s physical status and personal needs and preferences.

The Regulation / Improvement Plan / Questions

P118 ($31.25/ha): A resident with a limited range of motion or arthritis, appropriate treatment and exercise to increase range of motion and/or improved attendant decreases use of range of motion.

Are passive ROM exercises provided and are passive ROM exercises performed per the plan of care?

How can the resident provide the resident’s needs and how often does the plan for range of motion exercises change?

Active ROM means that the resident actively exercises the muscles and joints and they may only need to be reminded to do this.

Passive ROM

Do you have a schedule for passive ROM?

Many of the resident needs to stretch, bend, and move their joints; the residents can do this if you help them. That’s passive ROM.

This resident needs to have a routine to do massage. The resident needs to do this on a regular basis.

See Above

Stability

Activity. Activity that involves balance or stability, such as standing, standing with support, or sitting.

The resident’s ability to maintain balance will be determined by the resident’s physical status and personal needs and preferences.

See Above

Transfer

Activity. Activity used to improve or maintain the resident’s ability to transfer to and from a sitting position, on and off the bed, or from one surface to another.

The resident’s ability to transfer will be determined by the resident’s physical status and personal needs and preferences.

Walking

Activity. Activity used to improve or maintain the resident’s ability to ambulate with or without assistance.

The resident’s ability to ambulate will be determined by the resident’s physical status and personal needs and preferences.

Bathing or Grooming

Activity. Activity used to improve or maintain the resident’s ability to bathe or groom with or without assistance.

The resident’s ability to bathe or groom will be determined by the resident’s physical status and personal needs and preferences.

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### Regulation Cross-Walk (cont.)

<table>
<thead>
<tr>
<th>Transfer</th>
<th>Activity used to improve or maintain the resident’s self-performance in the ability to move whether with or without assistive device.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer (§483.25(a))</td>
<td>A resident’s ability is a function of daily living or self-care ability (i.e., ability to maintain personal hygiene, perform personal daily activities, or self-care ability). This includes the resident’s ability to — §483.25(a)(5)(i) Transfer: Some residents have difficulty moving from their beds or chairs or just standing. We must help them in this task.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Walking</th>
<th>Activity used to improve or maintain the resident’s self-performance in walking, walking with or without assistive devices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking (§483.25(a))</td>
<td>A resident’s ability is a function of daily living or self-care ability (i.e., ability to maintain personal hygiene, perform personal daily activities, or self-care ability). This includes the resident’s ability to — §483.25(a)(5)(ii) Walking: Walking is how the resident moves from one place to another even if it is using a wheelchair for support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dressing or grooming</th>
<th>Activity used to improve or maintain the resident’s self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing or grooming (§483.25(f)(1)(ii))</td>
<td>A resident’s ability is a function of daily living or self-care ability (i.e., ability to maintain personal hygiene, perform personal daily activities, or self-care ability). This includes the resident’s ability to — §483.25(f)(1)(ii) Dressing/Grooming: Identify relevant sections of the MDS and other measures that trigger the FARs and the FARs were followed. A resident’s self-care ability in functional situations can be assessed by evaluating how the resident’s ability to perform functional activities changed since the last assessment. Was the care plan driven by resident strengths identified in the comprehensive assessment? Was the care plan consistently implemented? What changes were made in treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?</td>
</tr>
</tbody>
</table>

### What is Advocacy?

**Advocacy** is....

- Actively supporting and/or intervening on behalf of another.
- Promoting another’s well-being.
- Looking out for another.
- Standing up for someone.
- Making something important known.

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The Purpose of Advocacy

- To support a resident at their highest level of function.
- To recognize that a resident’s functional ability may decline as they age in place and that interventions may be needed to reduce the decline.
- To assure that all team members assist in helping all residents maintain their highest level of function.

Advocacy In The SNF

- The purpose of a skilled nursing facility is to provide care for those in need.
- To do this, a resident’s needs must be identified and all care that is necessary must be provided.
- By identifying needs, we “ADVOCATE” for the residents in our care.
How Does the Advocacy Team Function?

- Ongoing orientation, training, education, and mentoring of staff.
- Developing acute, proficient and skillful observational abilities in staff.
- Setting examples and expectations.
- Consistent and repeated communication.

The Restorative Nursing Program Who Should Be Referred?

- Any resident with signs of:
  - weakness
  - poor sitting posture
  - balance problem
  - memory or mental status change
  - change in ability to eat or amount eaten
  - decreased participation in activities
  - difficulty swallowing
  - difficulty talking
  - memory problem
  - taking direction
Restorative Nursing Referral Opportunities

Restorative Nursing Program

- Refer a resident with signs of weakness:
  - Takes longer to accomplish a task/activity
  - Slows down during a task/activity
  - Becomes short of breath sooner
  - Requests frequent breaks.
  - Increases requests not to “get out of bed” or to “nap”
Restorative Nursing Program

- Refer a resident with signs of poor sitting position or posture:
  - Leans to one side in w/c or when sitting.
  - “Slumps” forward when up in a chair.
  - Lacks the ability to keep trunk or head up.
  - Difficulty with or unable to complete a task due to poor posture or positioning.

Restorative Nursing Program

- Refer a resident who has fallen or shows signs of balance problems:
  - Leans to one side while sitting, standing, transferring or walking.
  - Demonstrates increased need for support while standing, transferring, walking or sitting.
  - Looses balance when transferring or walking.
  - Any fall that cannot be explained reasonably or increased number of falls.
Restorative Nursing Program

- Refer a resident who shows signs of decreased participation in activities they have enjoyed before:
  - Frequently refuses to participate in group or one-on-one activities they used to attend.
  - Requests to stay in room, or in bed or chair.
  - Expects you to do more for them.

Restorative Nursing Program

- Refer a resident with signs of a change in ROM or joint contracture:
  - Ability to dress, eat or groom self has changed.
  - Ability to transfer out of bed or onto toilet or commode has changed.
  - Ability to move hands, arms, legs or feet has changed.
Restorative Nursing Program

❖ Refer a resident with signs of change in ability to eat:

- ↓ amount eaten during a meal/snack.
- ↑ food spills on table or on resident after a meal/snack.
- ↑ time to finish eating a meal/snack.
- ↑ assistance to set up for a meal/snack.

Restorative Nursing Program

❖ Refer a resident who has signs of difficulty swallowing:

- Food remains in mouth after a meal/snack.
- Choking or coughing spell during a meal or after taking a drink.
- Face becomes red during a meal.
- Nose becomes runny during a meal and the resident does not have a head cold.
Restorative Nursing Program

- Refer a resident who has a problem talking or taking direction:
  - Speech that is not clear, is mumbled or is low in volume.
  - Slow or no response to your directions.
  - Increased problem finding the right words.

Restorative Nursing Program

- Refer a resident who has signs of a change in memory or mental status:
  - Increased confusion.
  - Increased inability to remember caregivers.
  - Increased difficulty remembering recent events.
  - Difficulty remembering how to initiate or complete a particular functional task.
Restorative/Resident Advocacy

- BED MOBILITY AND POSITIONING PROGRAM
- RESTORATIVE DINING PROGRAM
- Range of Motion (ROM)/ Active/Passive
- Transfer Training
- Ambulation Walking
- Communication
- Bowel and Bladder

Nursing Rehab

- 2 or more Nursing Rehab services at least 15 min on 6 of the past 7 days
- Urinary and or bowel training program
- Passive or AAROM
- Splint or brace assistance
- Bed Mobility and or walking training
- Transfer training
- Dressing and Grooming Training
- Eating and or Swallowing Training
- Amputation/Prosthesis Care Training
- Communication Training
Become a Resident Advocate

- What signs do you see in the residents you interact with on a daily basis?

Restorative Nursing Program

- Handouts
  - Review
How To Advocate.....

- A Therapist will follow-up with your referral and address the specific problem or area of improvement noted.
- A therapist can assist you in developing a resident specific Restorative Nursing Program.

Become A Resident Advocate

- Take an active role in improving the quality of life of your residents and serve as a resident care advocate by identifying their needs and referring to therapy as appropriate.
## Restorative Nursing

### Companion Restorative Programs Matrix

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>Range of motion</th>
<th>Sphincter &amp; Bladder</th>
<th>Bed Mobility</th>
<th>Transfer</th>
<th>Dressing/Grooming</th>
<th>Eating/Swallowing</th>
<th>Amputation/Prosthesis</th>
<th>Communication</th>
<th>Bowel &amp; Bladder</th>
<th>Toileting</th>
</tr>
</thead>
</table>
| Commonly performed in conjunction with one of these programs | X | X | X | X | X | X | X | X | X | X |}

### Restorative Nursing – Care Plan Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Prevent falls</td>
<td>Resident demonstrates improved balance and gait.</td>
</tr>
<tr>
<td>2.</td>
<td>Promote oral health</td>
<td>Resident demonstrates improved oral hygiene and reduced risk of aspiration.</td>
</tr>
<tr>
<td>3.</td>
<td>Maintain skin integrity</td>
<td>Resident demonstrates improved skin condition and reduced risk of pressure ulcers.</td>
</tr>
<tr>
<td>4.</td>
<td>Promote effective communication</td>
<td>Resident demonstrates improved communication skills and reduced risk of hearing loss.</td>
</tr>
<tr>
<td>5.</td>
<td>Encourage socialization</td>
<td>Resident demonstrates improved social interaction and reduced risk of isolation.</td>
</tr>
</tbody>
</table>

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Restorative Nursing – Care Plan Goals (cont)

### Restorative Nursing – Examples of Care Plan Goals

- **Resident performs orientation of “W. L. Haber”**; “grasps” with “seizure/spasms” while bathing (person only)
  - Resident uses “seizure/spasms” for “hair” when out of bed
  - Resident maintains orientation over side of the bed with “seizure/spasms” “seizure/spasms” of “S. L. Haber”
  - Resident maintains orientation over side of the bed with “seizure/spasms” “seizure/spasms” of “S. L. Haber”
  - Resident moves out of bed with “seizure/spasms” “seizure/spasms” of “S. L. Haber”

- **Resident uses “seizure/spasms” during feeding, (A.D.A. “twitches” “seizure/spasms”)
  - Resident uses “seizure/spasms” during feeding
  - Resident uses “seizure/spasms” during feeding
  - Resident uses “seizure/spasms” during feeding

- **Resident moves patient to “B. K. to bed” while seizure (sequence) (A.D.A. “twitches” “seizure/spasms”) (person)
  - Resident uses “seizure/spasms” during feeding
  - Resident uses “seizure/spasms” during feeding

- **Resident demonstrates functional use of EMT’s ability to pull/pull“seizure/spasms” to “bedside” (person)
  - Resident uses “seizure/spasms” during feeding

### Dressing/Grooming

- Resident demonstrates functional use of “apartness” body with “seizure/spasms”
  - Resident uses “seizure/spasms” during feeding

- Resident uses “seizure/spasms” during feeding

### Eating/Gluttoning

- Resident demonstrates functional use of “apartness” body with “seizure/spasms”
  - Resident uses “seizure/spasms” during feeding

### Communication

- Resident demonstrates functional use of “apartness” body with “seizure/spasms”
  - Resident uses “seizure/spasms” during feeding

### Defecation

- Resident demonstrates functional use of “apartness” body with “seizure/spasms”
  - Resident uses “seizure/spasms” during feeding

### TBLG

- Resident demonstrates functional use of “apartness” body with “seizure/spasms”
  - Resident uses “seizure/spasms” during feeding

### Team Communication

- **Multidisciplinary**
  - Nurse
  - M.D.
  - Physical Therapist

- **Occupational Therapist**
  - Social Worker

**Resident**
Restorative Nursing

Questions?

Sample Menu of Services

- Medicare PPS Systems Assessment
- Medicare Program Training: Basic & Advanced
- Medicare Operations Quality Assessment
- MDS 3.0 Revenue Cycle Management
- MDS 3.0 / RUG IV Training
- MDS 3.0 Operations Review
- PPS Case Management Analysis
- Mock Survey
- Plan of Correction Development & Oversight
- Clinical System Support & Training
- Nursing Documentation Audit & Training

- DON Development/Management
- MDS Nurse Training
- Medicare Part B Utilization & Restorative Nursing Department Review & Training
- Case-Mix Review & Training
- Independent Review Organization Services
- RAC/ADR Preparation & Analysis
- Market Study/Market Analysis/Niche Feasibility
- In-House Therapy Department Efficiency Analysis
- Assisted Living Facility Medication Management
- Assisted Living Facility Mock Survey
The SunDance Difference
Linking People-Product-Performance-Partnership

"The achievements of an organization are the results of the combined effort of each individual" ~Vincent Lombardi