RESTORATIVE NURSING CARE

POLICY:

1. Restorative nursing care is carried out by Therapy Aides (TA), Certified Nursing Assistants (CNA) and Patient Care Assistants (PCA), and/or other trained staff under the direction and supervision of a licensed nurse (LN).

2. Staff who have been trained in restorative nursing care interventions can implement and document restorative interventions.

3. Group restorative activities are limited to no more than 1:4 staff to residents.

4. A resident may participate concurrently in restorative nursing care, the Restorative Nursing Program, or Skilled Rehabilitation Therapy if deemed therapeutic and beneficial in maximizing the resident's functional status.

5. Restorative treatments are reviewed monthly and as needed by the LN and quarterly by the Resident Care Team (RCT).

6. Any member of the RCT may recommend to a LN or physician that a resident be evaluated for restorative care.

7. Restorative nursing care does not require a physician's order and can be initiated by a licensed nurse. However, for residents with complex clinical conditions such as fractures or severe contractures, a consultation with a physician and/or licensed rehabilitation therapist may be appropriate.

8. Residents are referred to the Restorative Nursing Program by rehabilitation therapists.

9. If a lack of progress, a decline, or the achievement of goals is noted in the unit's monthly summary or the Restorative Nursing Program's quarterly summary, the treatments or program may be reevaluated for discontinuation or modification to be more appropriate for the resident.

PURPOSE:

To define and describe treatments provided to residents to maintain, and/or improve to their highest level of range of motion (ROM), mobility status, functional independence and ADLs, and prevent declines unless clinically unavoidable.

BACKGROUND:

A. Skilled Rehabilitation Therapy: rehabilitation therapy that is provided by a licensed therapist such as Physical Therapist (PT), Occupational Therapist (OT), and Speech Language Pathologist (SLP).

B. Restorative Nursing Care:

1. Nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible
2. Focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

3. Directed toward the conservation of resident's abilities, restoration of maximal levels of function and independence, promotion of quality of life, adaptation to an altered life style, and prevention of deterioration and complications of disability.
4. Planned, implemented and facilitated by the RCT to achieve the best individual outcomes.
5. Licensed Nurses provide direction, oversight and follow up for restorative nursing interventions performed regularly by CNAs/PCAs and other trained staff, with or without consultation by a licensed therapist.
6. The exercises, treatments or activities are individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

C. Restorative Nursing Program:

1. Restorative care provided regularly by TAs under the supervision of a LN with treatments recommended by a licensed rehabilitation therapist and requires an initial consult request from the physician.
   2. TAs provide restorative treatment in the wellness gym, on the neighborhoods (unit-based) and in the aquatics pool, under the supervision of a LN with initial recommendations and follow up consultations provided by the licensed therapist. Restorative therapy is reviewed quarterly and as needed for modifications and/or discharge by the LN and/or the RCT.

      a. Wellness gym: Restorative treatment in the wellness gym utilizes specialized equipment
      b. Neighborhood (unit-based) restorative programs: depending on the medical or physiological complexity of the resident, the restorative program can be done one-to-one or in a small group.
      c. Aquatics: This restorative program can be used for residents who may not tolerate therapy on land due to pain or other movement issues. The licensed therapist may be present for all sessions of this type of programming (refer to LHH PP 28-03 Aquatic Services).

	RESTORATIVE NURSING CARE	
	RESTORATIVE NURSING CARE	**RESTORATIVE NURSING PROGRAM**
STAFF	LN, CNA/PCA, AT	TA
PLAN OF CARE	Determined by LN	Recommended by licensed rehabilitation therapist
TREATMENTS	Can be safely carried out by nursing staff or trained staff	Complex treatments or specialized equipment
LOCATION	On unit	Wellness gym, on unit, aquatics
COMPONENTS	AROM, PROM, splint/brace assistance, amputation/prosthesis care, bed mobility, transfer, walking, dressing/grooming, eating/swallowing, communication, bowel/bladder training	AROM, PROM, splint/brace assistance, amputation/prosthesis care, bed mobility, transfer, walking

D. Restorative Care Components

1. **Technique:** Restorative activities provided by nursing staff and trained staff.

a. **Active Range of Motion (AROM)**: exercises performed by the resident, with cueing, supervision, or physical assist by staff. Includes AROM and active-assisted range of motion (AAROM).
   i. **AROM**: performance of an exercise to move a joint without any assistance or effort of another person to move the muscles surrounding the joint.
   ii. **AAROM**: the use of the muscles surrounding the joint to perform the exercise but requires some help from the staff or equipment.

b. **Passive Range of Motion (PROM)**: provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. PROM is the movement of a joint through the range of motion with no effort from the patient.

c. **Splint or Brace Assistance**: provision of:
   i. verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint.
   ii. a scheduled program of applying and removing a splint or brace.

2. Training and Skill Practice: Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

a. Amputation or Prosthesis Care: activities provided to improve or maintain the resident's self-performance 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., leg stump or eye socket). Dentures are not considered to be prostheses.

b. Activities of Daily (ADL) Training
   i. **Bed Mobility**: activities provided to improve or maintain the resident's self-performance in moving to and from a lying positon, turning side to side and positioning self in bed.
   ii. **Transfer**: activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.
   iii. **Walking**: activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.
   iv. **Dressing and/or Grooming**: activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks with or without assistive devices.
   v. **Eating and/or Swallowing**: activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids with or without assistive devices, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

c. **Communication**: activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

d. Bowel and Bladder Training:
   i. Urinary Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern targeted at decreasing or resolving incontinence (ex: bladder rehabilitation or retraining, prompted voiding, and habit training or scheduled voiding)
   ii. Bowel Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern targeted at maintaining bowel continence.

PROCEDURE:

A. Assessment for restorative nursing needs

1. The minimum data set (MDS) and Resident Assessment Instrument (RAI) process are the baseline functional assessment for restorative nursing.
2. Registered nurses (RN) assess restorative needs at the time of admission, monthly, quarterly, annually, and with significant change of condition.
3. Assessment includes any of the following that apply:
   a. Functional activities in which the resident has recently declined.
   b. Functional activities in which the resident believes there is potential for increased independence or a need for maintenance to prevent decline.
   c. Activities in which the nurse, licensed therapist, physician, or other member of the interdisciplinary team identifies that the resident has potential for improvement or a need for maintenance to prevent decline.
   d. Consideration of conditions that commonly cause functional decline such as stroke, Parkinson's Disease, Multiple Sclerosis, peripheral neuropathy, Muscular Dystrophy, spinal cord injury, or coma.
   e. Review of data that contributes to the assessment process such as the MDS, the Care Area Assessments (CAA), Certification and Survey Provider Enhanced Reports (CASPER), and assessment or progress notes from any clinical discipline.
   f. If the resident has a progressive illness/condition in which a decline in function is anticipated and the restoration in function is not realistic, and/or has goals of care that are primarily focused on comfort measures, restorative interventions may be utilized for preservation of function.

B. Planning restorative care

1. Using the assessment data, a plan of care is developed with restorative component treatments individualized to the resident.
   a. The LN develops a care plan:
      i. Problem statements are determined by the functional assessment and are generally functionally oriented.
      ii. Goals must be specific, measurable, and time oriented. Both maintenance and improvement goals are appropriate for restorative nursing.
   b. Restorative care: Informal consultation is often useful with the interdisciplinary team and clinical services such as PT, OT, or SPT for care planning and decision making related to restorative nursing.
   c. Restorative Nursing Program: rehab consult to the Restorative Nursing Program includes recommended treatments that the LN will incorporate into the care plan
2. All restorative minutes may be counted in section O of the MDS, regardless if they are provided as part of restorative care or the Restorative Nursing Program.

C. Documentation

1. Monthly Summary by the unit LN and Quarterly Summary by Restorative Nursing Program RN:

   a. For all residents receiving restorative nursing care or participating in the restorative nursing program, the nurse evaluates the effectiveness of the restorative treatments by documenting the progress toward or away from restorative goals, and describing the resident's related clinical status or changes to the interventions or goals as needed. (e.g., "Restorative goal of ambulating 60 feet BID with 1 assist and gait belt has been met. Goal increased to 60 feet TID").
      i. Periodic evaluation of restorative activities is demonstrated by routine documentation in the summaries and RCT notes. Progress toward or away from the restorative goal is documented followed by reason and/or modifications to the interventions or goals.
      ii. Resident and staff teaching related to the restorative program.

iii. Consultation with the interdisciplinary team and therapies, as needed, to modify the program.

iv. Consultation with ancillary services, interdisciplinary team members, and/ or a Clinical Nurse Specialist or Clinical Resource Nurse trained in restorative assessment and programming when the need for initial or additional staff development is identified.

b. The TA may initiate a Quarterly Summary for the Restorative Nursing Program that must be reviewed and co-signed by the RN.

2. Care Plan:

   a. The unit's LN responsible for the restorative nursing care problems, goals and interventions.
   b. The Restorative Nursing Program's RN responsible for the restorative nursing program problems, goals and interventions.
   c. Collaboration with RCT members or the resident as needed to determine the resident's preferences and choices.
   d. Care plans developed by other disciplines are appropriate to use for nursing restorative programs with the agreement of the discipline and by identifying nursing as one of the responsible services (e.g., Residents with individualized feeding plans written by the SLP are often restorative in nature and require nursing implementation).
   e. Individualized feeding plans for thickened liquids or special diet only are not appropriate for restorative nursing care.

3. Minimum Data Set (MDS):

   a. The MDS coordinator completes section O, "Nursing rehabilitation/ restorative care" of the MDS to indicate the number of days the restorative techniques or practices were provided for equal to or greater than 15 minutes per day in the last 7 days.
   b. The MDS coordinator records bladder retraining and scheduled toileting in section H0200 Urinary Toileting Program.

4. Electronic Health Record (EHR) ADL and Restorative Documentation:

   a. The licensed nurse indicates the restorative intervention(s) that CNA/PCAs/TAs are to perform in the EHR.
   b. The CNA/PCA/TA documents in the EHR, the completion of restorative interventions and the total number of minutes spent doing the activity per restorative component, except for bladder and bowel training.
   c. Observations of problems, reasons for not performing or participating in restorative interventions, or resident complaints during restorative care are reported to the licensed nurse and documented in the EHR (i.e., dizziness, pain, shortness of breath, resident refusal, etc.).
   d. Restorative Nursing Program:
      i. TAs will document in a note at least quarterly at a minimum, the resident's progress towards goals, the response to treatment and functional status. The documentation may compare the previous quarter's note for any changes. Documentation should reflect how the resident responds to the program in relation to behavior (e.g., refusal, anxious, combative, etc.), along with physical response (e.g., fatigue level, attention, distractibility, etc.). Content may include:
         1. Activity provided
         2. The specific distance or repetitions
         3. Use of assistive devices
         4. Resident response to activity (endurance and tolerance level)

5. Amount of assistance needed and why (i.e., verbal cues, stand by assist of one, moderate assist of one, etc.)
6. Outcomes, progress or lack of progress

ii. The TA will document and communicate any unusual occurrences, significant resident problems or significant changes to the Restorative Nursing Program Nurse Manager, and the RN.

APPENDIX:

NONE

REFERENCES:

CMS's RAI Version 3.0 Manual v1.16 (2018).
Medicare and Medicaid requirements for participation for Long Term care facilities (2017)

CROSS REFERENCES:

Nursing Policies and Procedures
C 3.1 Guidelines for Documentation of Resident Care by the Licensed Nurse
C 3.2 Documentation of Resident Care by Nursing Assistant
D1 2.0 Resident Activities of Daily Living (Basic Care)
D5 2.0 Limb Care following Amputation
D5 4.0 Arm Sling
D5 5.0 Braces - Leg
D6 2.0 Transfer Techniques
D6 3.0 Range of Motion Exercise
D6 4.0 Positioning and Alignment in Bed and Chair
D6 5.0 Ambulation
E1.0 Oral Management of Nutritional Needs
F1.0 Assistance with Elimination
F2.0 Assessment and Management of Urinary Incontinence
F3.0 Assessment and Management of Bowel Functions
F4.0 Application and Management of Condom Catheters
F 6.0 Colostomy Management

Hospitalwide Policies and Procedures
LHPP 20-37 Management of Dysphagia and Aspiration Risk
LHPP 20-48 In-house Requests for Rehab Consultations and Services
LHPP 28-03 Aquatic Services

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