

Discipline <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST	Month and Year of Service
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NURSING RESTORATIVE CARE PROGRAM

SECTION I – PLAN OF CARE

Goals	Date Restorative Initiated
1. _____	
2. _____	
3. _____	
4. _____	
Approaches (with frequency)	
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
_____ Signature–RN	_____ Signature–Therapist
_____ Signature–Therapist	

SECTION II – APPROACHES: W=Withheld R=Refused D=Discharged Document in Weekly Notes the reason if “Withheld” or “Refused.”

APPROACHES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Approach #1																															
Approach #2																															
Approach #3																															
Approach #4																															
Approach #5																															

NOTE: Each person who initials the approaches (above) must initial and sign below.

Initials	Signature	Initials	Signature	Initials	Signature
Initials	Signature	Initials	Signature	Initials	Signature

Resident Name: _____ Room No.: _____

SECTION III – DOCUMENT RESIDENT’S RESPONSE AND PROGRESS TOWARD GOALS(S):

Week 1 – Response _____ _____ _____ _____ Signature _____ Date
Week 2 – Response _____ _____ _____ _____ Signature _____ Date
Week 3 – Response _____ _____ _____ _____ Signature _____ Date
Week 4 – Response _____ _____ _____ _____ Signature _____ Date
Week 5 – Response _____ _____ _____ _____ Signature _____ Date

SECTION IV – MONTHLY REVIEW

A. Is the Plan of Care appropriate? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Are changes to the Restorative Program recommended? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are changes recommended to the Goals? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are changes recommended to the Approaches? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES to any items in B, update next month’s SECTION I–PLAN OF CARE with the changes.		
Comments: _____ _____ _____		
C. Continue Program? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Discharge to basic nursing? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ Signature–Licensed Staff		_____ Date