

Discipline

☐ PT

☐ OT

☐ ST

Month and Year of Service

NURSING RESTORATIVE CARE PROGRAM

SECTION I – PLAN OF CARE

Goals

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Date Restorative Initiated

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? \_\_\_\_\_ ☐ Yes ☐ No
- B. Are changes to the Restorative Program recommended? \_\_\_\_\_ ☐ Yes ☐ No
- Are changes recommended to the Goals? \_\_\_\_\_ ☐ Yes ☐ No
- Are changes recommended to the Approaches? \_\_\_\_\_ ☐ Yes ☐ No

**If YES to any items in B, update next month’s SECTION I–PLAN OF CARE with the changes.**

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- C. Continue Program? \_\_\_\_\_ ☐ Yes ☐ No      D. Discharge to basic nursing? \_\_\_\_\_ ☐ Yes ☐ No

\_\_\_\_\_ Signature–Licensed Staff \_\_\_\_\_ Date