Restorative Nursing Screen (RNS) v2020

Client:	**Effective Date:**	**Location:**
Initial Admission:	**Admission:**	**Date of Birth:**
Primary Language:	**Score:** NA	**Category:** NA
Physician:	**Facility:**	
Allergies:		
Diagnoses:		

1. RESTORATIVE PROGRAM - Eating and/or Swallowing

Eating/Drinking or Diet Order Change

1a. Resident diet order recently changed to a mechanical altered diet (required change in texture of food or liquids such as bite size cut, chopped or pureed or liquids being thicken to honey, nectar or pudding)

- 1. Yes - Specify in Summary
- 2. No

1b. Date of Diet Order Change

Caloric Intake/Energy Output

2a. Resident consuming less than 75% of most meals during last 7 days from date of this RNS

- 1. Yes - Specify in Summary
- 2. No

2b. Presence of Alzheimer's or other Dementia diagnosis with daily wandering (self ambulating or propelling wheelchair) episodes

- 1. Yes - Specify in Summary
- 2. No

Diagnosis of Dysphagia Present

2c. Dysphagia

- 1. Yes
- 2. No

Signs or Symptoms of a possible Swallowing Disorder

3a-3d "Check" all that apply

- 3a. ☐ Loss of liquids/solids from mouth when eating or drinking
- 3b. ☐ Holding food in mouth/cheeks or residual food in mouth after meals
- 3c. ☐ Coughing or choking during meals or when swallowing medications
- 3d. ☐ Complaints of difficulty or pain when swallowing

SUM. Eating and/or Swallowing Screen Summary

2. RESTORATIVE PROGRAM - BOWEL and/or BLADDER

Bowel / Bladder

Bowel and Bladder Screen

A. Recently treated for a UTI (30-days or less from date of this RNS)

- 1. Yes - Specify in Summary
- 2. No

- B1. ☐ Ostomy (including urostomy, ileostomy, and colostomy)
- B2. ☐ Intermittent catheterization

C. Newly documented episodes of incontinence (bowel and/or bladder)

1. Yes - Specify in Summary
2. No

D. Constipation present?

0. No
1. Yes
-. Not assessed/no information

E1. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. No
1. Yes
-. Not assessed/no information

E2. Is a toileting program currently being used to manage the resident's bowel continence?

0. No
1. Yes
-. Not assessed/no information

F. Uses a bedside commode, urinal or bedpan daily

1. Yes - Specify in Summary
2. No

G. Able to alert staff of toileting need?

1. Yes - Specify in Summary
2. No

SUM. Bowel and/or Bladder Screen Summary

3. RESTORATIVE PROGRAM - AMPUTATON / PROSTHESES CARE

Amputation / Prostheses Care Screen

A. New or recently repaired and fitted prosthesis

1. Yes - Specify in Summary
2. No

B. Recent amputation site and still in healing process

1. Yes - Specify in Summary
2. No

Phantom Pain Management

C. Amputation

1. Yes, specify
2. No

D. Limb prosthesis

E. Amputation / prosthesis care

SUM. Amputation / Prostheses Care Screen Summary

4. RESTORATIVE PROGRAM - RANGE of MOTION (ACTIVE/PASSIVE)

Range of Motion (Active / Passive) Screen

A1. Upper extremity (shoulder, elbow, wrist, hand)

- 0. No impairment
- 1. Impairment on one side
- 2. Impairment on both sides
- -. Not assessed

A2. Lower extremity (hip, knee, ankle, foot)

- 0. No impairment
- 1. Impairment on one side
- 2. Impairment on both sides
- -. Not assessed

B. Active disease (one or more): Degenerative joint disease, rheumatoid arthritis; or neurological disease such as cerebal palsy, traumatic brain inury, multiple sclerosis or an end stage disease process

- 1. Yes - Specify in Summary
- 2. No

C. Persistent vegetative state/no discernible consciousness

- 0. No
- 1. Yes
- -. Not assessed/no information

D. Bedfast status or Bedrest per physician order

- 1. Yes - Specify in Summary
- 2. No

SUM. Range of Motion (Active / Passive) Screen Summary

5. RESTORATIVE PROGRAM - SPLINT or BRACE ASSISTANCE

Splint or Brace Assistance Screen

A. New, readjusted or recently repaired splint or brace

- 1. Yes - Specify in Summary
- 2. No

B. Has splint/brace available for use

- 1. Yes - Specify in Summary
- 2. No

SUM. Splint or Brace Assistance Screen Summary

6. RESTORATIVE PROGRAM - BED MOBILITY

Bed Mobility Screen

A. Bedfast status or Bedrest per physician order

- 1. Yes - Specify in Summary
- 2. No

B. Active neurological diagnosis (one or more): (CVA, Stroke, Quadriplegia, Paraplegia, Hemiplegia or Hemiparesis)

- 1. Yes - Specify in Summary
- 2. No

D. Attempts to get out of bed without required assistance

- 1. Yes - Specify in Summary
- 2. No

SUM. Bed Mobility Screen Summary

7. RESTORATIVE PROGRAM - TRANSFER

Transfer Screen

A. Able to alert staff of transfer need

- 1. Yes - Specify in Summary
- 2. No

B. Use of device (walker, wheelchair, mechanical lift, slide board, trapeze)

- 1. Yes - Specify in Summary
- 2. No

C. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

- 0. Steady at all times
- 1. Not steady, but able to stabilize without staff assistance
- 2. Not steady, only able to stabilize with staff assistance
- 8. Activity did not occur
- -. Not assessed

D. Toilet transfer: The ability to get on and off a toilet or commode. - Admission Performance

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

SUM. Transfer Screen Summary

8. RESTORATIVE PROGRAM - WALKING

Walking Screen

A. Resident able to stand with assistance of 1 staff but has an unsteady gait and uses a wheelchair throughout day

- 1. Yes - Specify in Summary
- 2. No

Complete only if A0310B = 01

B. ☐ Walker

C. Does the resident walk? - Admission Performance

- 0. No, and walking goal is not clinically indicated
- 1. No, and walking goal is clinically indicated
- 2. Yes
- -. Not assessed/no information

SUM. Walking Screen Summary

9. RESTORATIVE PROGRAM - DRESSING and/or GROOMING

Dressing and/or Grooming

A. Resident occupation was that of barber, beautician or related occupation

- 1. Yes - Specify in Summary
- 2. No

C. Active neurological diagnosis (one or more): (CVA, Stroke, Quadriplegia, Paraplegia, Hemiplegia or Hemiparesis)

- 1. Yes - Specify in Summary
- 2. No

D. Resident is unable to dress or groom self without assistance

- 1. Yes - Specify in Summary
- 2. No

E. Resident is unaware of dressing or grooming needs without guidance of caregiver

- 1. Yes, specify
- 2. No

SUM. Dressing and/or Grooming Screen Summary

10. RESTORATIVE PROGRAM - COMMUNICATION

Communication Screen

A. Use of adaptive communication device or techniques such as gestures or sign language

- 1. Yes - Specify in Summary
- 2. No

B. New or ongoing diagnosis of apashia or dysphagia

- 1. Yes - Specify in Summary
- 2. No

D. Recent CVA or TIA requiring hospitalization or observation

- 1. Yes - Specify in Summary
- 2. No

E. Select best description of speech pattern

- 0. Clear speech
- 1. Unclear speech
- 2. No speech

- -. Not assessed

F. Ability to express ideas and wants, consider both verbal and non-verbal expression

- 0. Understood
- 1. Usually understood
- 2. Sometimes understood
- 3. Rarely/never understood
- -. Not assessed

SUM. Communication Screen Summary

11. RESTORATIVE PROGRAM POTENTIAL

Restorative Program Potential

A. Resident believes he or she is capable of increased independence in at least some ADLs

- 1. Yes - Specify in Summary
- 2. No

B. Direct care staff believe resident is capable of increased independence in at least some ADLs

- 1. Yes - Specify in Summary
- 2. No

Resident recently or soon to be discharged from skilled therapy services (SLP/OT/PT)

C. Therapy:

- 1. Yes, specify
- 2. No

SUM. Restorative Program Potential Summary

12. RESTORATIVE PROGRAM SCREENING OUTCOME

RESTORATIVE PROGRAM AREA(S):

A "YES" or "CHECKED" answer in Sections 1 through 10 along with at least one "YES" in section 11 indicates Restorative Nurse program assessment.

Mark all that apply

A. Restorative Nurse Assessment Indicated:

- [ ] 1. Eating and/or Swallowing
- [ ] 2. Bowel and/or Bladder
- [ ] 3. Amputation / Prostheses Care
- [ ] 4. Range of Motion (Active/Passive)
- [ ] 5. Splint or Brace Assistance
- [ ] 6. Bed Mobility
- [ ] 7. Transfer
- [ ] 8. Walking
- [ ] 9. Dressing and/or Grooming
- [ ] 10. Communication
- [ ] 11. None of the above

B. Restorative Program Potential (Section 11) had at least one question answered as "YES"

- 1. Yes, Restorative Nurse assessment indicated

Client: Initial Admission: Physician:

Facility:

- 2. Unable to complete screen
- 3. No restorative program needs indicated

C. Restorative Nurse Notified

Signature	Date