RESTORATIVE CARE MANAGEMENT POLICY AND PROCEDURE

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Purpose and Scope

The purpose of this policy and procedure is to outline Bilingual care's proactive, person-centred and reablement focused approach to delivering the Restorative Care Pathway under the Support at Home Program.

The Restorative Care Pathway supports consumers to maintain and/or regain functional capacity, maximise independence, and continue to live confidently and safely in their own home for as long as possible.

Restorative care focuses on what the consumer can do, rather than their limitations, and aims to avoid unnecessary dependence through early, targeted intervention following a functional decline, illness, injury, or hospitalisation.

A reablement approach underpins the Restorative Care Pathway, with the aim to:

- restore function
- prevent further functional and cognitive decline
- enhance quality of life and
- delay the need for higher levels of long-term care.

This policy and procedure applies to all Bilingual care staff, contractors, volunteers and health professionals delivering and coordinating services under the Support at Home Restorative Care Pathway and meets relevant legislation, regulations and Standards.

All staff and health professionals are accountable for their own practice and must work within their professional scope, registration requirements, the *Aged Care Code of Conduct* and relevant clinical guidelines when delivering restorative care services.

Applicable Strengthened Aged Care Quality Standards

- Standard 1: The Individual
- Standard 2: The Organisation
- Standard 3: The Care and Services
- Standard 4: The Environment
- Standard 5: Clinical Care
    - Outcome 5.1: Clinical Governance

Note: If the provider is delivering nursing services, they must comply with Standard 5, in full.[1]

[1] support-at-home-program-manual-a-guide-for-registered-providers.docx

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Definitions

Assistive Technology – Home Modifications (AT-HM): separate funding for products/equipment and minor home modifications based on assessment (not drawn from the ongoing/restorative care budget).

Goal Plan – a time-limited, individualised plan developed with the consumer that documents restorative care goals, services, reviews and exit arrangements for the duration of a restorative care episode.

MultiDisciplinary Team (MDT) – A group of health professionals from different disciplines who collaborate to plan, deliver and review restorative care services based on a consumer's assessed needs and goals.

Restorative Care Pathway – a short-term, intensive pathway under the Support at Home program that provides coordinated allied health and/or nursing services to restore or maintain function and support independence.

Restorative Care Partner – a suitably qualified clinician responsible for coordinating, managing and overseeing a consumer's restorative care episode, including goal planning, multidisciplinary coordination, monitoring, and exit planning.

Serious Incident Reporting Scheme (SIRS) - SIRS requires reportable incidents to be notified to the Aged Care Quality and Safety Commission. See Bilingual care's *Consumer Incident Management Policy and Procedure* for detailed guidance.

Support Plan Review – a formal process used, with consumer consent, to request changes to approved services, funding, assistive technology, or reassessment of care needs during or at the conclusion of a restorative care episode.

Policy

Bilingual care is committed to delivering the Restorative Care Pathway as a short-term, person-centred and reablement-focused approach that supports consumers to restore or maintain functional independence and remain living safely at home.

Bilingual care acknowledges that restorative care must be individualised, goal-driven and time-limited, with each consumer being supported through a tailored *Goal Plan* developed in collaboration with the consumer and an appropriately skilled multidisciplinary team.

Bilingual care recognises that effective restorative care relies on clinical coordination and oversight and ensures that a suitably qualified Restorative Care Partner is appointed to manage goal planning, service coordination, monitoring, review and exit planning.

Bilingual care and its staff are committed to delivering restorative care in accordance with the *Aged Care Act 2024*, *Aged Care Rules 2025* and the *Strengthened Aged Care Quality Standards*, ensuring services are safe, evidence-based, clinically appropriate and compliant with funding and program requirements.

Bilingual care is committed to early and planned transition from restorative care, ensuring consumers are supported to maintain gains achieved and, where required, are assisted to access appropriate ongoing supports through timely Support Plan Reviews and reassessment processes.

Background[2]

Support At Home Program - Restorative Care Pathway

The Restorative Care Pathway is a short-term, intensive program delivered within the Support at Home Program. It is a personalised pathway involving coordinated allied health and/or nursing services, delivered by a multidisciplinary team, to restore function and independence.

Restorative care is time-limited and goal focused. Each consumer must have an individualised *Goal Plan* aimed at:

- restoring or maintaining functional ability
- preventing further age-related decline
- managing new or changing health conditions
- delaying the need for ongoing or higher-level care and
- building skills to retain independence as the consumer ages.

Restorative care is particularly suited to individuals who require intensive clinical intervention following a setback, such as hospitalisation, illness or injury.

Eligibility

Eligibility for the Restorative Care Pathway is determined only through a MyAged Care Assessment.

To be suitable for restorative care, a consumer must demonstrate:

- a need for short-term targeted intervention
- the likelihood that intensive allied health and/or nursing services will improve function and
- motivation and capacity to participate in goal setting and active engagement

A consumer is **not eligible** for restorative care if they:

- are eligible for, or have recently accessed, the End-of-Life pathway
- have accessed two units of restorative care funding within the past 12 months, or completed an episode within the last 90 days
- receive, or are eligible for, the Transition Care Programme (TCP) or
- receive permanent residential aged care.

Episodes and Funding

An episode of restorative care provides up to **16 consecutive weeks** of intensive allied health and/or nursing services. Each episode provides one unit of funding of up to **$6,000.**

An individualised budget and Service Agreement must be developed and agreed to with the consumer.

Consumers may access a **maximum of two units of funding within a 12-month period,** which may be delivered as:

- two separate, non-consecutive episodes, or

[2] Support at Home Program - Restorative Care Pathway (November 2025) / Department of Health, Disability and Ageing

- two units of funding within a single episode, subject to approval via assessment or Support Plan Review.

Where two separate episodes are accessed, a minimum **three-month (90 day) gap** must occur between episodes.

Unused funding does **not** roll over, and funding cannot be used beyond the approved episode time frame.

Note: There is no option to temporarily stop services in the Restorative Care Pathway regardless of personal circumstances. Each episode is limited to 16 consecutive weeks.

Single Provider Model

Where a consumer is receiving both ongoing Support at Home services and the Restorative Care pathway, services must be delivered through a **single service delivery branch of a registered provider,** in accordance with the single provider model.

If Bilingual care is unable to deliver the Restorative Care Pathway, the consumer will be supported to change providers in a timely manner to ensure continuity of care and avoid service disruption.

Care Management – Restorative Care Partner

All consumers accessing the Restorative Care Pathway must receive **restorative care management**, delivered by a nominated **Restorative Care Partner**.

The Restorative Care Partner is responsible for:

- clinical coordination and oversight
- complex goal planning
- multidisciplinary team coordination
- monitoring, review and evaluation and
- exit planning and reporting.

Restorative care management funding is drawn from the individual restorative care budget and must be proportionate, transparent and in the best interests of the consumer.

When restorative care is delivered concurrently with ongoing Support at Home services:

- restorative and ongoing care budgets must be applied **only** to approved services and
- cross-subsidisation is not permitted.

Multidisciplinary Team (MDT)

Restorative care services are delivered using a multidisciplinary team (MDT) approach.

The MDT may include, based on assessed needs:

- Physiotherapists - to improve strength, balance and mobility
- Occupational therapists - to enhance daily living skills and home safety
- Nurses - for clinical oversight and recovery monitoring
- Exercise Physiologist - for tailored exercise programs
- Dietitian - for meal planning and nutrition advice
- Speech Pathologist - for communication or swallowing support and/or
- Nursing, Podiatry, Optometry, Hearing Services and other clinical care specialists

based on individual identified needs e.g. mental health

Medical practitioners may contribute where appropriate, however, restorative care funding **must not be used for services claimable under the Medicare Benefits Schedule (MBS)**.

The Restorative Care Partner leads the MDT and responsible for ensuring there is:

- appropriate skills mix
- regular communication and case conferencing
- integrated care notes and records and
- early and planned exit discussions.

Goal Planning

All consumers accessing restorative care must have an individualised *Goal Plan*, which replaces the *Care Plan* used for ongoing Support at Home services.

The *Goal Plan* must be:

- developed before or on the day services commence
- created collaboratively with the consumer and MDT and
- reviewed regularly throughout the provision of services.

Each *Goal Plan* **must** include:

- identified needs, goals, preferences and existing supports (from the Aged Care Assessment)
- strategies for risk management and preventative care
- services to be delivered, including frequency, volume and duration and
- review dates and a proposed exit date.

Goals must be developed utilising the SMART framework (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-bound).

Assistive Technology and Home Modifications (AT-HM)

Assistive technology and minor home modifications (AT-HM), for example, mobility and minor home modifications to improve safety and independence in the home) may be delivered where they support restorative goals and have been approved through assessment.

High-tier home modifications are **not available** under the Restorative Care Pathway unless already approved through an ongoing Support at Home classification.

Support Plan Reviews

A Support Plan Review must be requested (with consumer consent) where required to seek the following supports:

- additional services not approved at assessment
- additional unit of restorative care funding
- AT-HM approval or a higher AT-HM tier or
- reassessment for ongoing Support at Home services near episode completion.

All requests must be supported by clinical evidence linked to the *Goal Plan* and consumer's budget.

Consumer Contributions

Clinical supports, including nursing and allied health services delivered under restorative care, are fully funded and do not attract consumer contributions.

Consumer contributions may apply to services delivered under the independence and everyday living service categories. Any contribution towards the *Goal Plan* will be based on the consumer's income and assets assessment as per the MyAged Care assessment process.[3]

Exiting the Restorative Care Pathway

Exit planning must commence at the start of the restorative care episode.

An Exit Plan must be developed in collaboration with the consumer and the MDT and must include:

- episode start and end dates
- goals and whether they were achieved
- services delivered
- AT-HM supports provided
- MDT recommendations regarding functional status and future care needs.

A copy of the *Goal Plan* and *Exit Plan and Outcome Summary* is to be provided to the consumer and may be used as supporting evidence for future assessments.

It is important to note that a Restorative Care episode can be ended by the consumer at any time. This must be updated and documented in the consumer's *Service Agreement*.

Procedures

Principles[4]

To ensure effective delivery and positive outcomes, Bilingual care will deliver the Restorative Care pathway underpinned by the following principles:

- adopt a person-centred approach to meet the unique needs, preferences and circumstances of every consumer
- provide culturally safe services, including for Aboriginal and Torres Strait Islander people
- empower consumers by providing greater choice and autonomy in their care, fostering ownership and engagement
- provide flexibility to accommodate changes in individual circumstances
- develop a comprehensive goal plan centred on consumer defined goals, applying codesign principles to ensure plans reflect the needs, preferences and input of consumers, their families, and support networks
- promote self-esteem and independence by supporting consumers to achieve person-centred goals through taking reasonable risks
- provide coordination, by restorative care partners, including a comprehensive initial assessment and regular ongoing assessments to monitor progress and adapt interventions using standardised outcome measures
- identify consumer' strengths and ways they can be actively involved in achieving their

[3] https://www.myagedcare.gov.au/income-and-assets-assessments-support-home
[4] https://www.health.gov.au/resources/publications/restorative-care-pathway-clinical-guidelines?language=en

goals
- utilise assessment findings to inform and direct the focus of interventions
- engage a multidisciplinary team (MDT) to support the needs of each consumer, their family and support networks. The MDT may include medical practitioners, occupational therapists, nurses, physiotherapists, exercise physiologists, dietitians, speech pathologists, social workers, podiatrists, allied health assistants, aged care workers, carers and other relevant professionals.
- ensure the MDT providing restorative care are educated and equipped with the skills and knowledge to provide comprehensive care for consumers at risk of falls, with frailty, sarcopenia and or multimorbidity, dementia, and those who require support with their mental wellbeing, social connections, nutrition and swallowing difficulties
- facilitate regular communication and case conferences among the MDT to ensure optimal outcomes for consumers
- conduct pharmacist or physician-led medication reviews to manage, deprescribe, and educate on medications, and
- provide multicomponent interventions to improve the physical, functional, psychosocial and cognitive abilities of consumers, tailoring the delivery of these interventions by addressing diverse needs, incorporating effective communication strategies and technology integration such as telehealth and digital monitoring tools to support optimal outcome for consumers

Roles and Responsibilities

The **Leadership Team** is responsible for:
- ensuring Bilingual care complies with all Support at Home program rules, including requirements for the Restorative Care Pathway
- overseeing the delivery of safe, high-quality, rights-based restorative care
- embedding a goal-based, person-centred reablement approach across the organisation
- allocating appropriate resources (workforce, training, systems) to support effective restorative care delivery
- maintaining effective clinical and operational governance to monitor quality, outcomes, and improvement opportunities
- ensuring strong consumer and family engagement, including participation in goal setting and reviews
- promoting and ensuring structures are in place to allow person-centred communication and the ability to raise issues without fear of reprisal by having clear and transparent feedback and complaint handling mechanisms in place
- ensuring that multi-disciplinary teams engaged are equipped with the skills and knowledge to provide comprehensive care and are managed by an appropriately skilled and trained Restorative Care Partner.

The **Restorative Care Partner** is to be the nominated 'Restorative Care Partner' for Bilingual care and is responsible for:
- completing the required Support at Home training to help understand their responsibilities including service delivery, short-term pathways, goal planning, payment arrangements and required reporting and record keeping
- developing flexible Agreements and *Goal Plans* with the consumer, their families and supporters, and their MDT, ensuring funds that have been allocated are administered appropriately and meet the regular compulsory reporting requirements
- accessing and providing equipment, aides, assistive technologies and other devices needed for restorative care as per the consumer's *Goal Plan* in collaboration with the consumer, their families/supporters and the MDT professionals involved

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- facilitating minor home modifications where identified to promote safety and independence in the home in collaboration with the consumer and their families/supporters and within the consumer's available funding
- supporting assessment processes by ensuring cooperation with MyAged Care assessors and acting on assessment recommendations
- encouraging and facilitating of access to advocates, interpreters and significant others as needed to ensure the consumer can convey their requests and preferences based on their preferred method and mode of communication
- ensuring staff are provided with the required training according to each consumer's *Goal Plan* and undertakes regular supervision
- ensuring *Goal Plans*, *Service Agreements* and budgets developed are signed by the consumer agreeing to and confirming the need and consent to support
- providing a copy of the *Goal Plans* to the consumer and their family/supporters and it is kept readily available for staff to access where supports are delivered
- regularly reviewing *Goal Plans* to monitor consumer progress, track improvements and/or setbacks to support achievement of the consumer's goals as best possible
- undertaking the required and timely SIRS reporting of reportable incidents to the Aged Care Quality and Safety Commission, as required
- monitoring and reporting to the Leadership Team on the performance of restorative care, including functional outcomes, consumer experience, and service effectiveness

Staff are responsible for:

- communicating with consumers using their preferred communication method e.g. using interpreters, advocates or devices for them to fully understand and follow their *Goal Plan*
- reporting promptly to the Clinical Advisor if there are any changes or risks in the consumer's progress so that adjustments can be made to align with the identified goals and to maintain safe care for the consumer and
- documenting clear case notes in relation to the services provided and how the consumer has progressed towards the goals in their *Goal Plan* or challenges that are impeding progress.

Restorative Care Planning

Bilingual care will assist consumers with identified needs for Restorative Care to access the Restorative Care Pathway for Clinical and or Allied Health Services to regain and or maintain independence, through personalised, short-term interventions aiming to prevent and or reverse further aged related functional decline.

1. Referral and Eligibility

An Aged Care Assessment is conducted to determine the consumer's eligibility for Restorative Care. The assessment will verify pathway suitability vs other short-term pathways (AT-HM, End-of-Life) and/or ongoing Support at Home services. Once approved, the consumer will receive an individualised budget to access the necessary allied and/or clinical services for restorative care, usually up to 16 weeks.

2. Engagement and Consent

The Clinical Advisor will meet with the consumer to provide information on restorative care, explain the consumer's rights, costs and privacy, and obtain informed consent (or substitute decision-maker consent if applicable).

3. Assessment and Risk Assessment

The Clinical Advisor is to undertake an initial comprehensive clinical and home environment assessment to identify the consumer's goals according to assessed needs. This will determine the required services to achieve the goals and to develop a Restorative Care *Goal Plan*.

The initial assessment for a Restorative Goal Plan will cover:

- Physical function - assess mobility, strength, balance and endurance
- Cognitive Status - screen for memory, attention and decision-making capacity
- Emotional Well-Being - identify signs of anxiety, depression, social isolation
- Daily Living Skills - evaluate consumer's ability to undertake tasks like bathing, dressing, cooking and
- Home Environment - check for hazards and accessibility.

Support services for the consumer are to be assessed by the Clinical Advisor and will consider:

- Personal Care - help with showering and hygiene
- Communication Support - hearing aids, glasses
- Dietary Support - help with nutrition and meal preparation
- Skin Care - such as bandages and dressings
- Continence Care - disposal pads, commode chairs, urinals, bed pans
- Mobility Support - crutches, handrails, wheelchairs
- Support Services - cleaning, gardening, minor home modifications
- Social Support - assistance to take part in social activities
- Care Management - reviewing agreements and ensuring services are suitable and
- Clinical Care - Nursing, Podiatry, Physiotherapy, Occupational Therapy, Optometry, Hearing Services

4. Individual Goal Planning and Budget

The Clinical Advisor will collaborate with the consumer to define SMART goals (Specific, Measurable, Achievable, Relevant and Time-bound) that promotes autonomy and consumer preferences and fits into their lifestyle. Examples of goals could include things like "Walk independently to the mailbox within 2 weeks", or ''Prepare a simple breakfast by week 4".

The Clinical Advisor will develop a *Goal Plan*, flexible Service Agreement and budget that is to be signed by the consumer agreeing to and confirming the need and consent for support. The 16-week goal-aligned plan and episode budget will list services, frequencies, and disciplines, as well as any consumables the consumer requires.

A copy of the *Goal Plan* is provided to the consumer and their families/supporters and to be kept readily available for staff to access where supports are provided. If the consumer cannot sign or does not wish to sign the *Goal Plan* or agreement, this is to be documented in the consumer's file noting their reasons for not signing.

The Clinical Advisor will facilitate minor home modifications identified to promote safety and independence in the home in collaboration with the consumer and their families/supporters within the consumer's funding (e.g. grab rails, ramps, non-slip flooring), if budget is allocated.

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5. Service Delivery and Reablement

The Clinical Advisor will ensure staff are provided with the required training according to each consumer's *Goal Plan* and undertake regular supervision, providing the required support and resources needed for continuity of care in the home.

Staff to facilitate communication with the consumer using their preferred communication method e.g. use of devices, interpreters for them to fully understand and follow their goal plan.

When working with the consumer, staff are to prioritise enablement (do-with, not do-for), embed home programs that promote independence, and use engaging strategies to keep the consumer participating and motivated.

The Clinical Advisor will provide equipment, aides, assistive technologies and other devices needed for restorative care in the home, to be accessed and provided in collaboration with the consumer and their families/supporters and MDT professionals involved.

The Clinical Advisor and staff will acknowledge milestones achieved by the consumer towards their goals.

Progress notes/charts will be maintained to track improvements and setbacks and so that follow-up actions can be taken as necessary.

6. Monitoring and Review

Goal Plans are to reviewed by the Clinical Advisor at least every 2 weeks throughout the 16-week timeframe, to monitor, re-assess and adjust intervention progress/budget regularly based on outcomes and feedback.

The Clinical Advisor will work in collaboration with the MTD to achieve restorative goal outcomes, for example:

- Physiotherapist for mobility, balance exercise and strength training and fall prevention strategies
- Occupational Therapists for activities of daily living skills re-training e.g. dressing, cooking, hygiene routines
- Nurses and staff for monitoring and encouragement, memory stimulation exercises, social engagement activities for confidence building and
- Family, friends and/or supporters for support and motivation.

The Clinical Advisor will convene a case conference (including the consumer and their families/supporters and clinicians) at the mid-point of the episode to review goals and AT-HM utilisation.

If at any time there is indication that the consumer is deteriorating or there is an acute event, the Clinical Advisor will collaborate with the MDT and escalate to appropriate health services for review. The *Goal Plan* will be updated accordingly with the consumer, to ensure it remains appropriate and actively supports the consumer to achieve their goals within the timeframe.

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7. Exit Planning and Episode Closure

At or near week 16 (or earlier if goals are achieved), the Clinical Advisor is to meet with the consumer and their family/supporter to discuss exit planning. An *Exit Plan and Outcome Summary* is to be developed in collaboration with the consumer to help consumers review their goals and plan any extra support, if needed. This will cover:

- Goal Plan for Restorative Care - start and end dates
- goal progress and if they were achieved transparently
- explore any barriers the consumer experienced
- describe any services received from multi-disciplinary teams
- describe any AT-HM services received during the period and
- recommendations from the MDT and details about the consumer's functional requirements and
- confirm which goals remain important or whether priorities have changed.

The Clinical Advisor will complete a final assessment with outcome measures and compare these to the *Goal Plan*. This will include:

- progress achieved vs. baseline
- goals not achieved and contributing factors
- recommended next steps or referrals
- updated risks or escalation needs

A closure summary and recommendations will be prepared using the *Exit Plan and Outcome Summary* and provided to the consumer and the GP/primary care team (with the consumer's consent) including:

- continuation strategies (home program, community groups)
- the need for ongoing Support at Home services (separate budget) or referral back to My Aged Care for reassessment
- maintenance of AT-HM and education for ongoing safe use

When the goals are met, the Clinical Advisor will transition the consumer to maintaining routines.

If the consumer has <u>not</u> achieved the goals, the following options may be considered:

- the Clinical Advisor will provide an updated self-management plan, exercises, or strategies to continue progress independently. Reinforce safety considerations, equipment use and monitoring needs.
- if long-term support needs remain, the person may transition to ongoing Support at Home services (based on their classification and budget)
- if needs have increased or changed substantially, submit a reassessment request through MyAged Care for a higher classification or different pathway. Reassessment is essential when functional needs evolve beyond the original approval.
- if remaining goals relate to environmental barriers or equipment needs, complete or update AT-HM requests (separate budget per assessment)
- if clinical or functional barriers fall outside the reablement scope, refer to other relevant community health programs (e.g. community health, chronic disease programs).

8. Documentation and Record Keeping

A copy of the *Goal Plan* and *Exit Plan and Outcome Summary* will to be provided to

consumer, and a copy kept on the consumer's file in EziHealth, which may be used as supportive evidence for future aged care assessments.

At the conclusion of the episode, the Clinical Advisor must document in the consumer's file in EziHealth:

- progress achieved vs. baseline
- goals not achieved and contributing factors
- recommended next steps or referrals
- updated risks or escalation needs

All record keeping and information sharing will occur in accordance with Bilingual care's *Privacy and Confidentiality Policy and Procedure* and *Records and Information Management Policy and Procedure*.

9. Feedback and Continuous Improvement

Staff are to ensure consumers and their families/supporters are made aware of the complaints and feedback process and how to access it without fear of reprisal. Feedback and complaints are to be encouraged to improve services provided. See Bilingual care's *Feedback and Complaints Policy and Procedure* for further information.

Bilingual care will undertake periodic surveys of consumers receiving restorative care to evaluate feedback and identify areas for continuous improvement.

Incident Reporting

The Clinical Advisor is responsible for undertaking mandatory incident reporting in accordance with the Serious Incident Response Scheme (SIRS). This includes reporting any concerns or suspected breaches that meet SIRS definitions, such as unreasonable use of force, psychological or emotional abuse, neglect, unexpected death, unlawful or inappropriate sexual conduct, stealing or financial coercion by a staff member, inappropriate use of restrictive practices, and any unexplained absence of a consumer.

All reportable incidents must be escalated and managed in line with Bilingual care's *Consumer Incident Management Policy and Procedure* and must be followed to ensure correct reporting processes are applied.

Supporting Documents

Documents relevant to this policy and procedure include:

- *Governance Policy and Procedure.*
- *Clinical Governance Framework*
- *Feedback and Complaints Policy and Procedure*
- *Consumer Incident Management Policy and Procedure*
- *Staff Training and Development Policy and Procedure*
- *Incident Management Policy and Procedure*
- *Risk Management Policy and Procedure*
- *Service Access and Intake Policy and Procedure*
- *Initial Assessment and Care Planning Policy and Procedure*
- *Continuous Improvement Plan*
- *Case Notes Policy and Procedure*
- *Personal Care Policy and Procedure*

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- *Associated Providers Policy and Procedure*
- *Goal Plan*
- *Exit Plan and Outcome Summary*
- *Consumer Risk Assessment*
- *Home Risk Assessment*
- *Aged Care Code of Conduct*
- *Statement of Rights*

Monitoring and Review

This Policy and Procedure will be reviewed at least every two years by the Leadership Team. Reviews will incorporate staff, consumer, and other stakeholder feedback.

Bilingual care's feedback collection mechanisms, such as consumer satisfaction surveys, will assess:

- satisfaction with the competency and thoroughness of staff supporting consumers on the Restorative Care Pathway
- understanding of Bilingual care's assessment and planning processes for Restorative Care and documentation (clearly described by staff)
- satisfaction with support provided during a Restorative Care episode
- satisfaction with the choice, relevance and quality of referrals and connections provided by Bilingual care in forming the consumer's MDT and
- awareness of and access to information during the assessment and planning process that allows them to make informed choices and remain in control of their care and services.

Bilingual care's *Continuous Improvement Plan* will be used to record improvements identified and monitor the progress of their implementation. Where relevant, this information will be considered as part of Bilingual care's service planning and delivery processes.

DOCUMENT CONTROL

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