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Restorative Care Pathway Clinical Guidelines

Support at Home Program

Flinders University

About these guidelines

These guidelines provide clinical recommendations to support the delivery of the Restorative Care Pathway under the Support at Home program. They offer general guidance to providers to ensure service delivery aligns with the needs of older people living in the community and seeking restorative care.

During consultations for the design of the Restorative Care Pathway, stakeholders advised that clinical guidelines would enhance the pathway's effectiveness, specifically to:

- provide better outcomes for people receiving restorative care within aged care services
- help manage expectations of older people, their families and support networks as to the purpose and objectives of restorative care, and-
- ensure consistent delivery of the Restorative Care Pathway

These guidelines are intended as general guidance. Clinicians and carers should apply their professional judgement, experience and expertise to ensure high-quality clinical outcomes.

The Support at Home Program Manual also provides insight into delivering the Restorative Care Pathway.

Disclaimer

The Restorative Care Pathway Clinical Guidelines (the **clinical guidelines**) are general in nature and do not represent the Department's position on best practices for individual circumstances. When interpreting the clinical guidelines, an individual's circumstances should always be considered.

Practitioners must consider each individual's circumstances and use their professional and clinical judgment, skill, and care when providing care under the Support at Home Program, including the Restorative Care Pathway. The clinical guidelines are intended as general advice only and do not have the force of law or bind the Department.

At this time, the Department has no plan to update the clinical guidelines. Practitioners should ensure they seek updated information on clinical best practices and treatments. The Department does not guarantee or accept any liability for the accuracy, reliability, currency, or completeness of the material in this publication or for any injury, loss, or damage caused by its use.

Consumers, providers, and practitioners should obtain independent legal and medical advice as necessary. The Department gives no assurances regarding the currency, accuracy, or applicability of any content on third-party websites linked in this publication.

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Glossary

Term or abbreviation	Definition
ADL	Activities of daily living (ADLs) are fundamental skills required to independently care for oneself, such as dressing, and mobility
Cognitive Behavioural Therapy	A therapeutic approach to addressing mental health conditions, which involves identifying and restructuring maladaptive thought processes
Cognitive Rehabilitation	A therapeutic approach to improving cognitive impairment caused by brain injury, neurological conditions, and other factors affecting the brain
Dementia	A syndrome that causes progressive decline in cognitive function
DICE approach	A practical approach for understanding, identifying, and managing the behavioural symptoms of dementia. It involves 'Describing' the behaviour, 'Investigating' the triggers, 'Creating' potential solutions, and 'Evaluating' participant outcomes
Dysphagia	The medical term used to describe difficulty swallowing
Fall	An event which results in a person coming to rest inadvertently on the ground or floor or other lower level
Frailty	Age-related decline in physical reserves, increasing susceptibility to adverse health outcomes such as falls
GRADE	Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) is widely used for assessing the quality of evidence and strength of recommendations in healthcare
HCP	Home Care Packages
IAT	The Integrated Assessment Tool (IAT) is used to conduct aged care needs assessments to determine eligibility for government subsidised aged care
MDT	The multidisciplinary team (MDT) refers to a group of professionals from different disciplines who work together to provide person-centred care
Multimorbidity	The presence of two or more long-term health conditions
Oropharyngeal	The mid-region of the throat, comprising the soft palate, side and back walls of the throat, tonsils, and the back one-third of the tongue
PADL	Personal Activities of Daily Living (PADLs) are every day, basic tasks that need to be completed to maintain self-care such as bathing and eating
Polypharmacy	The simultaneous use of multiple medications by an individual
Restorative Care Partner	Restorative Care Partner**,** commonly referred to as Care Co-ordinators, are responsible for the provision of support services. This person participates in ongoing assessment, organises and co-ordinates care to support participants.
SAH	Support at Home program
Sarcopenia	The gradual, age-related loss of muscle mass, strength, and physical function
STRC	Short-Term Restorative Care Programme

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Restorative Care Pathway overview

This section includes:

- an overview of the Support at Home program
- an introduction to the Restorative Care Pathway
- the benefits of restorative care

The Support at Home program

The Support at Home (SAH) program consolidates previous in-home aged care programs including Home Care Packages (HCP) and Short-Term Restorative Care (STRC) programs into a more streamlined and equitable system. This initiative aims to help older adults remain in their homes longer by providing improved access to services, equipment, and home modifications, fostering their health, activity, and social connections within the community.

This framework specifies different funding levels based on assessment data which will work to enhance the existing four HCP levels and includes:

- eight ongoing Support at Home funding classifications
- three short-term care pathways: Assistive Technology and Home Modifications (ATHM) Scheme, the **Restorative Care Pathway**, and End-of-Life Pathway.

The Restorative Care Pathway

The Restorative Care Pathway will help older people to optimise, maintain and improve independence, delay reliance on ongoing services and continue to do the things they enjoy.

The Support at Home Restorative Care Pathway is a person-centred, goal-oriented approach that empowers participants to optimise their functional independence. This is achieved by enhancing a person's autonomy through a range of time-limited, intensive interventions led by health professionals and carers. The pathway provides collaborative, multidisciplinary support, including families and support networks, and focuses on 'doing with' rather than 'doing for' an individual.

Benefits of restorative care

Restorative care offers numerous benefits for older people by enhancing physical, functional and cognitive abilities. Restorative care promotes continued engagement in valued roles and activities whilst supporting safe and independent living at home. This approach can help slow functional decline, reduce falls risk, and promote better health outcomes for older people.

On a psychosocial level, restorative care can boost confidence, alleviate depression, and foster social engagement, reducing feelings of loneliness and social isolation while promoting connection. Restorative care upholds dignity by prioritising autonomy and aligning with individual goals, empowering older adults to make informed decisions about their own lives and ultimately enhancing their quality of life.

The Restorative Care Pathway aims to develop skills and capabilities to promote self-reliance by leveraging targeted interventions. This approach focuses on early intervention and prevention to build skills and capabilities that foster self-reliance and supports participants to remain at home for longer.

This pathway provides participants with tailored and coordinated support from health professionals and carers to optimise independence and facilitate participation in meaningful activities. This approach aims to empower participants, families, and support networks to take an active role in regaining function, rather than passively receiving care.

The diverse nature of restorative care approaches and their wide range of interventions underscore the importance of streamlined processes, to ensure consistency and promote best practices that effectively support older adults.

The Restorative Care Pathway aims to:

- maximise ongoing independence for older people
- prevent, delay and/or reverse physical, functional and cognitive decline through targeted interventions
- enhance quality of life

- support older people to remain living at home

Guideline development

Methods

Guidelines were developed with key stakeholders to ensure a wide range of perspectives were considered. Guidelines were developed and supported by a rapid scoping review of high quality, published systematic reviews and grey literature. GRADE methods were used to provide transparency about the quality of the evidence supporting guideline recommendations. An advisory group of key stakeholders with a range of backgrounds in aged care were consulted to support final guideline development.

A hierarchical approach to guide clinical recommendations was used, giving the highest weighting to high-quality randomised controlled trials with a low risk of bias. This evidence was combined with clinical guidelines, grey literature, and stakeholder feedback to inform clear, evidence-based recommendations to guide restorative care.

A detailed description of the methods used to develop evidence-based clinical guidelines are provided in the supporting documents.

Guideline development

The development of these clinical guidelines was informed by a comprehensive approach, including a rapid scoping review and extensive stakeholder engagement.

69
systematic reviews

24
grey literature resources

9
existing guidelines

Over 400
individual responses to sector surveys

4 workshops
(2 face to face and 2 online) to support guideline development with health professionals and STRC participants

Advisory group of 12 members
including representation from STRC participants, health professionals, care providers, and Integrated Assessment Tool (IAT) assessors

Clinical Recommendations

The guidelines provide clinical recommendations, supported by evidence, relevant to all restorative care interventions. The clinical recommendations can be generalised for restorative care interventions to a range of priority conditions, including neurodegenerative conditions. However, it is recognised that the guidelines do not cover all clinical scenarios, and it is important for clinicians and providers to use their clinical knowledge and ensure they remain up to date with evidence-based treatment approaches to provide quality, person-centred restorative care.

Additional recommendations are made for the following subgroups:

- people at risk of falls
- people with frailty, sarcopenia and or/multimorbidity
- people with dementia
- people who require support with their mental wellbeing and social connections
- people who require nutritional support
- people with swallowing difficulties

Restorative care recommendations

A wide range of interventions suitable for restorative care have been identified, with several key features consistently contributing to the success of these programs. These guidelines are intended to be applied holistically, considering each participant's unique health trajectory, social circumstances, and cultural norms. While there is significant overlap between overarching restorative care strategies and subgroup-specific recommendations, these elements can be generalised and adapted to deliver personalised and effective restorative care.

To effectively deliver in-home restorative care, the evidence highlights the following key recommendations.

Clinical recommendations

The Restorative Care Pathway should include the following practices to ensure effective delivery and positive outcomes:

- adopt a **person-centred** approach to meet the unique needs, preferences and circumstances of every participant.
- provide **culturally safe services** to Aboriginal and Torres Strait Islander people.
- empower participants 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 participant defined goals,** applying co-design principles to ensure plans reflect the needs, preferences and input of participants, their families, and support networks.
- promote **self-esteem** and **independence** by supporting participants 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 **participants' strengths** and ways they can be actively involved in achieving their goals.
- utilise assessment findings to **inform and direct** the focus of interventions.
- **engage a multidisciplinary team (MDT)** to support the needs of each participant, 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 participants 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.
- service providers should **facilitate regular communication** and case conferences among the MDT to ensure optimal outcomes for participants.
- provide **multicomponent interventions** to improve the physical, functional, psychosocial and cognitive abilities of participants**,** tailor 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 participants.
- conduct pharmacist or physician-led **medication reviews** to manage, deprescribe, and educate on medications.

- consider **other services, programs and supports,** new or ongoing**,** (e.g. chronic disease management plans) to meet the participant's goals, to prevent duplication, and maximise the benefit of the pathway.
- provide appropriate **mental health support** and facilitate referrals to relevant services for tailored interventions.
- promote functional independence through **task-specific training**, such as walking in parklands and practising stairs to improve confidence with **outdoor mobility.**
- **provide strategies to empower self-management** for participants, including reframing, motivational interviewing, problem-solving, and goal setting to support ongoing independence in personal activities of daily living (PADL).
- connect participants with **volunteer and community programs** that encourage participation in community services to enhance sense of purpose and social connection beyond the pathway.
- encourage community involvement and social activities to reduce isolation and **promote ongoing social connections.**
- collaborate with participants to develop an exit plan, providing **tailored recommendations and facilitating warm referrals to local community services** to optimise, maintain and enhance independence. This includes promoting self-management strategies, advanced care directives, and connections to other relevant supports.

What this means for service providers:

The evidence supports restorative care delivered by a MDT with the necessary skills to support participants with diverse clinical needs and cultural backgrounds. Service providers need to consider if their teams have the necessary skills to provide person-centred care and empower participants to enhance their physical, functional and cognitive abilities.

The evidence supports restorative care that incorporate ongoing assessment, participant and provider education, regular MDT communication and timely access to home modifications, assistive devices and technology to enhance care delivery.

It is strongly recommended that service providers consider the recommendations detailed above in the design and implementation of restorative care to enhance participant independence and quality of life.

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Additional recommendations for targeted subgroups

Restorative care for people at risk of falls

In Australia, the risk of falls is particularly high among individuals aged 65 years and over, who are almost 12 times more likely to get injured due to a fall than adults aged 25 to 44.

It is therefore crucial that the Restorative Care Pathway incorporates effective falls prevention strategies to enhance safety and wellbeing of participants.

It should be noted that *Best Practice Guidelines for Preventing Falls and Harm from Falls in Older People* (Falls Guidelines) are currently being updated by the Australian Commission on Safety and Quality in Health Care. These specific guidelines should be referred to when available.

Clinical recommendations

Restorative Care should consider the following practices to ensure effective delivery and positive outcomes:

- conduct thorough **assessment of the home environment** focusing on identifying and mitigating fall hazards within the home.
- include **comprehensive assessment of gait and mobility** to reduce falls risk and promote independence and improve function.
- support individuals with a **fear of falling** to regain confidence using tailored physical, cognitive and behavioural interventions.
- provide participants at risk of falls with **individualised exercise programs** that include lower limb strength training, personalised balance and functional exercises to reduce the risk of falls.
- provide appropriate **equipment, assistive aids and home modifications** to facilitate safer mobility and/or minimise harm from falls.
- **include visual training** techniques such as gaze stability exercises and visual cues training to improve participants' balance and walking abilities.
- provide **education and training** for participants, family and their support networks on:
    - fall prevention strategies
    - the importance of appropriate footwear and regular foot care
    - useful technology, and
    - regular medication review
- ensure that exercise programs to prevent falls extend beyond the duration of the restorative care program, either **through community-based group programs or tailored in-home exercise programs.**

What this means for service providers:

Evidence suggests that restorative care should incorporate falls prevention and balance training for participants. Tailored interventions to enhance functional independence are recommended, and visual assessments and training should be integrated to improve balance and walking capabilities. Providers should also consider community-based groups that support falls prevention to ensure continued support beyond the Restorative Care Pathway.

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Restorative care for people who have frailty, sarcopenia, and/or multimorbidity

Approximately 21% of Australians aged 65 years and above are frail, with the likelihood increasing with age. Frailty is linked to higher risks of falls, functional decline, longer hospital stays, and institutionalisation. To maintain and improve function, there is a need for comprehensive, integrated care to better manage frailty, sarcopenia, and multimorbidity.

It should be noted that Clinical Practice Guidelines for the Management of Frailty (2017); International Clinical Practice Guidelines for Sarcopenia (ICFSR): Screening, Diagnosis and Management (2018); and NICE Guideline for multimorbidity: clinical assessment and management (2016) exist. These guidelines should be used to inform the delivery of restorative care.

Clinical recommendations

Restorative care should consider the following practices to ensure effective delivery and positive outcomes:

- screen participants for frailty and sarcopenia using **validated measurement tools** or comprehensive geriatric assessments.
- **educate** participants, family, and support networks that frailty can be minimised.
- provide **integrated multidisciplinary care offering multicomponent interventions**, including mixed physical activity training (involving a mix of aerobic, muscle strengthening and mobilisation interventions) and nutritional education.
- **physical activity** interventions including resistance or strength training should be integrated in care ensuring moderate intensity activity is performed at least twice a week for 30-60 minutes. For the Restorative Care Pathway, participants' exercise tolerance may need to be increased gradually.
- a **comprehensive nutritional assessment** should be conducted to enable individualised nutritional education, protein and energy supplementation to improve participant function and independence.
- nutritional education and supplementation alone may not translate to functional improvements for older people with frailty, sarcopenia and multimorbidity and should be provided **in conjunction with physical activity interventions.**
- referrals to general practitioners (GP) or pharmacists may be required for the provision of supplementation for **vitamin D** deficiency (recommended dosage is 800-1000 IU of Vitamin D daily).
- **conduct pharmacist or physician-led medication reviews** to address polypharmacy that contributes to frailty in older adults.
- carry out **regular follow up assessments** to monitor progress and adjust treatment as necessary.

What this means for service providers:

The evidence supports physical and nutritional interventions to support participants with frailty, sarcopenia and multimorbidity to improve ADLs. Early detection of deficiencies can be useful to inform timely interventions that can prevent further decline and support ongoing functional independence. Providers need to engage health professionals who are capable of screening for frailty and directing appropriate restorative interventions.

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Restorative care for people with dementia

Most people with dementia live in the community with support from families, support networks, and aged care services. People with dementia have reported that they want programs that focus on their strengths rather than their deficits. The National Dementia Action Plan 2024-2034 outlines 8 high-level actions to improve the quality of life of people living with dementia, their family and carers. Action 5 of the Action Plan aims to improve treatment and support for people living with dementia, including by identifying, developing and promoting restorative care supports and resources for people with mild cognitive decline and dementia.

It should be noted that Clinical Practice Guidelines and Principles of Care for People with Dementia were approved in 2016 and are currently being updated. These specific guidelines should be referred to when available.

Clinical recommendations

Restorative care for people with dementia requires a person-centred approach that addresses their unique needs, promotes independence, and enhances their quality of life. Restorative care should consider the following practices to ensure effective delivery and positive outcomes:

- a **cognitive rehabilitation approach** should be offered to people with mild to moderate dementia to promote goal attainment.
    - cognitive rehabilitation should involve **identifying specific daily challenges, developing and implementing strategies in daily life** (e.g., memory aids, daily routines) that help the person to manage these.
- people with dementia should be involved in **goal setting** processes; additional strategies such as visual aids and support from families and support networks can be used to support this process.
- people with dementia should be **encouraged and supported to maintain participation in meaningful daily living and leisure activities**. This can be achieved by learning more about the past experiences, values, skill and interests of the participant.
- for people with dementia and changed behaviours, support should be offered through **strength-based behavioural interventions**.
- structured approaches that consider the behaviour, the underlying causes, and tailored solutions should be applied (e.g., Describe the behaviour, Investigate the cause, Create a support plan and Evaluate the outcome - **DICE approach**).
- health professionals and carers, families, and support networks should be provided with **education and skills training** in how to best communicate with and support the person with dementia and prevent or manage changed behaviours.

What this means for service providers:

The evidence suggests that restorative care approaches should work to include participants with mild to moderate dementia in setting their goal plans. Focusing interventions on specific functional challenges they face will allow for targeted interventions to be delivered to support ongoing autonomy. Providing comprehensive education and training to participants, families, support networks, health professionals, and carers is important to ensure changed behaviours are identified and supported.

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Restorative care for people who require support with their mental wellbeing and social connections

Older adults are more susceptible to loneliness and social isolation compared to younger individuals. This vulnerability is heightened for those living alone in the community who require restorative care. To support mental wellbeing and prevent loneliness and social isolation, the following clinical recommendations should be integrated into restorative care:

Clinical recommendations

Restorative care should consider the following practices to ensure effective delivery and positive outcomes:

- provide **thorough assessment** to determine the barriers to social participation (e.g., incontinence, mobility, transport, communication).
- **support services** such as counselling (including bereavement counselling) and group support programs should be offered to improve mental wellbeing for participants.
- **group based activities**, considering preferences including Yoga, Tai Chi, dance, gym, exercise and music should be offered.
- interventions and support services that **help older adults reframe and adapt their activities** in alignment with their physical, functional and cognitive capacities should be offered. These services should aim to maintain/promote both physical and social engagement.
- **support peer connections** individually or in groups should be considered to reduce loneliness.
- interventions should **target multiple objectives aimed at reducing loneliness** including social skill training, enhancing social support, increasing social opportunities and psychological reframing or cognitive behavioural therapy.
- interventions that provide **skill based and education support** that enable participation in community social environments should be provided.
- connect participants with **volunteer and community programs** that encourage participation in community services to enhance sense of purpose and social connection beyond the pathway.
- provide information and **advice on sleep hygiene, mindfulness and relaxation techniques.**

What this means for service providers:

The evidence suggests that restorative care should support participants' mental wellbeing and social connections with the aim to reduce loneliness and social isolation. Service providers need to ensure the MDT is competent in assessing, detecting and supporting participants with their mental health and recommending appropriate community activities that promote social interaction.

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Restorative care for people who require nutritional support

Nutritional support plays a critical role in restorative care, contributing to the effective management and optimisation of chronic health conditions as part of a short-term intervention. Adequate nourishment is essential for maintaining energy levels necessary to perform activities of daily living (ADLs), sustain independent function, and participate in physical and social activities. To promote long-term independence and wellbeing, restorative care programs must incorporate comprehensive nutrition and dysphagia management strategies. Additionally, targeted nutritional support should be provided for addressing malnutrition and aiding recovery from illness or surgery.

It should be noted that the Aged Care Quality and Safety Commission is consulting on draft guidance resources to support aged care providers, workers, and stakeholders in understanding the new, strengthened Quality Standards. Draft Provider Guidance Standard 6 – *Food and Nutrition* offers practical insights (specific to residential care). Once finalised, it is recommended that this standard be considered to inform nutritional practices in community aged care, ensuring optimal support for older adults' nutritional needs.

Clinical recommendations

Restorative care should consider the following practices to ensure effective nutritional support and positive outcomes:

- include **regular nutritional screening** to monitor and address any changes in nutritional status.
    - screening should be carried out by a qualified member of the MDT who can use **validated tools** to ensure early identification of participants who would benefit from nutritional input.
- ensure **adequate hydration** to support overall nutrition, health and active participation in restorative care interventions.
- consider **individual dietary preferences and restrictions** to ensure nutritional interventions are personalised, culturally appropriate, and aligned with the participant's health goals.
- integrate **education and training** for providers, participants, their families and support networks on the importance of nutrition and how to support the nutritional needs of participants.
- promote **regular general practitioner and MDT collaboration** with dietitians or nutritionists to develop and implement personalised nutrition plans.
- provide support strategies to **enable access to appropriate food and nutrition** for participants facing food insecurity.
- restorative care should include **multicomponent nutrition therapy**, including oral nutritional supplementation and individualised nutrition advice to support engagement in restorative care and ongoing functional independence.
- nutritional interventions (including oral nutritional supplements and nutritional advice) are recommended to **improve muscle strength** in participants.
- **integrated approaches** that combine swallowing assessments, tailored medication management, rehabilitation therapies, nutritional support, education, oral care and psychological support are recommended.

What this means for service providers:

Service providers need to ensure their staff screen for nutritional status and develop effective nutritional plans, considering participants' dietary preferences, to support good nutrition and hydration. The evidence suggests that for restorative care to be successful nutritional needs of participants need to be met to allow participants to actively engage and improve their functional independence.

Liu M, Chen X, Ma P, Deng M. Summary of the best evidence for the management of dysphagia in elderly patients. *Eur Arch Otorhinolaryngol*: 2024;281:3893-901. DOI: 10.1007/s00405-024-08530-2.

Takahashi K, Momosaki R, Yasufuku Y, Nakamura N, Maeda K. Nutritional therapy in older patients with hip fractures undergoing rehabilitation: a systematic review and meta-analysis. *J Am Med Dir Assoc.* 2020;21(9):1364.e6. DOI: 10.1016/j.jamda.2020.07.005.

Restorative care for people with swallowing difficulties

Dysphagia is a term used to describe difficulty swallowing, which can affect the ability to eat and drink. These difficulties can be caused by various conditions including neurological disorders. Dysphagia may have severe effects on a person's health as dysphagia can lead to dehydration, malnutrition, and aspiration pneumonia. Targeted interventions can support participants with dysphagia to maintain their independence and confidence eating.

It should be noted that Dysphagia Clinical Guidelines* are available and should be used to inform evidence based care for people with swallowing difficulties.

Clinical recommendations

Restorative care should consider the following practices to support participants with swallowing difficulties:

- an approach that combines **swallowing assessments**, rehabilitation therapies, compensatory strategies, nutritional support and oral care, complication management, and psychological support to support the management of dysphagia.
    - **swallow screening** should be undertaken by health professionals who have been trained, ideally using validated tools and are equipped with skills and knowledge to provide comprehensive ongoing care
    - **regular reassessments** of swallowing function should be included to monitor progress and adjust participant goals as required.
- **refer to pharmacist and GP** when it is deemed unsafe for a person to swallow oral medications.
- promote and maintain **adequate hydration** as a vital element in the effective management of dysphagia.
- **nutritional interventions should be integrated into goal plans** to support safe and effective swallowing for restorative care participants.
- **oropharyngeal exercises** (e.g. shaker exercise, chin tuck against resistance exercise, and expiratory muscle strength training) may be **prescribed by a health professional** to individually tailor a swallowing management plan to enhance swallowing outcomes for participants with oropharyngeal dysphagia.
- health professionals should participate in **regular dysphagia training** to enhance their ability to identify and manage dysphagia and develop appropriate goal plans in collaboration with the wider MDT.
- provide **dietary modifications**, such as texture-modified diets, to ensure safe and effective swallowing and deliver participant, family and support network education as appropriate.
- Participants have the right to make an **informed choice** about what they eat and drink, even when there is an identified risk due to swallowing difficulties. An Eating and Drinking with Acknowledged Risk (EDAR) management plan ensures that the participant (or their relevant decision-maker) receives tailored education following a comprehensive assessment. This plan outlines the identified risks, recommended management strategies, and guidance on suitable food and drink choices.

What this means for service providers:

Service providers need to ensure their staff are well-trained to assess swallowing efficiency and direct interventions and goal plans that support participants to obtain sustenance safely. Regular dysphagia training for nurses and caregivers is recommended to ensure that participants will benefit from more knowledgeable and skilled care providers.

Chua DMN, Choi Y-Y, Chan KM-K. Effects of oropharyngeal exercises on the swallowing mechanism of older adults: a systematic review. *Int J Speech Lang Pathol.* 2024;26(5):696-713. DOI: 10.1080/17549507.2023.2221409.

Liu M, Chen X, Ma P, Deng M. Summary of the best evidence for the management of dysphagia in elderly patients. *Eur Arch Otorhinolaryngol*: 2024;281:3893-901. DOI: 10.1007/s00405-024-08530-2.

Speyer R, Cordier R, Sutt AL, Remijn L, Heijnen BJ, Balaguer M, et al. Behavioural interventions in people with oropharyngeal dysphagia: a systematic review and meta-analysis of randomised clinical trials. *J Clin Med*. 2022;11(3). DOI: 10.3390/jcm11030685.

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Thiyagalingam S, Kulinski AE, Thorsteinsdottir B, Shindelar KL, Takahashi PY. Dysphagia in Older Adults. Mayo Clin Proc. 2021 Feb;96(2):488-497. doi: 10.1016/j.mayocp.2020.08.001. PMID: 33549267.

* Link to Dysphagia Clinical Guidelines requires Speech Pathology Australia membership to access.

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Exit planning

Transitioning from care can often be daunting for older people. Evidence suggests that positive gains can be quickly lost when participation ends. To help individuals maintain the benefits gained from the Restorative Care Pathway, well-structured exit plans are essential. These plans should support participants to integrate activities into their daily routines and support continued independence.

Clinical recommendations

The following recommendations should be used to guide the development of individualised exit plans:

- planning should be an individualised and collaborative process, **beginning weeks before Restorative Care Pathway completion** to facilitate warm referrals, strengthen community connections, link with co-ordinators and care managers and educate participants, families and support networks on sustaining self-management strategies.
    - exit plans should align with the participant's **values and priorities**, ensuring dignity of risk is at the centre of collaborative discussions.
- exit plans should be **informed by a comprehensive final assessment** that documents change in function and wellbeing, highlighting progress and goal achievement, and ensures participants have achieved sufficient improvement for safe discharge.
    - family and support networks should be encouraged to participate in caregiver training if applicable.
- providers should work with participants and their families and support networks to develop tailored exit plans, providing **personalised recommendations and facilitating warm referrals to local community services** to support ongoing independence.
- exit plans should highlight approaches to enable participants to maintain their current function, including potential transitions to appropriate local supports.
    - plans may include **education, promotion of self-management strategies and connections to appropriate community services.**
    - allied health interventions should incorporate strategies to **help participants sustain their restored function over time**.
- plans should facilitate connections with **volunteer and community programs** to foster social participation, enhance a sense of purpose, and promote long-term engagement beyond the care pathway.
- planning should ensure that ongoing care services are organised, well-co-ordinated and clearly communicated to minimise disruptions and **support a smooth transition for participants.**
    - this includes **communication** with the wider MDT and provider at the conclusion of the pathway.
    - ensuring every participant knows how to seek **further support** if required.
- **exit plans should educate participants and their families and support networks on the benefits of advanced care directives.**

Recommendations for exit planning specific to the Restorative Care Pathway have been informed by stakeholders and our evidence advisory group. For more information, please see supporting methods document.

Practical application of restorative care clinical guidelines

The following examples present practical case studies detailing how the Restorative Care Pathway can be delivered as early intervention to reduce the need for ongoing aged care services, maintain or regain independence and support participants with culturally and linguistically diverse backgrounds living in multi-generational homes.

Restorative care as an early intervention

Jacob, an 82-year-old man living alone, has recently experienced a decline in mobility, leading to more frequent tripping and a recent fall that left him struggling to get up from the floor. To help him maintain his independence and continue living in his own home, he has been referred to the Restorative Care Pathway.

Jacob's restorative care starts with a **comprehensive assessment** to evaluate his health, home environment, medical history, current medications, and interests. The findings of this assessment direct the restorative care interventions. Jacob is provided with a Support Plan outlining the results of the aged care assessment including services he is approved to receive. During this assessment Jacob expresses his wish to continue 'getting out in his garden and pottering around.' This desire shapes Jacob's Goal Plan and together with the team he sets a meaningful goal to be able to get out into his garden and get up and down to attend to his plants.

Multidisciplinary Team Approach: The MDT collaborate to support Jacob to achieve his goal and prioritise task specific training activities.

- The physiotherapist works through leg strengthening and balance exercises with Jacob to reduce his risk and fear of falling. Together they problem solve and practice getting up off the floor and have been walking out in the garden to increase his confidence. Task specific training allows Jacob to practice the individual tasks necessary to tend to his garden and provide the opportunity to work on each component individually.
- The occupational therapist carries out an environmental assessment to minimise trip hazards in Jacob's home. Together they remove all the rugs in the house and home modifications are made, adding a handrail to the front and rear of the house to support Jacob to get out into the garden. Together they work together to find and modify suitable gardening tools and work out a set up that allows Jacob to work safely and independently in his garden.
- The MDT support Jacob to problem solve and reframe previous tasks to his current abilities, this includes using a stool to sit on where he previously would have knelt or squatted down to attend his roses.
- The exercise physiologist assesses Jacob and identifies the need to improve his endurance so he can safely spend more time pottering in his garden. To support this goal, Jacob receives a tailored exercise program designed to enhance his strength, balance, coordination, and endurance. By following this program, he will be able to enjoy longer, safer periods in his garden
- The dietitian visits Jacob to assess his nutrition, he can swallow without issue and is educated to increase his protein and calorie intake to support him to use more energy in the garden. Jacob is advised to carry a bottle of water to ensure he remains hydrated regardless of the weather. As Jacob doesn't enjoy cooking, he decides that having meals delivered each week would be helpful and he makes arrangement with his family to organise meal delivery.
- On further discussion with Jacob, the social worker identifies that Jacob has lost touch with his social networks as he hasn't been able to get out and about as much as he used to. Jacob is encouraged to join a local seniors gardening group, and he now visits each week and enjoys the gardening activities and having a chat.

Education and Motivation: Throughout restorative care the team explain to Jacob the benefits of their activities and how they will support him to return to his garden safely. Jacob is diligent with his exercises and has been motivated to actively participate in his therapy sessions. He is now so good at getting up off the floor he doesn't need to think about it.

Outcome: By the end of the Restorative Care Pathway, Jacob has made significant improvements. He is now able to get out into his garden every day and is no longer fearful of falling (although he has a plan if he does). Jacob continues to attend his community gardening group and has started a weekly exercise class to make sure he stays independent, which will maintain the improvements he has achieved in the pathway.

Restorative care to prevent/delay residential aged care admission

Martina, an 88-year-old woman living alone, has multiple chronic conditions, including diabetes, arthritis, and heart disease. Her mobility has declined, and she faces challenges in managing her health at home despite receiving some aged care supports. To help her stay at home and avoid moving into a residential aged care facility, she has been referred to the Restorative Care Pathway.

Martina's restorative care begins with a **comprehensive assessment** to evaluate her health, home environment, medical history, current medications, and interests. During this assessment, Martina expresses her desire to continue cooking her own meals so she can remain living in her home. These interests shape Martina's goal plan, and together with the team, she sets a goal to ensure she can make her own meals each day.

Multidisciplinary Team Approach: The MDT collaborate to integrate task specific cooking activities into her tailored care.

- The general practitioner monitors Martina's chronic conditions and adjusts her treatment plans to support her ongoing wellbeing and quality of life. Regular telehealth check-ins are scheduled so that Martina does not have to travel, and a medication review is carried out.
- The occupational therapist visits Martina to support her with meal planning, they work together on strategies to support her to cook independently and set up the kitchen with utensils she can use easily. Martina now has a meal plan for the week which helps her to prepare meals and write her weekly grocery list.
- The physiotherapist provides exercises to improve Martina's physical strength and mobility, focusing on her specific conditions and managing her pain as best possible. Martina is provided with a rollator frame that fits in her kitchen and supports her to stand for longer periods whilst using the stove top.
- Martina is visited by the nurse who has been closely monitoring Martina's blood sugars. A referral is made to the dietitian as the team thinks more support with nutrition will be useful to manage her diabetes and will support her to continue cooking her own meals.
- The dietitian provides guidance on a suitable diet to support Matina's diabetes and provides detailed education to ensure that she stays motivated to follow the advice and avoids excessively processed, sugary, and fatty foods.
- The social worker connects Martina with a local diabetes support group, she attends each fortnight and likes to stay around afterwards for coffee.

Education and Motivation: Throughout restorative care, Martina is educated on the benefits of active participation in her care. Although initially reluctant to be active, Martina is motivated by staying in her own home and cooking foods she enjoys.

Outcome: By the end of restorative care, Martina is comfortable cooking her own meals, she is following the dietitian's advice closely and has found she has more energy and is in less pain than she was before. This is maintained through her attendance at her local diabetes support group and telehealth review by her general practitioner.

Restorative care to support a participant living in a multi-generational home

Irene, an 85-year-old woman of Greek ethnicity, lives in a multigenerational home with her daughter, son-in-law, and two grandchildren. Irene speaks limited English and primarily communicates in her native language, Greek. Recently, Irene has felt increasingly weak, she is increasingly frail and is finding it difficult to grip the rails in her bathroom. Her family are concerned they will not be able to care for her if she continues to decline. To help Irene maintain her independence and continue living in her family home, she has been referred to the Restorative Care Pathway.

Comprehensive Assessment: Irene's restorative care starts with a comprehensive assessment to evaluate her health, home environment, medical history, current medications, and interests. Her daughter is present to help translate and explain Irene's responses. During this assessment, Irene expresses her wish to continue living at home with her grandchildren but knows she needs help with her personal hygiene, she is also finding getting up to go to the bathroom difficult at night. She has declined further since her recent hospital admission for a chest infection. In collaboration with the team and her daughter, Irene sets a goal to be able to carry out her personal hygiene and toileting independently.

Multidisciplinary Team Approach: The MDT collaborates to support Irene in achieving her goal and prioritises task-specific training activities:

- The physiotherapist works with Irene to increase her arm and grip strength, they practice using the bathroom rails to get on and off the toilet. Irene is supported to strengthen her legs and practices stepping into and out of the shower safely. She is given an exercise program and practices balancing with her eyes closed in the kitchen with her daughter. Irene is encouraged that she has started to feel more confident using the bathroom.
- The occupational therapist carries out an environmental assessment to minimise trip hazards in Irene's home and reviews the handrail positions in the bathroom. Irene's daughter purchases a non-slip mat for the shower. A commode is ordered and setup in Irene's room so that she does not need to get up to use the bathroom in the middle of the night. Irene is working diligently to send this back as she doesn't really like the look of it.
- The dietitian assesses Irene's nutrition and educates her on maintaining a balanced diet to support her energy levels. Irene is advised to stay hydrated and is provided with culturally appropriate meal plans and supplements that she can enjoy with her family.
- The speech pathologist carries out a swallowing assessment, identifying decline in Irene's oropharyngeal stages of swallow. Irene is advised on relevant safe swallowing strategies and ways to modify her food and drinks to make them safer to swallow. This helps to combat further decline and maintain energy levels by making it easier for Irene to consume a nutritious diet and avoid further chest infections due to aspiration.
- The social worker is concerned that Irene has not been out of the house for some time and that her daughter needs support so she can take a break. Arrangements are made for a friend to take Irene to her Greek Orthodox Church twice a week where she participates in Greek activities- she enjoys singing along with Greek music with the community.

Communication: Irene's daughter is often present for her care and is happy to act as an interpreter. The team have provided visual diagrams with instructions (in Greek) to support Irene's ongoing exercises and she has enjoyed watching videos of herself performing a task and responds well to feedback. The family were offered an interpreter but were happier to communicate together and use visual aids.

Education and Motivation: Irene is diligent with her exercises and motivated to actively participate in her therapy sessions. She practices her exercises with her grandchildren, making it a fun and engaging activity for the whole family.

Outcome: By the end of the Restorative Care Pathway, Irene has made significant improvements. She is now able to take care of her personal hygiene independently and has noticed improved grip strength. Irene continues to attend her church activities.