CDCS
Culturally Directed Care Solutions

Client Documentation

Made Easy

Client Progress Notes & Effective Hand Overs

Table of Contents

The collection of information and compiling of client progress notes is an important aspect of providing quality care outcomes to a consumer of aged or disability care.

Key Subjects

What you will learn from reading this eBook:

- Why you need to document
- What information you should be capturing in your progress notes
- How to improve the way you write progress notes
- How to participate in an effective handover
- How to store client documents correctly

This eBook has been developed to assist direct care and support workers, coordinators and other health staff to write quality progress or client notes.

It can be used to teach staff and students of care services or be used as a refresher for staff on how to correctly document. You may also find it a handy resource to use when orientating staff.

While examples used in this book may differ from your organisational setting, the information is still relevant and you should contextualise for your service. The concepts are transferable to rural and remote, urban mainstream services and other Culturally and Linguistically Diverse (CALD) organisations.

So whether you are a support worker, health worker or coordinator, and wherever you are located, we hope that you find this resource valuable to you, your organisation and the people you support.

The CDCS Team

DISCLAIMER

This resource is intended as a guide only. Internal organisational documents and processes may differ from those outlined in this guide.

Although the authors have made every effort to ensure that the information in this guide was correct at the time of issue, the authors do not accept any liability for any loss, damage or disruption caused by errors or omissions, or reliance on the information (in whole or in part) in this guide.

COPYRIGHT

Version 2.0_Nov 2019

Who is CDCS

Culturally Directed Care Solutions (CDCS) is a Consultancy Service that helps aged and disability service providers to deliver quality care to the clients they support. We do this through the provision of appropriate and timely resources, training and consultancy support.

Rural & Remote Specialisation

CDCS works extensively with service providers operating in rural and remote settings.

We have unique insight into the concerns and challenges that working in a remote setting brings having consultants who have also lived and worked as remote area coordinators, and in rural and remote communities.

It is this knowledge and insight that we bring to our consulting work that allows us to develop sustainable and culturally appropriate solutions.

Our Vision

We believe in quality care for all people, regardless of their background, beliefs or where they live.

Why Document?

People working in the care industry usually agree that it is a requirement of their role that they should be regularly completing client progress notes or writing in the communication book. However, with so many tasks to complete in a shift or day, quality and detailed documentation is often relegated to second or third place in priorities. Unfortunately, people underestimate the importance of good documentation. It's not until something goes wrong that most people find out that value.

If there is a quality review, a court case, or family have questions about an incident, you want to ensure you have well-written evidence to back you up.

One of the most common reasons that organisations fail aspects of their audit or quality review is because their documentation is not in order. The organisation is unable to demonstrate on paper what has been happening in the workplace. While this might include documents such as assessments and care plans, these one-off documents, although time consuming, are sometimes easier to update, it is the day-to-day progress notes that people get stuck on.

It's not just the legal aspects that encourage good client documentation practices, there is also a practical angle. If you write detailed and clear progress notes, you contribute to the provision of quality care outcomes for individuals. You are also demonstrating your own competency in providing quality, individualised support to the person.

Just imagine you are providing personal care support to a client with incontinence. Your role includes reminding the person to take their medications and supporting them with showering. If the person declined to take a shower one morning because it was too cold or to take their tablets, you would want to ensure this was written into their progress notes; otherwise assumptions may be made by other staff or management that you have neglected your job responsibilities. The client may also miss out on essential medication which can lead to adverse health events. Of course, with something like medication you would also want to report this to your supervisor at the time of the incident occurring and notes can help you when writing up an incident report.

So, we document for many different reasons.

Purpose of Documentation

REASONS FOR DOCUMENTATION

Communication:

Client documentation is an effective method of sharing information amongst staff and other service providers. In the world of Consumer Directed Care there may be more than one service provider supporting an individual, so it's best for everyone to be on the same page.

Assessment:

Care managers can use client progress notes as a primary reference source for completing a re-assessment. They can utilise the information to measure how well a particular approach to support is meeting the individual's stated goals and are also able to ascertain improvement or deterioration of the individual.

Continuity of Care:

As well as being useful for effective communication, good documentation helps all staff to understand the current care needs of a client and provide ongoing support and care. Documentation can be used to prompt or remind specific action. For example, an individual may require additional short-term assistance due to family members or carers being absent for a time.

Shared Knowledge:

Think about a time when you have either been in hospital or visited a family or friend in hospital. Staff, including doctors, work different shifts and a patient may be seen and supported by a number of different staff members during the period of their stay. Client documentation allows each staff member to learn the history of the individual and any interventions that are relevant to their care and support needs. This history can then be used to direct future interventions and actions.

Legal Requirements:

As we discussed earlier, accurately reported facts are the best defense against litigation. Any and all documents that relate to the care and support of an individual can be called upon as evidence in a court of law. All consumers of care have a legal right to safe, professional care and support – including accurate and truthful documentation.

Purpose of Documentation

Continuous Quality Improvement:

This is an important aspect of providing quality care. Although there are identified standards that support the industry, and your organisations might be currently assessed as meeting these, you cannot become complacent. The expectations of individuals and their families change, good documentation can assist in picking up trends in the needs of an individual, your target consumer group and the needs of your workforce going forward.

Funding:

In residential settings, documentation assists aged care facilities to receive appropriate funding for an individual from government agencies. Progress notes act as a measure of the care needs of residents, allowing resident dependency to be correctly assessed. It is important that changes in the individual consumer are recorded so that correct subsidy levels can be accessed.

For consumers living in the community, good documentation can support a referral to My Aged Care for a higher level package.

Physical Evidence:

'If it isn't written down, it never happened.'

Without documentation you have no concrete evidence of services delivered or interventions implemented. As we noted earlier, some organisations fail their quality audit / review, primarily because they cannot prove they delivered services due to poor client documentation.

So,

- while you can provide the best possible care and support to an individual,
- while you might meet all the requirements of supporting the person with consumer directed care,
- and while you can see that what you are doing is effectively meeting the needs of the consumer,

without the accompanying documentation that captures all that has been done, you may be seen as ineffective and non-compliant.

When to Document

EXCEPTION REPORTING

Generally, it is recommended that care staff document by exception only.

This means there is no need to document anything that follows the individual's care plan or that is considered to be normal behaviour for that person, just deviations from the norm.

Example of Exception Reporting

For example, if Dilys normally goes to the dining room for lunch and participates in her normal activities such as attending a weekly diversional therapy session this does not necessarily need to be documented as it is already written into her care plan.

If, however, Dilys decides not to walk to the dining room or attend normal planned activities because she was feeling unwell that day, this should be documented.

Any event or observance that impacts on the individual's care plan should be documented.

This would include observations of changes in:

- behaviour
- emotional state
- physical wellbeing, or
- physical appearance

Other information that needs to be documented are incidents that have impacted on a client or relevant information that has been passed on by the client or their family to staff.

Who is responsible for completing a progress note?

That really depends on your organisation, the operational context and written procedures.

In a mainstream residential setting the organisation there may be an expectation of all staff to complete client notes. However, some facilities may ask support workers to write notes in a communication book or handover document.

All staff however are responsible for ensuring that essential information about a client is not lost and that it is either passed along to the responsible person or that it is documented appropriately.

Exception Reporting Examples

IDENTIFYING WHEN DOCUMENTATION or REPORTING IS REQUIRED

Did the client decline a service or was absent at the time of the planned service for any reason?

Example:

Jimmy's care plan states he attends a physio appointment every fortnight at 8am, however it's winter Jimmy does not want to get up out of bed as early and declines to attend his appointment. This needs to be documented along with the response or actions taken e.g appointment rescheduled.

Do services need to be suspended for a period of time?

Example:

Max has gone away for holidays to visit his daughter interstate; he plans to be away for three weeks and wants to suspend services for this period of time. Max's absence, the expected period of time he will be aware, as well as noting when Max returns need to be documented.

Was any service unable to be provided according to the person's care plan?

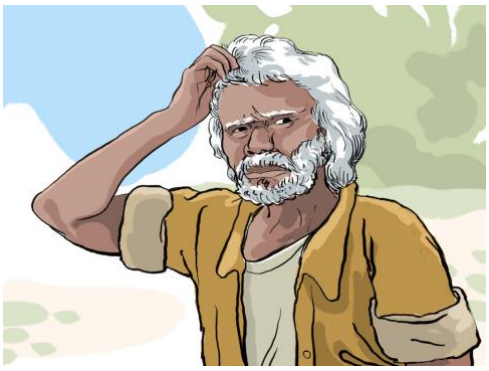
Example:

Sandra has a shower every morning at the day respite centre and is a two-person assist, she has a stated preference for female support workers. This morning the only staff who were available were male and due to cultural reason's, they were unable to shower Sandra. This needs to be document along with how the situation was managed.

Has there been a change in the individual's health that will impact on the long-term care plan?

Example:

Staff have noticed Malcolm has been wandering around the facility at night and has started repeating himself – a formal dementia assessment confirms that he has Alzheimer's Disease. His new diagnosis and any changes to his care plan and services that arose as a result of this confirmation.



Has there been a short-term change in the individual's health?

Example:

A staff member noted that Bessie has an ulcer on her leg and informed the nurse. The nurse amended Bessie's care plan requesting that she be assisted to have a shower daily and then to alert nursing staff so that the ulcer could be dressed. This change would be documented and notes would monitor the change.

Is there a change in the client's appearance that is concerning?

Example:

Bertie is an old stockman and is proud of his background and appearance. His support worker reported that lately he has been increasingly unkempt, and he is less interested in what he is wearing. This would be documented along with follow up actions that were taken to investigate his welfare.

Has there been a change in the caring arrangement that will affect the long-term care plan?

Example:

Tommy lives at home and attends the day centre. Tommy's son, Samuel, has been caring for him, however Samuel has recently had a stroke and is no longer able to physically care for his father. This would be documented in his notes along with the reassessment of supports this change would trigger.

Is there a change in the family or home dynamics that may adversely impact the client?

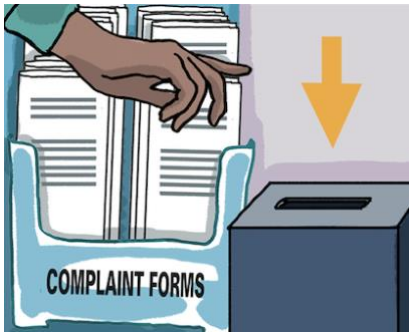
Example:

Phyllis is an elderly lady who has assumed the responsibility of caring for two of her orphaned grandchildren, one of whom has a significant physical disability. The change in responsibilities and support needs and any additional agencies involved would be documented.

Has the client or their family made a complaint

Example:

Billy complained to the staff that the meals are too small, bland-tasting and there is not enough meat. This would be documented as a complaint and any change in Billy's meals would be reflected in his care plan and your response in his notes.



Client of the Day / Week

FOLLOW YOUR ORGANISATIONAL POLICY

Whilst the general rule is **‘exception reporting’** there may be a requirement in your organisation to note something in the client’s progress notes on a daily or weekly basis as a minimum.

And while there is little benefit to be gained by noting down daily or even weekly in Billy’s progress notes that there is "no change noted," staff can, and should be encouraged to spend time with the individual on a regular basis, noting down comments and observations during this conversation. Perhaps the person will reveal additional activities they have been involved in, new historical information that may be of use in care planning, changes in family dynamics or fluctuations in health status that the staff might not have already picked up on.

Some organisations have a policy of identifying one or two clients to be the **‘client of the day or week’**. During this time staff may be expected to spend time observing the client and their needs in more detail. This practice aligns well with the need for ‘ongoing assessment and care planning’ in Standard two of the Aged Care Quality Standards. During this period staff may find they are capturing a lot more information about the person which should be reflected in their progress notes and other documentation.

So, to recap, **'exception reporting'** is the standard, but if you are required to report outside of this, make sure the note is worthy of documentation.

Tips for Writing Professional Notes

In this chapter, we look at how to write professional client progress notes or documentation.

When writing progress notes, keep in mind that they are legal documents which can be brought before a court of law, so here are a few tips to ensure that your notes are acceptable and defensible.

1. Always check that you are writing in the relevant person's notes

This means making sure you have the correct 'identifiers' on the page before you start. Identifiers are a person's name and their date of birth.

Some organisations also use a code for each individual - this helps when you have two Mary Browns with similar dates of birth.

Never write notes on a blank sheet, even if the notes are contained within the person's file; always ensure identifiers are noted on each individual page.

If you use an electronic Client Management System make sure you are logged into the correct client file and take extra care you don't accidentally write a 'global' note that copies across all client files.

2. Use a blue or black pen

Blue and black pens are the colours of preference for legal documents as they photocopy well and are easier to read.

Avoid the use of red or other coloured pens as these are harder to read and do not photocopy well; although pretty, they are not considered acceptable colours for legal documents.

Your written comments also need to be **indelible** – this means they **cannot be erased** – which means you cannot use either pencils or erasable ink pens.

Take care when using felt tipped pens, these can be prone to smudging if the paper becomes wet.

3. Write legibly

Your notes need to be clear and easy to read and decipher. This is not the time to see how many words you can cram onto a single line; take the time to write neatly and in a size that is easy to read.

Printed words rather than cursive lettering is fine and, although it can look like you are shouting, it is okay to print in capital letters if this ensures your notes are legible.

4. Note the date of your entry

You should always date your note to reflect the day that you are writing it. If you are writing about something retrospectively, include the date and time of the event within the body of the note.

5. Sign your entry

This may be a full signature or your initials - it will depend on your organisation's policy. Make sure you sign directly after your last word to minimise the possibility of anyone adding additional notes after yours.

e.g. …took Mr.'s Smith to clinic to pick up her medications.----*B. Jones*

Additionally, you may be required to add your designation after your name or initials e.g. RN if you are a registered nurse or PCW for personal care worker.

6. Avoid blank space between entries

It might appear crowded; however, you should never leave blank lines or space between entries.

If you have a blank line that you don't want to write on, draw a line through it, as this will avoid the possibility of someone inserting additional notes in the space.

Similarly, if you have accidentally started a new page and discover that the previous page still had white space, draw a 'Z' shaped line through the blank lines.

7. Make it clear if notes span more than one page

If you move from one page to another you need to highlight that your note continues. Add 'Note continues overleaf' at the end of the page. At the beginning of the next page add the words 'Continued from previous page' before resuming your entry.

This practice ensures that anyone reading the entry understands that the information is spread over the two pages and won't miss any important details.

8. Errors happen

If you make a mistake, simply place a line through the word.

Do not use white out or try to obscure the entry with a black ink pen.

If you have made a note in the wrong person's progress notes you will need to rule a line through the entry and make a note that the information was written in the wrong client's file by using the words 'notes entered against incorrect client'.

Remember to sign and date this!

9. Use the correct words

Do not try to write complex words unless you are sure of their spelling and meaning.

If you use a word incorrectly and your notes are subpoenaed due to an incident, it may appear that you or the organisation have taken an incorrect path of care.

For example, the words anuresis and enuresis look and sound similar, but they have opposite meanings:

anuresis – unable to urinate or lack of urine
enuresis – bedwetting

Even simple words can trip people up such as the words:

excess – too much of something
access – to gain entry

What about:

dysphagia – having difficulty in swallowing
dysphasia – the loss or difficulty in using or understanding speech

Remember that even many simple words that sound the same are spelt differently and have different meanings.

Plain and simple language is the best *coarse* course of action.

10. Beware the acronym and abbreviation

An **acronym** is a word or name created out of the initial letters of words in a phrase, for example:

CHSP = Commonwealth Home Support Programme

or

ADL's = Activities of Daily Living.

An **abbreviation** is a shorthand version of a word or phrase that may be used repeatedly, for example:

Mr = Mister (originally Master) or Mrs = Missus (originally Mistress).

It is best to use the full word/s where possible rather than use an abbreviation or acronym, as this is less likely to lead to misinterpretation. However, if you do use a shortened version of a word or phrase, ensure that it is either a standard across the industry, with no chance of misinterpretation, or one approved by your organisation.

Many large organisations have an approved list of abbreviations, with these being the only ones allowed when writing progress notes. Check with your supervisor if you are unsure.

However, here are just a few of the common abbreviations that you might encounter when working in aged care.

Abbreviation	Meaning
b.i.d.	Twice daily, as in medication taken twice daily
B.P.	Blood Pressure
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebral Accident (Stroke)
DNR	Do Not Resuscitate
PRN	As needed, e.g. for pain medication that is taken as needed
UTI	Urinary Tract Infection

11. Keep your entry professional

Ensure that your entry does not contain assumptions, judgmental language or red flag terminology.

Just because a person looks glum does not mean they are sad. Just because someone is staggering does not mean they are drunk.

Keep to known observations.

State only what you heard, saw, smelt or felt.

- Joe felt hot to the touch – **not** Joe has a fever (maybe he has been sitting out in the sun all day);
- Billy was observed to be unsteady on his feet – not Billy was drunk because he was staggering around (Billy may be exhibiting signs of a neuro degenerative condition such as Machado Joseph Disease - MJD);
- Sarah smelt strongly of urine – not Sarah was incontinent (Sarah may have been sitting on a chair that was urinated on by someone else).

When you state that Trixie was being offensive or obstructive, you are making a judgement call on her behaviour – Trixie's behaviour might offend you, however her intent might be otherwise. If you merely state the actions that Trixie has taken and your response to that, you are maintaining professional neutrality.

Be careful of using red flag terms, these might be great for the sellers of newspapers and magazines however, they have no place when writing standard progress notes.

Red flag terms describe words or phrases that can lead to sensationalism. These could be describing a person as being the '**victim** of financial abuse' or 'there is an **epidemic** of influenza within the facility'.

Just remember, stick to the facts and only the facts.

Electronic Client Management Systems

For organisations using electronic progress notes, some of the above points will be irrelevant as the computer system will generate a time and date stamp and your notes should be legible, but remember the content is still up to you.

12. Don't copy and paste or mindlessly repeat entries

While electronic client management systems address a number of the above issues you still need to take note of the content, don't copy and paste or mindlessly repeat a previous entry.

Copy and pasting from one client to the next is a lazy way of writing progress notes and has the potential for errors that can impact adversely on the payment received for a client under the ACFI system. More than one manager has reported how their facility has had a resident's status downgraded and been required to repay funds merely because staff have wrongly copy and pasted information into the resident's progress notes. If a person is a two-person assist, requires support in the shower and a wheelchair to get to the dining room however, a staff member accidently write that the resident walked to the dining room, the person's status will be downgraded.

If your client management system allows duplication of notes to multiple clients, do not use this facility unless you hold a position where you deliver services in a group setting such as the Diversional Therapist or Activity Officer. Otherwise you may find that you have 'accidently' delivered a service to all 100 residents in the facility, perhaps even to those recently deceased who haven't yet been removed from the list.

Take a minute to re-read your entry before you hit save, check the wording used and that your entry relates to that individual.

Always log out after making an entry, otherwise you are allowing another person to access your electronic signature.

Effective Handover Practices

EFFECTIVE HANDOVERS

An ineffective handover process contributes to delays and errors in care and support to vulnerable consumers. It will also leave your team feeling overwhelmed, which further places the wellbeing of residents at risk.

As a residential care facility operates on a 24/7 basis staff need to work around the clock to provide care, which means shift changeovers are inevitable. This is well a well organised and effective handover process can make all the difference.

An effective handover in residential care provides similar benefits to completing well written notes.

- Provides continuity of care for residents between different shifts, which helps residents and their family to feel more confident in the team and organisation.
- Helps staff to communicate issues and concerns, so the next shift can address them in a timely manner.
- Provides a written record of resident issues and progress.
- Promotes person-centred care.
- Saves staff time and energy, which in turn helps to prevent stress and minimises mistakes.
- Helps staff feel more prepared and confident in their role and in the care they provide to residents.
- Promotes a culture of teamwork and support in your care setting.

This is why each handover needs to be as comprehensive and clear as possible, so staff on the next shift can hit the ground running.

Handovers should be concise and timely, containing sufficient information to allow the incoming shift to understand any priorities and what to focus their attention on.

Hold handover meetings in an area that provides privacy, away from curious onlookers or where personal information about individual consumers could be accidently disclosed and where the team won't be interrupted.

Effective Handover Practices

Effective Delivery of Information

- Use notes or run sheet or electronic file notes - in residential care it is important that key information is not overlooked, you need to ensure the accuracy of information. A written or electronic daily run sheet is probably the most effective system used to pass on information as it allows staff to note key issues which can them be used as a quick reference during handover meetings.
- Have a standard procedure for handover that is relevant for your workplace and follow it. This is not the time for social chit chat and staff participating in a handover meeting need to be focused on the task at hand to ensure important information is not overlooked.
- The person conducting the handover has the floor. This means they are in control at that time. Other people participating should wait until the handover leader has completed the delivery of information about a resident to ensure that information is not accidently missed due to interruptions. The leader should allow time for questions at the end of each resident handover note, as relevant.
- Use simple language that each person in the team understands. Avoid jargon and if you need to use a technical term ensure that each person in the group understands what that means to avoid any confusion.

What information should be included in a handover?

Each organisation will more than likely have its own standard handover practice or paperwork, which is often related to the size of the facility, type of residents living there and what meets the needs of staff, you need to follow your organisation's practices.

As a general guide handover information may include:

- The identity of the resident - staff need to know who you are talking about, make sure to clearly define the relevant resident especially where there are two people with similar names.
- The location of the resident - note if they have moved rooms for any reason or where new residents are located.
- Any relevant background and/or personal information - especially where a new resident or respite consumer has entered the facility, or a staff member is returning after a significant time away such as four week's leave and new residents have arrived.
- Any current health issues or concerns - for example are they in quarantine due to an influenza outbreak.
- Any behavioural issues that arose during the shift and identified effective interventions.
- Any other interventions that have been taken.
- Any current and/or anticipated needs of the resident during the next shift and recommendations for the shift staff.
- Any time sensitive interventions that need completing.
- Any anticipated visits or appointments relevant to specific residents that are known.

Correct Storage of Information

STORING CLIENT INFORMATION CORRECTLY

Imagine you are a client of a business.

You have provided the business with your personal details;

- Your full name,
- Date of birth and
- Contact details, including your address.
- The fact that you are a single person is also noted on the form you have filled out.

Whilst seated in the office discussing your needs with the business manager, you notice the files of other clients lying open on the desk.

At one point in your conversation, the manager needs to go out of the office to clarify an issue with a colleague, leaving you alone with these client files. It would be easy for you to pick up any one of these and peruse if you so desired – in fact one of them is lying open in front of you, the person's details clearly accessible to anyone wanting to read them.

How confident are you feeling about this organisation's protection of your privacy?

Now look around you – how well are you protecting the privacy of the vulnerable clients in your organisation?

Record-keeping practices can impact on both client outcomes and the reputation of an organisation. Clients of any business trust that their personal information will be handled and stored in an appropriate manner – when it becomes evident that there has been a breach of this trust, the relationship between the organisation and the client is affected.

The disclosure of sensitive information can also cause negative consequences for the individual whose details are at risk. I remember an incident in one organisation where an unauthorised staff member accessed and disclosed private information – this action resulted in a life or death situation for the young and vulnerable person involved.

Document security is an important aspect of the job for staff working in the community services sector.

Client progress notes, personal information and other documentation (whether in paper or electronic format) contain personal and medical information about a person that must be protected from the casual observance of unauthorised people.

There are standards and best practice guidelines backed up by legislation that cover issues around access, confidentiality and disclosure of personal information.

Respecting the privacy of individuals should be a priority for all community service organisations.

Make sure you follow organisational practices such as:

- Locking file cabinets that contain personal information when not in use
- Covering or removing sensitive and personal documents when a visitor enters your office or work area
- Ensure that person information about an individual is only accessible to relevant personnel
- Ensure office doors that contain personal information are locked when not in use
- Secure computer access with passwords and log out when not using
- Provide visitors who need to use a shared computer or an online program with visitor access

STAFF INFORMATION

It's not only the clients who have sensitive information on file.

Staff members also have personal information stored within the workplace environment and this needs to be protected as well.

Confidential staff information might include:

- Police checks
- Medical Information
- Banking and Pay Information
- Addresses and other personal details

To safeguard against unauthorised use, disclosure or loss of client or staff records, all organisations should have policies and procedures that provide guidelines for the correct storage of client and staff documentation.

Tips for Maintaining Information Security

TIPS FOR MAINTAINING THE SECURITY OF SENSITIVE INFORMATION

- Paper-based copies of client records, including progress notes, should be kept in lockable storage such as a filing cabinet or cupboard, or in secured access areas when not in use.
- Any documents that are no longer required and which contain client information should be shredded or archived appropriately – archived client information should also be stored securely.
- Always log out of electronic Client Information Management systems immediately after you have completed your task to prevent someone accessing sensitive client information, as well as minimising the risk of someone adding additional notes under your electronic signature.
- When leaving a computer unattended, passwords and screensavers must be employed to avoid casual observation and access.
- Never share your password with another staff member, all staff should have their own personal password and access Client Management Systems under those.
- If your organisation uses daily client plans to inform staff of activities for a client, these should be placed in a folder or location away from the general public.
- Take care that staff who need to take paper-based client information away with them, such as addresses and contact details, are aware of and follow procedure for ensuring the security of this information.
- Any requests for information about an individual should be provided only to appropriate personnel with the individual's permission and / or according to your organisation's policies and procedures and privacy laws.
- All staff in your organisation should receive instruction on the correct handling and storage of client information and the organisational and legislative requirements of the Privacy Act.
- Ensure that your organisation has a policy and procedure in place to respond appropriately, and in a timely manner, should a data breach occur in your organisation to protect vulnerable individuals.

Remember! It is also important to maintain the same privacy and security standards mentioned above for staff documentation.

Thankyou

We hope you have found this resource useful.

This eBook is just one of a number of resources we have on the CDCS resource hub. We are always working on ways to support those who care for others.

If you're not already, why not consider becoming a CDCS Member.

Membership allows you access to a range of resources and training to help you go further in your career working in the aged care or disability industries.

Check out our website for details.

Check out the
CDCS Membership Site

Membership Hub - https//:www.culturallydirectedcaresolution.com

Website and regular blog posts - https//:www.cdcs.com.au

Like to learn by watching and listening? Search for the CDCS team on YouTube

YouTube - Culturally Directed Care Solutions