



Australian Government

Assessment Requirements for HLTAHW028 Provide information and strategies in chronic condition care

Release: 2

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Modification History

Release	Comments
Release 2	Updated: • assessor requirements statement • foundation skills lead in statement • licensing statement • modification history to reflect 2012 standards Equivalent outcome.
Release 1	This version was released in <i>HLT Health Training Package release 1.0</i> and meets the requirements of the 2012 Standards for Training Packages. Significant changes to elements and performance criteria. New evidence requirements for assessment, including volume and environment requirements.

Performance Evidence

The candidate must show evidence of the ability to complete tasks outlined in elements and performance criteria of this unit, manage tasks and manage contingencies in the context of the job role.

There must be evidence that the candidate has:

- provided on at least three separate occasions access to accurate health information on chronic conditions relevant to community and individual needs
- supported and guided at least three clients with chronic conditions
- referred at least three clients with chronic conditions to relevant services
- organised and ensured follow-up care for at least three clients.

Knowledge Evidence

The candidate must be able to demonstrate essential knowledge required to effectively do the task outlined in elements and performance criteria of this unit, manage the task and manage contingencies in the context of the identified work role

This includes knowledge of:

- organisation policies and procedures and legislation or regulations relating to:

- client confidentiality
- referral, including various levels of urgency, and follow-up of clients
- mandatory reporting
- notifiable communicable diseases
- limits of own ability and authority
- reporting procedures
- documentation
- prevalence and statistical incidence of diabetes, heart disease and chronic kidney disease in Aboriginal and/or Torres Strait Islander populations compared to non-Aboriginal and/or Torres Strait Islander populations
- importance of self-management and the promotion of health-seeking behaviours
- importance of developing care plans that involve the client and the multidisciplinary care team
- health promotion strategies for all chronic conditions (primary, secondary and tertiary prevention), including:
 - maternal and infant/child health
 - smoking cessation
 - national recommendations for healthy eating (including avoiding foods high in saturated fat and salt)
 - national recommendations for physical activity
 - vaccination (hepatitis B, pneumococcal, influenza & HPV)
 - oral health
 - safe alcohol consumption
 - social and emotional wellbeing
 - annual child and adult health checks
- features of chronic illness, including:
 - complex causality
 - multiple risk factors
 - long latency periods
 - a prolonged course of illness
 - functional impairment or disability
- specific chronic conditions affecting Aboriginal and/or Torres Strait Islander clients and communities, including:
 - cardiovascular disease
 - diabetes
 - cancer
 - chronic respiratory disease
 - chronic kidney disease
 - asthma
 - arthritis
 - oral disease

- specific impact of chronic conditions on major body organs and systems
- groups at high risk of chronic conditions
- determinants of chronic conditions, including:
 - smoking
 - physical activity
 - nutrition
 - alcohol intake
 - use of illicit drugs
 - obesity, weight and waist circumference
 - unsafe sexual practices
 - genetic factors
- treatment and management of chronic conditions, including:
 - working strategically with clients, family and significant others to promote self-management as far as possible
 - medication
 - surgery
 - regular exercise
 - good nutrition
 - cessation of smoking
 - cessation or moderation of alcohol use
 - cessation of illicit drug use
 - regular screenings for changes in disease presentation and detection of other diseases
- in relation to cardiovascular diseases:
 - the concept of ‘cardiovascular risk factors’, the significance of an individual having multiple risk factors
 - the development of atherosclerosis and the basic pathophysiology of coronary heart disease, cerebrovascular disease and peripheral vascular disease
 - basic medical and surgical management of coronary heart disease
 - basic knowledge of the causes, prevention and management of other cardiovascular diseases including rheumatic heart disease, heart failure and cardiomyopathies
- in relation to diabetes mellitus:
 - basic pathophysiology of type II contrasted with type I diabetes mellitus and gestational diabetes
 - complications of diabetes (macrovascular: coronary heart disease, cerebrovascular disease and peripheral vascular disease; and microvascular: neuropathies, retinopathy and nephropathy)
 - main elements of the ‘diabetes annual cycle of care’
 - importance of follow-up for women with gestational diabetes and their children
 - role of other members of the multidisciplinary care team (e.g. GP, endocrinologist, diabetes educator, podiatrist, dietitian, ophthalmologist/optometrist, psychologist)
- in relation to chronic kidney disease:

- basic pathophysiology of chronic kidney disease (causes, body systems affected, progression/staging)
- importance of early detection of chronic kidney disease in effort to defer or prevent end-stage kidney disease
- screening and monitoring of chronic kidney disease (including blood and urine tests)
- strategies to delay progression of chronic kidney disease (including control of blood sugar, blood pressure and smoking cessation)
- complications (including hypertension, anaemia, bone demineralisation and high potassium levels) and major causes of death
- options for management of end-stage kidney disease (palliative care, haemodialysis, continuous ambulatory peritoneal dialysis, transplant).
- dilemmas and difficulties faced by Aboriginal and/or Torres Strait Islander people and their families who need to relocate to distant centres in order to access dialysis treatment
- supporting clients in self-care, including diet, physical activity, foot care, self-monitoring of blood sugar, and use of diabetes medicines in relation to chronic renal disease, :
 - basic pathophysiology of chronic renal failure (causes, body systems affected, natural history)
 - factors which may worsen or accelerate renal failure (including: high blood pressure, anti-inflammatory drugs, poor diabetes control, dehydration, high protein diet)
 - clinical features of advanced renal failure
 - the importance of early detection of renal disease in efforts to defer or prevent end-stage renal failure
 - options for treatment of end-stage renal failure (haemodialysis, chronic ambulatory peritoneal dialysis, transplant)
- the dilemmas and difficulties faced by Aboriginal people and their families who need to relocate to distant centres in order to access dialysis treatment
- familiarity with a range of other common chronic conditions in Aboriginal populations:
 - chronic liver disease – causes, clinical features and principles of management (including hepatitis B, hepatitis C, alcoholic liver disease and cirrhosis)
 - chronic obstructive lung disease, relationship to smoking and principles of management
- agencies able to provide support and assistance to Aboriginal and/or Torres Strait Islander people with chronic disabilities
- strategies to assist Aboriginal and/or Torres Strait Islander people with disabilities to live fulfilling and productive lives in the community
- methods of organising care of clients with chronic conditions (e.g. disease registers, care plan schedules in medical files, tagging files, computerised client information and recall systems)
- value of the opportunistic approach to chronic condition surveillance (comprehensive check-ups as people come to the clinic)

Assessment Conditions

Skills must be demonstrated working:

- in a health service or centre
- as part of a multidisciplinary primary health care team
- with Aboriginal and/or Torres Strait Islander clients and communities.

In addition, simulations and scenarios must be used where the full range of contexts and situations cannot be provided in the workplace or may occur only rarely. These are situations relating to emergency or unplanned procedures where assessment in these circumstances would be unsafe or is impractical.

Simulated assessment environments must simulate the real-life working environment where these skills and knowledge would be performed, with all the relevant equipment and resources of that working environment, including medical equipment used to conduct checkups, such as sphygmomanometer and glucometer to monitor blood pressure and blood sugar.

Assessors must satisfy the Standards for Registered Training Organisations (RTOs) 2015/AQTF mandatory competency requirements for assessors.

Assessment must be undertaken by a workplace assessor who has expertise in this unit of competency and who is:

an Aboriginal and/or Torres Strait Islander Health Worker or:

- accompanied by an Aboriginal and/or Torres Strait Islander person who is a recognised member of the community with experience in primary health care.

Links

Companion Volume implementation guides are found in VETNet -

<https://vetnet.gov.au/Pages/TrainingDocs.aspx?q=ced1390f-48d9-4ab0-bd50-b015e5485705>