



Australian Government

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.

Application

This unit describes the skills and competencies required to conduct health promotion related to chronic conditions as part of primary health care services for Aboriginal and/or Torres Strait Islander communities.

The unit applies to those Aboriginal and/or Torres Strait Islander Health Workers providing a range of primary health care services to Aboriginal and/or Torres Strait Islander clients and communities.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

Elements and Performance Criteria

ELEMENT

PERFORMANCE CRITERIA

Elements define the essential outcomes.

Performance criteria specify the level of performance needed to demonstrate achievement of the element.

1. Promote the prevention of chronic conditions

1.1 Consider identified community and individual client needs in determining priorities and potential areas

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to be addressed by chronic condition health promotion

1.2 Identify primary, secondary and tertiary prevention strategies for prevalent chronic conditions across the lifespan

1.3 Provide accurate information about the nature, prevalence and potential impacts of chronic conditions in relation to Aboriginal and/or Torres Strait Islander communities

1.4 Provide health information in plain language, using culturally appropriate and safe communication skills, and visual aids where appropriate

1.5 Discuss risk factors relating to specific chronic conditions in the context of local, cultural, community, family and individual issues

1.6 Explain and/or demonstrate practices for early detection of specific chronic conditions

1.7 Provide practical advice relating to maintaining good health in relation to prevalent chronic conditions and in line with individual and community needs and organisational guidelines

2. Provide support to clients with chronic conditions

2.1 Equip clients with common chronic conditions to make decisions about their health

2.2 Assist clients with chronic conditions to actively participate in the development of multidisciplinary care plans

2.3 Use culturally appropriate educational resources for chronic condition programs

2.4 Provide information about resources available in the community and state in relation to addressing chronic condition issues

2.5 Support clients to take a self-care approach to maintaining health in line with individual needs

2.6 Make appropriate referrals for clients with chronic conditions in accordance with organisation procedures and policies

ELEMENT**PERFORMANCE CRITERIA**

Elements define the essential outcomes.

Performance criteria specify the level of performance needed to demonstrate achievement of the element.

2.7 Maintain confidentiality to reflect community and organisation guidelines

2.8 Offer brief interventions for smoking cessation as required, using motivational interviewing and other relevant techniques

2.9 Identify patterns of alcohol consumption and offer brief interventions as required

3. Follow-up clients with chronic conditions

3.1 Identify clients with chronic conditions who are significantly overdue for health care checks and engage follow-up and active recall strategies according to organisation procedures and policies

3.2 Identify social and environmental factors that impact on chronic conditions and address them in partnership with the Aboriginal community and other agencies

Foundation Skills

The Foundation Skills describe those required skills (language, literacy, numeracy and employment skills) that are essential to performance.

Numeracy

- in order to offer blood pressure checks, check medication dosages, and blood glucose readings

Reading

- in order to interpret protocols for the management of conditions, and interpret and contribute to the development of implementation of care plans

Other foundation skills essential to performance are explicit in the performance criteria of this unit.

Unit Mapping Information

No equivalent unit.

Links

Companion Volume implementation guides are found in VETNet -

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

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

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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, dietician, 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.

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