



Australian Government

Department of Education, Employment and Workplace Relations

HLTAHW415B Provide information and strategies in chronic disease care

Release: 1

HLTAHW415B Provide information and strategies in chronic disease care

Modification History

Not Applicable

Unit Descriptor

Unit Descriptor

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

Specific advice provided may be limited by close supervision or established guidelines in line with community needs and health provider guidelines

Application of the Unit

Application

This unit is intended to address skills and knowledge required by those working with Aboriginal or Torres Strait Islander communities to deliver primary health care services at Certificate IV level

Licensing/Regulatory Information

Not Applicable

Pre-Requisites

Not Applicable

Employability Skills Information

Employability Skills

This unit contains Employability Skills

Elements and Performance Criteria Pre-Content

Elements define the essential outcomes of a unit of competency.

The Performance Criteria specify the level of performance required to demonstrate achievement of the Element. Terms in italics are elaborated in the Range Statement.

Elements and Performance Criteria

ELEMENT

1. Promote the prevention of chronic disease

PERFORMANCE CRITERIA

- 1.1 Consider identified community and individual client needs in determining priorities and potential areas to be addressed by chronic disease promotion
- 1.2 Provide accurate *information* about the nature, incidence and potential *impacts of chronic diseases* in relation to Aboriginal and/or Torres Strait Islander communities
- 1.3 Provide health information regarding chronic disease in plain language, using visual aids where appropriate
- 1.4 Discuss *risk factors* relating to specific chronic disease in the context of local, cultural, community, family and individual issues
- 1.5 Provide information on practices to prevent chronic disease to address identified individual and community needs
- 1.6 Explain and/or demonstrate practices for early detection of specific chronic diseases in line with organisation guidelines
- 1.7 Provide practical advice relating to maintaining good health in relation to prevalent chronic diseases and in line with community needs and organisational guidelines

ELEMENT**PERFORMANCE CRITERIA****2. Provide *support* to clients with chronic disease**

- 2.1 Provide support for clients with common chronic diseases in Aboriginal and/or Torres Strait Islander communities in line with organisation guidelines and identified protocols
- 2.2 Provide guidance about health issues related to chronic disease in line with community needs and organisational guidelines
- 2.3 Use culturally appropriate educational resources for chronic disease in programs
- 2.4 Provide information about resources available in the community and state in relation to addressing chronic disease issues
- 2.5 Support clients to take a self-care approach to maintaining health in line with individual needs and organisation and community requirements
- 2.6 Make appropriate referrals for clients with chronic disease in line with organisation guidelines
- 2.7 Maintain confidentiality to reflect community and organisation guidelines
- 2.8 Offer brief interventions for smoking cessation
- 2.9 Establish patterns of alcohol consumption and offer brief interventions

3. Follow-up clients with chronic disease

- 3.1 Organise follow-up care for clients with chronic disease using computer and/or paper based registers
- 3.2 Produce lists of clients with chronic disease who are significantly overdue health care checks and employ active-recall strategies
- 3.3 Identify social and environmental factors that impact on chronic disease and address them in partnership with the Aboriginal community and other agencies

Required Skills and Knowledge

REQUIRED SKILLS AND KNOWLEDGE

This describes the essential skills and knowledge and their level required for this unit.

Essential knowledge:

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:

- Statistical incidence of diabetes, heart disease and kidney failure in Aboriginal populations compared to the non-Aboriginal population
- In relation to cardiovascular diseases:
 - the concept of 'cardiovascular risk factors', the significance of an individual having multiple risk factors and the concept of 'high absolute risk'
 - the importance of reduction of saturated fats and sugar-sweetened soft drinks, increased physical activity and smoking cessation in reducing the risk of heart and kidney disease in Aboriginal population
- In relation to diabetes mellitus:
 - basic pathophysiology of type II contrasted with type I diabetes mellitus
 - complications of diabetes (including heart disease and stroke; renal failure; retinal damage and blindness; nerve damage and infection resulting in amputation; impotence)
 - the main elements of the 'diabetes checkup'
 - the procedure for taking retinal photographs
 - basic anatomical features and abnormalities on a retinal photograph
 - the content of client education for diabetes covering diet, physical activity, foot-care, 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

REQUIRED SKILLS AND KNOWLEDGE

- 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
 - major types of chronic disability (psychiatric, physical and mental)

continued ...

Essential knowledge (continued):

- Agencies able to provide support and assistance to Aboriginal and/or Torres Strait Islander people with chronic disabilities
- Strategies that can assist Aboriginal and/or Torres Strait Islander people with disabilities to live fulfilling and productive life in the community
- Methods of organising the care of clients with chronic diseases (eg: disease registers, care plan schedules in medical files, tagging files, computerised client information and recall systems)
- The value of the opportunistic approach to chronic disease surveillance (comprehensive check-ups as people come to the clinic)
- The use of computerised client information and recall systems to follow-up clients
- Ways of evaluating a chronic disease program
- Methods of providing feedback to health service management and community on the effectiveness of a chronic disease program

Essential skills:

It is critical that the candidate demonstrate the ability to:

- Communicate effectively in a group and one-on-one environment to promote healthy practices and discuss health issues
- Provide accurate and relevant information and guidance about chronic disease care in line with identified individual and community needs

In addition, the candidate must be able 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 the ability to:

REQUIRED SKILLS AND KNOWLEDGE

- Explain and describe procedures and illnesses/ disorders in clear, simple language to clients
- Work with groups in the community to seek input and feedback on health services
- Read and write reports, interpret statistics, charts and test results, write letters, keep client documentation
- Use computers for client records, report writing, letters and use client information and recall systems
- Observe clients
- Negotiation with clients, colleagues, community members and other agencies
- Work with a team to deliver effective health promotion and education for Aboriginal and/or Torres Strait Islander communities and clients using appropriate facilitation, problem solving and instructional practices

Evidence Guide

EVIDENCE GUIDE

The evidence guide provides advice on assessment and must be read in conjunction with the Performance Criteria, Required Skills and Knowledge, the Range Statement and the Assessment Guidelines for this Training Package.

Critical aspects of assessment:

- The individual being assessed must provide evidence of specified essential knowledge as well as skills
- Consistency of performance should be demonstrated over the required range of situations relevant to the workplace
- Where, for reasons of safety, space, or access to equipment and resources, assessment takes place away from the workplace, the assessment environment should represent workplace conditions as closely as possible

EVIDENCE GUIDE

Conditions of assessment:

This unit includes skills and knowledge specific to Aboriginal and/or Torres Strait Islander culture

Assessment must therefore be undertaken by a workplace assessor who has expertise in the unit of competency or who has the current qualification being assessed and who is:

- Aboriginal or Torres Strait Islander him/herself

or:

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

Context of assessment:

Competence should be demonstrated working individually, under supervision or as part of a primary health care team working with Aboriginal and/or Torres Strait Islander clients

Assessment should replicate workplace conditions as far as possible

Related units:

This unit may be assessed independently or in conjunction with other units with associated workplace application

Range Statement

RANGE STATEMENT

The Range Statement relates to the unit of competency as a whole. It allows for different work environments and situations that may affect performance. Add any essential operating conditions that may be present with training and assessment depending on the work situation, needs of the candidate, accessibility of the item, and local industry and regional contexts.

Cultural respect

This competency standard supports the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples

It recognises that the improvement of the health status of Aboriginal and Torres Strait Islander people must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance

Its application must be culturally sensitive and supportive of traditional healing and health, knowledge and practices

Community control

Community participation and control in decision-making is essential to all aspects of health work, and the role of the health worker is to support the community in this process

RANGE STATEMENT

Supervision

Supervision must be conducted in accordance with prevailing state/territory and organisation legislative and regulatory requirements

References to supervision may include either direct or indirect supervision of work by more experienced workers, supervisors, managers or other health professionals

A person at this level should **only** be required to make decisions about clients within the organisation's standard treatment protocols and associated guidelines

Legislative requirements

Federal, state or territory legislation may impact on workers' practices and responsibilities. Implementation of the competency standards should reflect the legislative framework in which a health worker operates. It is recognised that this may sometimes reduce the application of the Range of Variables in practice. However, assessment in the workplace or through simulation should address all essential skills and knowledge across the Range of Variables

Aboriginal and/or Torres Strait Islander health workers may be required to operate in situations that do not constitute 'usual practice' due to lack of resources, remote locations and community needs. As a result, they may need to possess more competencies than described by 'usual practice circumstances'

Under all circumstances, the employer must enable the worker to function within the prevailing legislative framework

RANGE STATEMENT

Support for clients with common chronic diseases may include but is not limited to:

- Support for clients with Type II Diabetes Mellitus information on:
 - diet
 - medication
 - physical activity
 - foot-care
 - the importance of regular blood tests, urine tests and medical review

Regular offer of a diabetes check for:

- glycaemic control
- development of diabetes complications
- presence of other cardiovascular risk factors
- Support for clients with impaired renal function and chronic renal failure [and their families], with advice regarding:
 - the natural history of the disease
 - the importance of blood pressure control
 - control of diabetes
 - regular monitoring to maintain renal function
- Information about options for management of end-stage renal failure (ESRF)
- Support for clients with coronary heart disease:
 - education about their condition
 - information about risk factors and use of medication to reduce risk
 - cardiovascular risk status determined on the basis of age, sex and presence of risk factors
- Support for clients with asthma and chronic obstructive pulmonary disease:
 - education on their condition including the appropriate use of symptom-relieving and suppressant medication
- Support for clients with chronic disabilities (physical, psychiatric, and cognitive) and their families:
 - referral
 - liaison with other agencies
- Support offered to all clients with chronic disease as per NH&MRC guidelines:
 - arrangement for immunisation against pneumococcal disease and influenza

RANGE STATEMENT

- Support for clients re acute rheumatic fever and rheumatic heart disease, including:
 - referral for diagnosis
 - education about their condition
 - regular follow up with monthly injections (secondary prevention strategy)

- Social and environmental factors that impact on chronic disease may include but are not limited to:*
 - Access to good food
 - Structured physical activity programs/initiatives, through, for example:
 - sport and recreation opportunities
 - active recreation
 - supportive environments for active transport
 - Medication supply

- Dietary information includes:*
 - Assessment of usual dietary patterns, particularly sources of dietary fat
 - Promotion of low-fat foods and food preparation techniques that are consistent with individual and families dietary habits
 - Promotion of foods high in fibre, vitamins and minerals

- Physical activity information includes:*
 - Assessment of adult, children and adolescent physical activity patterns
 - Promotion of incidental physical activity, such as walking to school
 - Promotion of supportive environments for physical activity

RANGE STATEMENT

Cardiovascular risk factors include:

- Tobacco smoking
- Obesity
- Central obesity
- Hypertension
- Diabetes mellitus
- Family history of ischaemic heart disease
- Hyperlipidaemia
- Proteinuria

Unit Sector(s)

Not Applicable