UNIT CODE	**HLTAHCS010**
UNIT TITLE	**Provide support to clients with chronic disease**
APPLICATION	This unit describes the performance outcomes, skills and knowledge required to provide information and support to Aboriginal and/or Torres Strait Islander clients with chronic disease and their families to enable informed choices about treatment and self-care. It requires the ability to assist clients to participate in the planning of their ongoing treatment and care, take self-management approaches, and to access chronic disease support services. It covers the coordination of ongoing care for clients with chronic disease. Support for clients with diabetes, and cancer is covered by additional specific units. This unit is specific to Aboriginal and/or Torres Strait Islander people working as health practitioners. They work as part of a multidisciplinary primary health care team to provide primary health care services to Aboriginal and/or Torres Strait Islander clients. No regulatory requirement for certification, occupational or business licensing is linked to this unit at the time of publication. For information about practitioner registration and accredited courses of study, contact the Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA).
PREREQUISITE UNIT	Nil
COMPETENCY FIELD	Health Care and Support
UNIT SECTOR	Aboriginal and/or Torres Strait Islander Health
ELEMENTS	**PERFORMANCE CRITERIA**
Elements describe the essential outcomes	*Performance criteria describe the performance needed to demonstrate achievement of the element.*

1. Assist clients with self-management approaches for chronic disease.	1.1 Provide information about relevant chronic disease, treatment and health care options in plain language using culturally appropriate and safe communication. 1.2 Explain to client their role in managing the disease and elements of self-management. 1.3 Assist client to express their needs and preferences and encourage their own choices for treatments and health care. 1.4 Assist clients with chronic disease to actively participate in the ongoing development of multidisciplinary care plans.
2. Provide resources and information about chronic disease support services.	2.1 Provide culturally appropriate consumer based education resources about relevant chronic disease and its treatment to clients and their families. 2.2 Inform clients about relevant chronic disease support services available in the community, state or territory. 2.3 Facilitate access to chronic disease support services according to client needs and preferences.
3. Provide information and support to clients with chronic disease.	3.1 Communicate consistently in culturally appropriate and safe ways with client, using plain language. 3.2 Provide information on key psychosocial issues facing Aboriginal and Torres Strait islander people with chronic disease. 3.3 Identify clients at higher risk of psychosocial distress and determine need for assessment. 3.4 Facilitate referrals for clients with chronic disease according to multidisciplinary clinical partnerships. 3.5 Discuss barriers faced by client in accessing chronic disease treatments and recommend resolutions. 3.6 Explain to client importance of regular check-ups, tests and reassessments in the management of chronic disease.
4. Advise on chronic disease self-care strategies.	4.1 Explain, to relevant clients, the importance of self-monitoring blood pressure, blood glucose and urine, and providing records to health care professionals. 4.2 Demonstrate use, care and maintenance of home monitoring equipment and confirm client understanding. 4.3 Provide accurate information about nutrition and lifestyle choices, and impact of unhealthy choices, including alcohol and smoking. 4.4 Provide education resources and offer advice on nutrition, exercise and weight management. 4.5 Offer brief interventions for smoking cessation and reduction or cessation of alcohol consumption. 4.6 Encourage active involvement of client and/or significant others in self-care to ensure optimum outcomes

5. Complete documentation and provide ongoing care for clients with chronic disease.	5.1 Update client records to include details of services, information and referrals provided to client, according to organisational procedures. 5.2 Plan and provide continuity of care in consultation with client and multidisciplinary team. 5.3 Organise ongoing care for clients with chronic disease using organisational registers. 5.4 Identify when clients are overdue for health care checks and employ active-recall strategies.
FOUNDATION SKILLS	
Foundation skills essential to performance in this unit, but not explicit in the performance criteria are listed here, along with a brief context statement.	
SKILLS	**DESCRIPTION**
Reading skills to:	▪ interpret detailed and sometimes unfamiliar client records, involving medical terminology and abbreviations ▪ interpret detailed and sometimes unfamiliar plain language consumer based education resources.
Writing skills to:	▪ use fundamental sentence structure, health terminology and abbreviations to complete forms and reports that require factual and subjective information.
Oral communication skills to:	▪ use language and terms sensitive to clients' values and emotional state ▪ incorporate motivational interviewing techniques into client interactions and brief interventions ▪ ask open and closed probe questions and actively listen to determine client understanding of information.
Learning skills to:	▪ use information provided in credible evidence-based consumer resources to update and extend knowledge of chronic disease, treatments and available support services.
Initiative and enterprise skills to:	▪ source information that meets the specific needs of clients and families.
UNIT MAPPING INFORMATION	No equivalent unit. For details, refer to the full mapping table in the Draft 2 Validation Guide.
LINKS	Companion Volume Implementation Guide

TITLE	**Assessment Requirements for HLTAHCS010 Provide support to clients with chronic disease**

PERFORMANCE EVIDENCE	Evidence of the ability to complete tasks outlined in elements and performance criteria of this unit in the context of the job role, and: ■ provide support to a total of five Aboriginal and/or Torres Strait Islander clients with chronic disease to collectively include: ◦ females ◦ males ◦ people across the lifespan ◦ people with different types of chronic disease ■ for each of the five clients, and according to their individual needs: ◦ source credible consumer based education resources from relevant chronic disease support services, and clearly explain these to the client ◦ provide clear information and explanations about relevant types of clinical chronic disease treatments ◦ provide information on these types of client self-care: • self-monitoring and recording results • nutrition, exercise and weight management • smoking cessation (for at least one of the five clients) • alcohol cessation or reduction (for at least one of the five clients) ◦ source information about relevant chronic disease support services, explain their key features and advise the client how to access services ◦ plan and organise continuity of chronic disease care in consultation with the client and multidisciplinary team ◦ use organisational registers and recall strategies to book two appointments for chronic disease health care checks ◦ document, in client records, accurate details of each client contact including details of services, information and referrals provided.
KNOWLEDGE EVIDENCE	Demonstrated knowledge required to complete the tasks outlined in elements and performance criteria of this unit: ■ organisational procedures for client record keeping ■ key elements of the psychosocial impact of chronic disease and the importance to health outcomes of managing this aspect of health: ◦ emotional ◦ psychological ◦ physical ◦ practical ■ techniques used to communicate with clients and families dealing with the emotional impact of chronic disease diagnosis and treatment ■ the following knowledge for each of the below-listed chronic diseases of high incidence in Aboriginal and/or Torres Strait Islander populations: ◦ plain language definitions and explanations, and ◦ overview of the common forms of clinical treatment including their aim, and ◦ basic pathophysiology sufficient to understand the impact/functional changes on relevant body organs and systems, and ◦ the concept of comorbidity and an overview of the main complications that can result in the co-occurrence of other diseases or conditions: • cardiovascular disease • chronic respiratory disease including Asthma and obstructive lung disease • chronic kidney disease and end stage renal failure • chronic liver disease including hepatitis B, hepatitis C, alcoholic liver disease and cirrhosis • musculoskeletal conditions including arthritis • eye, ear and oral disease

- for chronic kidney disease in particular:
  - the importance of early stage management in deferring or preventing end-stage kidney disease (renal failure)
  - the importance of monitoring through regular blood and urine tests
  - factors which may accelerate or worsen renal failure including high blood pressure, anti-inflammatory drugs, poor diabetes control, dehydration, high protein diet
  - strategies to delay progression including control of blood sugar and blood pressure
  - options for treatment of end-stage kidney disease (renal failure) including haemodialysis, continuous ambulatory peritoneal dialysis, transplant and palliative care

- lifestyle risk factors that can contribute to, exacerbate or progress all types of chronic disease:
  - smoking
  - physical inactivity
  - unhealthy nutrition and body weight
  - consumption of alcohol at unsafe levels
  - use of illicit drugs
  - unsafe sexual practices

- the importance of clients modifying their lifestyle in the management of their chronic disease
- key elements of national guidelines for physical activity
- key elements of national guidelines for healthy eating and weight management
- the particular importance, for Aboriginal and Torres Strait Islander populations, of reducing the intake of foods high in saturated fat and salt, and sugar-sweetened soft drinks
- for home testing equipment, relevant to blood pressure, urinalysis, blood glucose and ketones:
  - operational features
  - ways to avoid inaccurate readings
  - care and maintenance
  - how to read and record levels

- the role of traditional or bush healers, particularly any in the local community
- the elements of client self-management of chronic disease, and the importance of the client's role in managing the disease:
  - knowing about the particular type of disease
  - sharing in decision-making about treatments and ongoing health care, and plans for these
  - following an agreed care plan
  - monitoring and managing signs and symptoms as well as side effects of treatments
  - managing the impact on physical, emotional and social life
  - adopting a healthy lifestyle
  - accessing and using chronic disease support services

- factors that may impact on client choice of treatment and health care:
  - adherence to traditional and spiritual belief systems
  - perceptions of risk and benefits
  - potential for physical disability or impaired function and their impacts on ability to work, family and personal relationships
  - ability to manage treatments and ongoing self-care

- the importance of:
  - current and credible consumer based education resources about the chronic disease and its treatment in the client decision making process
  - patient treatment choices on chronic disease outcomes
  - respecting client values and choice of treatment, and how to provide

	balanced and evidence based information to assist with decisions ◦ determining treatments and planning for supportive care services before treatment starts ■ barriers and difficulties faced by Aboriginal and/or Torres Strait Islander people and their families who need to travel or relocate to distant centres to access treatments ■ chronic disease support services available in the community, state or territory: ◦ for chronic disease in general and for particular types of diseases ◦ specialist services available to people of different genders or ages and to Aboriginal and Torres Strait Islander people ◦ how to access information about the types of services and consumer based education resources they provide ◦ how clients can access services and the role of health practitioners in facilitating access ■ how multidisciplinary team members work together to coordinate chronic disease treatments and care, and how to facilitate referrals ■ the importance of continuity of care for clients with chronic disease; the need for regular attendance, check-ups, re-assessment for changes in disease presentation and detection of other related diseases ■ how to use client information systems and recall functions to follow-up clients for care and regular check-ups ■ the principles and philosophy of palliative care and the role of different members of the multidisciplinary care team in discussing palliative care with clients ■ for palliation: ◦ methods to manage advanced symptoms and pain for people with terminal disease ◦ methods to manage the psychosocial aspects of symptoms and pain ■ for Advanced Care Directives: ◦ their purpose, and overview of the purpose of and differences between wills, powers of attorney and enduring guardianships ◦ inclusions - the person responsible for making medical decisions when client is unable, treatments the client would like or would refuse, and personal values and beliefs about things such as treatments and dying ◦ how they are used by medical practitioners, nurses and other members of a multidisciplinary care team to provide end of life care ◦ overview of legal requirements for the local state or territory.

ASSESSMENT CONDITIONS	Skills must be demonstrated in a health service workplace within a multidisciplinary primary health care team. Evidence of performance must be gathered: ■ during on-the-job assessments in the workplace under live conditions while interacting with Aboriginal and/or Torres Strait Islander people, or ■ during off-the-job assessments in the workplace, not under live conditions, using simulated activities while interacting with Aboriginal and/or Torres Strait Islander people. Evidence of workplace performance can be gathered and reported through third party report processes. (Refer to the Companion Volume Implementation Guide for information on third party reporting.) Evidence can be supplemented by assessments in a simulated workplace environment using simulated activities, scenarios or case studies only when: ■ the full range of situations covered by the unit cannot be provided in the individual's workplace, and or ■ situations covered by the unit occur only rarely in the individual's workplace. Assessment must ensure the use of: ■ home testing equipment for blood pressure, urinalysis, blood glucose and ketones ■ client records ■ current and credible consumer based education resources from chronic disease support services covering different types of disease, clinical treatments and self-care ■ information about different types of chronic disease support services designed to meet the needs of people of different ages, genders, and those for Aboriginal and/or Torres Strait Islander people if available ■ dietary and exercise guidelines from credible sources which could include those produced by government agencies and chronic disease support services ■ organisational procedures for client record keeping. Assessors must satisfy the Standards for Registered Training Organisations requirements for assessors, and: ■ be an Aboriginal and/or Torres Strait Islander person who has applied the skills and knowledge covered in this unit of competency through experience working as an Aboriginal and/or Torres Strait Islander health practitioner, **or** ■ be a registered health practitioner with experience relevant to this unit of competency and be accompanied by, or have assessments validated by, an Aboriginal and/or Torres Strait Islander person.
LINKS	Companion Volume Implementation Guide