UNIT CODE	**HLTAHCS004**
UNIT TITLE	**Complete comprehensive physical health assessments**
APPLICATION	This unit describes the performance outcomes, skills and knowledge required to complete health assessments of Aboriginal and/or Torres Strait Islander clients as part of a multidisciplinary health care team. It requires the ability to complete physical examinations and pathology tests, and to assess their health. This unit covers the ability to evaluate short term or uncomplicated health conditions, and also chronic diseases. Health assessments may be routinely scheduled at specific intervals, could be completed when a client presents with a specific health issue or as part of ongoing care for a diagnosed condition, including chronic disease. 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. Obtain client information and determine health assessment requirements.	1.1 Complete health assessments according to scope of practice and standard treatment protocols used by the organisation. 1.2 Consult relevant health professionals and client health records to evaluate current status of client's health and impact of any previous treatment strategies. 1.3 Obtain current client medical and social history and discuss specific presenting problems using culturally appropriate and safe communication. 1.4 Obtain client information about effectiveness of any current treatments and self-care strategies. 1.5 Explain organisational requirements for maintaining confidentiality of information and permissions for disclosure. 1.6 Accurately document client history according to organisational policies and procedures. 1.7 Determine specific examination and clinical test requirements from information gathered.
1. Complete physical examination and tests.	1.1 Explain the reason and procedures for each examination and test to the client, confirm understanding and obtain informed consent. 1.2 Implement required infection control precautions according to examination and test requirements. 1.3 Use correct protocols to measure vital signs and identify any significant variation from normal reference range. 1.4 Conduct physical examination and clinical tests based on observations and client presentation, and with respect for community values, beliefs and gender roles. 1.5 Use correct clinical protocols to collect, record and send specimens for pathology testing. 1.6 Accurately record details of all measurements, examinations and tests according to organisational policies and procedures.
2. Interpret, document and confirm health assessment findings.	2.1 Evaluate pathology test results, check numerical test values against normal reference range and identify abnormal results. 2.2 Identify, from examination results, any significant variations from normal reference range or client's baseline and previous measurements. 2.3 Evaluate significance of outcomes on the clinical progress or regression of any pre-existing client disease. 2.4 Accurately identify any signs, symptoms and test results that indicate emerging or worsening disease and/or comorbidity. 2.5 Determine own interpretation of client's current health status based on history, presenting problems, examination and test results. 2.6 Provide clear and accurate reports and consult with other health care team members to verify results and confirm client's health status. 2.7 Report any confirmed notifiable diseases according to procedural and legal requirements and within scope of own responsibility. 2.8 Update client records with health assessment details according to organisational policies and procedures.

3. Provide assessment outcomes to clients and/or significant others.	3.1 Provide information about verified assessment results in plain language using culturally appropriate and safe communication. 3.2 Explain significance of examination and pathology test results in the context of any pre-existing client disease and health care plan. 3.3 Explain to client importance of regular check-ups and tests for the ongoing management of their health. 3.4 Provide client with recommendations and referrals to assist with ongoing treatment and management of their health. 3.5 Encourage client and/or significant others to question and clarify outcomes, and purpose of potential treatments and interventions. 3.6 Confirm understanding and document information provided in client records.
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 familiar organisational policies and procedures ■ interpret sometimes complex and unfamiliar client records and standard treatment protocols involving medical terminology and abbreviations.
Writing skills to:	■ use fundamental sentence structure, health terminology and abbreviations to complete forms and reports that require factual information.
Numeracy skills to:	■ interpret sometimes complex medical numerical data and abbreviations in standard treatment protocols and client records ■ take and record accurate measurements involving weights, lengths, rates and degrees ■ interpret pathology test results involving graphs, percentages and ratios ■ document medical numerical abbreviations in client records.
Planning and organising skills to:	■ determine a structured approach for health assessments and complete physical examinations and tests in a logical, time efficient sequence.
Technology skills to:	■ select and use appropriate medical equipment suited to purpose of physical examination, clinical tests and client characteristics.
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 HLTAHCS004 Complete comprehensive physical health assessments**

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: ■ complete a comprehensive health assessment of a total of five Aboriginal and/or Torres Strait Islander clients to collectively include: ◦ females ◦ males ◦ people across the lifespan: children and adolescents through to the elderly ◦ people presenting with varying diseases to collectively include: ● complex acute conditions ● chronic disease ● communicable disease ■ for each of the five clients, complete a head to toe physical examination and tests to include: ◦ measurement of height, weight and waist circumference and calculation of body mass index ◦ measurement of temperature ◦ measurement of blood pressure, pulse rate and rhythm ◦ measurement of lung function - respiratory and peak flow rate and spirometry breathing test ◦ examination of: ● eyes, including physical examination and vision test ● ears and hearing, including otoscopy ● mouth, throat, teeth and gums ● skin and any wounds present ● hands and feet - observations for infective and fungal issues, oedema, abnormalities in the structure and shape, nerve damage ● chest - visual and aural observation of respiration for any signs of congestion or distress ● abdomen - visual observation and palpation ◦ urinalysis via dipstick and pathology testing ◦ blood glucose test with a blood glucose testing meter ◦ examinations for specific presenting problems ■ for each of the five clients: ◦ determine requirements for specific pathology tests according their individual presentations ◦ collect and process blood samples for pathology testing ◦ process swabs (collected by self or client) for pathology testing ◦ evaluate the results of pathology tests ◦ evaluate all assessment information and report own interpretation of client's current health status to health care team ◦ consult with the health care team to verify assessment results and confirm client's health status ◦ discuss assessment outcomes with the client ◦ document, in client's records, accurate details of: ● medical and social history ● observations, examinations and tests completed ● evaluation notes about the health of each client ● information and referrals provided to the client ■ from assessments personally completed or from case study assessment documentation: ◦ identify signs of emerging comorbidity for two clients with existing chronic disease ◦ identify signs of the following conditions or diseases: ● cardiovascular disease ● acute or chronic respiratory disease, including Asthma

	• kidney disease • liver disease • cancer • diabetes • musculoskeletal conditions, including arthritis • eye, ear and oral disease • communicable disease ◦ identify one notifiable disease and implement procedures to notify.
KNOWLEDGE EVIDENCE	Demonstrated knowledge required to complete the tasks outlined in elements and performance criteria of this unit: ■ organisational policies and procedures for: ◦ maintaining client confidentiality ◦ documenting health assessments ■ local state or territory legal requirements, and associated organisational procedures for notifying communicable diseases ■ legal and organisational responsibilities and role boundaries of those involved in comprehensive, complex health assessments: ◦ Aboriginal and/or Torres Strait Islander health practitioners ◦ medical practitioners, registered nurses and other members of the multidisciplinary care team ■ the role of standard treatment protocols in health assessments: ◦ types that are used by primary health care organisations including Standard Treatment Manuals (STM) and how to access ◦ purpose, format and inclusions ◦ how to use to identify physical health assessment requirements for clients with complex needs ■ key information collected and recorded in medical and social histories for health assessments and how this may differ according to the age of the client ■ key elements of comprehensive physical health assessments and how types of examinations and tests may differ according to the age of the client and their presentation ■ the meaning of primary and secondary survey in health assessments ■ the value of an opportunistic approach to chronic and communicable disease surveillance (completing comprehensive health assessments and tests as people come to the clinic for any reason) ■ different types of infection control precautions and when these would be used for different types of physical examinations and collection of specimens for pathology testing ■ equipment and procedures for health examinations and tests, and 'normal' reference range of outcomes for adults: ◦ height, weight, waist circumference and body mass index ◦ temperature ◦ blood pressure, pulse rate and rhythm ◦ lung function - respiratory and peak flow rate; spirometry tests ◦ examination of: • eyes, including physical examination and vision test • ears and hearing, including otoscopy • mouth, throat, teeth and gums • skin and wounds • hands and feet - observations for infective and fungal issues, oedema, abnormalities in the structure and shape, nerve damage • chest - visual and aural observation of respiration for any signs of congestion or distress • abdomen - visual observation and palpation

- urinalysis via dipstick testing
- blood glucose test with a blood glucose testing meter

- the following knowledge, and where to locate information in Standard Treatment Manuals, for each of the below-listed pathology tests:
  - indications - what signs and symptoms may trigger tests; what diseases or conditions are diagnosed and monitored using these tests, and
  - correct methods of collection, storage and transport of specimens, and requirements for documentation, and
  - 'normal' range of test values, and
  - the significance of results that vary significantly from the normal range; what types of conditions or diseases abnormal results may indicate:
    - full blood examination
    - erythrocyte sedimentation rate (ESR)
    - random and fasting blood glucose
    - haemoglobin and glycated haemoglobin
    - blood ketones
    - electrolytes and creatinine
    - liver function
    - lipid profile
    - thyroid function
    - iron studies
    - cardiac enzymes
    - urinary albumin-creatinine ratio
    - urine microscopy, culture and sensitivity
    - microscopy, culture and sensitivities for infections via body fluid or swab collection

- typical inclusions of pathology request forms, and the importance of accuracy when completing
- understanding of anatomy and physiology sufficient to identify major body systems, associated organs and their functions:
  - circulatory system
  - digestive system
  - endocrine system
  - immune system
  - integumentary system
  - muscular system
  - nervous system
  - reproductive system, female and male
  - respiratory system
  - skeletal system
  - urinary system

- common acute conditions associated with major body systems and organs and common presenting signs and symptoms, and required examinations
- features of chronic disease, including:
  - complex causality
  - multiple risk factors, including genetic and lifestyle
  - long latency periods
  - a prolonged course of illness
  - functional impairment or disability

- 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 following knowledge for each of the below-listed chronic and

	communicable diseases of high incidence in Aboriginal and/or Torres Strait Islander populations: ◦ the major signs and symptoms, and ◦ blood and other tests used to diagnose and monitor, and ◦ basic pathophysiology sufficient to understand the impact/functional changes on relevant body organs and systems, and ◦ the concept of comorbidity and overview of the main linkages between diseases sufficient to understand that signs and symptoms may indicate the presence of multiple diseases: • cardiovascular disease including coronary heart disease, heart failure, cardiomyopathy, rheumatic heart disease, atherosclerosis, peripheral vascular disease cerebrovascular disease • chronic respiratory disease, including Asthma and obstructive lung disease • chronic kidney disease and end stage renal failure • chronic liver disease including alcoholic liver disease and cirrhosis • cancer • diabetes • musculoskeletal conditions, including arthritis • eye, ear and oral disease • sexually transmitted infections (STIs) • blood borne viruses including HIV, hepatitis A, hepatitis B and hepatitis C • communicable diseases of current significance in the local state, territory or local community ■ for cardiovascular disease in particular, the concept of 'cardiovascular risk factors', the significance of an individual having multiple risk factors, and the concept of 'high absolute risk' ■ for chronic kidney disease in particular, the importance of early stage detection in deferring or preventing end-stage kidney disease (renal failure) ■ for diabetes in particular: ◦ main elements of the diabetes annual cycle of care ◦ causes, signs and symptoms of diabetic foot disease ◦ screening tools and procedures that can be used to assess diabetic foot disease.
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: ■ personal protective equipment for infection control ■ medical equipment and consumables used for health assessments ■ clinical waste and sharps disposal bins ■ specimen collection documents ■ pathology results ■ client records ■ template forms or reports for documenting client histories, assessment details and results ■ health assessment standard treatment protocols used by the organisation, which can include Standard Treatment Manuals ■ organisational procedures for: ◦ maintaining client confidentiality ◦ documenting health assessments ◦ notifying communicable diseases. 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