UNIT CODE	**HLTAHCS006**
UNIT TITLE	**Implement complex health care plans**
APPLICATION	This unit describes the performance outcomes, skills and knowledge required to review health assessments and contribute to the development of complex health care plans as part of a multidisciplinary health care team. It covers skills to implement, monitor and review plans for the care of clients with complex health conditions, including chronic disease, that require systematic long term management. Plans might include a focus on modification of lifestyle risk factors. Implementation involves making referrals, administering clinical treatments and coordinating ongoing care. 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. Contribute to the planning of treatment and care for clients with long-term or complex conditions.	1.1 Review client history and health assessments to ascertain specific requirements of health care plan. 1.2 Evaluate current status of client's condition and impact of previous treatment strategies. 1.3 Identify proposed treatments using organisational standard treatment protocols and within scope of own practice. 1.4 Discuss with multidisciplinary team members treatment proposals and options that respond to the complexity of client needs. 1.5 Develop proposed care plan in collaboration with multidisciplinary primary health care team. 1.6 Establish clear responsibilities for implementing care plan.

2. Communicate proposed health care plan to client.	2.1 Use culturally appropriate and safe communication to discuss proposed care plan with client and explain how it relates to health assessment results. 2.2 Provide client with information about each aspect of proposed care plan and reasons for inclusion. 2.3 Encourage client questions about proposed care plan to support understanding, cooperation, and agreement. 2.4 Assist client to express their needs, preferences and goals, and encourage their choices about own health care. 2.5 Encourage active involvement of client and/or significant others in health management to ensure optimum plan outcomes. 2.6 Explain to client importance of regular check-ups, tests and reassessments in the ongoing management of their health. 2.7 Consult with primary health care team about client-suggested plan changes and adjust as appropriate. 2.8 Update client records to include the finalised plan, according to organisational policies and procedures.
3. Implement referrals and clinical treatments.	3.1 Select and use medical equipment suited to purpose of treatment and according to manufacturer's specifications. 3.2 Implement required infection control precautions according to treatment requirements. 3.3 Administer clinical treatments according to scope of practice and standard treatment protocols used by the organisation. 3.4 Demonstrate and explain, to client, correct techniques for self-care treatments. 3.5 Discuss required lifestyle modifications and offer brief interventions for smoking cessation and reduction or cessation of alcohol consumption, as relevant. 3.6 Facilitate referrals to health professionals and support services according to client needs and preferences. 3.7 Update client records to include details of referrals, treatments and self-care information provided.
4. Monitor client's health and review effectiveness of health care.	4.1 Organise follow-up care for client and use active recall strategies for overdue care. 4.2 Monitor client's health through ongoing scheduled assessments incorporated in care plan. 4.3 Gain feedback from client and/or significant others about their level of comfort and adherence to care plan. 4.4 Evaluate improvement of client's health, compare with care plan expectations and consult with primary health care team to determine impact of health care. 4.5 Provide clear information to client and/or significant others about health outcomes and relationship to care plan and adherence. 4.6 Coordinate review of care plan to suit client's current health status and for ongoing health management.
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 complex and sometimes unfamiliar health assessments involving health terminology and abbreviations ■ interpret sometimes complex and unfamiliar 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.
Oral communication skills to:	■ provide unambiguous information to clients using plain language and terms easily understood ■ incorporate motivational interviewing techniques into client interactions and brief interventions ■ ask open and closed probe questions and actively listen to elicit information from clients and to determine client understanding of information provided.
Numeracy skills to:	■ interpret sometimes complex medical numerical data and abbreviations in standard treatment protocols and client records ■ complete a range of calculations for treatments and plan evaluations involving volume, percentages and ratios.
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 HLTAHCS006 Implement complex health care plans**

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: ■ develop a complex health care plan, in collaboration with the health care team and client, for 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 with varying diseases to include: • complex acute conditions • chronic disease • communicable disease ■ for each of the five clients, and according to their individual needs and care plan: ◦ explain all aspects of their health care plan ◦ discuss the need for lifestyle modifications and provide advice on support services that can assist ◦ administer clinical treatments within scope of practice (this must collectively cover at least five different treatments across the five clients) ◦ monitor the client's ongoing health and evaluate, in consultation with the health care team, outcomes against their health care plan ◦ document, in client records, accurate details of each client contact, referrals provided, treatments administered and the evaluation of health outcomes. ■ offer a brief intervention for smoking cessation to one client ■ offer a brief intervention for reduction or cessation of alcohol consumption to one client.
KNOWLEDGE EVIDENCE	Demonstrated knowledge required to complete the tasks outlined in elements and performance criteria of this unit: ■ organisational policies and procedures for recording health care plans in client records ■ legal and organisational responsibilities and role boundaries of those involved in developing and implementing complex health care plans: ◦ Aboriginal and/or Torres Strait Islander health practitioners ◦ medical practitioners, registered nurses and other members of the multidisciplinary care team ■ how multidisciplinary health teams work together to coordinate treatments and care, and how to facilitate referrals ■ the role of standard treatment protocols in developing and implementing complex health care plans: ◦ 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 treatment options and administer treatments for complex health conditions and chronic disease ■ the concept of holistic health care management, and the broad meaning of a 'treatment' within a health care plan ■ common types of treatments included in complex health care plans for the management of complex health conditions and chronic disease and when the following would be indicated: ◦ use of medications ◦ clinical treatments ◦ client self-care strategies

	◦ surgery ◦ management of lifestyle risk factors and modification of lifestyle choices ▪ formats and typical inclusions of written health care plans for complex health conditions: ◦ clinical risks of treatments to the individual client ◦ details of planned treatments and referrals ◦ treatment and client goals ◦ schedules for follow-up care, monitoring and re-assessment ◦ roles and responsibilities of health care team members ▪ the importance of developing care plans that involve the client, significant others and multidisciplinary health care practitioners ▪ how to access information about lifestyle modification support services available in the community, state or territory ▪ for brief interventions: ◦ meaning, opportunistic nature and how to judge when they would be useful or counterproductive ◦ aims associated with brief interventions and how these differ from counselling and cessation support services ◦ motivational interviewing techniques that can be used ▪ the following knowledge for each of the below-listed chronic and communicable diseases of high incidence in Aboriginal and/or Torres Strait Islander populations: ◦ pathology and other tests used to monitor, and recommended intervals, and ◦ overview of the common forms of clinical treatment including their aim, and ◦ types of treatments that are administered by Aboriginal and/or Torres Strait Islander health practitioners, and associated standard treatment protocols, equipment and infection control precautions: • cardiovascular disease • chronic respiratory disease, including Asthma and obstructive lung disease • chronic kidney disease • 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 ▪ wound management and care associated with chronic disease including prevention, basic suturing, wound closure, cleaning and dressing ▪ 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 ▪ methods of organising ongoing care, monitoring and evaluation of clients with complex health conditions or chronic disease including: ◦ disease registers ◦ care plan schedules in medical files ◦ tagging files ◦ computerised client information systems and recall functions.

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 suited to the treatment of complex and chronic conditions ■ clinical waste and sharps disposal bins ■ client records including results of health assessments ■ health care plans ■ standard treatment protocols used by the organisation which can include Standard Treatment Manuals ■ organisational policies and procedures for recording health care plans in client records. 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