UNIT CODE	**HLTAHCS009**
UNIT TITLE	**Provide support to clients with diabetes**
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 diabetes 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 diabetes support services. It covers the coordination of ongoing care for clients with diabetes. This unit is specific to Aboriginal and/or Torres Strait Islander people working as health workers or 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 diabetes.	1.1 Provide information about diabetes, treatment and health care options in plain language using culturally appropriate and safe communication. 1.2 Explain to client their role in managing diabetes 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 diabetes to actively participate in the ongoing development of multidisciplinary care plans.

2. Provide resources and information about diabetes support services.	2.1 Provide culturally appropriate consumer based education resources about diabetes and its management to clients and their families. 2.2 Inform clients about diabetes support services available in the community, state or territory. 2.3 Facilitate access to diabetes support services according to client needs and preferences.
3. Provide information and support to clients with diabetes.	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 diabetes. 3.3 Identify clients at higher risk of psychosocial distress and determine need for assessment. 3.4 Facilitate referrals for clients with diabetes according to multidisciplinary clinical partnerships. 3.5 Discuss barriers faced by client in accessing diabetes treatments and recommend resolutions. 3.6 Explain to client importance of regular check-ups, monitoring and reassessments in the management of diabetes.
4. Advise on diabetes self-care strategies.	4.1 Explain to client the importance of self-monitoring levels of blood glucose, and ketones as relevant, and providing records to health care professionals. 4.2 Demonstrate use, care and maintenance of home testing equipment and confirm client understanding. 4.3 Show client how to take and record readings of blood glucose and ketones, as relevant, and explain normal and out of range readings. 4.4 Provide accurate information about nutrition and lifestyle choices, and impact of unhealthy choices, including alcohol and smoking. 4.5 Provide education resources and offer advice on nutrition, exercise and weight management. 4.6 Offer brief interventions for smoking cessation and reduction or cessation of alcohol consumption. 4.7 Advise on foot and eye care and provide client with resources to assist. 4.8 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 diabetes.	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 diabetes in line with the diabetes annual cycle of care and 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 diabetes, 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. (New Unit)
LINKS	Companion Volume Implementation Guide

TITLE	**Assessment Requirements for HLTAHCS009 Provide support to clients with diabetes**

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 diabetes to collectively include:
	  ○ females
	  ○ males
	  ○ people across the lifespan
	  ○ people with different types of diabetes
	
	■ for each of the five clients, and according to their individual needs:
	  ○ source credible consumer based education resources from diabetes support services, and clearly explain these to the client
	  ○ provide clear information and explanations about relevant forms of diabetes treatments and their side effects; this must collectively cover the following across the five clients:
	  • insulin by injection or pump
	  • other injectable diabetes medications
	  • oral glucose lowering medications
	
	  ○ provide clear information on client self-care:
	  • self-monitoring and recording blood glucose levels (and ketones as relevant), frequency and reference ranges for client
	  • how to manage hypoglycaemia and hyperglycaemia and when to seek medical attention
	  • nutrition, exercise and weight management
	  • foot and eye care
	  • 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 diabetes support services, explain their key features and advise the client how to access services
	  ○ plan and organise continuity of diabetes care in consultation with the client and multidisciplinary team
	  ○ use organisational registers and recall strategies to book two appointments for diabetes 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
	■ how scope of practice for diabetes support may differ between Aboriginal and/or Torres Strait Islander health workers and health practitioners, and common role boundaries for each
	■ how multidisciplinary team members work together to coordinate diabetes treatments and management, and how to facilitate referrals
	■ the potential reach of a multidisciplinary diabetes health care team, and an overview of their roles including general practitioner, registered nurse, endocrinologist, podiatrist, dietitian, credentialled diabetes educator, ophthalmologist, optometrist, psychologist
	■ key elements of the psychosocial impact of diabetes, 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 diabetes diagnosis and management

- for the three main types of diabetes - type 1, type 2 and gestational:
  - how they contrast
  - plain language definitions and explanations
  - basic pathophysiology sufficient to understand the impact/functional changes on relevant body organs and systems
  - the progressive nature of type 2 diabetes and the need to change treatments and management over time
  - short term complications of diabetes, hypoglycaemia and hyperglycaemia, ways to manage these and the need for clients to have emergency action plans
  - overview of main complications sufficient to identify other body systems that can be affected and the other resultant serious diseases or conditions that can occur, to include:
    - heart disease
    - stroke
    - retinal damage (vision impairment and blindness)
    - chronic kidney disease
    - sexual dysfunction
    - nerve damage, infection, potential for amputation
    - adverse outcomes of gestational diabetes for mothers and their babies
  - overview of the common forms of clinical treatment including their aim, and their side-effects, to include:
    - insulin via injection or pump
    - other injectable diabetes medications
    - oral glucose lowering medications
- lifestyle risk factors that can contribute to diabetes and diabetes complications:
  - smoking
  - physical inactivity
  - unhealthy nutrition and body weight
  - consumption of alcohol at unsafe levels
  - stress
- the importance of clients modifying their lifestyle in the management of diabetes
- key elements of nutrition and physical activity guidelines for people with diabetes and for weight management
- for home blood glucose and ketones testing equipment, including flash glucose monitors:
  - operational features
  - ways to avoid inaccurate readings
  - care and maintenance
  - how to read and record levels
- 'normal' range of values for blood glucose and ketones and when clients should seek medical attention
- foot and eye care checks that can be completed by people with diabetes and self-care methods used to maintain health
- the role of traditional or bush healers, particularly any in the local community
- the elements of client self-management of diabetes, and the importance of the client's role in managing the condition:
  - knowing about the particular type of diabetes
  - 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 diabetes support services ■ factors that may impact on client choice of diabetes 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 diabetes and its management in the client decision making process ◦ patient treatment and management choices on diabetes 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 diabetes management 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 and care ■ diabetes support services available in the community, state or territory: ◦ for diabetes in general and for particular types of diabetes ◦ specialist services available to people of different genders or ages and to Aboriginal and Torres Strait Islander people ◦ National Diabetes Support Scheme (NDSS) ◦ 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 workers and practitioners in facilitating access ■ main elements of the 'diabetes annual cycle of care' and available Medicare benefits ■ the importance of continuity of care for clients with diabetes, in particular: ◦ the importance of follow-up for women with gestational diabetes and their babies ◦ the importance of transitioning care for young people moving to adult services ◦ the need for regular attendance, check-ups, re-assessment for changes in diabetes 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.

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 glucose and ketones ■ client records ■ current and credible consumer based education resources from diabetes support services about different types of diabetes, diabetes clinical treatments and self-care ■ information about different types of diabetes 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 diabetes 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 worker or 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