UNIT CODE	**HLTAHCS003**
UNIT TITLE	**Complete routine 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 routine physical examinations and tests, and to assess client health. This unit covers the ability to evaluate short term or uncomplicated health conditions and also to recognise serious presentations that require further investigation. 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. This unit is specific to Aboriginal and/or Torres Strait Islander people working as health workers and 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 scope of assessment.	1.1 Complete health assessments according to scope of practice standard treatment protocols used by the organisation. 1.2 Consult relevant health professionals and available documentation about client health. 1.3 Obtain client and family 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 medications and treatments. 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 test requirements from information gathered.
2. Complete physical examination and tests.	2.1 Explain the reason and procedures for each examination to the client, confirm understanding and obtain informed consent. 2.2 Implement required infection control precautions according to examination and test requirements. 2.3 Use correct protocols to measure vital signs and identify any significant variation from normal reference range. 2.4 Conduct physical examination and tests based on observations and client's presentation, and with respect for community values, beliefs and gender roles 2.5 Accurately record details of all measurements, examinations and tests according to organisational policies and procedures.
3. Evaluate, present and confirm health assessment findings.	3.1 Evaluate examination and test results to identify signs and symptoms of common, uncomplicated health conditions. 3.2 Recognise from examinations and tests signs and symptoms of potentially serious health problems and trigger referral for further investigation. 3.3 Determine own interpretation of client's current health status based on history, presenting problems, examination and test results. 3.4 Provide clear and accurate reports and consult with other health care team members to verify results and confirm client's health status. 3.5 Report any confirmed notifiable diseases according to procedural and legal requirements and within scope of own responsibility. 3.6 Update client records with health assessment details according to organisational policies and procedures.
4. Discuss assessment outcomes with client and/or significant others.	4.1 Provide information about verified assessment results in plain language using culturally appropriate and safe communication. 4.2 Discuss options for treatments and other interventions. 4.3 Encourage client and/or significant others to question and clarify outcomes, and purpose of potential treatments and interventions. 4.4 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 ■ complete calculations involving, 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 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 HLTAHCS003 Complete routine 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 physical 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 ■ 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 respiratory rate and peak flow ◦ examination of: • eyes, including physical examination and vision test • ears and hearing, including otoscopy • mouth, throat, teeth and gums • skin • 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 ◦ urinalysis via dipstick testing ◦ blood glucose test with a blood glucose testing meter ◦ examinations for specific presenting problems ■ for each of the five clients: ◦ 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, symptoms and implications of four different potentially serious health problems, and report on and refer ◦ 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 health assessments:
  - Aboriginal and/or Torres Strait Islander health workers and 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

- 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 routine physical health assessments and how types of examinations and tests may differ according to the age of the client and their presentations
- different types of infection control precautions and when these would be used for different types of physical examinations and tests
- equipment and procedures for health examinations and tests, and 'normal' reference range for adults:
  - height, weight, waist circumference and body mass index
  - temperature
  - blood pressure, pulse rate and rhythm
  - respiratory and peak flow rate
  - examination of:
    - eyes, including physical examination and vision test
    - ears and hearing, including otoscopy
    - mouth, throat, teeth and gums
    - skin
    - 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

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

- 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 short term/uncomplicated health conditions (those that would generally respond to a course of treatment or ongoing self-care), common presenting signs and symptoms and required examinations, to include at least the following:
  - respiratory tract infections
  - eye, ear and mouth infections
  - bacterial, viral, fungal and parasitic skin infections
  - digestive and gastrointestinal conditions including gastroenteritis
  - urinary tract infections

- for chronic and communicable diseases of high incidence in Aboriginal

	and/or Torres Strait Islander populations, the major risk factors, signs and symptoms that would trigger referral for investigation: ◦ cardiovascular disease ◦ chronic respiratory disease, including Asthma and obstructive lung disease ◦ chronic kidney disease ◦ chronic liver disease ◦ 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.

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 ■ 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 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