A

CHS39 Assess an individual's health status

OVERVIEW

This standard is about assessing an individual with a suspected health condition. It covers baseline observations, history taking, physical examination, and evaluation of symptoms, requesting further investigations and agreeing next action. The assessment may take place in a wide range of contexts in emergency, primary and secondary care. The assessment will usually take place with the individual and relevant carers present.This standard is applicable to a wide range of health contexts and roles in emergency, primary and secondary care. It may include patients in conscious or unconscious states.Users of this standard will need to ensure that practice reflects up to date information and policies.Version No 1

KNOWLEDGE AND UNDERSTANDING

You will need to know and understand:

1. the importance of gaining valid consent from individuals or from others where individual's lack capacity to do so
2. your own level of competence, authority and knowledge in relation to undertaking assessments and forming initial judgements on individuals' health conditions
3. the importance of a systematic and logical approach to assessment
4. how to manage the privacy and dignity of individual's throughout required procedures
5. the aspects of individuals' and their families' past medical history which may be relevant to the assessment, diagnosis and treatment of specific health conditions
6. the importance of obtaining full and accurate information about individuals, and how to do so, using a range of communication media
7. conditions which may present with similar symptoms to suspected health conditions
8. how individuals' current medication may affect their presenting symptoms
9. the range of communication media and their relevance for communicating with individuals and relevant carers in a manner that is consistent with their level of understanding, culture, background and preferred ways of communicating.
10. methods and techniques for reassuring individuals who are stressed or anxious and how to do minimise unnecessary anxiety
11. how information obtained from individuals and others should be recorded and stored in accordance with information governance
12. the range of assessment tools, their purpose and correct use
13. organisational procedures on use of assessment tools, recording mechanisms and their use
14. importance of calibration requirements and recognition of mal function in medical

devices used as assessment tools
15. pre-assessment requirements relating to diet, exercise or other factors and their relative importance
16. infection control, personal protective equipment, and health and safety when undertaking assessments
17. the anatomy and physiology of the human body as it applies to the clinical condition to be assessed
18. the different stages of specific health conditions including the short-, medium- and long term effects of specific health conditions on the individual's physiological, psychological, mental and biological states and function
19. the relevant range of relevant baseline observations and tests, and appropriate methods for performing them
20. where the further investigations can be carried out, who undertakes them and the timescales involved
21. the current European and National legislation, national guidelines, organisational policies and protocols and Clinical Governance which affect your work practice for conducting health assessments
22. your responsibilities and accountability in relation to the current European and National legislation, national guidelines and local policies and protocols and Clinical Governance

PERFORMANCE CRITERIA

You must be able to do the following:

1. work within your level of competence, responsibility and accountability and respond in a timely manner to meet individual's needs
2. check the individuals identity and confirm the valid consent of the individual or that of a relevant carer has been obtained
3. obtain and confirm past and current health history and details of signs and symptoms experienced from the individual and relevant carers, ensuring that ambiguous or unusual information is clarified
4. determine the clinical objectives and priorities for the assessment of the individual's health status
5. agree the purpose, nature and timing of the assessment with the individual and all relevant people, in line with organisational procedures
6. establish and confirm the roles and responsibilities of practitioners who will be involved in the assessment
7. use appropriate communication media/method to explain the nature, purpose and process of assessment to the individual and relevant carers and share information in accordance with information governance
8. respect the individual's rights and wishes relating to their consent, privacy, beliefs and dignity
9. identify potential contra-indications or risks associated with the proposed assessment and associated options for risk management.
10. ensure the pre assessment preparations for the individual have been completed prior to undertaking the assessment

11. select assessment tools, equipment and methodologies which take account of the needs and goals of the individual and that address the clinical question, priorities or reason for referral
12. check the suitability for use of medical devices and equipment for the assessment process and perform the required calibration
13. ensure effective infection control at all times
14. encourage the individual and relevant carers' full participation in the assessment and provide reassurance concerning their concerns or anxieties
15. perform relevant baseline observations and physiological measurements to obtain information relevant to the purpose of assessment
16. arrange, conduct and interpret a systematic clinical examination if required to support the assessment process
17. make arrangements for any additional observations and tests necessary to complete the assessment of the individual's health needs
18. determine the nature, severity and current status of the presenting condition
19. make a full, accurate and clear record of the information obtained, results of baseline observations, tests, clinical examinations, interpretations and agreed follow-up action in line with national/local policies and guidelines
20. confirm next action and provide support to the individual and relevant carers to enable them to make informed choices
21. make referrals to other practitioners, where required, providing full and accurate information in accordance with information/ clinical governance

ADDITIONAL INFORMATION

This National Occupational Standard was developed by Skills for Health.This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):Dimension: HWB6 Assessment and treatment planning