FP95 04 (CHS168) Obtain a patient/client history

About this Unit

This standard covers gathering information to obtain a relevant history from the individual and where appropriate a third party to establish the health status and needs of the individual to support and inform their assessment, intervention, care or treatment plan.

Users of this standard will need to ensure that practice reflects up-to-date information and policies.

Your **knowledge and understanding** will be specifically related to legal requirements and codes of practice and conduct applicable to your job, and the NHS Knowledge and Skills Framework. This will relate to your work activities; the job you are doing, and the setting, eg in hospital and community, domiciliary, residential care, and the individuals you are working with.

Values — the values underpinning this Standard are embedded within the 2009 NHS Code of Conduct for Health Care Support Workers. These are stated in full within the Assessment Strategy and Guidance document for the awards.

Key Words and Concepts — a glossary of definitions, key words and concepts used in this Standard is contained in the Assessment Strategy and Guidance document.

In occupational standards it is quite common to find words or phrases used which you will be familiar with, but which, in the detail of the standards, may be used in a very particular way. **You should read the Assessment Strategy and Guidance document before you begin working with the standards and refer to it if you are unsure about anything in the Unit.**

Specific Evidence Requirements for the Unit
It is essential that you adhere to the Evidence Requirements for this Unit

SPECIFIC EVIDENCE REQUIREMENTS FOR THIS UNIT
Simulation:
♦ Simulation is **NOT** permitted for any part of this Unit.
♦ **The following forms of evidence ARE mandatory:**
♦ **Direct Observation:** Your assessor or expert witness must observe you in real work activities. Their confirmation of your practice will provide evidence for a significant amount of the performance criteria in this Unit. **For example**, how you check the individual's understanding of the purpose of obtaining relevant history and how you gather information about the individual and about their previous health. ♦ **Professional discussion:** Describes your actions in a particular situation and reflect on the reason(s) why you practice that way. **For example**, discuss with your assessor/expert witness why all records are confidential and who you can share the information with.
Competence of performance and knowledge could also be demonstrated using a variety of evidence from the following:
♦ **Reflective Account:** These are written pieces of work which allow you to reflect on the course of action you took in a specific situation to identify any learning from the piece of work and to describe what you might do differently in the light of your new knowledge. ♦ **Questioning/professional discussion**: May be used to provide evidence of knowledge, legislation, policies and procedures which cannot be fully evidenced through direct observation or reflective accounts. In addition your assessor/mentor or expert witness may also ask questions to clarify aspects of your practice. ♦ **Expert Witness**: A designated expert witness, eg a senior member of staff, may provide a direct observation of your practice, or record a professional discussion they have held with you on a specific piece of practice. ♦ **Witness Testimony**: Can be a confirmation or authentication of the activities described in your evidence which your assessor or mentor has not seen. ♦ **Products:** These can be any record that you would normally use within your normal role, eg you should not put confidential records in your portfolio; they can remain where they are normally stored and be checked by your assessor and internal verifier. ♦ **Prior Learning:** You may be able to use recorded prior learning from a course of training you have attended within the last two years. Discussion on the relevance of this should form part of your assessment plan for each Unit. ♦ **Simulation:** There may be times when you have to demonstrate you are competent in a situation that does not arise naturally through your work role, eg dealing with violent or abusive behaviour. The Evidence Requirements in each Unit provide specific guidance regarding the use of simulation.
GENERAL GUIDANCE
♦ Prior to commencing this Unit you should agree and complete an assessment plan with your assessor which details the assessment methods you will be using, and the tasks you will be undertaking to demonstrate your competence. ♦ Evidence must be provided for ALL of the performance criteria, ALL of the knowledge. ♦ The evidence must reflect the policies and procedures of your workplace and be linked to current legislation, values and the principles of best practice within the Health Care sector. This will include the National Service Standards for your areas of work. ♦ All evidence must relate to your own work practice.

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KNOWLEDGE SPECIFICATION FOR THIS UNIT

Competent practice is a combination of the application of skills and knowledge informed by values and ethics. This specification details the knowledge and understanding required to carry out competent practice in the performance described in this Unit.

When using this specification **it is important to read the knowledge requirements in relation to expectations and requirements of your job role**.

You need to provide evidence for ALL knowledge points listed below. There are a variety of ways this can be achieved so it is essential that you read the 'knowledge evidence' section of the Assessment Guidance.

	You need to show that you know, understand and can apply in practice:	**Enter Evidence Numbers**
1	Work within your own level of competence, authority and knowledge base.	
2	The need to confirm your role and responsibilities and the individual's identification prior to obtaining a relevant history.	
3	How to obtain the individual's identity and information from a third party where an individual is unable to participate themselves and/or where there are communication difficulties.	
4	What evidence you should seek to demonstrate a third party's ability and authority to provide information about an individual.	
5	How to report any unexpected, inconsistent or untoward information or evidence and the appropriate protocols, procedures and communication channels for doing so.	
6	How to communicate effectively in the appropriate medium to meet the individual's or relevant other's needs and preferences.	
7	The steps you would take to ensure that ethical, cultural and confidentiality are maintained when taking an individual's history in line with legislation and organisational requirements.	
8	The steps you would take to try to clarify and confirm any information which is ambiguous or missing from an individual's or third party's narrative.	
9	The types of information that need to be gathered and why each is necessary.	
10	What information would be important to capture about the circumstances leading up to an individual requiring immediate medical assistance.	
11	The importance of recording information clearly, accurately and in a systematic manner in accordance with legislation and organisational requirements.	
12	The current national legislation, guidelines, and local policies and protocols which affect your work practice.	
13	The policies and guidance that clarify your scope of practice, accountabilities and the working relationship between yourself and others.	

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Performance Criteria	DO	RA	EW	Q	P	WT	PD
1 Explain your role and responsibilities and check the individual's identity according to local guidelines before the taking of an individual's history relevant to your work area.							
2 Follow national and local guidelines if the individual is unable to provide a relevant history.							
3 Communicate effectively in the appropriate medium to meet the individual's or third party's needs and preferences.							
4 Check the individual's or third party understanding of the purpose of obtaining an individual's relevant history.							
5 Respect the individual's privacy, dignity, wishes and beliefs and maintain the confidentiality of the information obtained in line with legislation and organisational requirements.							
6 Obtain details of the individual's prior health status and circumstances over a sufficient period of time to inform the assessment and requirements for your work activities.							
7 Use appropriate questions to explore, clarify and confirm any unusual or ambiguous information and record the information clearly and accurately in a systematic manner.							
8 Accurately answer any questions at a level and pace that is appropriate to the individual's or third party needs.							
9 Maintain full, accurate and legible records of information collected in line with current legislation, guidelines, local polices and protocol.							

DO = Direct Observation *RA = Reflective Account* *Q = Questions*
EW = Expert Witness *P = Product (Work)* *WT = Witness Testimony*
PD = Professional Discussion

To be completed by the candidate
I SUBMIT THIS AS A COMPLETE UNIT

Candidate's name: ……

Candidate's signature: ……..

Date: ……..

To be completed by the assessor
It is a shared responsibility of both the candidate and assessor to claim evidence, however, it is the responsibility of the assessor to ensure the accuracy/validity of each evidence claim and make the final decision.

I CERTIFY THAT SUFFICIENT EVIDENCE HAS BEEN PRODUCED TO MEET ALL THE ELEMENTS, PCS AND KNOWLEDGE OF THIS UNIT.

Assessor's name: ……..

Assessor's signature: ……..

Date: ……..

Assessor/Internal verifier feedback

To be completed by the internal verifier if applicable
This section only needs to be completed if the Unit is sampled by the internal verifier

Internal verifier's name: ……

Internal verifier's signature: ……..

Date: ……..……..