SFHCHS40
Establish a diagnosis of an individual’s health condition

Overview

This standard is about determining a diagnosis following initial assessment and investigations of an individual's suspected health condition. It involves reviewing the results of the initial assessment and initiating any further tests to confirm the diagnosis and the possible underlying causes.

This is applicable to a wide range of health contexts and roles in both primary and secondary care.

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

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Performance criteria

You must be able to:

- P1 check the individuals identity and confirm valid consent has been obtained for the healthcare investigations or activities required to establish a diagnosis
- P2 explain your own role, its scope, your responsibilities and accountabilities clearly to the individual and relevant carers
- P3 respect the individual's privacy, dignity, wishes and beliefs at all times
- P4 communicate with the individual in an appropriate manner, recognising the stressful nature of a potential diagnosis
- P5 consider all the relevant evidence from the individual's history, baseline observations and tests, and clinical examination
- P6 make use of clinical interpretations and reports to make justifiable assessment of the nature, likely causes and prognosis of the individual's health condition in accordance with clinical governance
- P7 request further investigations, if required, following national, local and organisational guidelines and protocols
- P8 explain to the individual why you are requesting further investigations, if any, what can be expected to happen and the expected timescales to review the findings and possible implications of normal and abnormal results
- P9 provide opportunities for the individual to ask questions and increase their understanding of their condition
- P10 assess the need for support and provide reassurance where appropriate
- P11 discuss with colleagues, or seek advice from others who are able to assist, where the information you have gathered is difficult to interpret
- P12 discuss the diagnosis with the individual to enable them to think through the implications and how these can be managed
- P13 make a full, accurate and clear record of the information obtained used to establish the diagnosis
- P14 reassure the individual and relevant carers and explain and confirm understanding for the next steps
- P15 ensure you maintain the confidentiality of information at all times in accordance with information governance

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Knowledge and understanding

You need to know and understand:

K1 your own level of competence, authority and knowledge in relation to undertaking a diagnosis of a individual's health condition
K2 the importance of respecting individuals' privacy, dignity, wishes and beliefs and how to do so
K3 the importance and methods of obtaining valid consent and how to do so
K4 the importance of obtaining full and accurate information about an individual's and their family past medical history and how to do so
K5 how to interpret evidence from an individual's history, baseline observations and tests, and further investigations in order to make a diagnosis of suspected health conditions
K6 the importance of communicating with individuals and relevant carers in a manner that is consistent with their level of understanding, culture, background and preferred ways of communicating
K7 the anatomy and physiology of the human body relevant to the individuals presenting health condition
K8 the range of baseline and additional observations/ investigations that can be undertaken, how and when they are performed, their relevance to the diagnostic process
K9 clinical examination skills and procedures appropriate to establishing a diagnosis of suspected health conditions
K10 the difference between assessment and diagnosis
K11 normal and abnormal results from investigations and their implications
K12 the factors which determine the risk of specific health conditions and the relative impact of these factors
K13 signs, symptoms and indications of the different stages of specific health conditions
K14 conditions which may present with similar symptoms to suspected health conditions
K15 short-, medium- and long term effects of specific health conditions on physical, psychological, mental and biological states and functions
K16 the socio-economic and epidemiological factors affecting specific health conditions
K17 the effects, side-effects and potential interactions of different drugs and their effect on the diagnostic process
K18 the methods for establishing prognosis and the implication of different types of prognosis
K19 how information concerning individuals should be recorded and stored in accordance with information governance
K20 the information technology available to maintain registers and call and recall people for assessments to establish a diagnosis, and how to use it
K21 the current European and National legislation, national guidelines,

	organisational policies and protocols and Clinical Governance which affect your work practice
K22	your responsibilities and accountability in relation to the current European and National legislation, national guidelines and local policies and protocols and Clinical Governance

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Additional Information

External Links

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB6 Assessment and treatment planning

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