

What's New

interRAI Software Upgrade

August 2024

Version 4.00.0142.0056

Version 5

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Introduction

This document outlines the new and updated features for the upgrade of the interRAI Assessment Software from version 4.00.0138.0017 to version 4.00.0142.0053. The upgrade will occur in August 2024.

Please note: This document is subject to change up to and immediately post the upgrade. If you have saved or printed a copy, please check that you are referring to the most recent version on our [website](#).

Please contact interRAI@tas.health.nz if you require any further information.

1. New features for this upgrade

1.1 Changes that affect all users

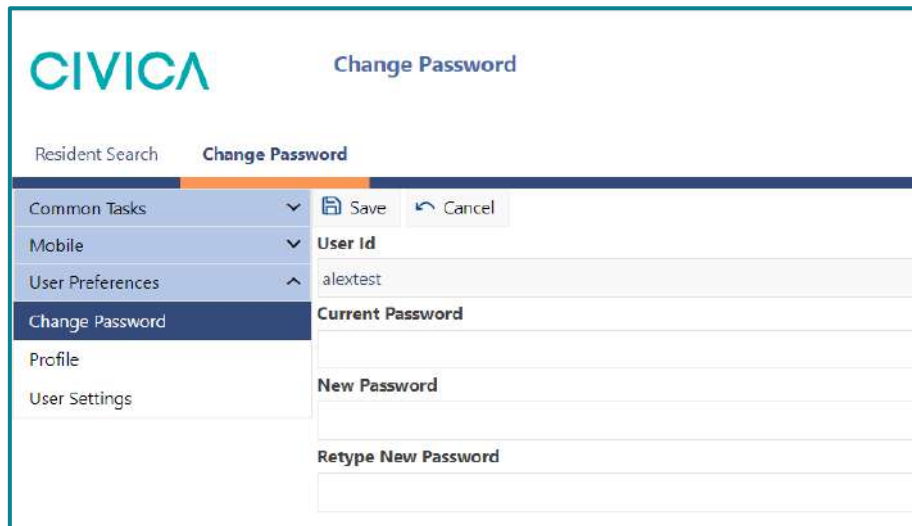
1.1.1 New mobile app is available for completing assessments offline.

Details of the app and its use can be found in [Section 3](#) of this document.

1.1.2 The Gender option 'Indeterminate' has been changed to 'Other'.

1.1.3 Current password must be used when resetting a password.

When resetting your password, users will need to enter their current password as well as their new password to complete the change (except when using the 'Forgot Password' function).



The screenshot shows the CIVICA 'Change Password' interface. On the left is a navigation menu with options: Resident Search, Change Password (selected), Common Tasks, Mobile, User Preferences, Change Password (highlighted), Profile, and User Settings. The main area contains a 'Save' button, a 'Cancel' button, and three input fields labeled 'User Id' (with value 'alextest'), 'Current Password', 'New Password', and 'Retype New Password'.

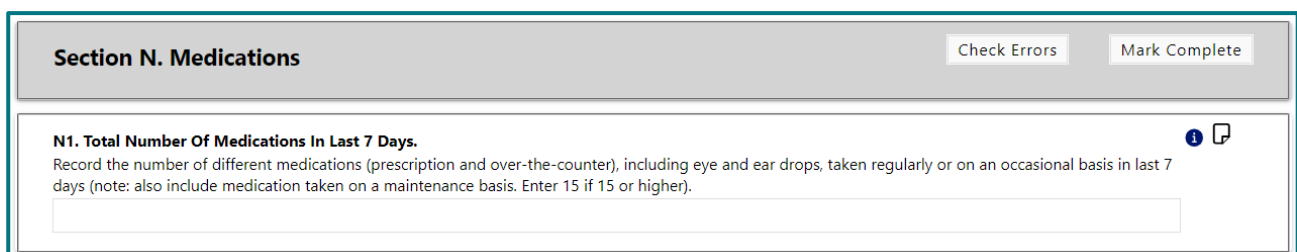
1.2 Changes that affect LTCF users

1.2.1 New look for the LTCF assessment

The LTCF assessment has a new design. Please see [Section 2](#) of this document for navigating this new format. When completing the first assessment after the upgrade, using the new design, there will be no data carried forward from previous assessments.

1.2.2 Change to Section N – Medications

Medications are no longer entered individually for N1, instead only a count of the number of prescribed medications is entered.



The screenshot shows the 'Section N. Medications' form. At the top right are 'Check Errors' and 'Mark Complete' buttons. Below is a section for 'N1. Total Number Of Medications In Last 7 Days.' with a description: 'Record the number of different medications (prescription and over-the-counter), including eye and ear drops, taken regularly or on an occasional basis in last 7 days (note: also include medication taken on a maintenance basis. Enter 15 if 15 or higher).' and an empty input field.

For information on this change, please refer to the [Total Number of Medications](#) coding help on our website.

1.2.3 New layout for Advanced Directives items (P2)

P2. Advance Directives	
P2a. Advance Care Planning discussions started	
<input type="text"/>	Not started (0)
<input type="text"/>	Started (1)
P2aa. Note	
<input type="text"/>	
P2b. Advance Care Plan documented	
<input type="text"/>	Not documented (0)
<input type="text"/>	Documented (1)
P2ba. Note	
<input type="text"/>	
P2c. Advance directive documented	
<input type="text"/>	Not documented (0)
<input type="text"/>	Documented (1)
P2ca. Note	
<input type="text"/>	
P2d. Other treatment restrictions	
<input type="text"/>	Not documented (0)
<input type="text"/>	Documented (1)
P2da. Note	
<input type="text"/>	

For information on these items and how to code them, please refer to the [Responsibility and Directives guide](#) on our website.

1.2.4 New Outcome Scales for LTCF assessment –First Fall Risk Scale, Clinician-rated Mood Scale, Composite Mood Scale and Self-Report Mood Scale

For information on these scales, please refer to the [New LTCF Outcome Scales guide](#) on our website.

1.2.5 Number of diagnoses from the Disease and Diagnoses History that can be added in I2 in the assessment is reduced to six

When more than six diagnoses are checked for ‘Use in MDS’ only the first six in alphabetical order will be included in the assessment.

1.3 Changes that affect Community users

1.3.1 New version of the Contact assessment

The Contact assessment is now version 10. There are a number of changes to the assessment items, with some items removed and some new ones added. Please attend a [Skills Booster](#)

[session](#) so that you can be updated on all of the changes. If you are unable to attend, here is a recording of a session that you can view: <https://youtu.be/XP9aBwKqwUI?si=deK4zfedwxzELx0v>

1.3.2 New look for the Home Care and Contact assessments

The Home Care and Contact assessments have a new design. Please see [Section 2](#) of this document for navigating this new format. When completing the first assessment after the upgrade, using the new design, there will be no data carried forward from previous assessments.

1.3.3 New item Home Care and Contact assessments (HC – A13d&e, CA – B3b&c)

The Home Care and Contact assessments have two new items around home rental/ownership.

A13d. Rented Dwelling ? 📄 ✓

Ask the person (or if they do not know and there are other adult members of their household) "Do you or anyone else living here rent this home?"

- Rented dwelling** – Rented dwellings may include rooms, houses, flats, apartments, boarding houses and informal dwellings such as caravans, sheds or garages. (1)
- Dwelling owned, or partly owned, or held in a family trust** – The assessed individual does not need to be the owner of the dwelling, but one member of the household must be an owner of the dwelling. (2)
- Unable to determine** – The person declines to provide an answer, does not know, or other sources of information do not clarify. (8)

A13e. Sector of Landlord ? 📄

Ask the person, "Who owns this rental property?"

- Private person, trust or business** – Any individual, a trust such as the Masonics or Abbeyfield, iwi, a community housing provider or a not-for-profit or for-profit company. Where a person says a property manager such as a real estate agent or a letting agency or property company such as Quinovic, this code should be used. This should also include homes owned by an employer of one of the residents. (1)
- Local authority or city council** – Often known as council or pensioner housing. Note some councils have put the management of their council housing with a community housing provider or trust. If this is the case and the respondent is aware of management by a trust, use code 1 ('private person, trust or business'). (2)
- Housing New Zealand** – A dwelling provided by the state housing provider. This will typically be referred to as Housing New Zealand but some people might refer to the landlord as Housing New Zealand Corporation or Housing Corporation of New Zealand or simply as a 'state house'. (3)
- Unable to determine** – Use this code if the person cannot answer or declines to provide an answer or no one else in the household is willing or able to specify the landlord. (8)

For information on these items and how to code them, please refer to [Rented Dwelling and Sector of Landlord Items](#) on our website.

1.3.4 Change to Section M – Medications (Home Care)

Medications are no longer entered individually for M1, instead only a count of the number of prescribed medications is entered.

Section M. Medications Check Errors Mark Complete

M1. Total Number of Medications ? 📄

Record the number of different medications (prescription and over-the-counter), including eye and ear drops, taken regularly or on an occasional basis in last 7 days (note: also include medication taken on a maintenance basis. Enter 15 if 15 or higher).

For information on this change, please refer to the [Total Number of Medications](#) coding guide on our website.

1.3.5 New layout for Advanced Directives items (O2 – Home Care)

O2. Advance Directives

O2a. Advance Care Planning discussions started 1

Not completed (0)

Completed (1)

O2aa. Note

O2b. Advance Care Plan documented 1

Not documented (0)

Documented (1)

O2ba. Note

O2c. Advance directive documented 1

Not documented (0)

Documented (1)

O2ca. Note

O2d. Other treatment restrictions 1

Any treatment restrictions recorded?

No (0)

Yes (1)

O2da. Note

For information on these items and how to code them, please refer to the [Responsibility and Directives](#) resource on our website.

1.3.6 New automatic coding rule for P1 and P2

When P1a1 is coded as ‘No Informal Helper’ all items in P1 will automatically be coded as ‘No informal helper’, and P2a-c will be coded as ‘No’ and are not able to be modified until P1a1 coding is changed.

When P1a2 is coded as ‘No informal helper’, P1b2-P1d2 will automatically be coded as ‘No informal helper’ and are not able to be modified until P1a2 coding is changed.

1.3.7 New Outcome Scales for Home Care assessment – Caregiver Risk Evaluation (CaRE), Frailty Scale, First Fall Risk Scale, Clinician-rated Mood Scale, Composite Mood Scale and Self-Report Mood Scale

For information on these scales, please refer to the [New HC Outcome Scores](#) guide on our website.

1.3.8 Number of diagnoses from the Disease and Diagnoses History that can be added in I2 (Home Care) or D5 (Contact) in the assessment is reduced to six

When more than six diagnoses are checked for ‘Use in MDS’ only the first six in alphabetical order will be included in the assessment.

1.4 Changes that affect Palliative Care users

1.4.1 New look for the Palliative Care assessment

The PC assessment has a new design. Please see [Section 2](#) of this document for navigating this new format. When completing the first assessment after the upgrade, using the new design, there will be no data carried forward from previous assessments.

1.4.2 Item O4d: Family or close friends report feeling overwhelmed by person's illness.



This item is now compulsory.

1.4.3 New automatic coding rule for O2 and O4

When O2a1 is coded as 'No Informal helper' all items in O2 will automatically be coded as 'No informal helper', and O4a-d will be coded as 'No' and are not able to be modified while until O2a1 coding is changed.



When O2a2 is coded as 'No informal helper', O2b2-O2e2 will automatically be coded as 'No informal helper' and are not able to be modified until O2a2 coding is changed.

1.4.4 New items Palliative Care assessments PC – A16b&c

A16b. Rented Dwelling  

Ask the person (or if they do not know and there are other adult members of their household)
"Do you or anyone else living here rent this home?"

- Rented dwelling** – Rented dwellings may include rooms, houses, flats, apartments, boarding houses and informal dwellings such as caravans, sheds or garages. (1)
- Dwelling owned, or partly owned, or held in a family trust** – The assessed individual does not need to be the owner of the dwelling, but one member of the household must be an owner of the dwelling. (2)
- Unable to determine** – The person declines to provide an answer, does not know, or other sources of information do not clarify. (8)

A16c. Sector of Landlord  

[Note. Only code this item if question, Rented Dwelling, was coded as '1']
Ask the person, "Who owns this rental property?"

- Private person, trust or business** – Any individual, a trust such as the Masonics or Abbeyfield, iwi, a community housing provider or a not-for-profit or for-profit company. Where a person says a property manager such as a real estate agent or a letting agency or property company such as Quinovic, this code should be used. This should also include homes owned by an employer of one of the residents. (1)
- Local authority or city council** – Often known as council or pensioner housing. Note some councils have put the management of their council housing with a community housing provider or trust. If this is the case and the respondent is aware of management by a trust, use code 1 ('private person, trust or business'). (2)
- Housing New Zealand** – A dwelling provided by the state housing provider. This will typically be referred to as Housing New Zealand but some people might refer to the landlord as Housing New Zealand Corporation or Housing Corporation of New Zealand or simply as a 'state house'. (3)
- Unable to determine** – Use this code if the person cannot answer or declines to provide an answer or no one else in the household is willing or able to specify the landlord. (8)

For information on these items and how to code them, please refer to [Rented Dwelling and Sector of Landlord Items](#) guide on our website.

1.4.5 Change to Section L – Medications

Medications are no longer entered individually for L2, instead only a count of the number of prescribed medications is entered.

Section L. Medications		Check Errors	Mark Complete
L1. Allergy to Any Drug		i	
No known drug allergies (0)			
Yes (1)			
L2. Total Number of Medications		i	
Record the number of different medications (prescription and over-the-counter), including eyedrops, taken regularly or on an occasional basis in the last 7 days. (Note: Also include medications taken on a maintenance basis.)			
Code number (enter 15 if 15 or higher)			
-			

For information on this change, please refer to the [Total Number of Medications](#) guide on our website.

1.4.6 New layout for Advanced Directives items (N2)

N2. Advance Care Planning		
N2a. Advance Care Planning discussions started		i
Not started (0)		
Started (1)		
N2aa. Note		
N2b. Advance Care Plan documented		i
Not documented (0)		
Documented (1)		
N2ba. Note		
N2c. Advance directive documented		i
Not documented (0)		
Documented (1)		
N2ca. Note		
N2d. Other treatment restrictions		i
Any treatment restrictions recorded?		
No (0)		
Yes (1)		
N2da. Note		

For information on these items and how to code them, please refer to [Responsibility and Directives](#) guide on our website.

1.4.7 New Outcome Scale for Palliative Care assessment – Caregiver Risk Evaluation (CaRE)

For information on this scale, please refer to the [New Palliative Care Outcome Scores](#) guide on our website.

1.4.8 Number of diagnoses from the Disease and Diagnoses History that can be added in A10 in the assessment is reduced to six

When more than six diagnoses are checked for 'Use in MDS' only the first six in alphabetical order will be included in the assessment.

1.5 Changes that affect Acute Care users

1.5.1 New look for the Acute Care assessment

The AC assessment has a new design. All Acute Care assessments (AC – Admission, AC – Discharge, or a review assessment) are completed by loading the same form (interRAI™ AC v9.3 (New Zealand v1)). Please see [Section 2](#) of this document for navigating this new format. When completing the first assessment after the upgrade, using the new design, there will be no data carried forward from previous assessments.

1.5.2 Outcome scores are now available for this assessment.

ADL Hierarchy Scale, ADL Short Form Scale, Body Mass Index (admission and review only), Cognitive Performance Scale (CPS), Communication Scale, Short Depressive Scale (admission and review only), Pain Scale, Pressure Ulcer Rating Scale (admission only) are now available for the interRAI Acute Care assessments.

For information on these scales, please refer to the resources from the [AC Outcomes, Screeners and CAPs guide](#) on our website.

1.5.3 Screeners and identifiers for risk of adverse outcomes are now available for this assessment.

ADL Decline Risk Screener, Delirium Screener, Dementia Screener, Depression Screener (admission and discharge only), Falls Risk Screener, Pressure Ulcer Risk Screener, Readmission Screener, and Undernutrition Screener (admission and review only) are now available for the interRAI Acute Care assessments.

For information on these screeners, please refer to the resources from the [AC Outcomes, Screeners and CAPs guide](#) on our website.

1.5.4 Clinical Action Points (CAPs) are now available for the Acute Care Admission and Review assessments.

The Activities of Daily Living Prevention, Activities of Daily Living Treatment, Behaviour, Delirium Treatment, Depression and Anxiety, Falls and Pressure Ulcer Prevention, Pressure Ulcer Treatment, Readmission (admission only) and Undernutrition (admission only) CAPs are now available for the interRAI Acute Care Admission and Review assessment.

For information on these Clinical Action Points, please refer to the resources from the [AC Outcomes, Screeners and CAPs guide](#) on our website.

1.5.5 There is now an Assessment Summary section in the Acute Care assessment.

Information on how to use the Assessment Summary can be found here: [AC Outcomes, Screeners and CAPs guide](#)

1.5.6 Responses are cleared from Sections B-M of the Acute Care Discharge assessment when the person is marked 'Deceased' in A12 and the assessment is then marked complete.

1.5.7 Planning and research consent item has now been added at the start of the assessment.

To code this item, ask the person if they consent to their assessment data being used for research. All identifying information such as name, address and NHI will be removed. Please note, this consent item relates to data only. For consent to complete the assessment, please follow your organisation's processes and add a note if this is a requirement. More information can be found in the online workbook in Unit 1.

2. Single Page Application (SPA) assessments

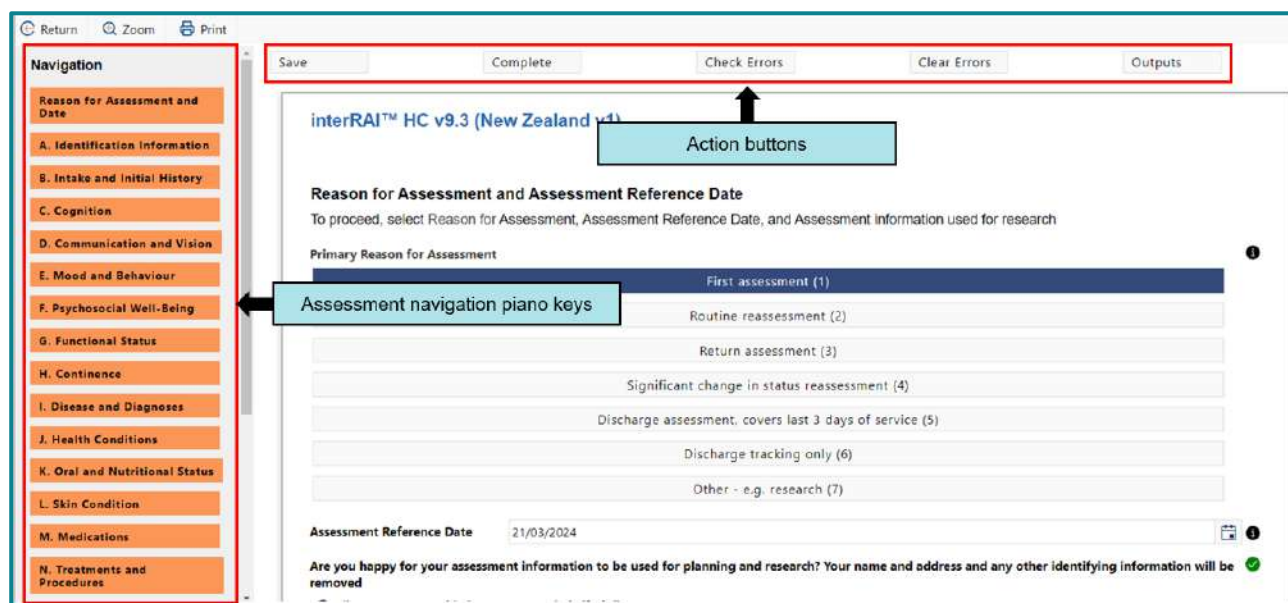
This section applies to the new design for the LTCF, Home Care, Contact, Palliative Care and Acute Care assessments.

Assessment Controls

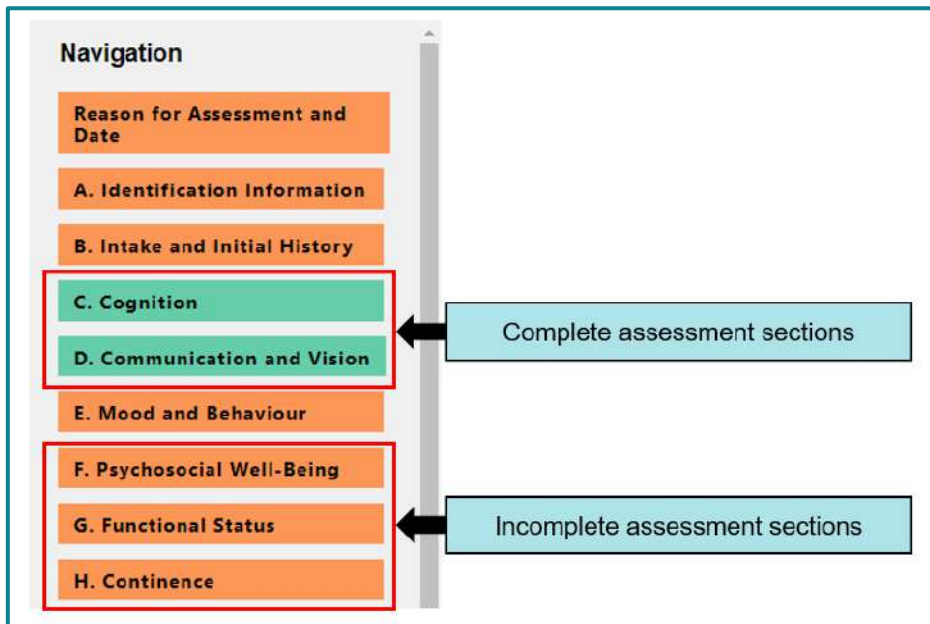
There are the 5 action buttons at the top of the assessment, and section piano keys on the left-hand side to navigate through sections.

The action button functions are:

- Save – saves the assessment as draft.
- Complete – marks the assessment complete.
- Outputs – opens an Outcomes and CAPs window on the right-hand side of the assessment window. These outputs update in real time as the assessment is completed.
- Check Errors – checks the entire assessment for errors. The view of the assessment changes to show only those items that need correcting.
- Clear Errors – clears the red arrow cross from errors that have been corrected and returns the assessment to the standard view showing all assessment items.



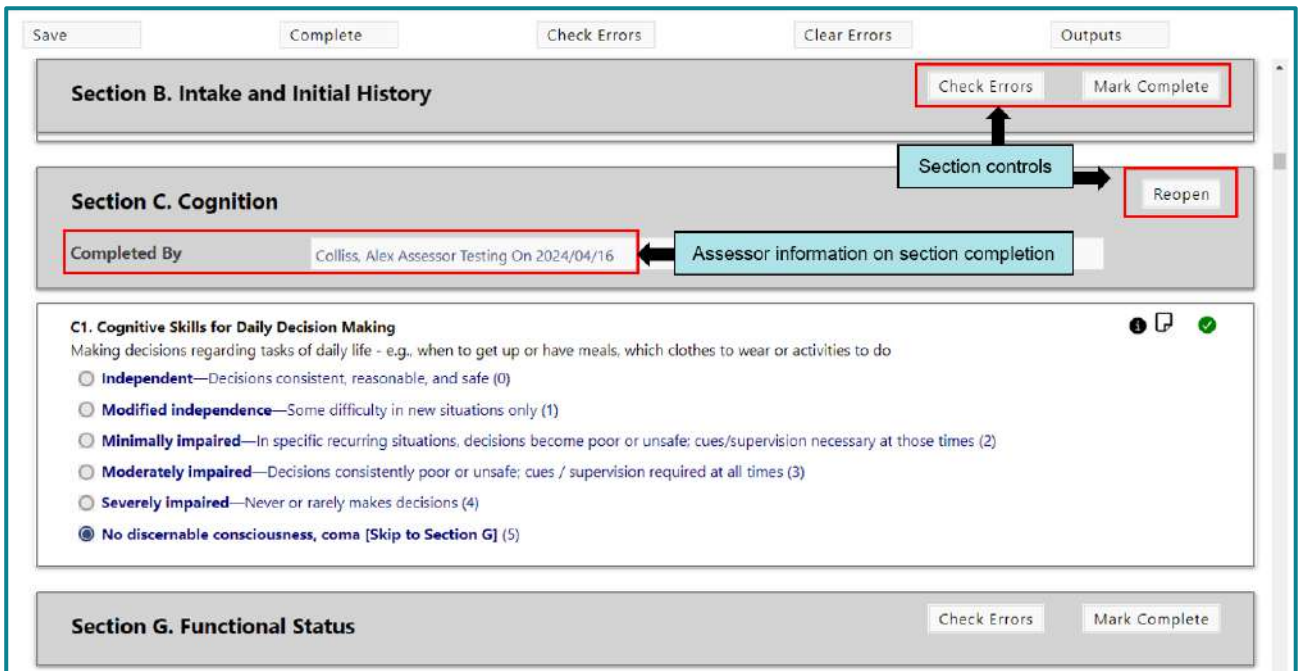
The piano key is orange when the section is in draft, and changes to green when the section is marked complete.



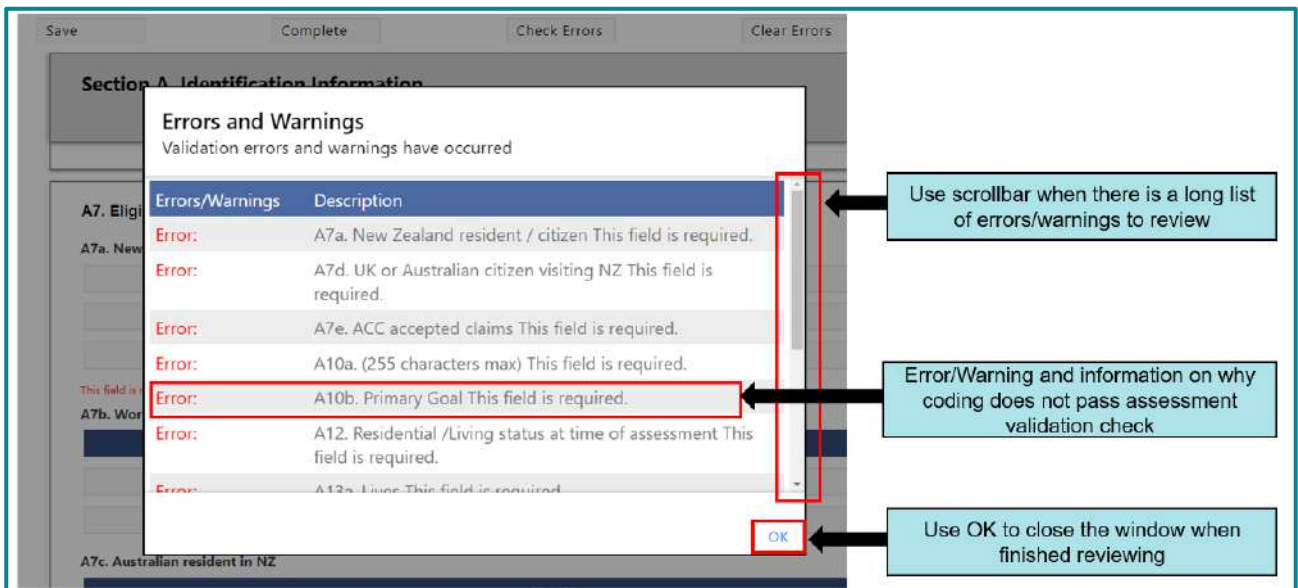
The assessment opens on one page that users can scroll through or use the navigations keys to go to a certain section.

Only sections needing to be completed (based on coding of previous sections) will be displayed.

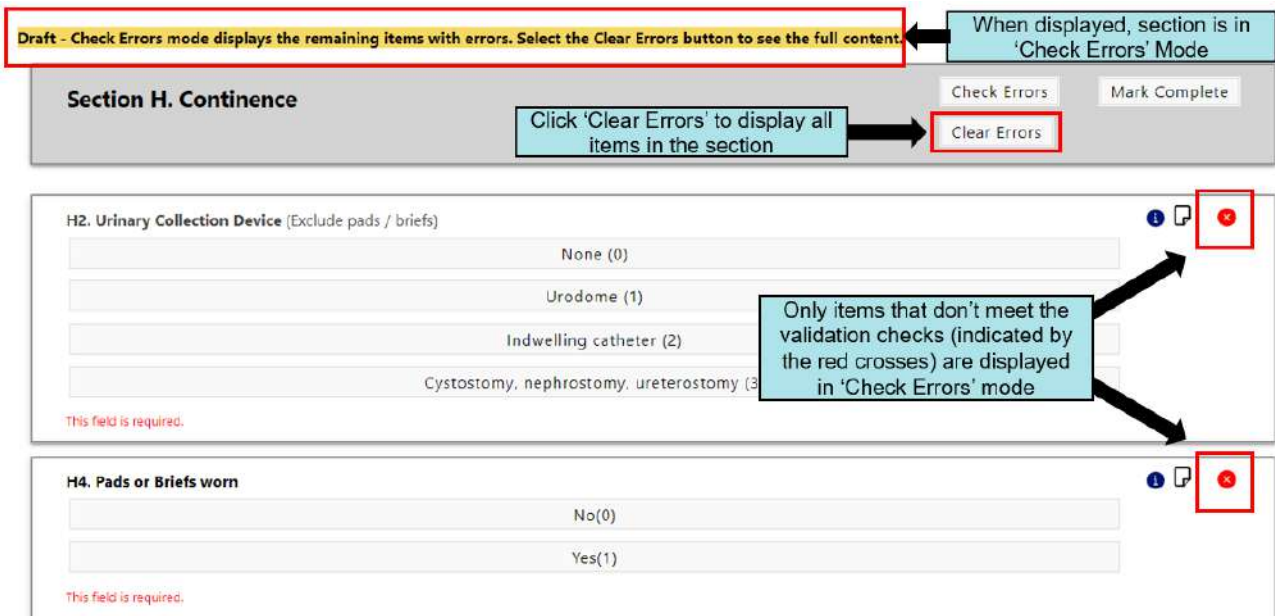
Section headers ‘stick’ at the top of the section being completed. On the right-hand side of the section header, for a section in draft, are the Mark Complete, Check Errors and Clear Errors action buttons for that section. When a section is complete, the section Reopen button appears here instead. The name of the person and the date the section was completed also appears.



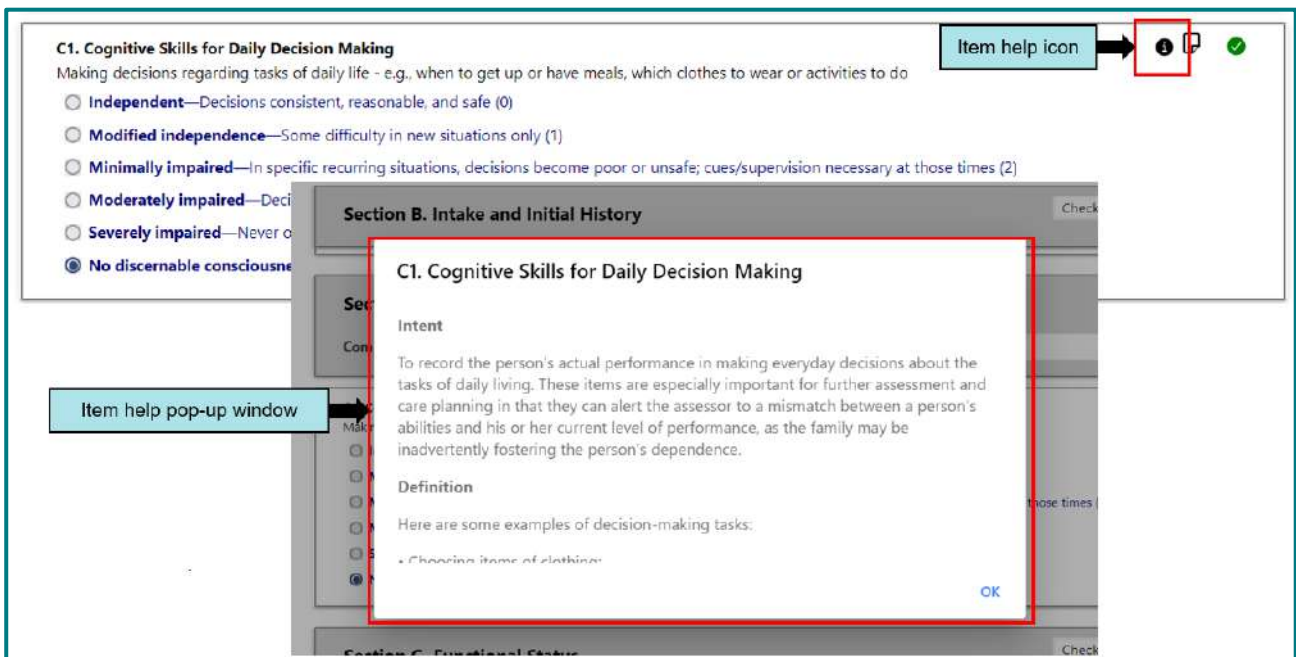
Check Errors opens a pop-up window with the section errors and warnings listed. There is a scrollbar if there is a number of errors/warnings to review. Clicking on OK closes the pop-up.



Items in the section that do not have any warnings or errors are hidden. Only items which still require coding, or don't meet validation are visible. There is a yellow message bar at the top of the assessment which displays when the section is in 'Check Errors' mode. Click on 'Clear Errors' to display all of the items in the section.



Section Help is now available at an item level. Each item has an information icon, which opens a pop-up window with the information needed.



Comments are added to items by clicking on the page icon. This brings up a text field below the item which the comment can be typed into. Comments are now visible alongside the coding they support.

C1. Cognitive Skills for Daily Decision Making
 Making decisions regarding tasks of daily life - e.g., when to get up or ha

- Independent**—Decisions consistent, reasonable, and safe (0)
- Modified independence**—Some difficulty in new situations only (1)
- Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times (2)
- Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times (3)
- Severely impaired**—Never or rarely makes decisions (4)
- No discernable consciousness, coma [Skip to Section G]** (5)

Comment icon is white when no comments are entered. Clicking on the icon makes the comment field visible.

C1. Cognitive Skills for Daily Decision Making
 Making decisions regarding tasks of daily life - e.g., when to get up or have meals, which clothes to

- Independent**—Decisions consistent, reasonable, and safe (0)
- Modified independence**—Some difficulty in new situations only (1)
- Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times (2)
- Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times (3)
- Severely impaired**—Never or rarely makes decisions (4)
- No discernable consciousness, coma [Skip to Section G]** (5)

Comments:

Add your comments here ← **Comment text field.**

Added By Date ← **Comment entry details.**

Comment icon is yellow if there is a comment entered.

Uncoded required items, or items that don't pass validation checks in the assessment are indicated by the red X icon on the right. Red text under the item gives the information about why the item doesn't pass validation. A coded, required item that passes validation is indicated by a green tick on the right.

A7. Eligibility For Publically Funded Health Services in New Zealand

A7a. New Zealand resident / citizen

No (0)

Yes (1)

Unknown (First Assessment only) (11)

A7b. Work Visa

No (0)

Yes (1)

Unknown (First assessment only) (11)

This field is required.

Required item, not coded or coding does not pass assessment validation check

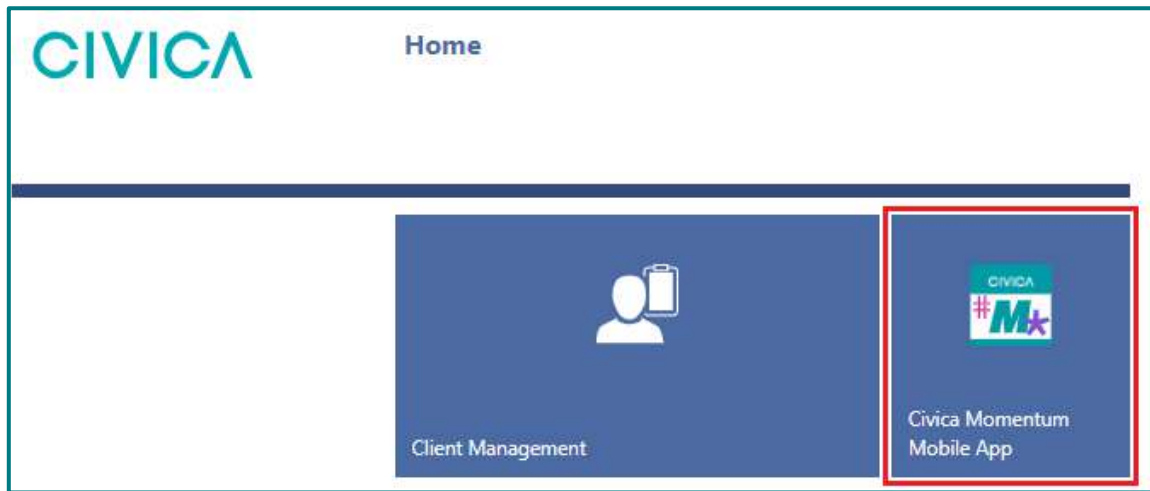
Required item, coded and passes assessment validation check

3. Mobile app (for offline use)

The mobile app is available to use with the new SPA assessments. It will work for the Home Care, Contact, Palliative Care, LTCF and Acute Care assessments. Currently the ACC Contact is not able to be completed using the mobile app.

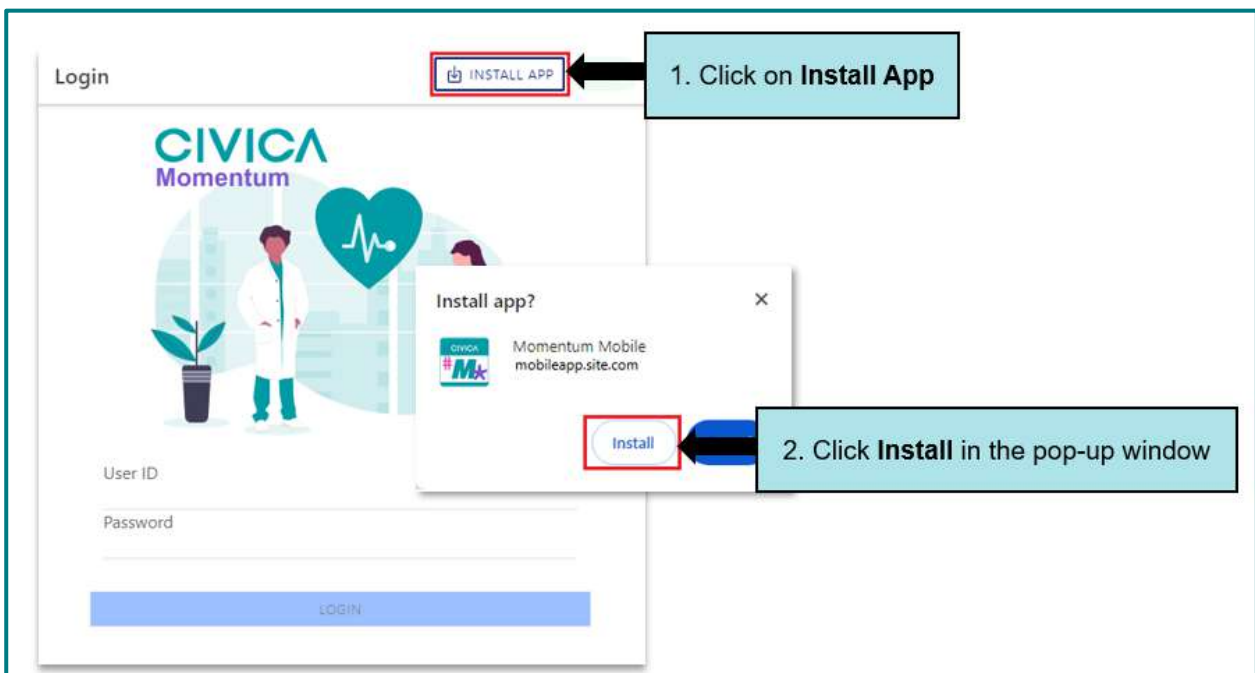
3.1 Installing the Mobile app

- 3.1.1 Make sure your device is connected to the Internet.
- 3.1.2 Open the interRAI Assessment Software and log in. If you have access to more than one organisation, choose a working organisation.
- 3.1.3 Click on the **Civica Momentum Mobile App** tile.



3.1.4 Google Chrome

- 3.1.4.1 A new tab will open with the app. If this is the first time opening it, you will have the option to install the app in the top right corner of the screen. Click on **Install App** and then click **Install** in the pop-up window that appears.



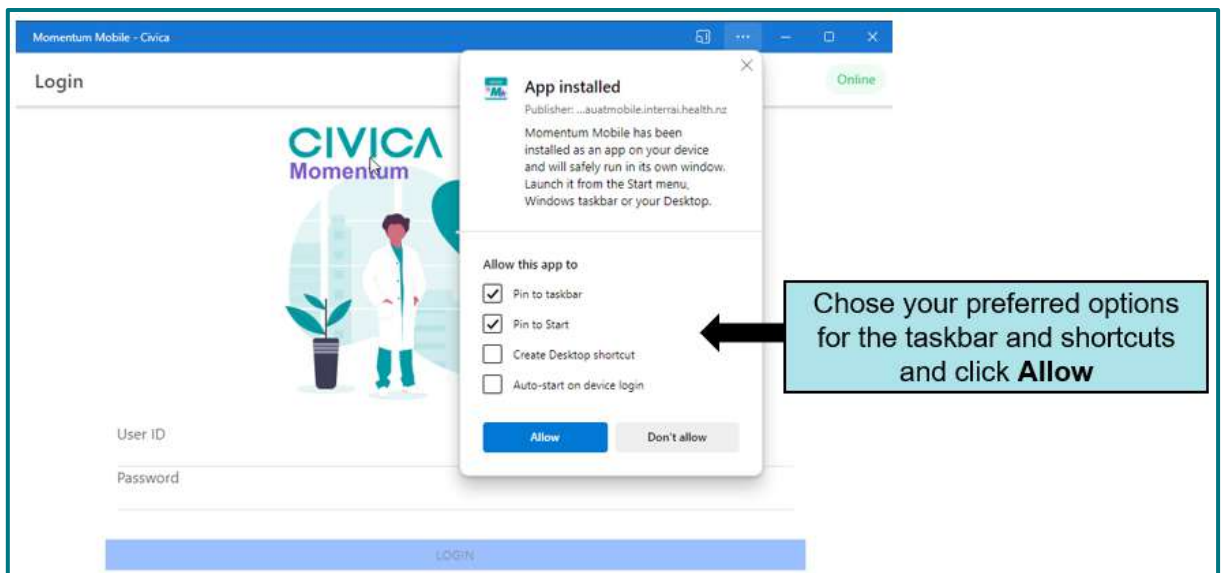
- 3.1.4.2 You can now close the browser window with the Mobile app log in page. The app should open separately from your browser. We recommend pinning the app to your task-bar so it is easy to locate.

3.1.5 Microsoft Edge

- 3.1.5.1 A new tab will open with the app. If this is the first time opening it, you will have the option to install the app in the top right corner of the screen. Click on **Install App** and then click **Install** in the pop-up window that appears.

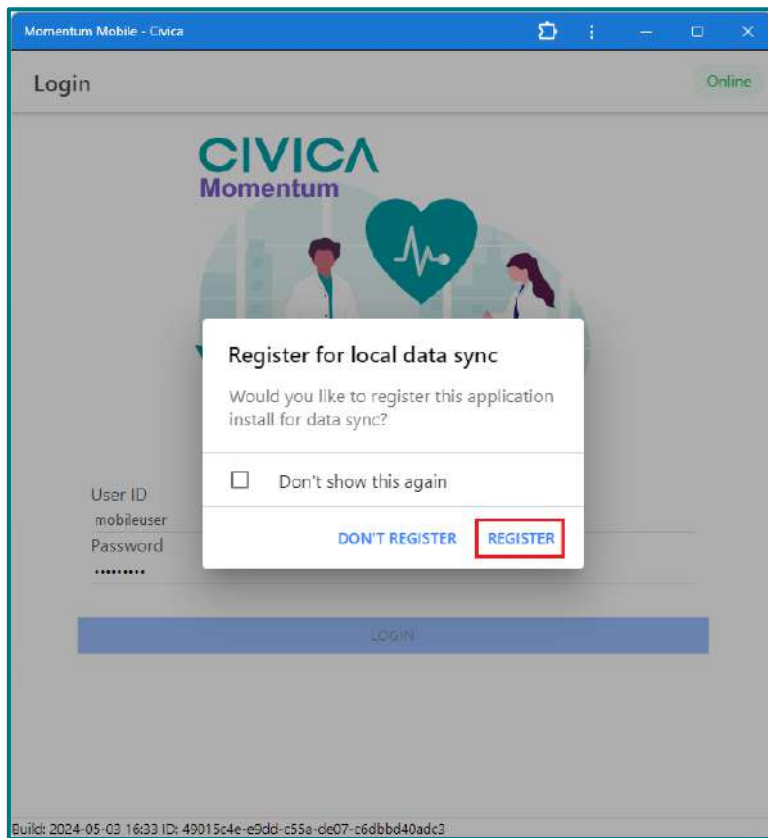


3.1.5.2 Choose the preferred options for adding the app as shortcuts and to your task-bar and click **Allow**



3.1.6 Once the app has been installed, enter your UserID and password and click Login. The first time you open the app may take some time to synchronise.

3.1.7 The first time you log in to the app, you will be asked to register for local data synchronization. Click 'Register' in the pop-up window and check 'Don't show again'.



3.1.8 Once successfully logged in and synchronised, the app will open and the 'Select Organisation' page will be displayed if you have access to multiple organisations. If you only have access to a single organisation, then the 'Select Client/Resident' page will be displayed.

3.2 Adding and removing client/resident files for offline use

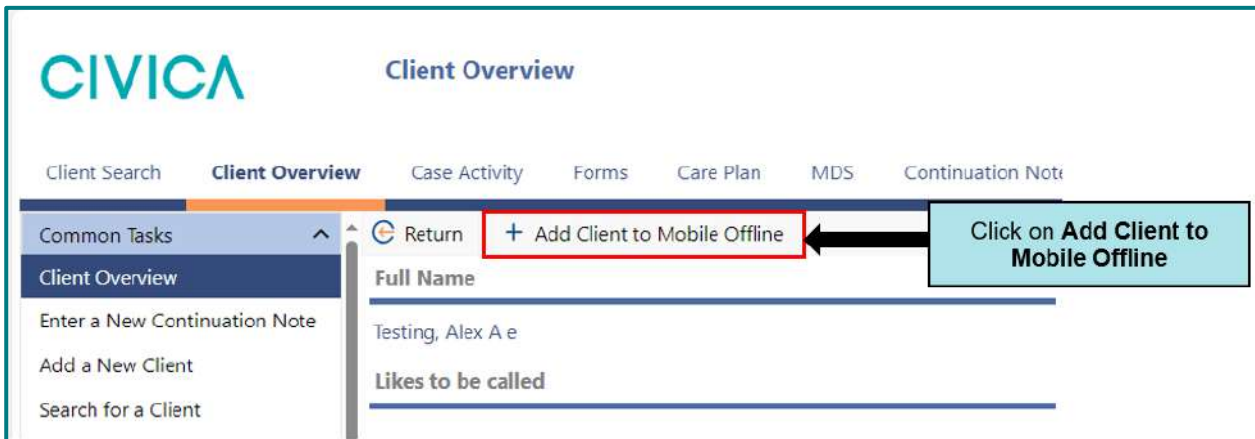
3.2.1 Make sure your device is connected to the internet.

3.2.2 Log in to the web-based version of the interRAI Assessment Software at [Production \(interrai.health.nz\)](https://interrai.health.nz).

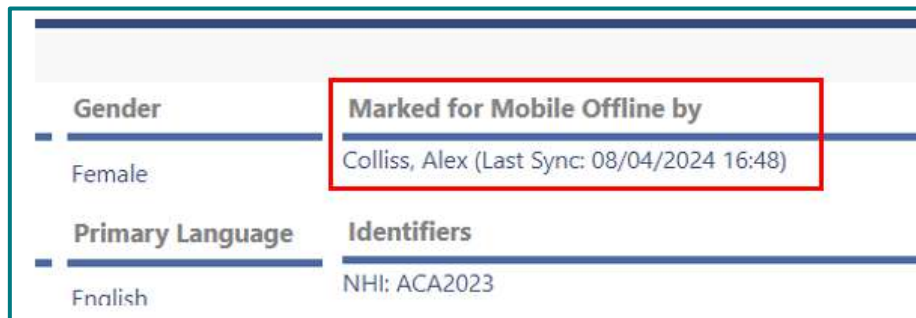
First Method

3.2.3 Search for the client and go to their overview page.

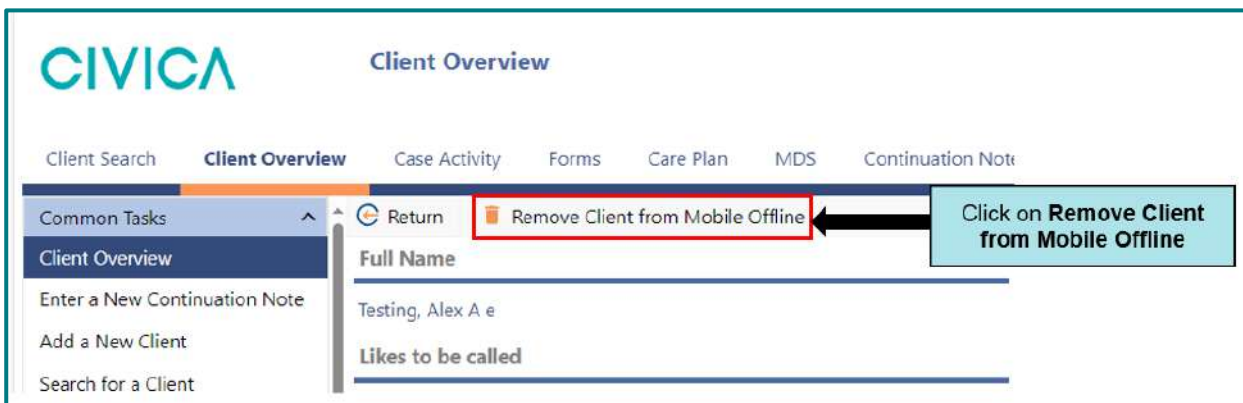
3.2.4 To add the person for use offline, click on **Add Client to Mobile Offline**.



3.2.5 On the right side of the overview page will now be displayed the name of the user with the record marked for Mobile Offline use.

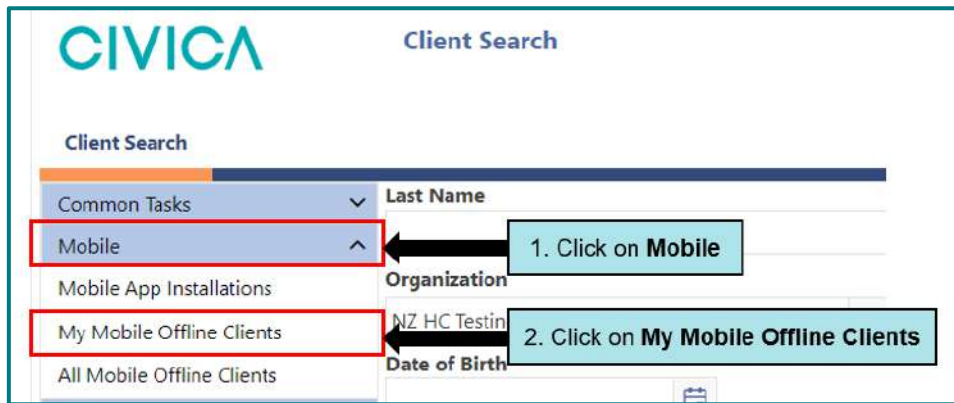


3.2.6 To remove the person for use offline, click on **Remove Client from Mobile Offline**.

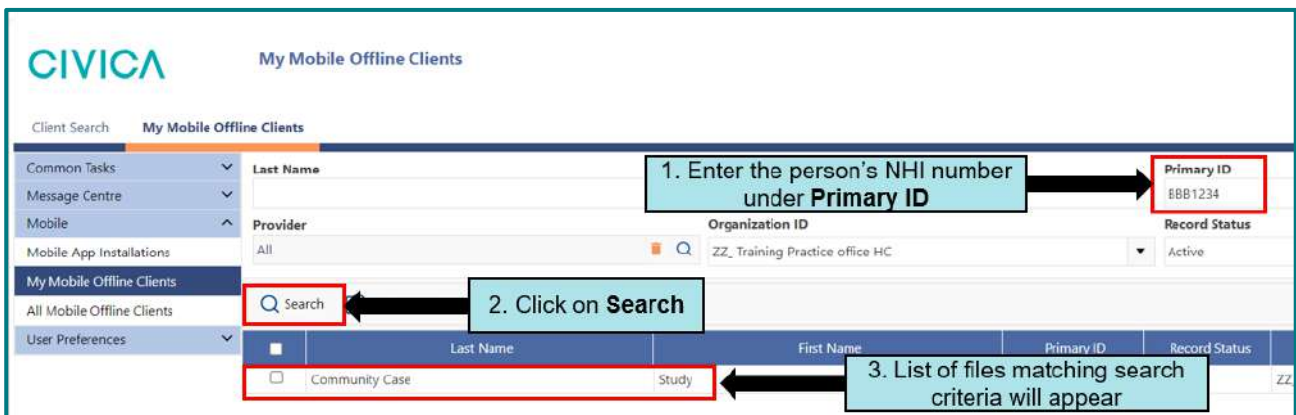


Second Method

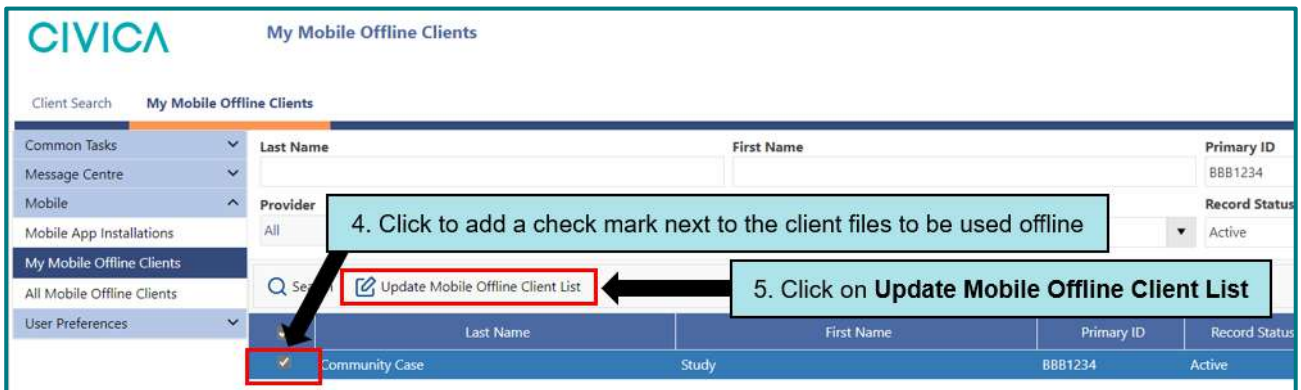
3.2.7 On the left-side menu, click on **Mobile** and then **My Mobile Offline Clients**.



3.2.8 Enter the person's NHI (or other search criteria) into the appropriate fields and click **Search**. A list of clients matching the criteria will be displayed.



3.2.9 Add a check mark to the client/s for offline use, and click on **Update Mobile Offline Client List**.

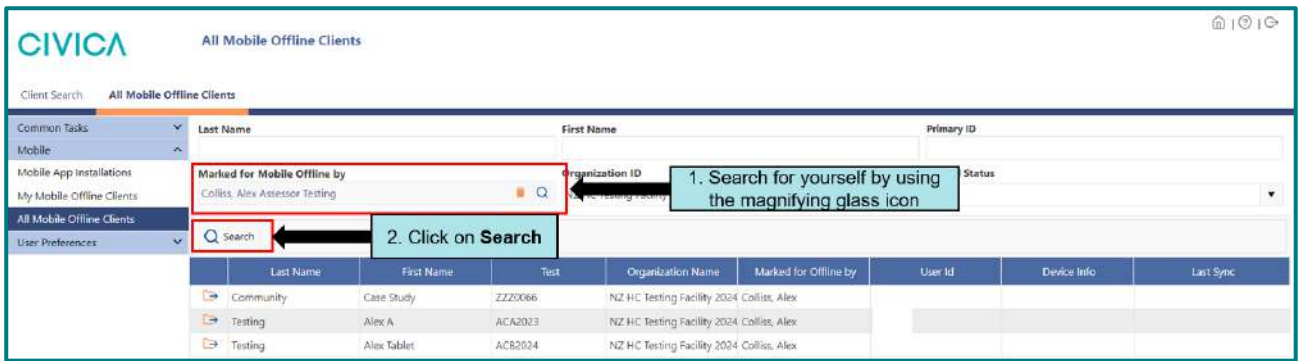


3.2.10 To remove the client from the list, search for them again under **My Mobile Offline Clients**, remove the check mark, and click on **Update Mobile Offline Client List**.

3.3 Checking clients/residents marked for offline use

3.3.1 Go to **All Mobile Offline Clients**

3.3.2 Search for your name using the magnifying glass icon beside the **Marked for Mobile Offline** by field and click on search. A list of the clients/residents that you have marked will appear here.



3.3.3 You can use the file icon to the left of the persons name to go to their file and make changes.

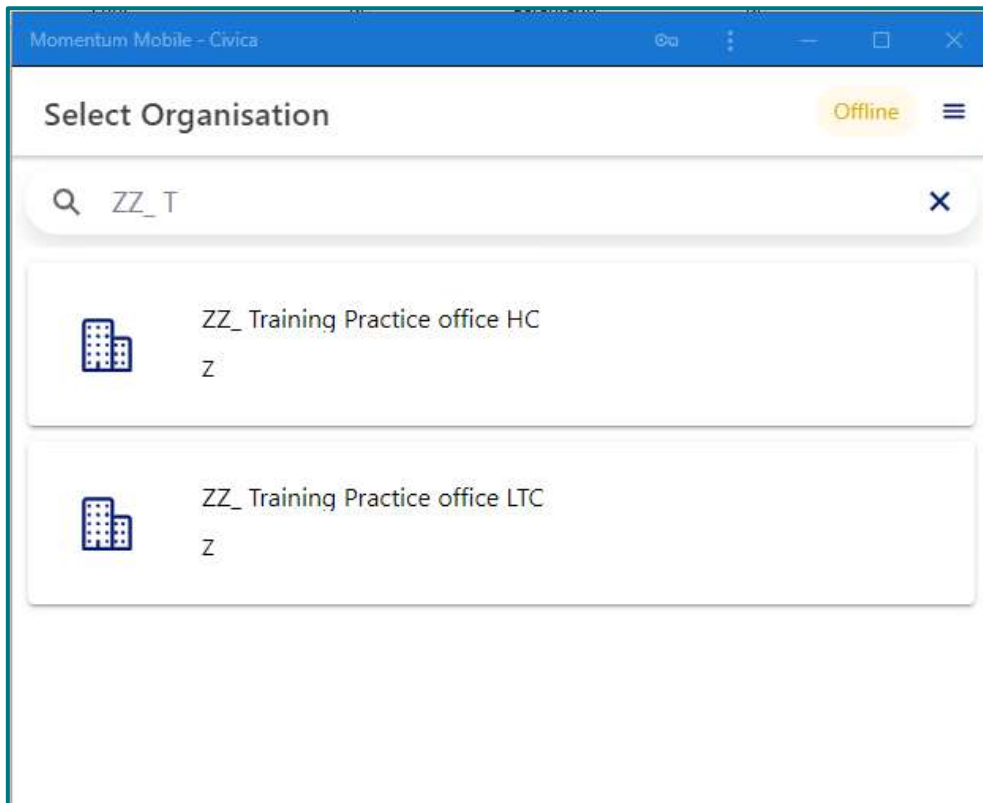
3.4 Synchronisation between the Mobile app and web-based application

- 3.4.1** While using the Mobile app connected to the internet, the client record and assessments are continuously synchronised.
- 3.4.2** After adding clients to use offline, log into the app before disconnecting from this internet. This transfers your client/resident information into the app.
- 3.4.3** When you are not connected, you can continue to work or create client assessments. Your work will be automatically saved on your local device's storage.
- 3.4.4** Re-connecting to the internet and logging to the Mobile app automatically updates the client/resident records you marked for synchronisation in the web-based application.
- 3.4.4.1 After reconnecting to the internet, and before making any changes to your assessment in the web-based version, log in to the app again. This transfers the client/resident information entered offline back into the web-based version.
- 3.4.4.2 After this, we recommend removing all the clients from your list of clients/residents marked for offline use.

3.5 Navigating the app

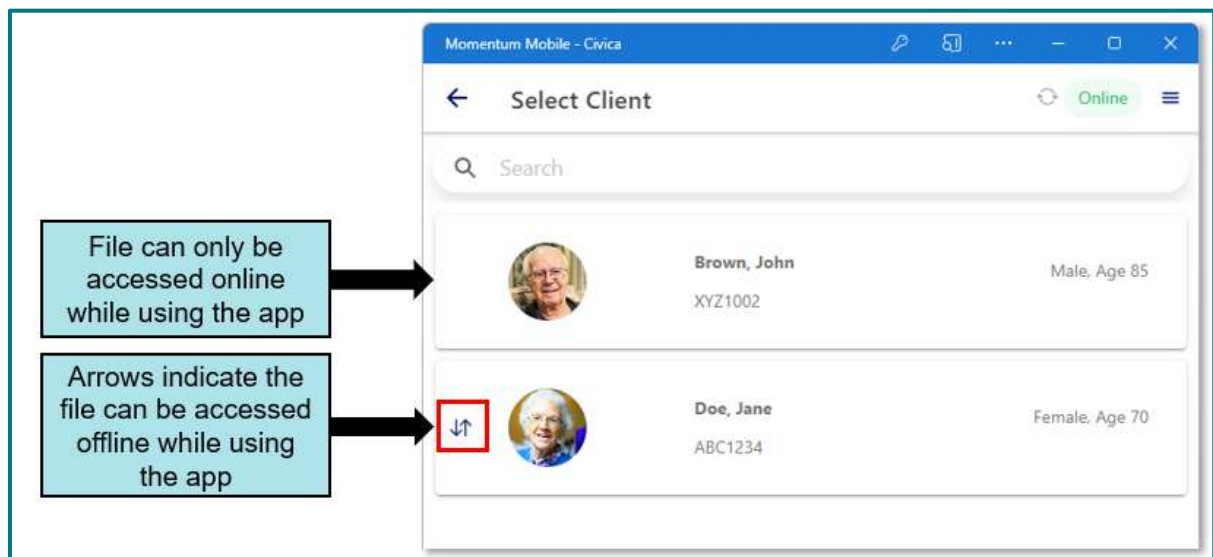
3.5.1 Selecting an organisation

- 3.5.1.1 Only those organisations that you have permission to access are displayed
- 3.5.1.2 Select the organisation you want to work with.



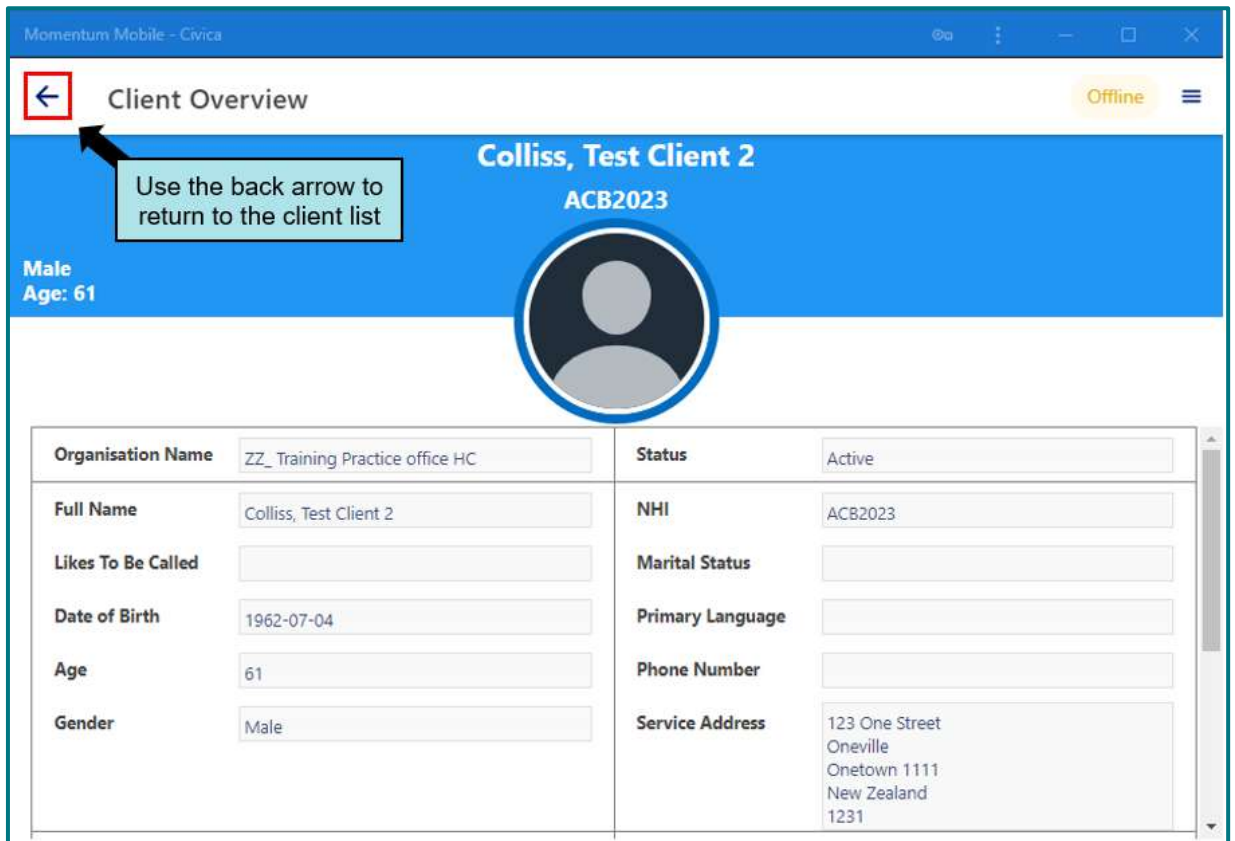
3.5.2 Selecting a client record

3.5.2.1 All client records in an organisation are visible when the Mobile app is online. You can search for the person by name. Those clients/residents who have been synchronised for offline use with have an arrow icon next to their name.



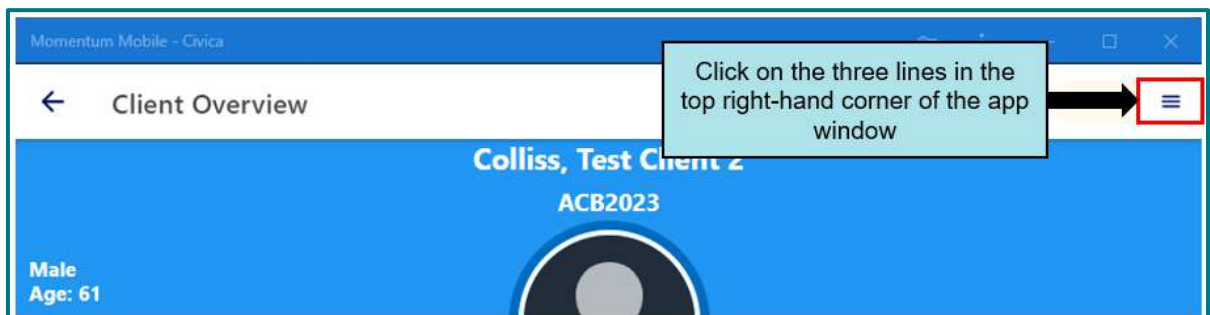
3.5.2.2 When you access the *Select Clients* page in mobile offline, only those client records you have marked for synchronisation are displayed. See section 4.2 for instructions on marking clients for synchronisation.

3.5.2.3 Click once to open the client record you want to work with. The record will open to an overview page. The information in the overview page is display only, and is not able to be edited in the app. All changes to this information need to be made in the web-based application.

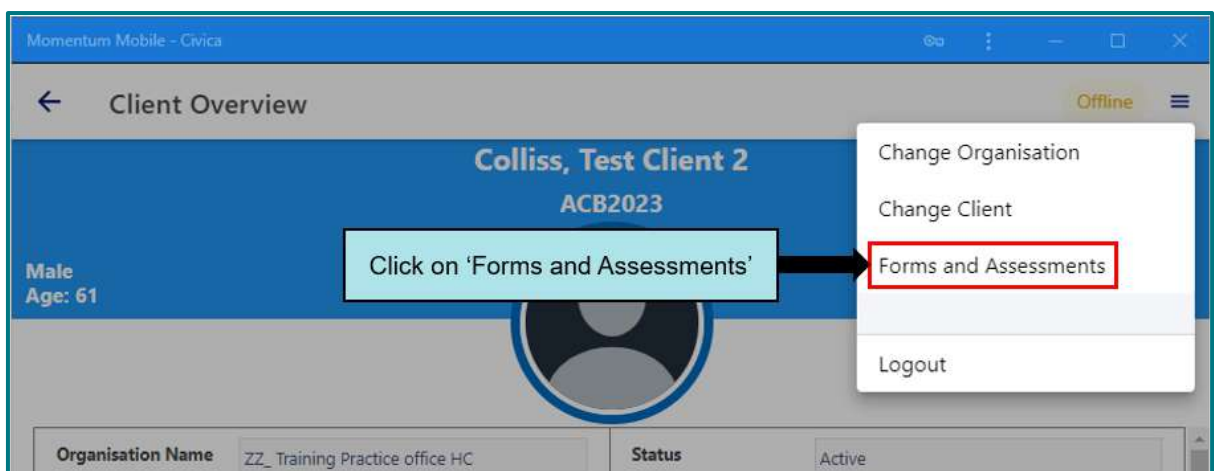


3.5.3 Finding an existing assessment

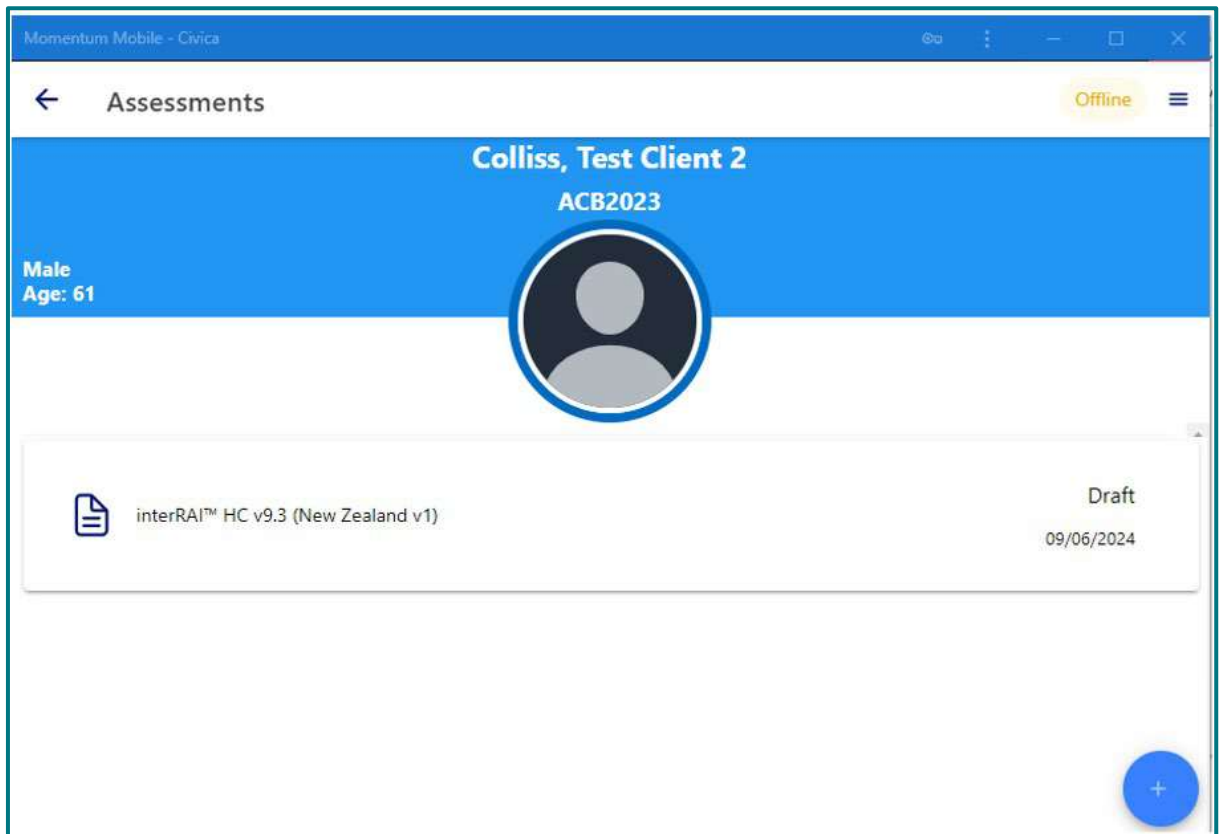
3.5.3.1 On the client overview page, click on the three lines in the top.



3.5.3.2 Click on 'Forms and Assessments'



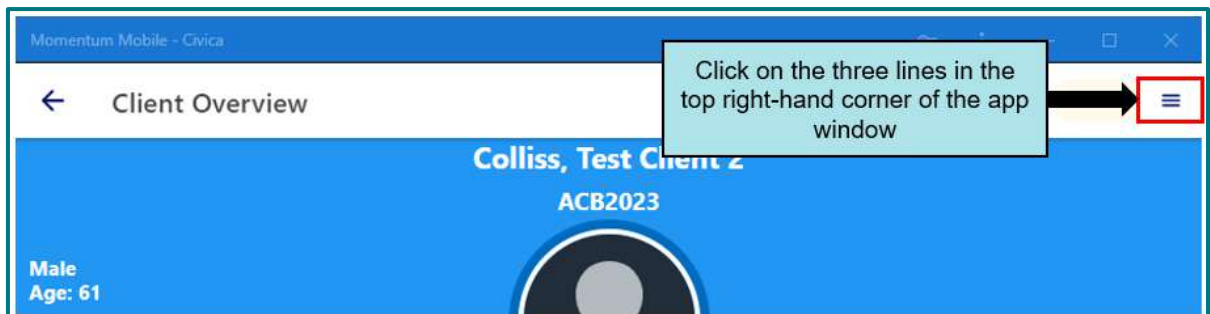
3.5.3.3 Any completed or draft assessments or forms will be displayed in a list



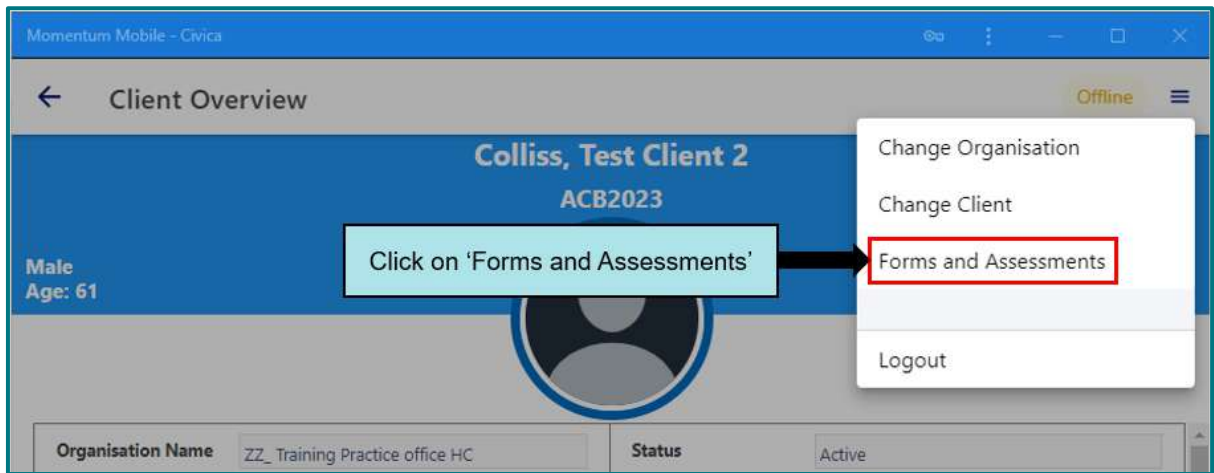
3.5.3.4 Click once on the required assessment to open it. The assessment is displayed in the same format as the web-based assessments and can be navigated in the same way. See [Section 3](#) of this document.

3.5.4 Add a new assessment or form.

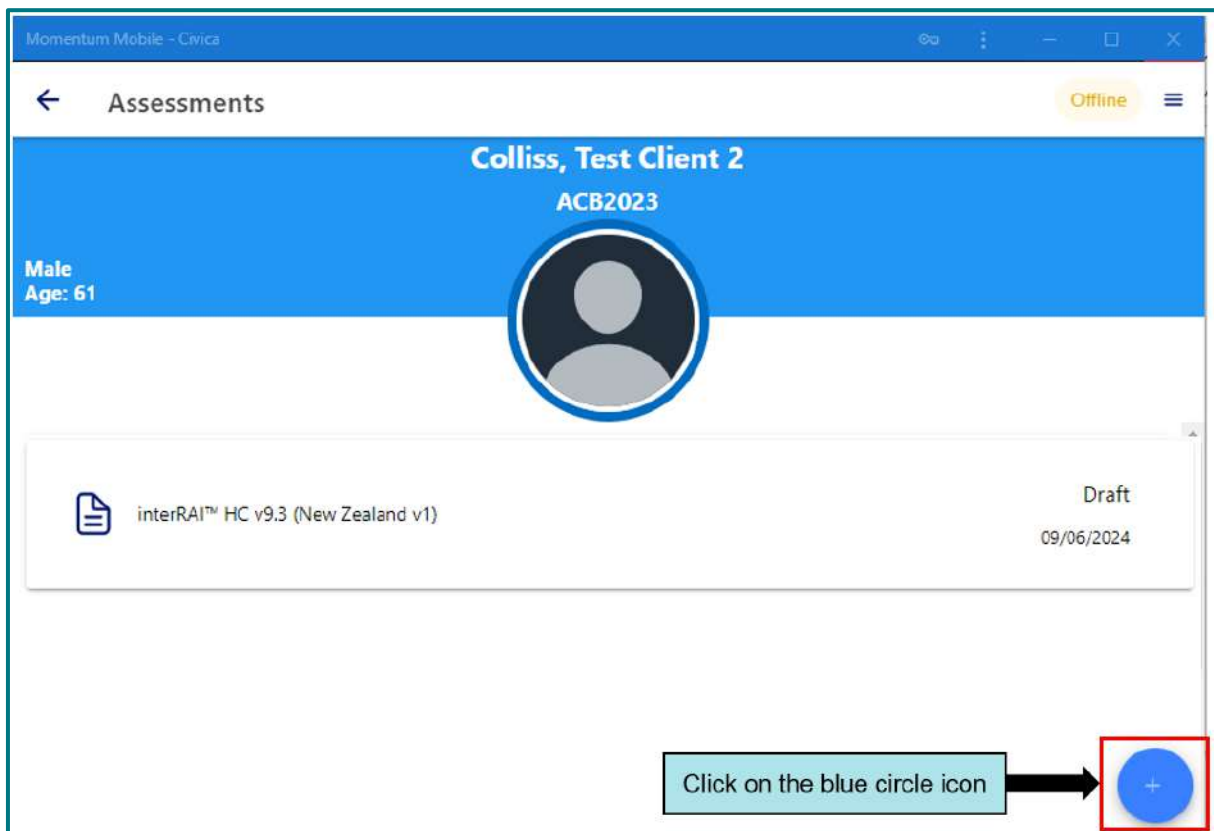
3.5.4.1 One the client overview page, click on the three lines in the top right-hand corner of the app window.



3.5.4.2 Click on 'Forms and Assessments'.



3.5.4.3 Click on the blue circle with the plus sign.



3.5.4.4 Select the required assessment or form from the list

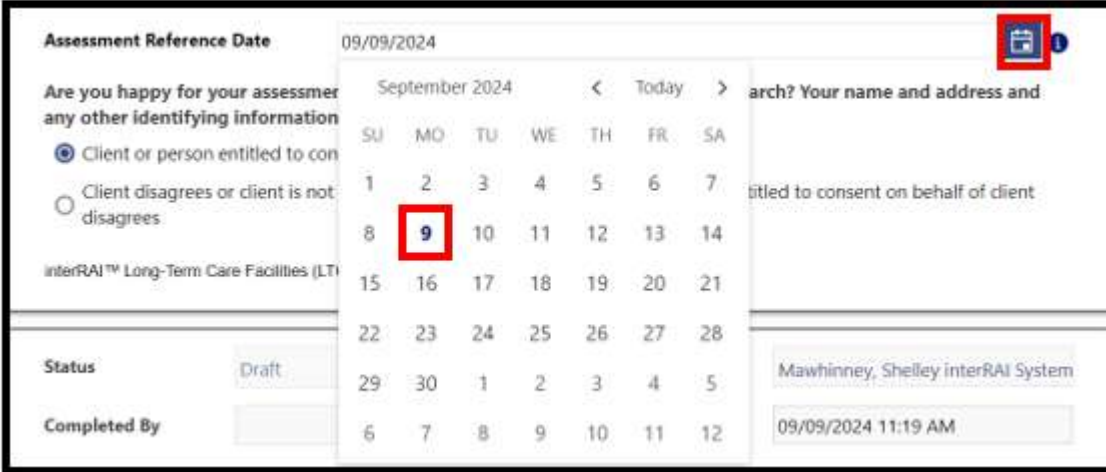


3.5.4.5 The assessment is displayed in the same format as the web-based assessments and can be navigated in the same way. See [Section 3](#) of this document.

4. Known Issues

The list below are issues that are present at the time of the upgrade. We are continuing to work with our software vendor to have these corrected as soon as possible. Where needed, we will have a documented workaround for you.

Issue	Status
<p><u>Erroring out assessments</u></p> <p>Users are currently not able to error out an assessment. If you need assistance with this, or correcting an assessment that has been marked complete, please contact your interRAI Educator or email interRAI@tas.health.nz</p> <p>This can only be requested by the person who has completed the assessment.</p> <p>For corrections to an assessment:</p> <ol style="list-style-type: none"> 1. The request must be within five days of the assessment being marked complete. 2. Open a new draft assessment of the same type and make the changes needed. 3. Contact us to error out the incorrect assessment. You will not be able to save your new draft assessment as complete until we have errored out the incorrect one. We will let you know when we have completed this. 4. Mark your new assessment complete. 	Fix in progress
<p>Urinary Incontinence CAP not calculating correctly in the Home Care assessment. Please review this CAP with each assessment to make sure there are not issues that need addressing even if the CAP hasn't triggered.</p>	Fix completed
<p>There are some minor cosmetic issues (for example spelling and grammar in item help sections) that we are aware of and will be resolved in coming updates.</p>	Fix in progress
<p>The community care plan presenting situation is not displaying with line breaks in the current care plan screen.</p> <p>The line breaks entered are present when viewed in the presenting situation, and in the care plan report.</p>	Fix in progress
<p>Domicile code, language, or facility code are not populating from the overview into the assessment. This error is happening on occasion for a few users. Please email interRAI@tas.health.nz for help resolving this issue.</p>	Fix in progress

<p>Middle name character limit in LTCF assessment. This field is currently limited to 11 characters. To correct:</p> <ol style="list-style-type: none"> 1. Click on the resident's name on the Overview Page 2. Click +Add 3. Enter the first and second names without the middle name on a new line 4. Tick 'Display as Current' for this new name, and untick 'Display as Current' on the other line. 5. Navigate back to your assessment and the name will have updated and you will be able to mark your assessment complete. 	<p>Fix in progress</p>
<p>Return button in Diseases and Diagnoses and Continuation notes creates a new draft assessment when these screens are access from within a SPA assessment.</p> <p>When in Diseases and Diagnoses or the Continuation notes, go back to the assessment by clicking on MDS/Assessment in the banner menu, and then choose the draft assessment from the list.</p>	<p>Fix in progress</p>
<p>Audit Report by User – Assessments completed</p> <p>This report will not return information for assessments completed in the SPA format.</p>	<p>Fix in progress</p>
<p>Some users are not able to properly complete their assessments when manually entering the Assessment Reference Date (ARD). This is because if a user types '24' as the year, the software registers this as 0024, not 2024. The user can still mark the assessment complete but the software leaves it in draft. We recommend users avoid manually entering the ARD and instead use the date picker, remembering to click only once and to give the software a few seconds for the date to populate.</p> 	<p>Fix in progress</p>