

interRAI Home Care Assessor competency requirements

Information for training assessors

interRAI Competency Process

Once you have completed the following competency process, you will be able to carry out interRAI Home Care assessments without supervision:

- Full attendance at three days training.
- Undertake and complete a minimum of ten clinical assessments. Each assessment must be reviewed by your Educator. You will be provided with feedback and have the opportunity to discuss this via telephone or face to face discussion.
- Complete and pass ten AIS online evaluations to consolidate your learning.
- Full Assessor competency is achieved when all the competency items in the work book have been discussed and signed off by your Educator. This becomes documented evidence of competency for your particular Health Professional Registration Board.

Home Care Assessment Competencies

In order to become an approved interRAI Home Care assessor, assessors must achieve each competency in both part A and B.

PART A: Methodology

	Competency Standards	Activities	Measures (Specific examples will be provided during training)	Date Achieved
1	Familiarity with guiding documents	<ul style="list-style-type: none"> Prepare for training (pre-reading) 1) New Zealand Best Practice Evidence Guidelines '<i>Assessment Processes for Older People.</i>' 2) Sharing Clinical information Across Care settings: The Birth of an Integrated Assessment System. Gray, Berg, Fries, Henrard, Hirdes, Steel & Morris (2009). 3) The Tikanga Policy relevant to the assessor's workplace. 	<ul style="list-style-type: none"> Satisfactorily described how the relationship between the recommendations for assessment of older people are implemented by the assessor in his/her individual assessment practice. Satisfactorily described the interRAI integrated suite. Satisfactorily described the relationship between the workplace Tikanga policy and the assessor's individual assessment practice. 	
2	Understand critical components of a culturally relevant conversation in New Zealand	<ul style="list-style-type: none"> Attend classroom-based training. Participate in discussion about relevant documents such as Meihana Model: a Clinical Assessment Framework. Pitama, Robertson, Cram, Gillies Huria & Dallas-Katoa (2007). Participate in discussion about components of a cultural conversation. Understand the National Criteria for Māori assessment as described in the interRAI National DHB Project Implementation Plan 2008-2010. 	<ul style="list-style-type: none"> Described at least three ways to establish trust and respect with the person. Named at least three resources (provided in training) that assist assessors to understand Māori assessment requirements. Described techniques that may be used to elicit issues pertinent to the person and to develop culturally relevant goals with the person. 	

	Competency Standards	Activities	Measures (Specific examples will be provided during training)	Date Achieved
3	Understand the purpose and general principles of interRAI	<ul style="list-style-type: none"> Read Assessor interRAI HC workbook. Attend classroom-based training. Read the introduction: The interRAI CAPs in interRAI Clinical Assessment Protocols (CAPs) Manual. 	<ul style="list-style-type: none"> Fully participated in the training programme as evidenced by attendance and contribution at all sessions. Discussed the value of the interRAI in the assessment of and care planning for older people. 	
4	Accurately record assessment information	<ul style="list-style-type: none"> Use the manual as a coding guide. Use multiple sources of information e.g. referral note, person interview, observation, discussion with family or carers or health professionals to gain accurate information. Understand the role of the assessor for making clinical decisions. Use relevant timeframe for each section. Complete ten audited assessments. Complete 'competency coding' evaluation using AIS Central software. 	<ul style="list-style-type: none"> Used the manual as a reference source for accurate coding. Described the sources of information used and why these sources were needed. Discussed the elements of the manual i.e. intent, process, definition and coding. Described a process for reconciling conflicting information. Described a process for managing information gathered that is wider than the assessment form. Used timeframes relevant to the section sub-section i.e. Default of 3 days, or 90 days in most cases as evidenced by accurate phrasing of questions in each section. Assisted person in focusing on the correct 'look back' period for each activity. Satisfactorily completed ten audited assessments. Discussed three persons' status accurately from case reports provided which contain CAPs and outcome scale results. Achieved a 'pass' for all evaluations using competency 	

	Competency Standards	Activities	Measures (Specific examples will be provided during training)	Date Achieved
			coding software 'AIS Central' Learning Management System.	
5	Correctly analyse and interpret the assessment findings (i.e. CAPs and outcome measures) before developing care plan	<ul style="list-style-type: none"> • Understand how items trigger CAPs. • Understand outcome scales and how to use them. • Manage all outcome measures in a holistic way, to prioritise planning and /or identify information gaps for the person. • Integrate outcome measures with person goals. 	<ul style="list-style-type: none"> • Demonstrated how to check why a CAP was triggered as evidenced by location of specific CAP descriptions and components in the Coding Manual. • Demonstrated how to use the CAPs Manual as a reference source for interpreting an assessment. • Demonstrated knowledge of outcome measures as evidenced by discussion about the person's specific results and the likely implications of these. • Demonstrated process for using outcome measures to successfully prioritise planning with the person. 	
6	Develop a comprehensive person care plan	<ul style="list-style-type: none"> • Follow care planning process relevant to workplace guidelines and incorporate: <ul style="list-style-type: none"> - appropriate CAPs for care plan - note reasons for not responding to any CAP triggered - clinically congruent person outcomes and services • Refer to the relevant local policy or guidelines for managing referrals. 	<ul style="list-style-type: none"> • Accurately described rationale for the alignment of outcome measures and person goals with plan. • Incorporated application of relevant local policy or guidelines for managing referrals in the persons care plan. 	
7	Generate relevant reports	<ul style="list-style-type: none"> • Understand the purpose and use of the 	<ul style="list-style-type: none"> • Dispatched relevant reports appropriately. 	

	Competency Standards	Activities	Measures (Specific examples will be provided during training)	Date Achieved
		different reports available. <ul style="list-style-type: none"> Understand local requirements for managing persons file. 	<ul style="list-style-type: none"> Described how the persons file was closed / episode concluded. 	

PART B:Software Use

	Assessment Competency	Activities	Measures	Date Achieved
1	Access the software system	<ul style="list-style-type: none"> Access the Momentum software system. Log on to the interRAI application. Open Client Management. 	<ul style="list-style-type: none"> Demonstrated successful software access. 	
2	Manage profiles of the assessed person	<ul style="list-style-type: none"> Find an existing person. Enter new person's details in 'Client Overview' window. 	<ul style="list-style-type: none"> Found specified person. Completed all required fields for new person in 'Client Overview'. Added yourself as a Provider correctly. Diagnoses entered with primary/secondary rank. Person's addresses, phone number and domicile code are entered correctly. 	
3	Accurately reference the sources of information in the assessment		<ul style="list-style-type: none"> Information sources are recorded in the assessment 	
4	Complete the assessment using the specified software	<ul style="list-style-type: none"> Navigate around the assessment form. Sign off each section and the assessment when completed. Use notes appropriately. Access online coding manual. 	<ul style="list-style-type: none"> Demonstrated form navigation by completion of all items in all sections of 'MDS'. Demonstrates sign off of each section and the 'MDS' is marked 'complete.' Used notes in relevant sections to record the assessment in line with Momentum Business Rules 2001 document & Assessor Workbook. 	
5	Develop a care plan for the person using specified software	<ul style="list-style-type: none"> Use care planning software in accordance with processes relevant to workplace guidelines. 	<ul style="list-style-type: none"> Described relevant sections of care plan and their use. Demonstrated an accurately completed care plan. 	

	Assessment Competency	Activities	Measures	Date Achieved
6	Generate and file relevant reports	<ul style="list-style-type: none"> • Refer to the relevant local policy/guidelines for managing referrals. • Understand the purpose and use of the different reports available. • Understand how to print off or e-transfer reports. • Send appropriate reports to service providers/others. • Understand local requirements for managing a person's file. 	<ul style="list-style-type: none"> • Dispatched relevant reports appropriately. • Described how the person's file was closed and/or episode was concluded. 	

	Process for interRAI Home Care Assessment Competency and Quality Monitoring in a workplace setting <i>(schedule may be varied at LP discretion and with agreement of Service Manager where applicable)</i>	
Pre-training	Pre-reading	<i>Assessment Processes for Older People, Birth of an integrated assessment system, and Meihana Model.</i>
	AIS Central eTraining	Self-directed <i>Mastering interRAI HC</i> online training modules 3. <i>interRAI HC Introduction</i> , 6. <i>Assessment Process</i> , 7. <i>Care Planning</i> . Other videos and presentations are optional pre-learning.
Week 1	Attend Training days	Full attendance at classroom-based training (methodology, software) including 1 st assessment?
	AIS evaluation	<i>interRAI Concepts</i> completed in class with Educator.
Week 2	2 nd Assessment	Complete real client assessment and care plan with Educator present and assisting as required.
	AIS evaluation	<i>Assessment Process</i> . If up to the third take, 'Save and Leave Evaluation' and contact Educator before submitting.
Week 3	3 rd and 4 th Assessments	Complete additional assessments and care plans on real clients within a realistic and specified timeframe. Meet with Educator for competency review of each assessment in turn before completing the next one.
	AIS evaluation	<i>Form Basics</i>
Week 4	5 th and 6 th Assessments	Educator reviews 5 th Assessment with Assessor. 6 th - 10 th Assessments completed with support as required.
	AIS evaluation	<i>Coding Part 1</i>
Week 5	7 th and 8 th Assessments	Complete 7 th and 8 th Assessments.
	AIS evaluation	<i>Coding Part 2</i>
Week 6	9 th and 10 th Assessments	Complete 9 th and 10 th Assessments. Advise Educator of 6 th - 10 th clients' NHI details.
	AIS evaluation	<i>Coding Section G</i>
Week 7	Final review	Educator reviews 6 th - 10 th Assessments with Assessor. Additional training/support at the Educator discretion.
Week 8	Final AIS evaluations	<i>Coding Section E, Coding Section N, Outcome Scales, CAPs</i> . Advise Educator when completed.
	Final sign-off	Once competency is achieved, given a certificate with Professional Development hours and Workbook signed off. AIS evaluations certificate 10hrs Training 50hrs TOTAL 60hrs
ONGOING	Attend workplace group education meetings. Random assessment quality reviews (min of two annually) with written/verbal feedback as required. Annual online AIS coding evaluations with certificate. Maintain Annual Health Professional Registration.	

Assessor name: _____

Educator name: _____

Assessor signature: _____

Educator signature: _____

Date: _____

Date of competency: _____