Momentum Upgrade November 2020

General Software changes (5/11/2020)

Adding a New Client

At times duplicate files have been created, when the NHI has been incorrectly recorded in the software. A user searching for the file is unable to find them and subsequently creates another file in the system.

Now, it will be necessary to use the 'look up' function to add an NHI and this will not be able to be altered, which will eliminate human error in entering this information.

Other fields such as name/gender/DOB will still be able to be altered.

Diseases and Diagnoses (Formerly known as 'Diagnosis History')

Changes have been made to the Momentum software and it is now more streamline for entering Diseases and Diagnoses.

The intent for coding remains unchanged: 'To document the presence of diseases or infections relevant to the person's current ADL status, cognitive status, mood or behaviours status, medical treatments, nursing monitoring, or risk of death. In general, these types of conditions are associated with the type and level of care needed by the person. Do not include conditions that have been resolved or no longer affect the person's functioning or care needs.'

Source: interRAI Home Care (HC) Assessment Form and User's Manual Version 9.1.3 Canadian Edition

A disease is a specific disorder of structure or function, especially one that produces specific symptoms and is not simply a direct result of physical injury. A diagnosis is the identification of the nature of an illness, or other problem, by examination of the symptoms.

Source: https://languages.oup.com/google-dictionary-en

Therefore, for the intent of this section, Diagnoses refer to all other identified health problems, that are not diseases, that impact on the person as per the intent and definitions provided by interRAI.

Diseases and Diagnoses software

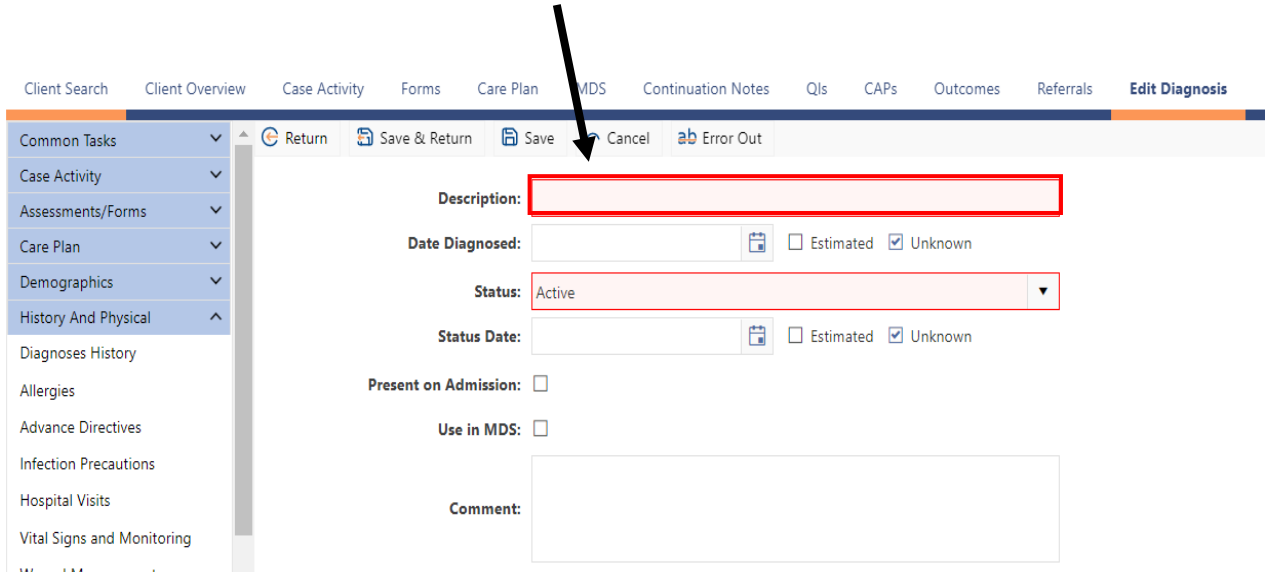
Description: Enter a disease or diagnosis here, writing in full and providing any abbreviation in brackets.

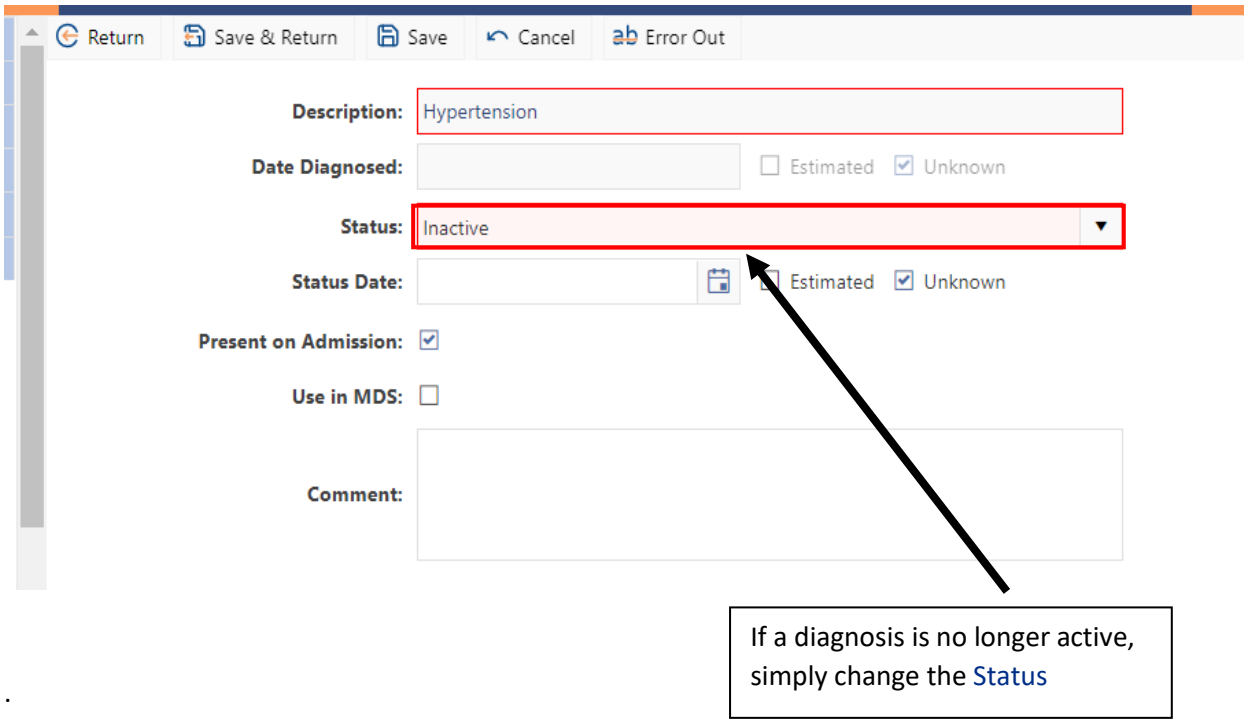
Date Diagnosed and the Status Date: defaults to 'unknown'. These can be altered if, for instance, there is a known date of the diagnosis.

Rank: No longer required when loading a disease/diagnosis. Diseases and diagnoses as are only ranked in Section I of the MDS now. All Diseases and Diagnoses will still appear on the Overview screen in LTCF and on printable reports.

Status: All diseases or diagnoses that are currently impacting on function, have the potential to, or are being treated, should be coded 'Active'. If the assessor needs to leave a diagnosis on this page (e.g. a history of cancer that informs medical history) they have the option to make the diagnosis inactive and it will only display here.

Add name of disease or diagnosis directly in the 'Description' box. Add abbreviation after full name in brackets if applicable.





If a diagnosis is no longer active, simply change the Status

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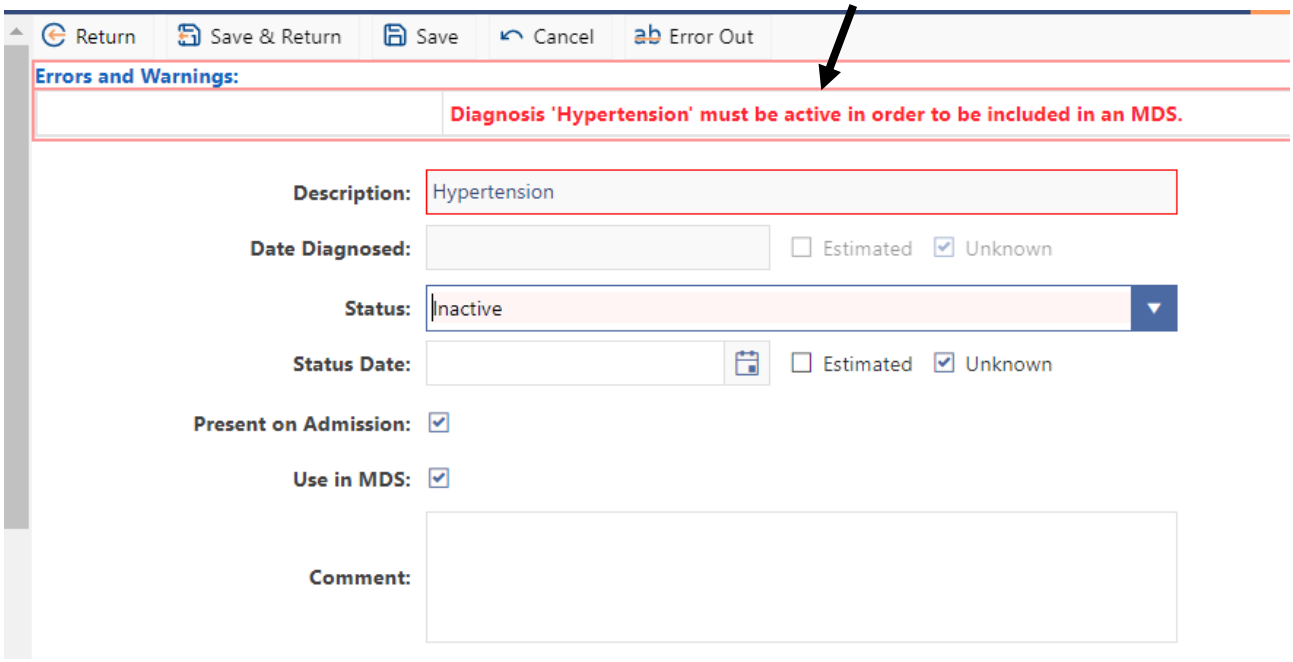
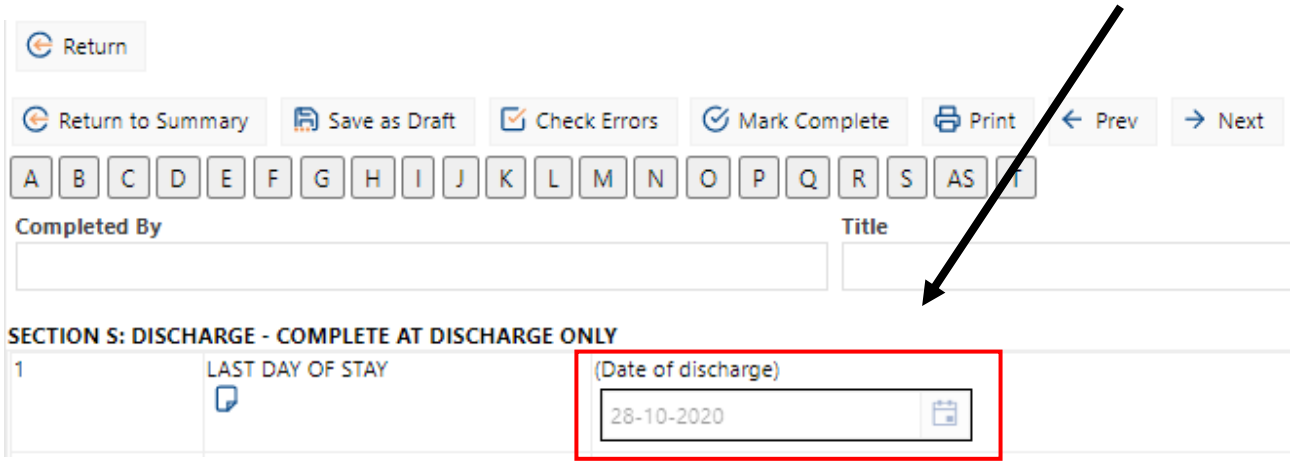
A warning will appear if an inactive disease or diagnoses is attempted to be added to the MDS.

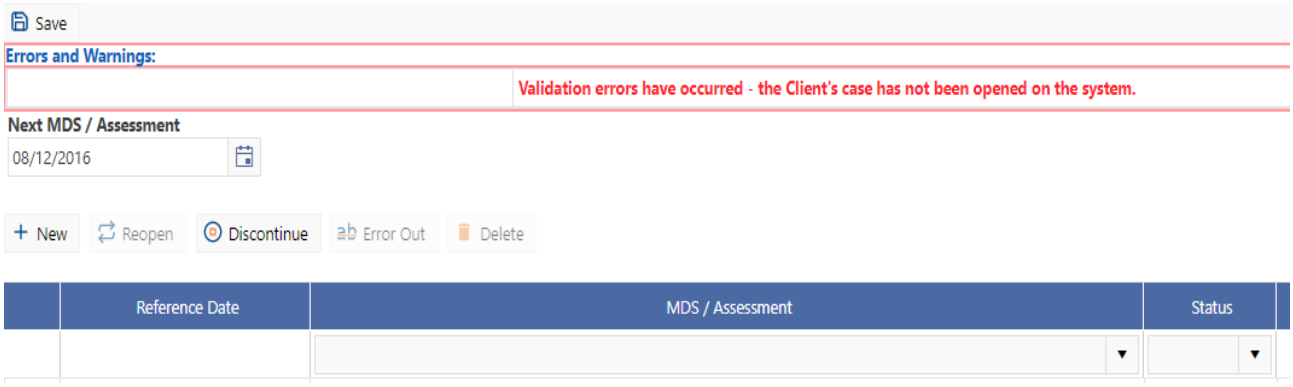


Opening a New MDS Assessment

In the past, if a person's file was not admitted into a service, the file was labelled 'Inactive', but it was still possible to open an MDS assessment. However, it wasn't possible to mark the MDS complete as the software acknowledged the person had been discharged and recorded the discharge date into the MDS.



Now, the software will not allow the user to open a new assessment if the file is 'Inactive'. The following warning will appear to alert the user to admit the person's file into the service.



Auto-population

Momentum software enables 'auto-population' of information from one assessment to another. This can save time for the assessor, when there has been no change in function and circumstances between assessments, in specific areas. It also means the assessor has the information from the last assessment in front of them while re-assessing, to test for changes since that last assessment was completed. interRAI assessment instruments used in New Zealand have an 80% commonality so auto-population is very useful.

There are two aspects to auto-population: coding and comments.

Coding: where an item is the same between assessment instruments, the coding will auto-populate from a completed assessment to the next draft assessment.

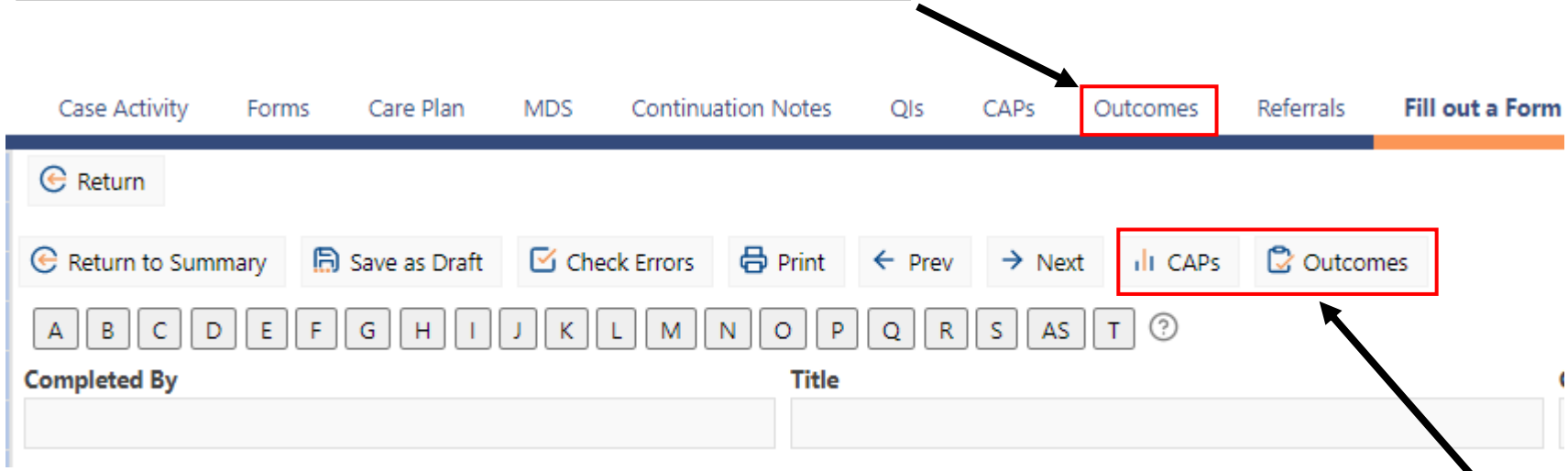
Comments: The assessor needs to determine what clinical information is added to each assessment, in support of the coding. Notes should be considered to provide further information about the person's current function and/or situation, or to provide pertinent information outside the look back period. All notes should enhance the reader's ability to provide appropriate services/support. Notes made in the Comments boxes will auto-populate into the next assessment if it is the same instrument, for example, Home Care into Home Care, LTCF into LTCF. These should be checked by the assessor for ongoing relevancy. Notes are no longer carried over between different assessment instruments, e.g. Contact Assessment to a Home Care assessment, or Home Care assessment to an LTCF assessment.

Accessing CAPS and Outcomes

It is possible to view the CAPs, relative to your draft assessment, from any section of the MDS. This is useful when working on the Assessment Summary.

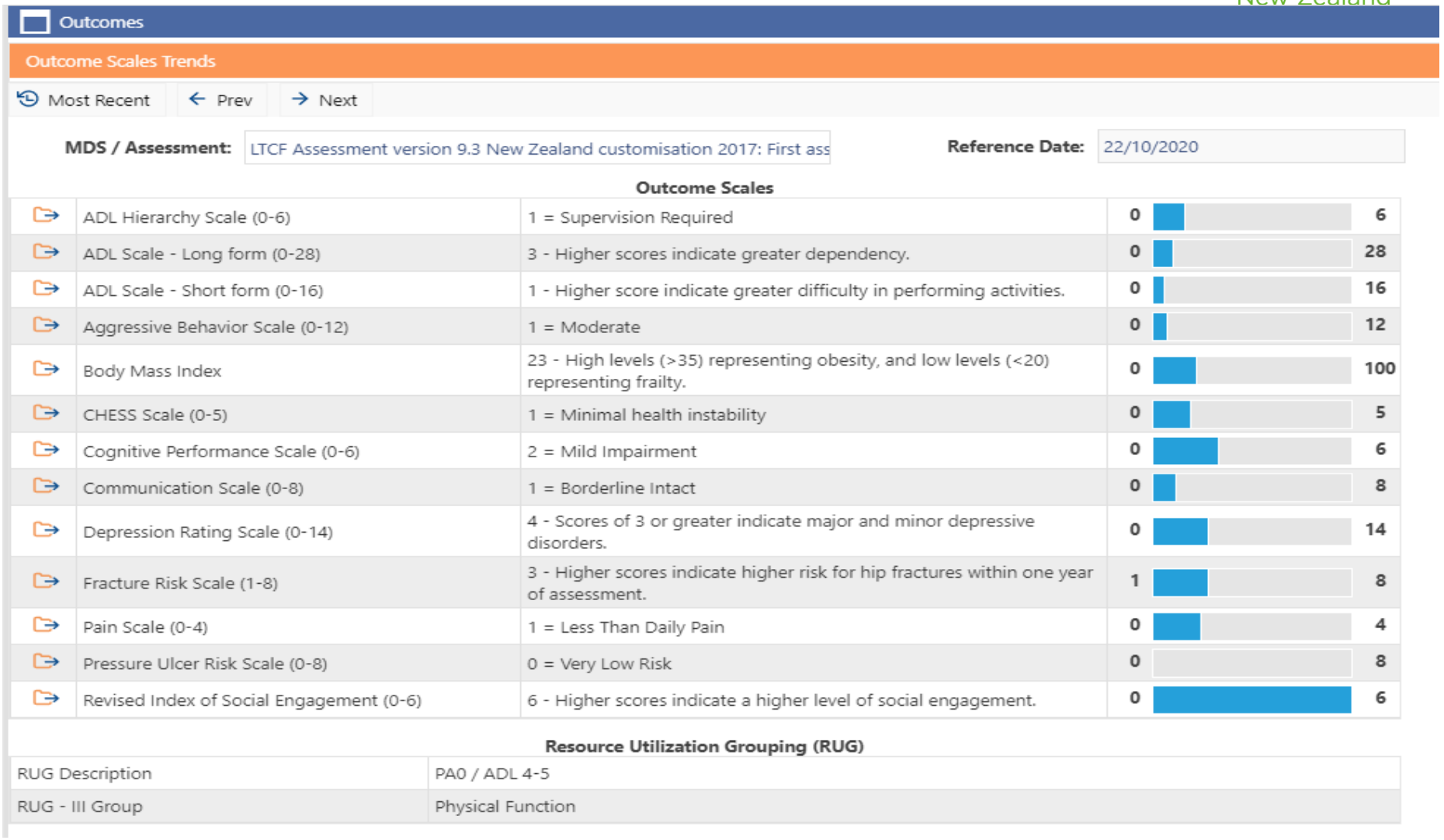
The additional benefit is that you will navigate directly to the current CAPs and Outcomes for your draft assessment.

To see results from previous completed assessments, select the Outcomes tab from the top of the page, outside of the MDS assessment



Select these tabs to see the current CAPS or Outcomes from your draft assessment

The Outcomes will now display the results with both a description and a graph, to provide a quick visual indicator of the areas where function is or is not compromised. Note that the RISE score is the only exception, where a higher score indicates positive social interaction.



Outcomes

Outcome Scales Trends

Most Recent | Prev | Next

MDS / Assessment: LTCF Assessment version 9.3 New Zealand customisation 2017: First ass **Reference Date:** 22/10/2020

Outcome Scales

	ADL Hierarchy Scale (0-6)	1 = Supervision Required	0	6
	ADL Scale - Long form (0-28)	3 - Higher scores indicate greater dependency.	0	28
	ADL Scale - Short form (0-16)	1 - Higher score indicate greater difficulty in performing activities.	0	16
	Aggressive Behavior Scale (0-12)	1 = Moderate	0	12
	Body Mass Index	23 - High levels (>35) representing obesity, and low levels (<20) representing frailty.	0	100
	CHESS Scale (0-5)	1 = Minimal health instability	0	5
	Cognitive Performance Scale (0-6)	2 = Mild Impairment	0	6
	Communication Scale (0-8)	1 = Borderline Intact	0	8
	Depression Rating Scale (0-14)	4 - Scores of 3 or greater indicate major and minor depressive disorders.	0	14
	Fracture Risk Scale (1-8)	3 - Higher scores indicate higher risk for hip fractures within one year of assessment.	1	8
	Pain Scale (0-4)	1 = Less Than Daily Pain	0	4
	Pressure Ulcer Risk Scale (0-8)	0 = Very Low Risk	0	8
	Revised Index of Social Engagement (0-6)	6 - Higher scores indicate a higher level of social engagement.	0	6

Resource Utilization Grouping (RUG)

RUG Description	PA0 / ADL 4-5
RUG - III Group	Physical Function

The Outcome Scales Trend can be used to measure the efficacy of care planning interventions over time or note the impact of expected decline relative to disease progression.

Return takes you to back to the list of MDS assessments

X will return you to the previous screen you were viewing

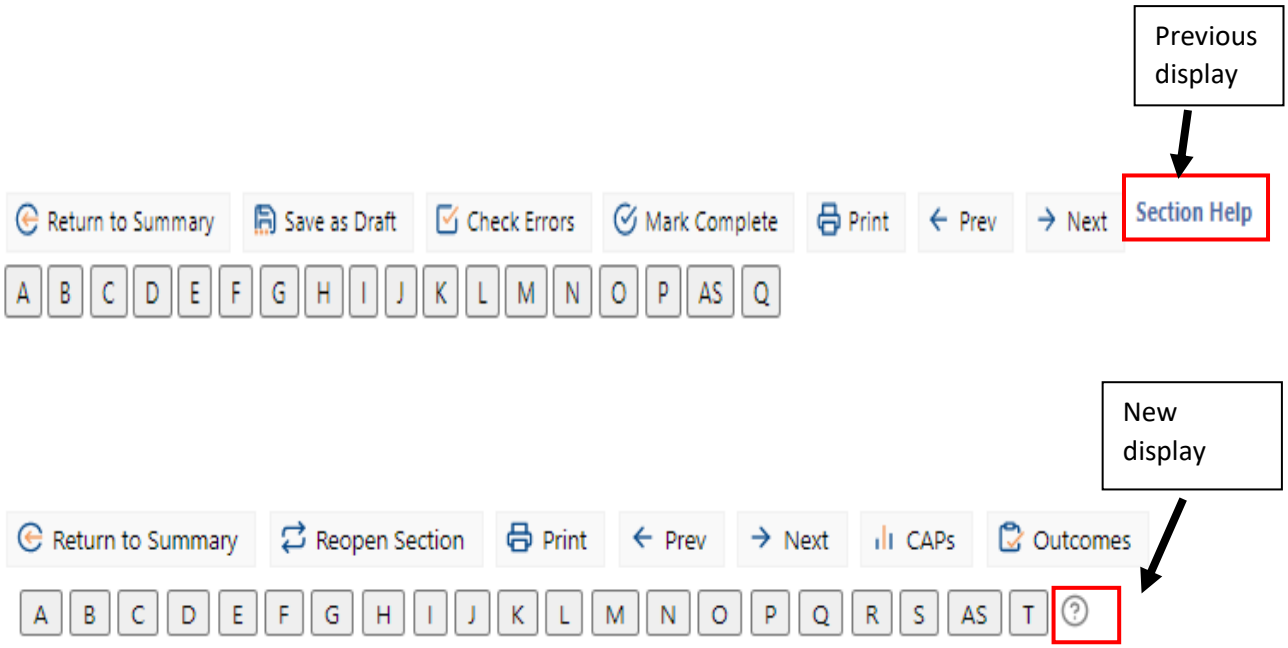
V reveals the Outcome Scale Trends

Outcome Scales Trends

Outcome Scales Calculated	Palliative Care Assessment version 9.3 New Zealand customisation 2018: Significant change in status ARD 22/10/2020	LTCF Assessment version 9.3 New Zealand customisation 2017: First assessment ARD 22/10/2020
ADL Hierarchy Scale (0-6)	1	1
ADL Scale - Short form (0-16)	1	1
Body Mass Index	23	23
Cognitive Performance Scale (0-6)	2	2
Depression Rating Scale (0-14)	4	4
Pain Scale (0-4)	1	1
CHESS Scale (0-5)	3	1
Pressure Ulcer Risk Scale (0-8)	0	0
Communication Scale (0-8)	-	1
Aggressive Behavior Scale (0-12)	-	1
ADL Scale - Long form (0-28)	-	3
Revised Index of Social Engagement (0-6)	-	6
Fracture Risk Scale (1-8)	-	3

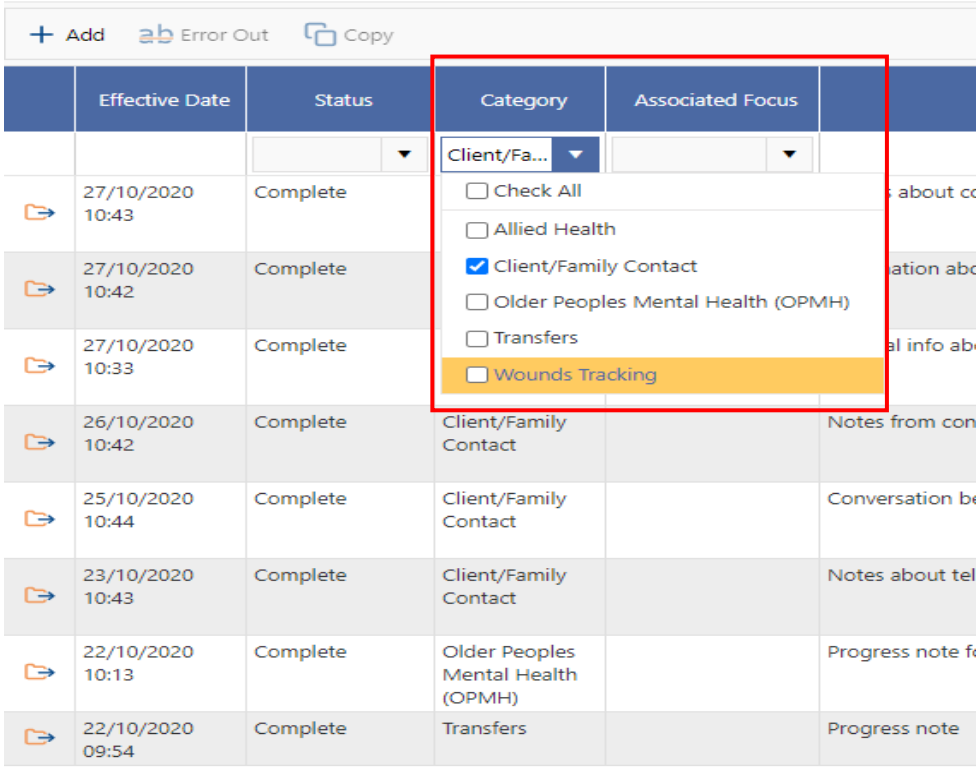
Section Help

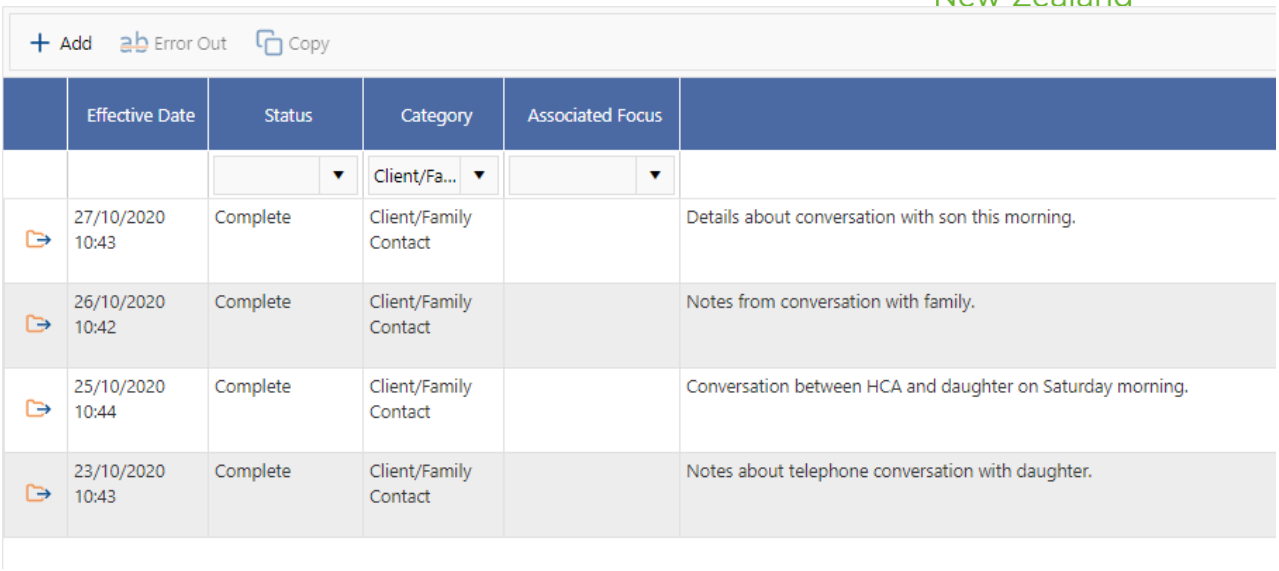
Section help is available at the top of each Section of the MDS assessment but has changed in appearance.



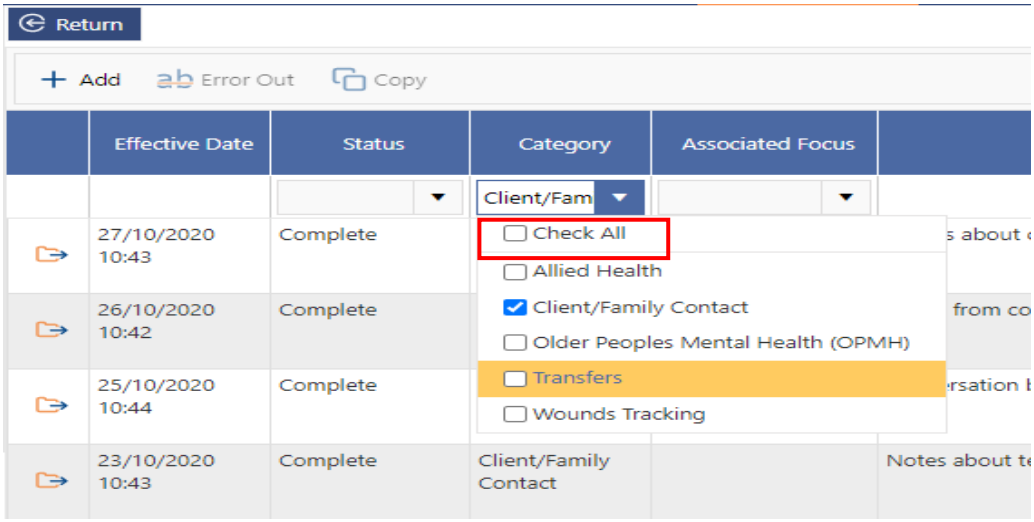
Continuation Notes

It possible to filter continuation notes to find all entries that relate to a certain subject. Use the category drop box to find all entries made under the category you've chosen.





The software will retain your filter until you manually return it to 'all', even if you navigate away from this page. Therefore, change category back to 'All' once your enquiry is complete.



Advance Directives

All advance directives will now display on both the Care plan and Transfer Referral Reports. This information is taken from the Overview Screen, not the MDS. Therefore, the assessor needs to ensure the Overview screen is kept updated if reports are routinely used.

Undernutrition and Prevention CAPs

If no BMI has been entered the Nutrition CAP will no longer trigger. The Prevention CAP will trigger once any items related to this is coded but will no longer trigger on a blank assessment.