NORTHWEST Kidney Centers

Clarity – Social Workers

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Contents

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Navigation

You will be logging into the Clarity training environment using the Username and Password you received prior to training.

When using Clarity, use **Internet Explorer**. This is the web browser that is used for build and testing by the vendor, making Internet Explorer the optimal browser to use. If you use another web browser, it will not function as smoothly, and you will notice differences in how things are displayed (pages will be in super small font).

If this is your first time logging in, you will see a few pop-ups that we will address.

Home Page

The Home Page is the first page you will see each time you log into Clarity. Here you will see updates and messages from Visonex about new releases, new events, or new Lunch-and-Learn opportunities. Keep an eye on this page for events you may want to participate in.

At the top of the page, you will **Northwest Kidney Centers – (Your Default Center Name)** and your name in the upper-right hand corner. It is helpful to double-check on who is logged in when using a shared workstation.

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It is important to point out that while Clarity does have features that allows for messaging within the application, we will not be using this functionality. DO NOT MESSAGE PHYSICIANS IN CLARITY. This is not the physician's primary EMR and they will not be checking for messages. Please continue to use the methods of communication that you use now.

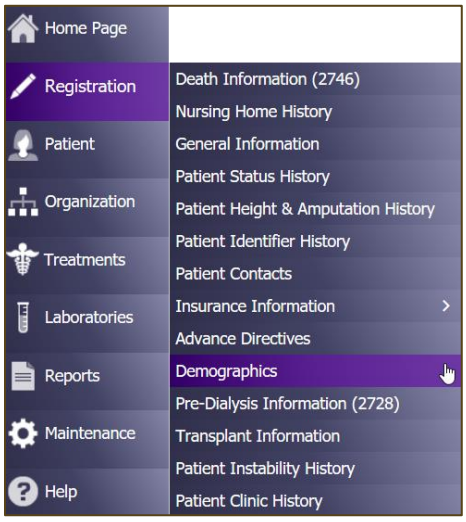
Under the Home Page on the left-hand side, you will see a list of menus. As you click through each menu, sub-menus appear.

Take a minute to look through the contents of each of the menus.

Let's do a quick review of what sub-menus & items you will find within each menu. We will work with a few of these menus/sub-menus during the training today.

Registration

Patient registration will still be done in TIME. TIME will interface with Clarity and you will see that information populate to the appropriate screens within this menu.



- Death Information (2746)
- Nursing Home History
- **General Information**
- Patient Status History
- Patient Height & Amputation History
- Patient Identifier History
- **Patient Contacts**
- **Advance Directives**
- **Demographics**
- Pre-Dialysis Information (2728)
- **Transplant Information**
- Patient Instability History
- Patient Clinic History

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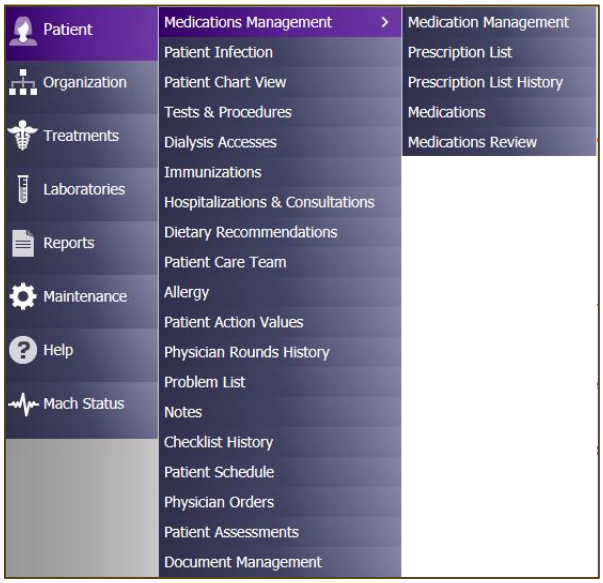
Patient

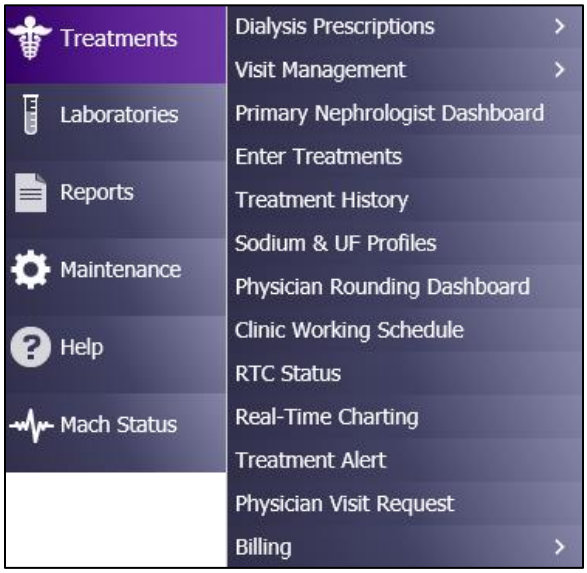
The Patient menu gives you the ability to view and/or update items outside of a patient's treatment. This is where you do things like-- document patient assessments, view a patient's care team, and view a patient's schedule.



- Medication Management
- Patient Infection
- **Patient Chart View**
- Tests & Procedures
- Dialysis Accesses
- Immunizations
- Hospitalizations & Consultations
- Dietary Recommendations
- **Patient Care Team**
- Allergy
- Physician Rounds History
- Problem List
- **Notes**
- Checklist History
- **Patient Schedule**
- Physician Orders
- **Patient Assessments**
- **Document Management** (DocuWare)

Treatments

The Treatments menu is where you will find the information regarding a patient's Dialysis Prescription, Treatment documentation (In-Center = Real Time Charting (RTC) & Home = Visit Management), and Treatment History.



- Dialysis Prescriptions
- Visit Management
- Primary Nephrologist Dashboard
- Enter Treatments
- Treatment History
- Sodium & UF Profiles
- Physician Rounding Dashboard
- Clinic Working Schedule
- Real-Time Charting
- **RTC Status**
- Treatment Alert
- Physician Visit Request

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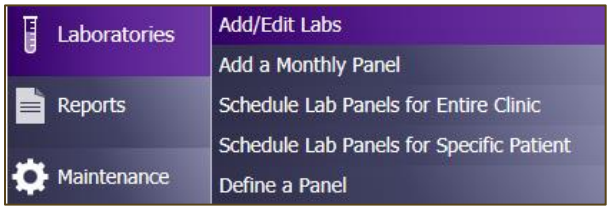
Laboratories

Lab results will be available in Clarity from Ascend. At this point in time, lab orders will continue to be ordered in Ascend. Add/Edit Labs are where the labs are stored within Clarity. Lab results can be reviewed in other areas within Clarity—Reports, Patient Chart View, etc.



Reports

Reports are found within the Report Wizard. You will be able to run Clinic reports and Patient reports. We will talk more about reports and how to run them a little later.

Machine Status

Machine Status will display all machines at the clinic (that have been active within the last 48 hours) and the patients that are running.

This screen will list which patients are on which machines and how long they have left on their run. You can change the unit it displays by selecting a different clinic from the drop-down. This information is automatically updated every minute. If you would to update it yourself click the **Search** button and this will refresh it.

Typically, when things are functional the station number will not having any colors/highlights. This screen can also help identify machines that are not sending information to Clarity. If the station number is highlighted in **red**, this indicates that there is a problem with the machine communicating to Clarity.

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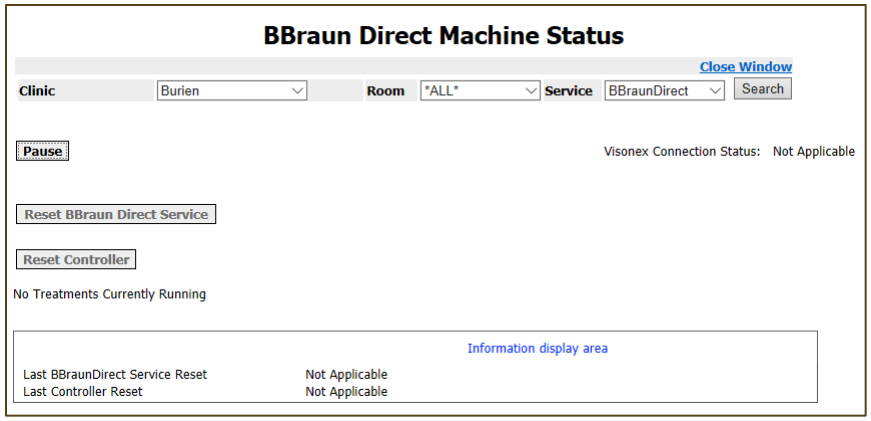
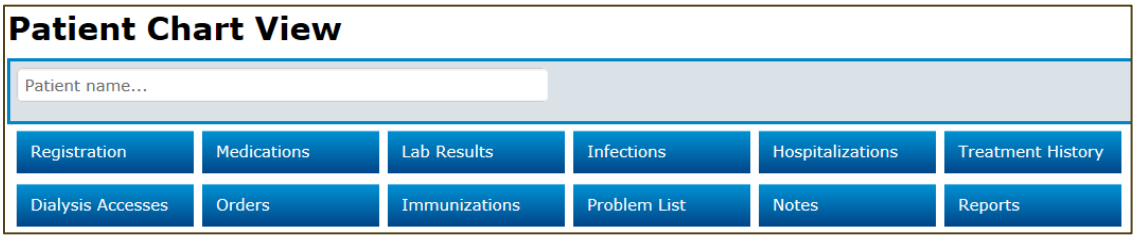


Initial Comprehensive Assessment

A new patient has been referred to the unit. You will meet with new patient and discuss introductory information and assess barriers to treatment. Upon determining the patient's CIA schedule, prepare for the assessment meeting. Make any phone calls or schedule an interpreter if needed.

At this point, you want to review the patient's medical history, Patient Chart View will give you a lot of information in one place. To access **Patient Chart View,** go to **Patient > Patient Chart View** and select/search for your patient (if they are not already selected)



From here, you can review Registration Information, Lab Results, Treatment History, Problem List, etc.

Click through the various tabs to find and review the patient's information.

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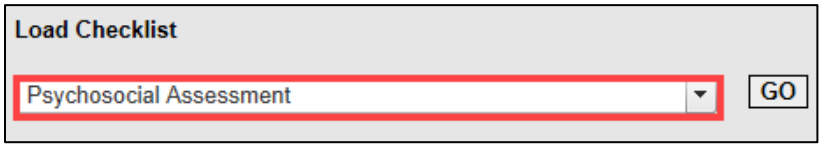
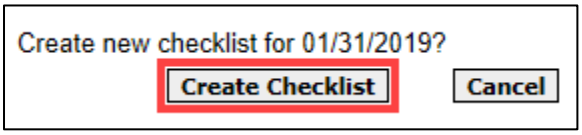
As you continue preparation for the patient's initial CIA, you consult with the IDT. When you are ready to enter begin documentation, open the Psychosocial Assessment and enter any known data.

To document a new **Psychosocial Assessment,** go to **Patient > Patient Assessments**, select the **Psychosocial Assessment**, and click **Go**.



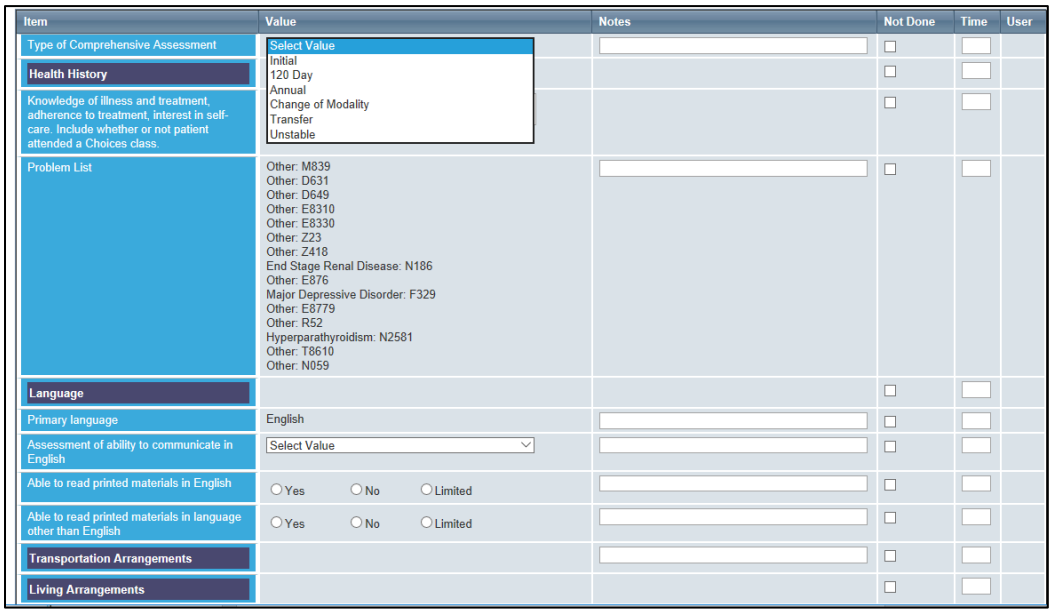
Select the appropriate **Clinic**, **Patient**, and **History**. Under **History,** create a new assessment by clicking **Add New.** Choose a date and press **Submit.**

Click **Create Checklist** (if the assessment is new).



At this point, you can document the patient's **Psychosocial Assessment** using your computer or tablet. As you work through the various assessments within Clarity, you will notice the different ways you can document.

You will see drop-down menus, checkboxes, radio buttons (like a checkbox, but a circle and it only allows you to choose one answer/option), and free text boxes.



Let's take a few minutes to work through the **Psychosocial Assessment**.

When you have completed documenting the assessment or would like to save it to complete later, enter your **Username** and **Password** and click **Save Changes**.

As part of the **Psychosocial Assessment**, you have completed the **PHQ-2** with your patient. If your patient's score is higher than 3, administer the **PHQ-9** (**Patient > Patient Assessments**).

Fax the patient's nephrologist if PHQ-9 is greater than 4.

If your patient answers 1, 2, or 3, to question 9 of the **PHQ-9**, administer the **Columbia Suicide Severity Rating Scale** assessment. You can access the assessment by going to **Patient > Patient Assessments > Columbia Suicide Severity Rating Scale.**

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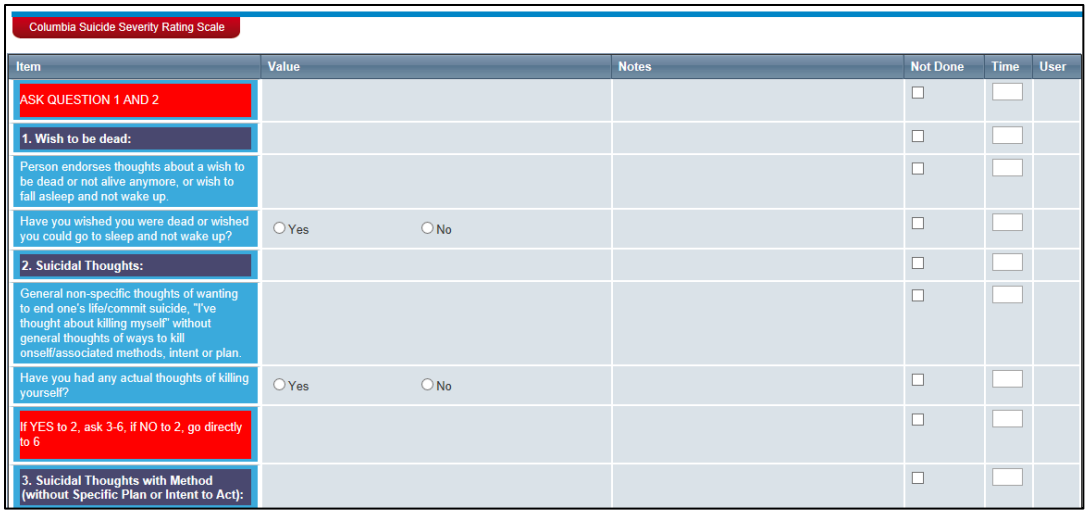

Upon completion, follow recommendations for follow-up based on the risk. Complete safety plan for those at medium or high risk. Be sure to notify the appropriate staff in the unit and the patient's nephrologist.

Let's take a few minutes to document on these assessments.

If your patient has a negative **PHQ-2** score, you can continue your workflow.

When you complete any assessment or want to save changes to complete later, you will want to make sure you enter your **Username** and **Password** and click **Save Changes**.

As we continue working with our patient let's review/update the following items:

a. **General Information** (**Registration > General Information)**
    i. Some of the items that we would want to make sure we address are found within General Information. We would want to be sure to enter the following:
        1. Language
        2. Citizenship Status & Effective Date
        3. Vocational Rehab & Effective Date
        4. School Status & Effective Date
        5. Transportation Arrangements
        6. Other Transportation Arrangements
b. **Patient Contacts** (**Registration > Patient Contacts**)
    i. We would want to make sure we review the Patient Contacts to make sure we have the correct and appropriate information.
        1. Emergency Contacts
        2. Next of Kin
        3. Power of Attorney (if there is one) contact information
c. **Advance Directives** (**Registration > Advance Directives)**
    i. We would want to be sure to review the patient's Advance Directives information and discuss with your patient.
        1. Living Will
        2. DPOA Healthcare
        3. Document Advance Care Planning Discussion
            a. Documents to be scanned by the Unit Coordinator
d. **Demographics** (**Registration > Demographics**)
    i. Continuing with our review, in Demographics, we find the following:
        1. Ethnicity
        2. Race
        3. Tribe Code
        4. Country (Country of Origin)
        5. Prior Employment Status
        6. Current Employment Status and Effective Date
e. **Transplant Information (Registration > Transplant Information)**
    i. You can see if a patient has a transplanted kidney, are a Transplant Candidate, and if they are on a Transplant Wait List

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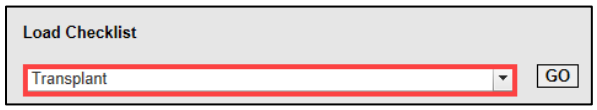
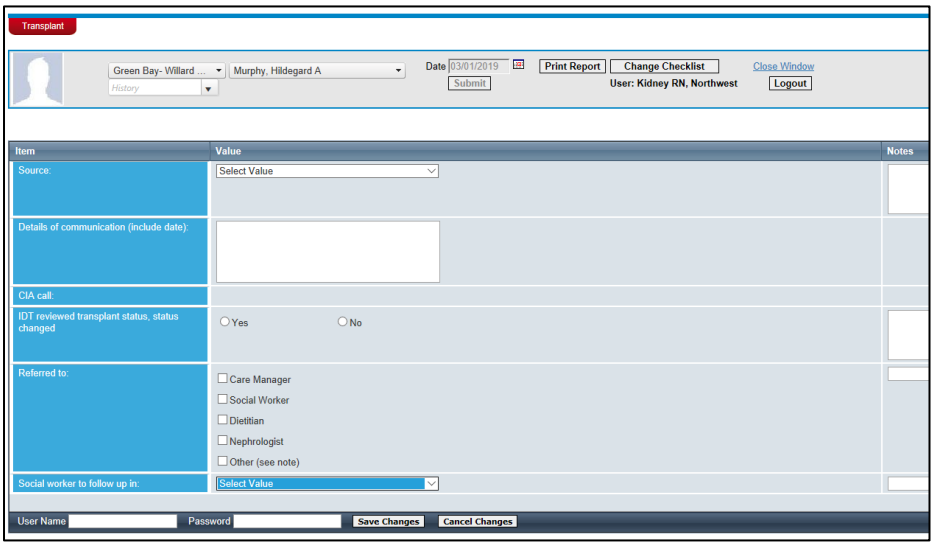
As we continue working, you complete **Transplant Assessment**, by going to **Patient > Patient Assessments**, select the **Transplant** assessment, and click **Go**.





Take a couple of minutes to document the **Transplant Assessment**.

Once you have completed documenting the **Transplant Assessment** or would like to save it to complete later, enter your **Username** and **Password** and click **Save Changes**.

You have completed your documentation needed prior to your POC meeting. At this point, you will implement POC goals and follow up (as needed).

POC Follow-up

Let's fast-forward in time and say that it is the start of new month and our new POC Follow-ups are due.

The Scheduled CFC Assessment report may be helpful in determining the POC follow-up due dates.

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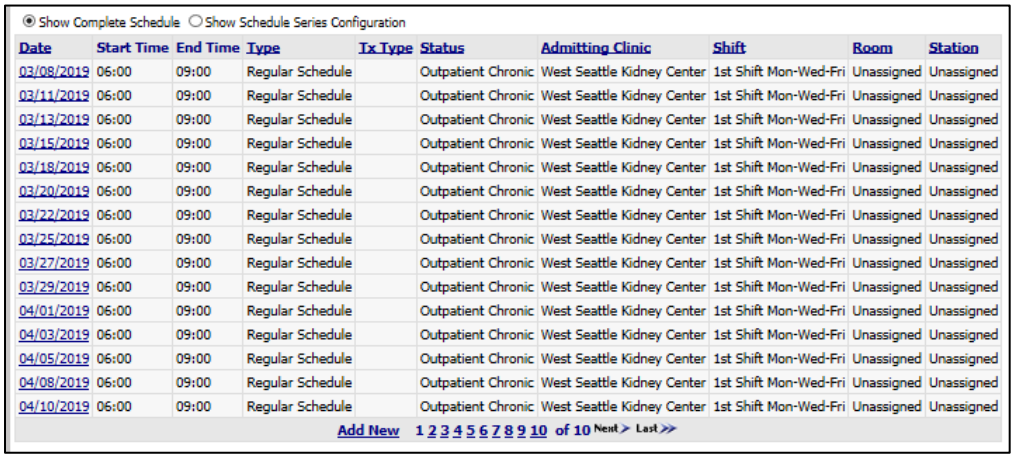
Patient Schedule

We would like to review our patient's schedule, so to do this, let's navigate to **Patient > Patient Schedule**. Once you select the **Clinic** and **Patient**, the patient's schedule will be displayed.



◉ Show Complete Schedule ○ Show Schedule Series Configuration

Date	Start Time	End Time	Type	Tx Type	Status	Admitting Clinic	Shift	Room	Station
03/08/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/11/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/13/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/15/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/18/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/20/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/22/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/25/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/27/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
03/29/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
04/01/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
04/03/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
04/05/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
04/08/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned
04/10/2019	06:00	09:00	Regular Schedule		Outpatient Chronic	West Seattle Kidney Center	1st Shift Mon-Wed-Fri	Unassigned	Unassigned

Add New 1 2 3 4 5 6 7 8 9 10 of 10 Next > Last >>

From this screen, you can see the next **15** treatments that are scheduled for the patient.

At this point, we will review our patient's medical record and their Plan of Care goals. Go to **Patient > Patient Assessments**, select the **Social Worker Plan of Care**, and click **Go**. Notice how the goals we entered in the **Psychosocial Assessment** pulls forward for you to view. Here you can document the status of goals, issues, and update the plan for each goal.

We will take a couple of minutes for you to complete some documentation on the **Plan of Care**.

As you are reviewing your patient's chart and their goals, you consult with IDT regarding any concerns you may have.

Following your discussion with IDT about your concerns, you meet with your patient.

At this point, you will complete your **Social Worker Plan of Care** Assessment. To submit, enter your **Username** and **Password** and click **Save Changes**.

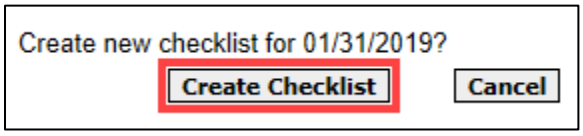
CIA

Psychosocial Assessment

Just like we did with our new patient, we will use the **Psychosocial Assessment** for our patients that are due for a 120-Day Assessment, Annual Assessment, Change of Modality, or Transfer Assessment.

In **Patient > Patient** Assessments, select the **Psychosocial Assessment.** Select the appropriate **Clinic**, **Patient**, and **History**. Under **History,** create a new assessment by clicking **Add New.** Choose a date and press **Submit.**

Click **Create Checklist** (if the assessment is new).



At this point, you can document the patient's **Psychosocial Assessment** using your computer or tablet. As you work through the various assessments within Clarity, you will notice the different ways you can document.

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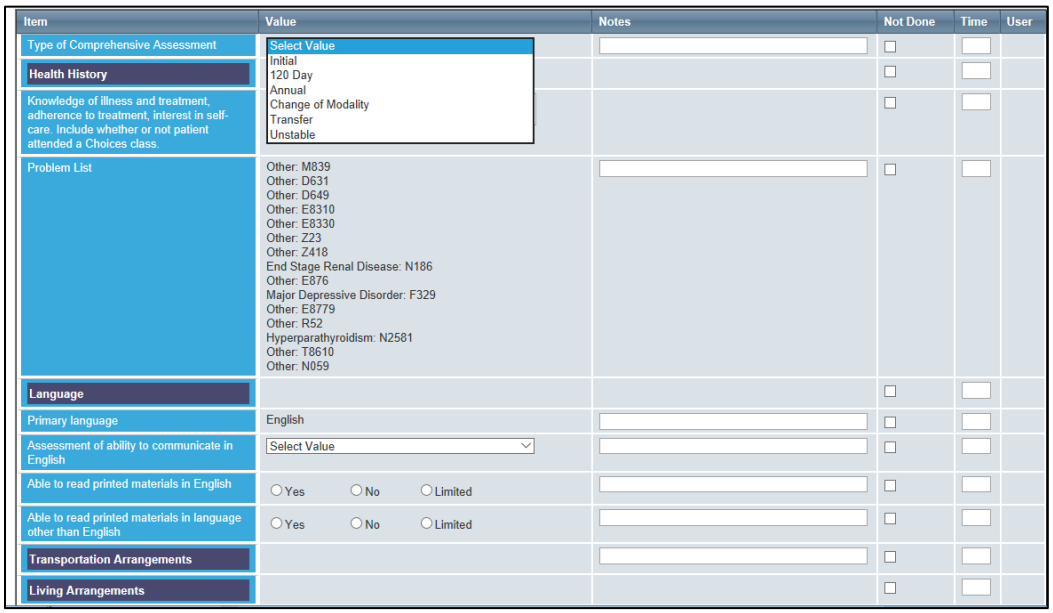


Let's take a few minutes to work through the **Psychosocial Assessment**. There is some information that will pull forward, but there may be

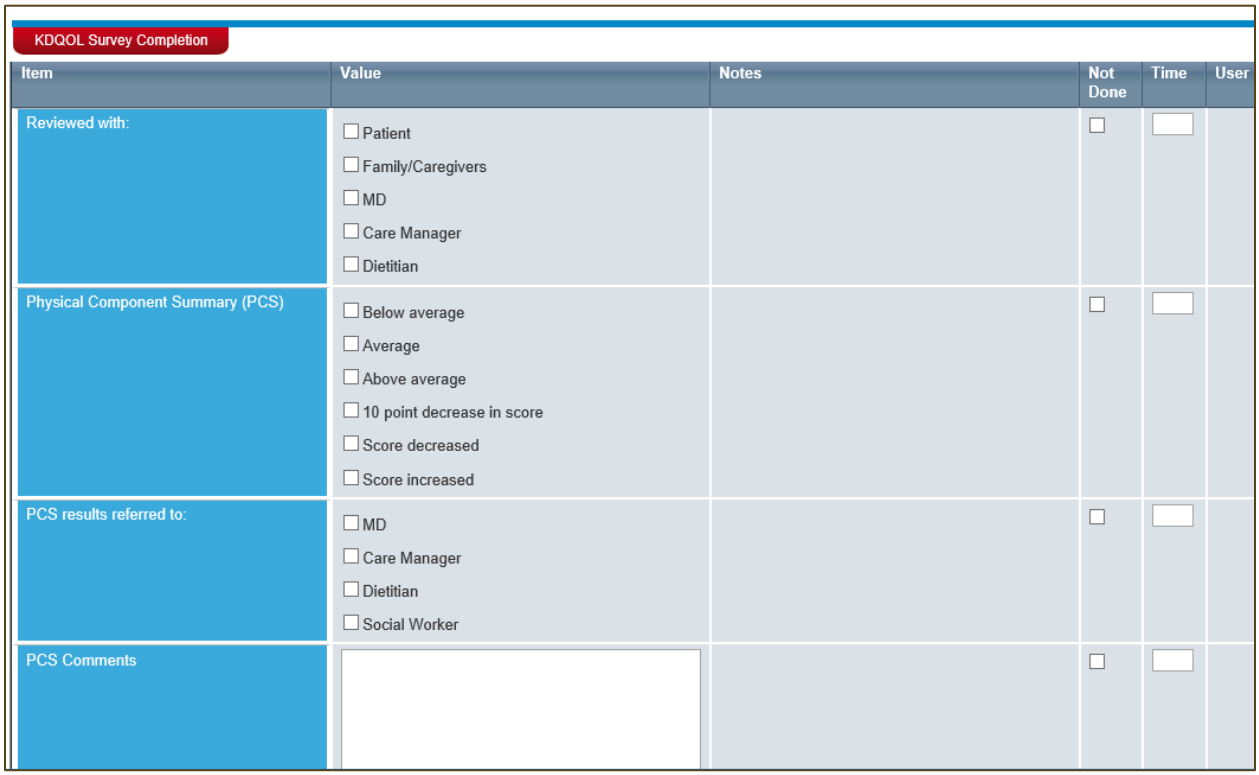
information you wish to replicate from previous Psychosocial Assessments. You can open a previous assessment by going back to "main" Clarity > **Patient > Patient Assessments**. Select the **Psychosocial Assessment.** After selecting the correct patient, in the **History** drop-down, select the previous **Psychosocial Assessment**. This should open in a separate tab for you. You can use this tab to refer to as you complete your preparation for your meeting—allowing you to account for changes or differences within your current documentation.

If this is an annual assessment, be sure to go over Rights and Responsibilities and check the checkbox within the **Psychosocial Assessment**.

When you have completed documenting the assessment or would like to save it to complete later, enter your **Username** and **Password** and click **Save Changes**.

KDQOL

At this point we want to make sure we document the **KDQOL Survey Completion** assessment. To do so, go to **Patient > Patient Assessments** and select the **KDQOL Survey Completion**.



Unstable Patients

Using the **Psychosocial Assessment**, you can do a more limited Psychosocial (if it is not something you are involved in) for a patient with an **Unstable** status. This just means you would not have to update everything within the **Psychosocial Assessment**.

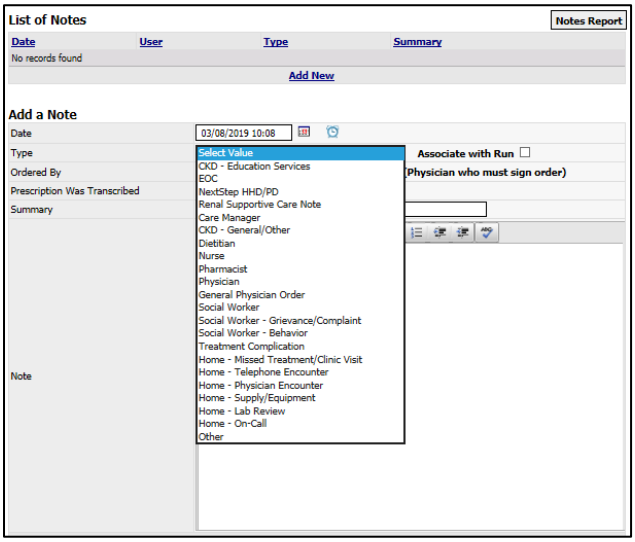
The IDT will discuss when a patient is ready to go to **Stable** status. You will then do a complete **Psychosocial Assessment** (so you would not have to do one for another year).

General Notes

One of the ways you can document your interactions with your patient is through a note. To access notes, go to **Patient > Notes**. Once in **Notes**, you can review notes by other staff or click **Add New** to add your own note.

Once you click Add New, you will have the ability to select the **Type** of note. There are **3** note types built for Social Workers—**Social Worker**, **Social Worker – Grievance/Complaint**, and **Social Worker – Behavior**.

If there is any other documentation you currently do now that does not fit into an assessment or a note type, you would use the **Social Worker** note type. Because we are using assessments for KDQOL, Advance Care Planning, CIAs, and Depression Screenings, you do not need to write a note.



Transplant Tracking

One week prior to the QAPI meeting, review most recent Transplant Roster from 3 programs on S Drive.

Look for your patients that are highlighted yellow (as this denotes a change).

Compare new status with transplant status in the **Transplant Information** (**Registration > Transplant Information**) screen and update (as needed)

If your patient missing from the list, first look for the Transplant Agency letter scanned into Clarity (DocuWare). If you are not already in the patient's chart, go to **Patient > Document Management**.

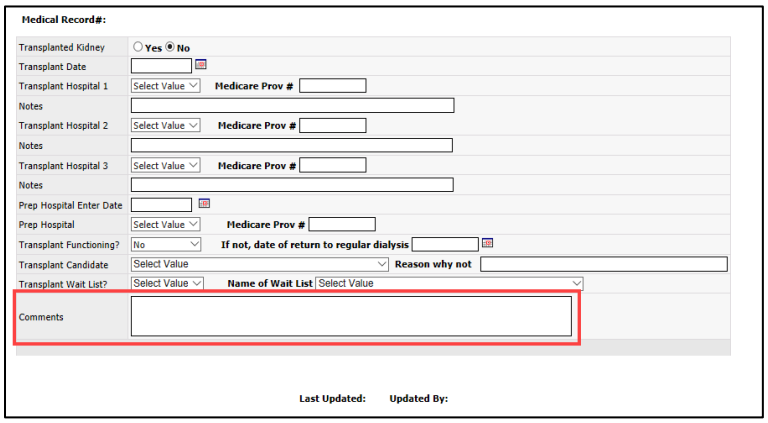
You can search for your patient using their MRN or their name. You can filter by using the **Document Type** filter.

If you find the Transplant Agency letter:

1. Read the letter
2. Change **Transplant Status** in **Transplant Information** screen
3. Site the date and source in the Comments box
4. Record details in the **Transplant Assessment**
5. Message the IDT, if there is a barrier to transplant

If the letter is not scanned into Clarity (DocuWare):

1. Call the Transplant Center for clarification
2. Change the transplant status in the **Transplant Information** screen
3. Cite date and source in the Comments box
4. Record details in your patient's **Transplant Assessment**
5. Message IDT (if there are barriers to transplant)



If your patient is not present on the Transplant Roster, message IDT if barrier to transplant.
Discuss new status with patient and enter details in **Transplant Assessment**.

Follow-up as needed.

Depression Screening

You have determined that your patient needs a Depression Screening and it is not time for an assessment, so we will complete the **PHQ-2** with our patient. To complete the **PHQ-2**, go to **Patient > Patient Assessments**. Be sure you have the correct patient. Select the correct patient, if not.

If your patient's score is higher than 3, administer the **PHQ-9** (following the same steps as the PHQ-2—**Patient > Patient Assessments**).

Fax the patient's nephrologist if PHQ-9 is greater than 4.

If your patient answers 1, 2, or 3, to question 9 of the **PHQ-9**, administer the **Columbia Suicide Severity Rating Scale** assessment. You can access the assessment by going to **Patient > Patient Assessments > Columbia Suicide Severity Rating Scale.**

Upon completion, follow recommendations for follow-up based on the risk.

Complete safety plan for those at medium or high risk. Be sure to notify the appropriate staff in the unit and the patient's nephrologist.

Home Program Patient Referrals

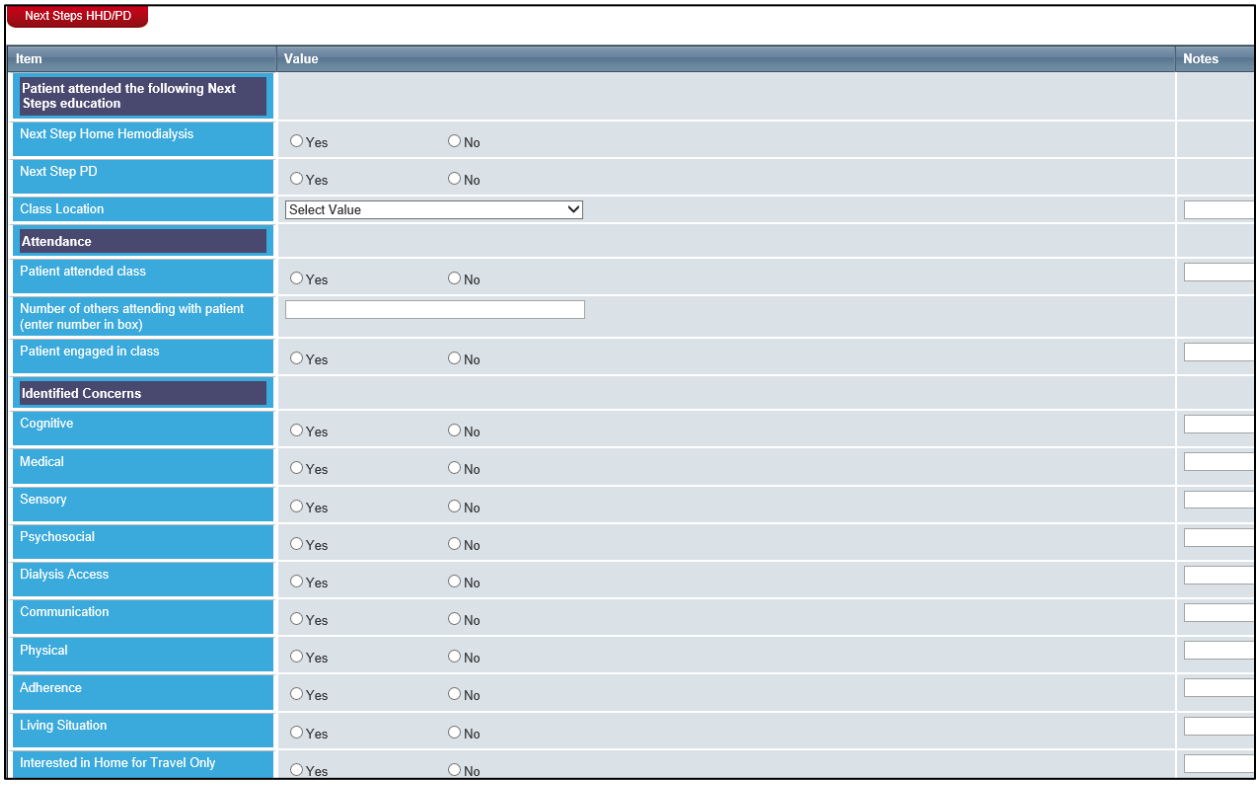
You learn that your is patient interested in the Next Steps program. Find the list of upcoming classes from Home Patient referrals.

You consult patient to determine the following:

a. Do they have someone to help them?
b. Vision impairment not correct with glasses?
c. Dialysis Access
d. Cannulation Status
e. Class, location, and date they are interested in attending and if they will bring a guest
f. Who should we contact if there is follow-up needed?

From here, you will register your patients for Next Steps. Enter information obtained from patient, print out confirmation of class registration and class information, and provide this to your patient.

To document the patient's attendance in the **Next Steps** class in **Clarity**, go to the **Next Steps HHD/PD** assessment (**Patient** > **Patient Assessments** > **Next Steps HHD/PD**).

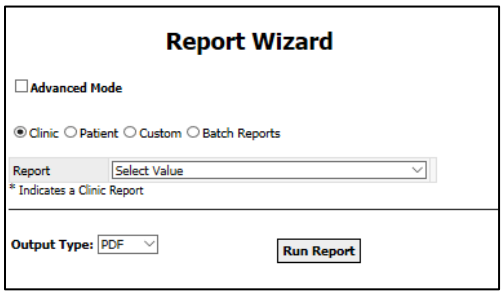


Reports

There are two types of reports that you will use frequently within Clarity—**Clinic** reports and **Patient** reports. **Patient** reports will give you the selected report on a particular patient. Whereas **Clinic** reports give you the selected report within your clinic's population.

Let's begin by using reports by going to **Reports > Report Wizard.**

Select the **Clinic** or **Patient** radio button (depending on what type of report you want to run).



In the drop-down menu, select the desired report. Select the appropriate **Patient Shift/Patient**, as needed.

Some reports that will be helpful in your work:

- Patients Eligible for Depression Assessments
- Patients by Transplant Status
- Transportation Arrangements
- Plans of Care

Once you have selected your report, click **Run Report.** The report will be in a separate web browser window.

If you would like to run a **Clinic** report for multiple clinics, you can do so using **Advanced Mode**.

To use **Advanced Mode**, check the checkbox in **Report Wizard**.

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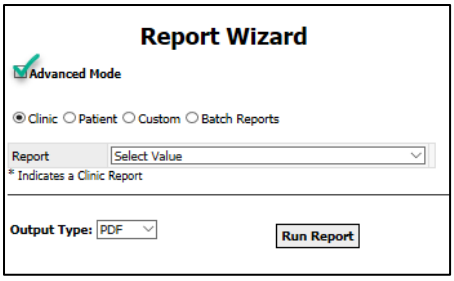
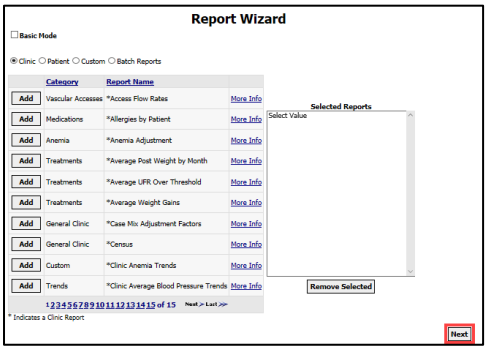
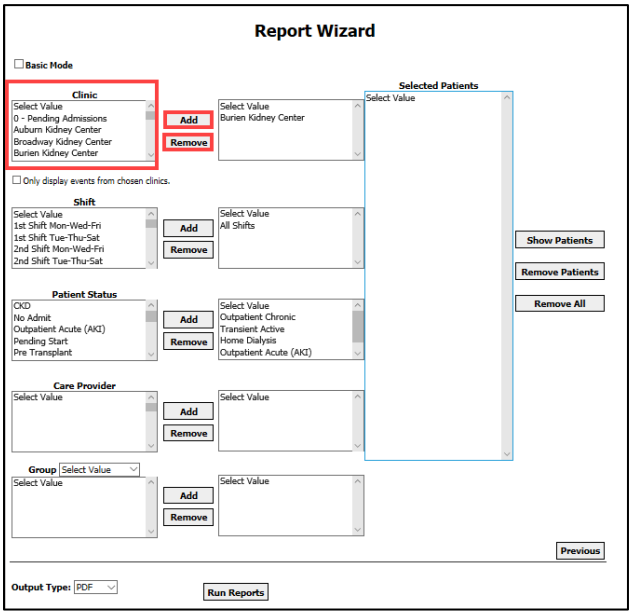


Once **Advanced Mode** has opened, click the **Next** button.



Once the window opens, you will see you have multiple options to add multiple **Clinics**, **Shifts**, **Patient Status**, **Care Providers**, and **Groups**.



If desired, click **Show Patients** to verify the list of patients.

After your make your selections, click **Run Reports** and the report will be in a separate web browser window.

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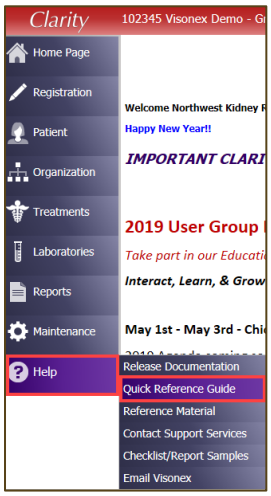
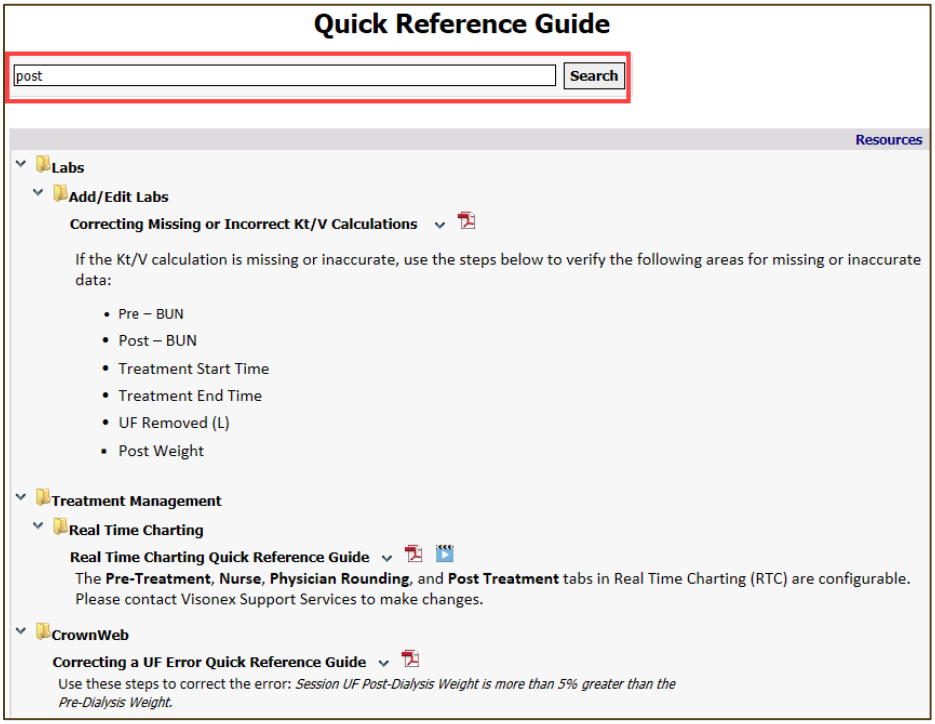
Help

Within Clarity, there are a number of available resources to help guide and troubleshoot. These **Quick Reference Guides** cover a multitude of topics and are available under the **Help > Quick Reference Guides.**



To find the Quick Reference Guide you are looking for you, you can open the category folders to find the topic you are looking or search for keywords in the Search box.



Click the icon to open the document as a PDF. If there is a icon, there is a video available to watch about the topic.

You can also find help materials, recorded Lunch-and-Learns, and videos under **Reference Material.**