**Saratoga Bridges’**

**Procedure for Intake Monitoring and Management with Therap**

**INTAKE MONITORING:**

1. It is the responsibility of *all DSPs and nursing staff* in residential and day programs to report and document intake only for individuals in need of intake monitoring. Individuals are identified by nursing, nutrition, and/or clinical provider recommendation.
2. Intake will be documented in the Intake and Elimination section of the Health Tracking module of Therap by the end of each shift.
3. The person assigned to care for the individual will add the intake data into the Intake and Elimination grid.
4. Use the following conversion factors when recording intake data:
   1. For fluids, enter quantity as CC’s (1 ounce = 30 cc’s). In cases where the fluid amount is outside an established fluid restriction protocol, a comment must be included.
   2. For food, enter only percentages of 0%, 25%, 50%, 75%, or 100%. In cases where the percent consumed is less than 100%, a description of that eaten must be included in the comments section.

**INTAKE MANAGEMENT FOR INDIVIDUALS ON FLUID RESTRICTION:**

1. At the start and end of each shift, staff assigned to care for the individual will review the Intake and Elimination grid for the individual.
2. Once reviewed, if a scheduled beverage has not been recorded on the grid, notify nursing for further instruction.
3. Howto review an individual’s intake data:
4. From the Therap dashboard, left-click the “Health” tab on the left side of the screen. The list of Health Tracking modules will appear. A right-click will bring up a context menu that will not be useful.
5. Left-click “Report” to the right of “Intake/Elimination”. The screen will refresh and “Intake and Elimination Report Parameters Input” will appear in the top region of the screen.
6. In the field “Individual’s Name”, type in the individual’s name. If the individual’s name does not appear, verify that you are using the correct user profile that gives you access to that individual.
7. Set the Begin Date field to one day prior to the current date. Set the End Date to the current date.
8. Check the following boxes in the Type field: Fluid Intake, Comments.
9. Left-click the “Search” button. The screen will refresh and show entries meeting the criteria specified in the previous steps.
10. If data shown is not in accordance with the individual’s protocol, notify nursing.

**For individuals whose food intake is being monitored, staff review of the data is not necessary.**

**PROCEDURE FOR RECORDING INTAKE DATA IN THE INTAKE SECTION OF THERAP’S HEALTH TRACKING MODULE:**

1. From the Therap dashboard, left-click the “Health” tab on the left side of the screen. A right-click will bring up a context menu that will not be useful.
2. Go to Intake/Elimination,
3. Left-click the word “New” and a new screen will appear.
4. Type in the individual’s name in the field labeled “Individual Name”.
   1. The field will auto-populate with individuals in your caseload. If the person’s name does not appear, verify that you are using the correct user profile that gives you access to the individual.
5. Left-click the box for “Program Name”. Select the program at which intake occurred.
6. Left-click the icon (little picture) of the calendar and select the actual date on which intake occurred.
7. Left-click the “Submit” button. The browser window will refresh, and you will now see “Intake and Elimination Daily Data Input Form” in the top region of the page.
8. First, complete **Section 2**, the Intake and Elimination Grid. To do this, left-click the “Add Intake Elimination Entry” text below the grid. The grid will refresh and text/drop-down fields to be used for recording data will now be available. Proceed to complete the relevant fields, i.e., those specific to the type of intake.
9. Each intake occurrence must be entered separately (even if within the same hour time period) using the steps that follow.
10. Begin by recording the time of the intake in the field labeled “Time”. Time is divided into 1-hour increments in the drop-down. Select the interval during which the event occurred. If the event, e.g., a beverage is scheduled for 10 a.m., select 10am-11am.
11. The field “Fluid Intake (cc)” should be completed with the amount of fluid consumed/administered during the specified time period. NOTE: 1 ounce = 30 cc’s.
12. “Fluid Type”: **DO NOT** use this field.
13. In the field “% of Meal Eaten” enter data in accordance with the instructions provided above.
14. **DO NOT** use the field “Calorie Intake”.
15. In the field “Reporter” your name will automatically appear.
    1. If you did not witness what is being reported, use the drop down box to select the name of the Therap user who gave you the information.
    2. In the event the information was given from someone other than a Therap user (e.g., parent, other family member, etc.), scroll all the way down to the bottom of the list and left click “Other” then use the text box “If other” to record the reporter’s name.
16. Once you have entered information about the act of intake into the appropriate fields, click the “Add” button.
17. Next, turn your attention to **Section 1**, which contains General Information. Complete the comments box with information relevant to the intake. Once you have completed the comments, using no more than 3000 characters, left-click the “Add” button. A comments field will appear below the comment entry region, and the comment you added will be listed.
18. When all data has been recorded, left-click the “Submit” button at the bottom of the screen. The screen will refresh and you will see a message stating that the form has been successfully submitted. This action incorporates the information into the permanent record and makes it available for review by others who have access to the individual’s health record.

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