**Saratoga Bridges’**

**Procedure for Reviewing and Reporting Blood Glucose with Therap**

1. As a means of maintaining health and safety, it is the policy of Saratoga Bridges to monitor and report blood glucose levels for the individuals diagnosed with diabetes/pre-diabetes that we serve.
2. In Residential and Day Programs, data is recorded per the individual’s diabetes protocol and as-needed. The frequency of obtaining data is determined by individual health care needs as determined by a qualified medical professional.
3. Only AMAP Certified Res/Day DSPs or nursing staff are to perform blood glucose checks and enter results into Therap.
4. Data will be shared between Residential and Day Programs using the Health Tracking module and accompanied by a T-Log. All reports are to be labeled HIGH.

**How to record blood glucose data:**

Section 1- General Information

1. From the Therap dashboard, left-click the “Health” tab on the left side of the screen.
2. Scroll down to Blood Glucose.
3. Left-click the word “New”, the screen will refresh and the blood glucose report form will appear.
4. Type in the individual’s name in the field labeled “Individual Name”.
	1. The field will auto-populate as you are typing 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 in which the data were obtained.
6. In the field “Reported by” your name will appear by default.
	1. If you are recording the data, leave your name in the “reported by” box.
	2. If an authorized Therap user reported the data to you, use the drop-down box to select their name.
	3. If someone other than an authorized Therap user reported the data to you, e.g., a relative, scroll to the bottom of the drop-down list select “other” and enter that person’s name in the “If Other” box below this field.
7. Left-click the icon (little picture) of the calendar and select the date on which data was obtained.
8. Select HIGH for the notification level

**Section 2 – Blood Glucose Information**

1. Insert the date on which data were obtained in the “Date of Reading” field.
2. Enter the time data was obtained.
3. Record the value obtained from the glucometer and record it in the “Value” field.
4. For “Method Used”, use the drop down to select “machine”.
5. “Fasting?”: **DO NOT USE**
6. “Time Since Last Meal” : **DO NOT USE**
7. “Insulin Given” select “Yes” or “No” as appropriate.
8. “Insulin Amount”: enter the amount given, when applicable. Enter the value (# units).
9. If the individual’s diabetic protocol was used, select “Other” for “Treatment Type”, and document the specific intervention in the comments section. All other fields within the “Other Treatment” section are not to be altered.
10. Check “Yes” or “No” for “Nurse/Doctor Notified” as appropriate.
11. In the comments section, document as required above and provide any other additional information in the comments section as appropriate, e.g., nursing instructions, etc.

If at any given time you need to save your work and return back to it when it is convenient, hit the **“Save”** button at the bottom of the page. NOTE: If you only “Save” your data no one but you can see it. When you are ready to continue and complete data entry for the record, return to Blood Glucose in the Heath Care module and follow the steps outlined above.

If you are ready to submit your data, and make it available to others who have the individual in their caseload, hit the **“Submit”** button in the bottom far right corner and you work will be uploaded for the appropriate staff to view.

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