**Saratoga Bridges’**

**Procedure for Reviewing and Reporting Seizures with Therap**

1. It is the policy of SB to monitor and report seizures experienced by the individuals we serve as a means of maintaining their health and safety.
2. It is the responsibility of all DSPs and nursing staff to document seizure data into Theap.
3. In Residential and Day Programs, data is recorded following the observation of a seizure event, and reviewed when indicated to do so by a medical provider/nurse, e.g., seizure protocol. The frequency of obtaining data is determined by individual health care needs as determined by a qualified medical professional.
4. Data will be shared between Residential and Day Programs using the Health Tracking module and accompanied by a T-Log. All reports of seizures are to be labeled HIGH.

**How to record seizure 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 Seizures.
3. Left-click the word “New”, the screen will refresh and the seizure 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 seizure occurred.
6. In the field “Reported by” your name will appear by default.
   1. If you are reporting the seizure, leave your name in the “reported by” box.
   2. If an authorized Therap user reported the seizure to you, use the drop-down box to select their name.
   3. If someone other than an authorized Therap user reported the seizure 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 the seizure occurred.
8. Select HIGH for the notification level

**Section 2 - Seizure Information**

1. The drop-down box for “If not at Program site” is to be left with the default entry, “-Please Select-“ if the seizure took place at a Saratoga Bridges program site.
   1. Select from the items in the drop-down box to record seizures occurring some place other than a Saratoga Bridges program site.
   2. If “Other” is selected as the location, a description of the location must be inserted into the “If Other” text box.
   3. In the event a protocol was implemented and/or a nurse was notified this must be included in the comments section and a T-Log submitted.
2. Enter the time the seizure started using the fields for “Begin Time”.
3. Record how long the seizure lasted in the fields for “seizure Duration”.
4. Complete the “Description” field by clicking the blue hypertext link, “Add”. A list of behaviors, descriptions of respiration, and skin color opens in a new window and you should select those items that apply. Click “Add” when you have made your selections
5. Complete the “Behavior after seizure” field by clicking the blue hypertext link, “Add”. A new window will open and you will see a list of descriptors. Select those that apply. Click “Add” when you have made your selections.
6. Complete the “Staff Action” field by clicking the blue hypertext link, “Add”. A new window will open and you will see a list of staff actions. Select those that apply. Click “Add” when you have made your selections.
7. Describe the “Precipitating Factors” in the text box provided.
8. Describe the “Resulting Injuries” (if any) in the text box provided. If there were no injuries, state that “There were no injuries”.
9. Provide additional comments in the “Comments” text box provided, e.g., #VNS swipes/meds given. *Post seizure vital signs* ***must*** *be entered here.*

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 the Seizure form 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.

**Reviewing seizure data in the Health Tracking Module**

1. From the Therap dashboard, left-click the “Health” tab on the left side of the screen.
2. Left-click “Search” to the right of “Seizures”. The screen will refresh and “HT Seizure Search” will appear in the top region of the screen.
3. In the field “Individual”, 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.
   1. Searches may also be performed using the “Form ID”, “Program (Site)”, and “Entered By” fields.
4. Set the begin date field to one month prior to the current date. Set the End Date to the current date.
5. Left-click the “Search” button. The screen will refresh and show entries meeting the criteria specified in the previous steps. The individual entries can be reviewed by left-clicking the blue hypertext in the Form ID column of the chart.

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