# PHOENIX RESIDENCE INC. GUIDE TO THERAP

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# INTRODUCTION

You may be asking yourself, what is Therap and why do PRI (Phoenix Residence Inc.) employees need to know how to use it? PRI is "committed to developing person centered quality living experiences for individuals with disabilities." What does that have to do with Therap? Therap is the primary communication device at PRI. Other than face-to-face interaction and telephone calls, Therap is the primary source of information on clients. Therap can be used for communicating between Support Professionals or providing crucial information to the President of PRI. This manual is intended to be for the use of Support Professionals. This guide isn't intended for other types of employees at PRI.

If you know how to competently use Therap, then you will further contribute to the mission of PRI. House Nurses need to know if a client has not been eating lately. Program Managers need to know the mental stability of a client. Support Professionals need to have urgent information relayed to them. Therap will take care of all of these concerns and more. When used properly, Therap can make a difference in individuals' lives. If this is something you're interested in, then you're in the right place. This manual will provide you with everything you will need to utilize the core components of Therap. Therap is a communication tool that you'll want to have a good grasp upon. Once you figure out how to use Therap you'll maximize communication between each other.

## LOGGING INTO THERAP

During your Neo-Orientation, you should have been provided with a username and a password. Your username will typically consist of the first letter of your first name, proceeded by your full last name. For example: let's say your name is Joe Smith, therefore your username is "JSmith.". Your password should have been provided at Neo-Orientation. Please call your Program Manager if you have any questions about your password.

The last log in requirement will be the *Provider Code.* Now, if you're logging into Therap from your work computer, this will typically be auto-filled in. However, if you are accessing Therap at home, PRI's code is: PRI-MN. The *provider code* is case-sensitive. Submit the requirements in order to land on the Therap homepage. The tour of Therap will now begin.

## T-LOGS

A **T-Log** can be thought of as a Therap blog post. At the end of your shift, you will create a separate T-Log for each assigned client. You may be writing a T-Log that only contains routine information about a client (for that shift). However, there may be times in which you have something that is urgent or significant.

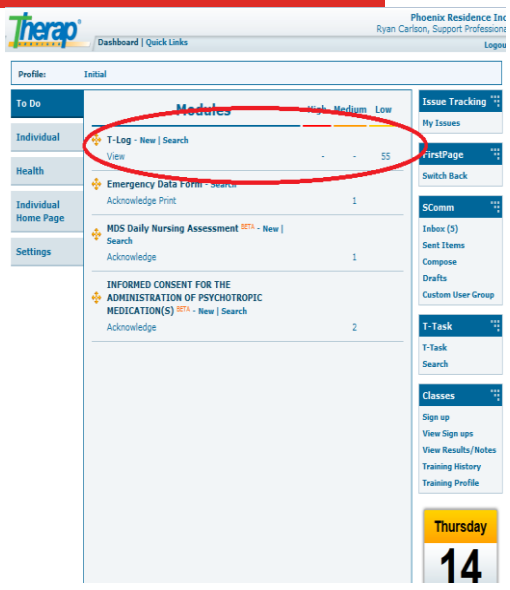


Figure 1

You will learn how to format, classify, and select the notification level of the T-Log. This manual covers the technical

details regarding how to compose and view a T-Log. To create a new T-Log or read a T-Log, you need to find the T-Log section at the top of your homepage (Figure 1).

## FORMAT OF T-LOGS

PRI formats their T-Logs in a particular way. They call it the *DAR* format. The *DAR* format has three components: *Data*, *Action*, and *Reaction*.

*Data* is any information about the client for your shift. This information can be something as serious as a health concern or simply what they ate tonight for supper. Put all information about the client in a *Data* component by typing the letter "D" and adding a dash (refer to example below).

**D- Joe Smith ate pizza for supper and drank all of his evening liquids. Joe Smith had all of his evening cares completed. He is now in bed sleeping. No concerns.**

If this was all the information you had about the client, you would only document a *Data* component. There may not be a need for an *Action* or *Reaction*. You will soon discover this. What about the *Action* portion?

The *Action* component of the *DAR* format contains any action you made as a result of your *Data.* There may not be an *Action* at all. For example, the previous *Data* component didn't warrant an action. Here is an example of a *Data* component that does warrant an *Action*.

**D-** Joe Smith had an all right day today. He ate all of his supper and drank all of his evening fluids. However, before completing all of his evening cares, Joe told staff that he had a headache.

**A** -Staff called the house nurse and informed her of his headache. Staff followed the nurse's instructions and gave Joe 325 mg of Tylenol for his headache.

******PRI writes their T-Logs in third person. This practice is to reinforce that the focus of the T-Log is the client.**

The staff member's *Action* was that he called the nurse and gave Tylenol to the client due to the information contained in the *Data*. As you can see, the *Action* component was entered the same way as the *Data* component. Type the letter "A" and then add a dash symbol.

What about the *Reaction* component? The *Reaction* is defined as the result of the *Action*. Sometimes you won't be around long enough to observe the *Reaction*. You should consider making it a habit to put in your *Reaction* components that there were not results observed from your *Action (*if that's the case). Here is an example of a *Reaction* component added to the previous T-Log.

**D-** Joe Smith had an all right day today. He ate all of his supper and drank all of his evening fluids. However, before completing all of his evening cares, Joe told staff that he had a headache.

**A-** Staff called the House Nurse and informed her of his headache. Staff followed the nurse's instructions and gave Joe 325 mg of Tylenol for his headache.

**R-** After a half hour, Joe explained to staff that his headache had gone away. Joe Smith is now in his bed sleeping. No further concerns.

The *DAR* format is quite simple. As you continue and are provided with more examples to work with, it will come together quite nicely. You will now follow the technical aspects of a T-Log. You may realize that entering a client's information with this format is as easy as entering it into a Word document. The *DAR* format isn't required by Therap. It's simply a format that PRI has adopted to organize information. The *DAR* format is another way to enhance communication between employees at PRI.

## T-LOG CLASSIFICATION/TYPE

There are six types of T-Logs, but PRI utilizes only five of them. The type that you will select is dependent on what kind of information you're documenting on. A few of these types won't pertain to a Support Professional. You will read T-Logs of all types, therefore you will want to learn about them all (Figure 2).

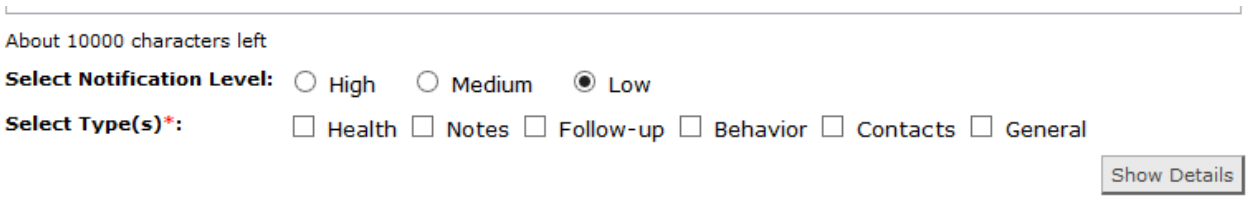


**Figure 2**

*******The photograph above is located on the bottom of T-Log composing page.**

*Health* is relative to the earlier *DAR* example. The client was having a headache and that's a health related concern. In that case you would simply check the "Health" box.

*Notes* will be used by your Program Manager or House Supervisor. They will usually relay second-hand information from a client's day program representatives.

*Follow-Up* would be checked if you were responding to another T-Log with a T-Log. A Support Professional doesn't usually do this. Your House Nurse could choose to write a *Follow-Up* T-Log in response to a *Health* T-Log. The House Nurse may do this because she observed something further that needs to be added to your T-Log.

As for the *Behavior* type, this would be used if a client had a behavior of some kind. Your Program Manager will describe for you the types of client behaviors that require documentation.

*General* would be used when there isn't anything significant. If nothing out of the ordinary happened, then you probably just need to check the "General" box.

As you gain experience, these five types of T-Logs are fairly easy to recognize. *Types* help organize T-Logs, so that the appropriate parties are notified of these T-Logs. For example, selecting *Health* triggers Therap to send an e-mail to the House Nurse.

## T-LOG NOTIFICATION LEVELS

A six client group home has at least eighteen T-Logs submitted every day. The *Notification Level* filters T-Logs by priority. They are organized into three different levels: *High*, *Medium* and *Low (*Figure 3). Please keep some of these guidelines in mind when you select the *Notification Level*.

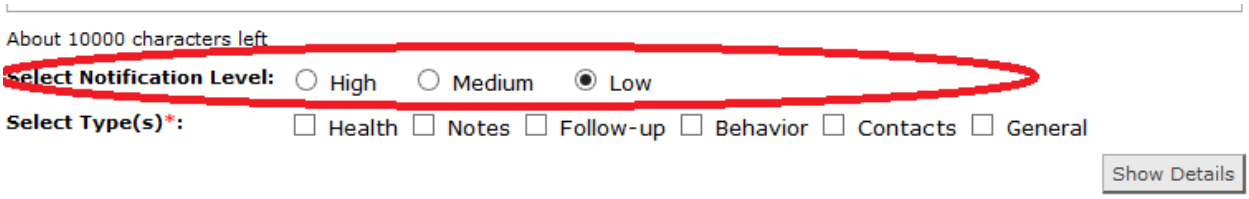


Figure 3

*********As you can see the location of the Notification level is located right above the T-Log type**

A *High-level* notification would qualify as something that is urgent and needs to be shared with right away. For example, if a client went to the hospital, you need to know immediately. You need to know immediately if a client received a suppository. Clients who had significant behaviors could be dangerous. You should document violent behaviors as *High-level*. Most of the time a *High-level* T-Log will be accompanied by a call to your Program Manager or your House Nurse (depending on the type of concern). Your Program Manager will describe to you his preferred protocol.

You would select *Medium-level* for your T-Log if it's something that you feel needs to be read, but isn't urgent. You could be telling others that a client had a poor appetite. Perhaps the client seemed to be emotionally distant. The selection is at your discretion, but if anything seems abnormal, at least select *Medium-level*.

You should select *Low-level* for an ordinary recap. You select this level if you're simply summarizing the client's day. *Low-level* T-logs typically contain only a *Data* component.

As you can tell, having the different levels can help narrow a T-Log's urgency. This enables employees to read *High-level* and *Medium-level T*-Logs first. Employees can then read *Low-level* T-Logs at their leisure.

## T-LOG TECHNICAL DETAILS

It would be in your best interest to go over the navigational/technical aspects of Therap. Refer to the appropriate screenshots while you follow along.

- Log into Therap with your username.
- View the promotional, landing page (Figure 4).


**Figure 4**

The promotional page informs you of Therap updates. PRI doesn't have control over this content. If you do not want to see this page again, follow these instructions:

- Check the "Do not show me this message again" box.
- Select the "First Page" button (Figure 5).


**Figure 5**

You will then be brought to the Therap homepage (Figure 6).The T-Log section for composing and reading T-Logs will be located at the top of your page. You can read the T-Logs on the right side of the T-Log section. They are organized by *High*, *Medium* and *Low*.

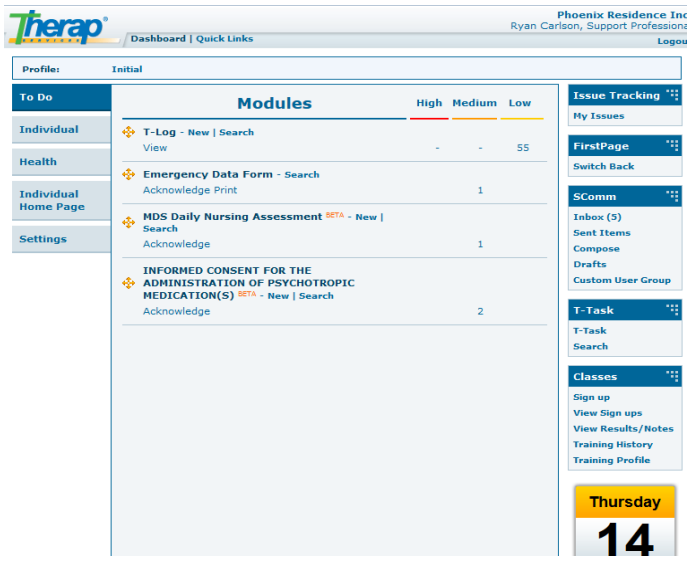


Figure 6

- To view a T-Log, click on the blue number (indicates how many T-Logs are unread) to read about clients (Figure 7).


Figure 7

- To create a T-Log, click the "New" link, located on the left side of the T-Log toolbar (Figure 8).
- Select the individual you are documenting on (this screen is just a list of the clients at your group home).


Figure 8

Everything should come together now. As you view the T-Log screen (Figure 9), you will see all of the familiar T-Log components. However, you may not be familiar with one section though. At the top of T-Log screen you will see a section called: *Give your T-Log a Summary*.

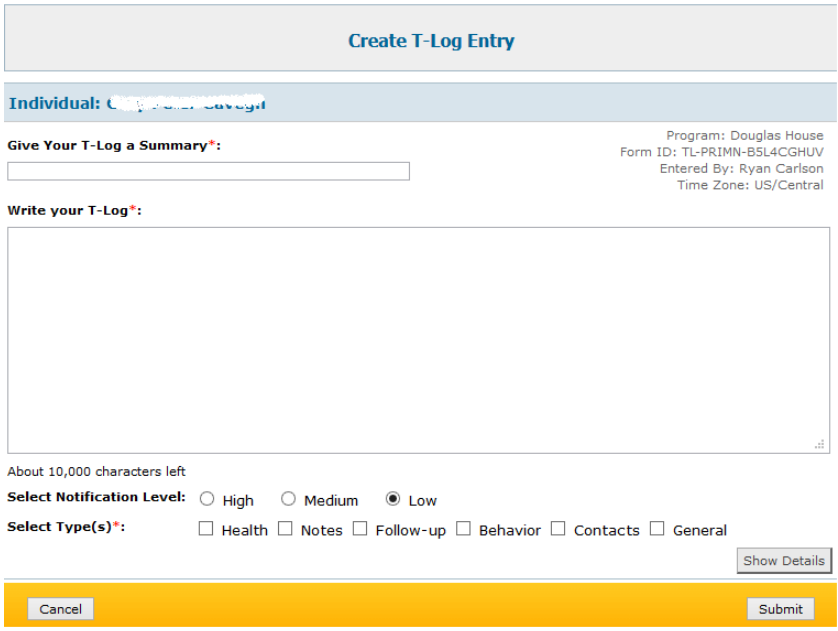


Figure 9

In that section enter the shift you have just worked on (Mornings, Evenings, or Overnights). Otherwise everything should look familiar.

- Write your *DAR* format in the *Write Your T-Log* section.
- Select your *Notification Level*.
- Select the T-Log *type*.
- Click the "Submit" button to publish your T-Log.

Now you should have everything you need to know about a T-Log. However, there is more to Therap that you need to know. It's important for everyone to know the specifics of how much a client has eaten, how much fluids the client has consumed, his or her bowel movement patterns, and the frequency of voids. Therap has a function that is dedicated to this.

## INTAKE AND ELIMINATION

When you are working with your clients throughout your shift, it's important to take note and chart their **Intake and Elimination**. If you are assigned two clients to work with that night, you will document their intake. Intake is simply what a client has drunk and eaten. If you assist a client to the bathroom remember and chart her bowel movements and urinating (voiding) details. What exactly are those details?

### INTAKE DETAILS

Depending on your shift, you may witness clients eating one to two meals. Chances are that you will see them have a snack too. You will need to record the food intake by a percentage (0% to 100%). By doing this, you will help the House Dietician and House Nurse. It's important that clients are drinking an appropriate amount of fluids. You will need to note how much clients have consumed.

PRI measures liquid in cubic centimeters (cc). For those of you unfamiliar with cubic centimeters:

PRI typically uses 8 oz. glasses of fluids for all meals. Remember the following: 240 cc = 8 oz. Therefore, if a client consumed two glasses of fluids, you would chart that he consumed 480 cc (240 + 240). You don't have to be exact, but take an educated guess. If a client consumed about half of a glass, chart that they drank about 120 cc.

The important thing to know is if a client has eaten less than 50% of his meal, you need to document this. If you're in any doubt about whether he consumed 50% of his meal, then just chart that it was less.

Intake is important, but elimination is as well. You will need to be observant while you assist a client in the bathroom.

## ELIMINATION DETAILS

Some of this is graphic, but remember you will encounter it all. If a client uses a urinal (which many do) you will document the amount of urine. The urinal will actually have measurement lines on the side of the urinal (in cubic centimeters), so this should be fairly simple. If they do not use a urinal (or have a catheter) you will simply record that they voided "1 time." This will become clearer when you see the Therap interface of Intake and Elimination.

As far bowel movements go, you will need to note the size and consistency. For size you will select small, medium, large, or extra-large. Also you will distinguish whether the bowel movement is soft, loose, diarrhea, hard, or normal.

Now, the context of what you're documenting should be clear. However, you still need the technical/navigational aspects of the Therap section: Intake and Elimination.

## INTAKE AND ELIMINATION TECHNICAL DETAILS

Start from the homepage again, and you will then see a link on top called "Quick Links" (Figure 10).

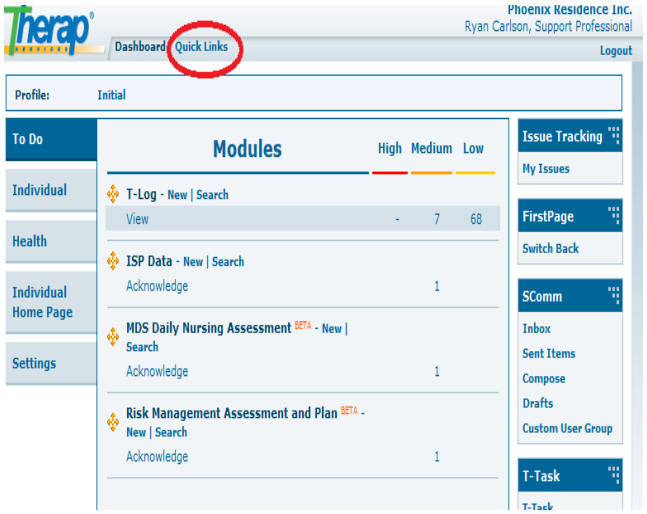


Figure 10

- Click "Quick Links."
- Select the "New" link (by Intake and Elimination).
- Type in the client's name (Figure 11).
- Select your group home (under *Program Name).*
- Click the "Submit" button.

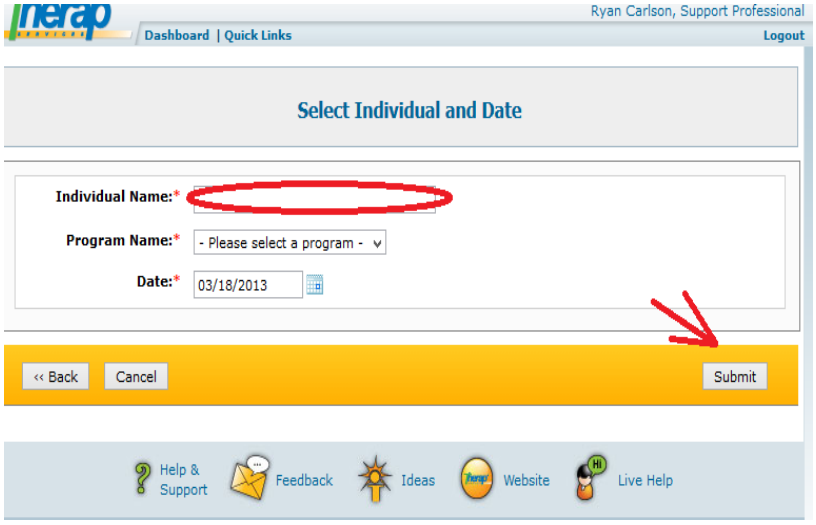


Figure 11

Next, you will be brought to a screen containing all hours in a day. In order to start charting, click the particular time slot that you are trying to chart on (located on the left side of the screen). In the example provided, it's targeting a client's activity at 9:00 a.m. (Figure 12).

| Time | Fluid Intake (cc) | % of Meal Eaten | # of Fluid Voids | Fluid Void (cc) | Bowel Movement | BM Type D=Diarrhea H=Hard L=Loose N=Normal S=Soft | BM Amount X=XL (Extra Large) L=Large M=Medium S=Small | Blood in BM? Y=Yes N=No | Bowel Aids E=Enema L=Laxative S=Suppository O=Other | Emesis L=Large M=Medium S=Small | Blood in Emesis? Y=Yes N=No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 12am-1am | | | | | | | | | | | |
| 1am-2am | | | 1 | 0 | 0 | | | | | | |
| 2am-3am | | | | | | | | | | | |
| 3am-4am | | | 1 | 200 | 0 | | | | | | |
| 4am-5am | | | | | | | | | | | |
| 5am-6am | | | 1 | 200 | 0 | | | | | | |
| 6am-7am | 280 | | 1 | 400 | 0 | | | | | | |
| 7am-8am | | | | | | | | | | | |
| 8am-9am | 240 | | 1 | | 0 | | | | | | |
| 9am-10am | | | | | | | | | | | |
| 10am-11am | 120 | | | | 0 | | | | | | |
| 11am-12pm | 240 | 100 | 1 | | 0 | | | | | | |
| 12pm-1pm | | | | | | | | | | | |

Figure 12

Next you will be brought to a new screen that contains all of the Intake and Elimination fields. This screen should be fairly straight forward. If you're unable to get the cc information, type a "1" after *Number of Voids*. After you input your information, click the "Continue" button. (Figure 13).

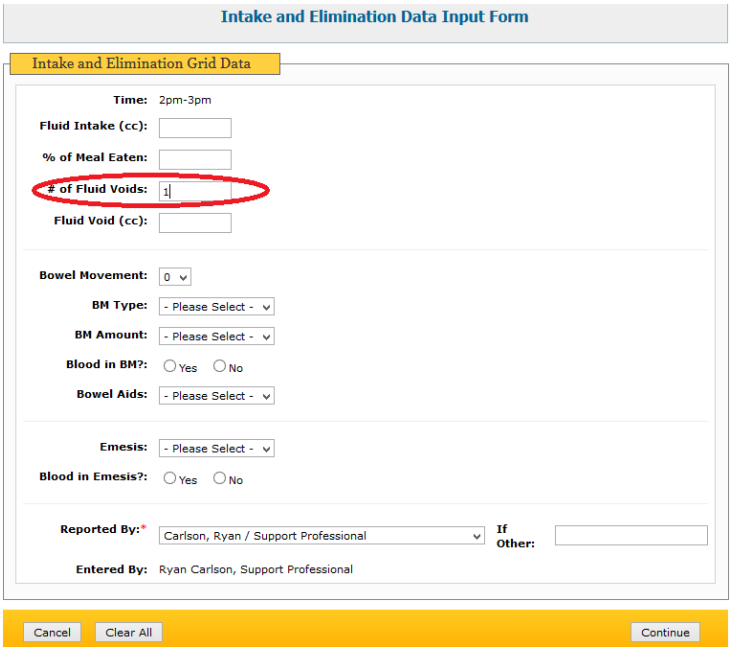


Figure 13

In order to save your documentation:

- Click the “Continue” button.
- Scroll to the bottom of the familiar page (Figure 13).
- Click the “Submit” button (Figure 14).

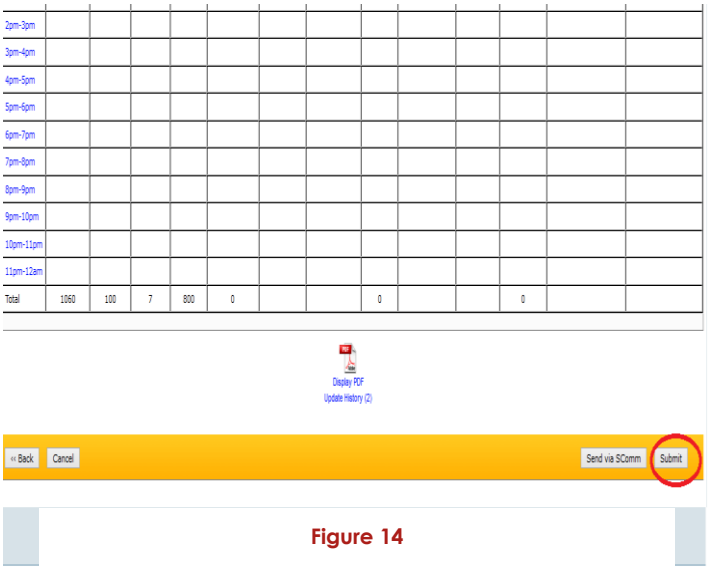


Figure 14

This is the final step of charting on Intake and Elimination. This process will become very natural for you. The important part is to remember to click “Submit.”

This is a lot to take in, but this is valuable to everyone at PRI. Support Professionals need to know that clients have a healthy diet and are hydrated. Most clients are very susceptible to illness. Appropriate medical action needs to be taken if a client hasn’t had a bowel movement for a period of time. PRI staff need to have access to this information. You can start contributing by knowing how to chart.

Another function of Therap pertains to a client’s medications and treatments. You will not be giving medications to the client unless you are the designated Medication Passer (for the shift). However, on days you aren’t, you still need to know how to use *MAR*. All Support Professionals administer treatments. Treatment administrations are documented within the *MAR*, so the *MAR* is important to everyone.

# MEDICATION ADMINISTRATION RECORDS

The *MAR* contains all of the information you need to view and record from a medical standpoint. You will need the *MAR* for:

1. A source of information for passing medications.
2. A source of information for administering scheduled treatments.

The *MAR* has some helpful filtering features to assist you. If you haven't yet taken your TMA class, then a lot of this may be confusing. It will be helpful though, so please proceed.

## PASSING MEDICATION

You should be very careful when passing medications. The *MAR* is a great tool to reference though. It allows you to see when and how to administer a medication. The *MAR* also describes where you can physically locate a medication (within the medication cart).

Filtering a client's medications will help you efficiently administer medications. Dependent on your group home, you are most likely passing medications at 7:00 a.m., 4:00 p.m., or 7:00 p.m. The *Filter Medications* function narrows the medications that you're viewing. Knowing the functionality and interface of the *MAR* is very important.

## FILTERING THE MAR

Start from the homepage, so that you will always be able to locate the *MAR*. At the homepage you will notice a tab entitled "Health," go ahead and click on it. You then will be brought to a page with an overwhelming amount of content. Your House Nurse uses the more advanced components of the *MAR*.

- Click the "Record Data" link, located at the top of this page (Figure 15).
- Select the appropriate client.


Figure 15

The top of the client's MAR page will contain her photograph, her name, and some other miscellaneous information. This helps Support Professionals be sure they're viewing the correct page.

This page contains all Scheduled Medication, Scheduled Treatments, and PRN Medications. This can be overwhelming, so reduce your stress by clicking the "Filter Medications" button (Figure 16).

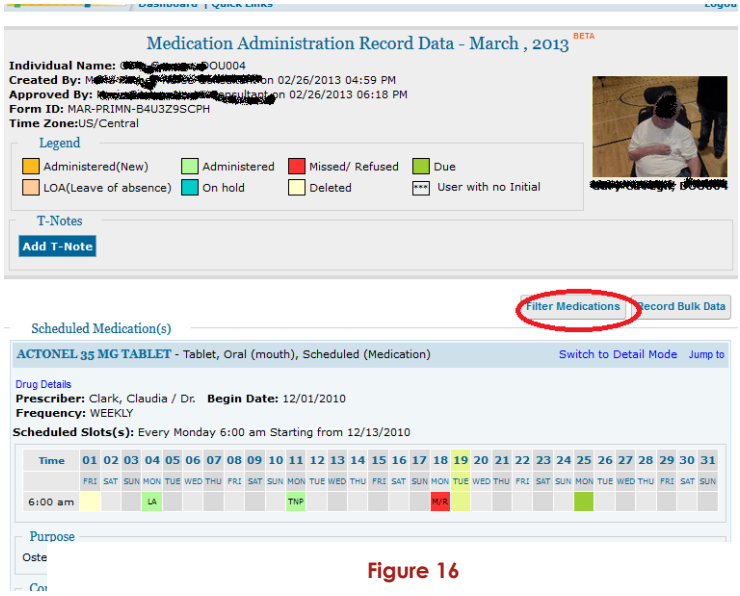


Figure 16

You will then be given some parameters to fill in (Figure 17):

- Select the group home you are working at.
- Click on the “Scheduled Medication” bar.
- Select the approriate time interval.

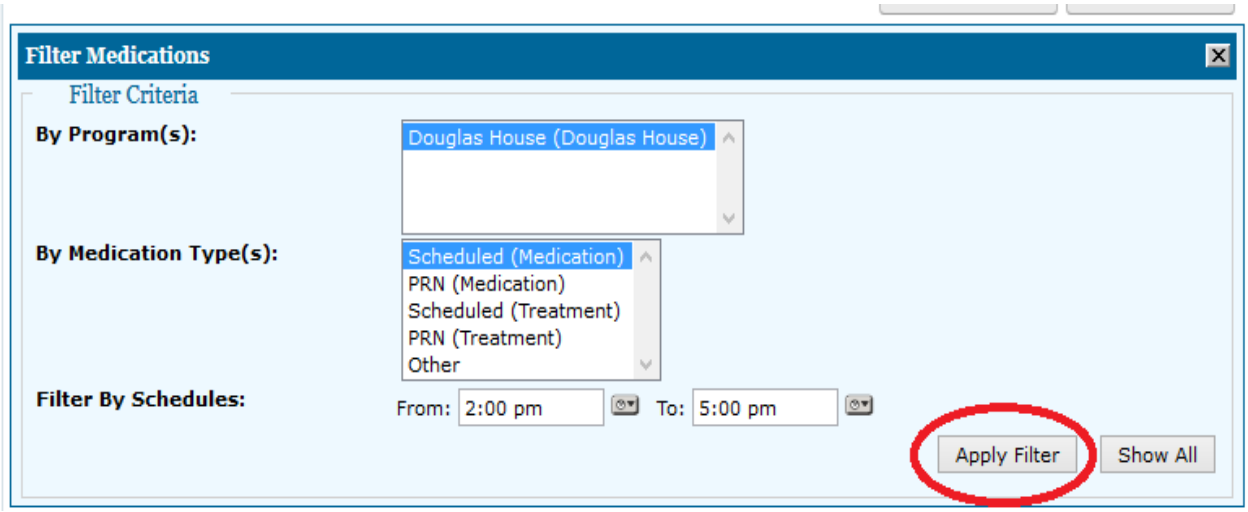


Figure 17

If you are passing medications at 4:00 p.m., select 2:00 p.m in the *From* box and 5:00 p.m in the *To* box. The general guideline to follow is: two hours before and an hour after the medication passing time. Although you will be adminstering the medications at 4:00 p.m., some medications will be scheduled an hour before or after. This is OK though, the details will be described by your House Nurse. Follow these tips and select the time parameters. Next hit the “Apply Filter” button (Figure 18).

The *MAR* page will narrow the medications that you need to adminster (based on your set parameters). How do you read about each medication though?

## MEDICATION INFORMATION

Each medication is broken up into blocks and each contains crucial medication information.

Each block contains (Figure 18):

- The *Medication Name*
- The *Dosage* (if applicable)
- The *Route* (eye, ear, nose, rectal, and oral)

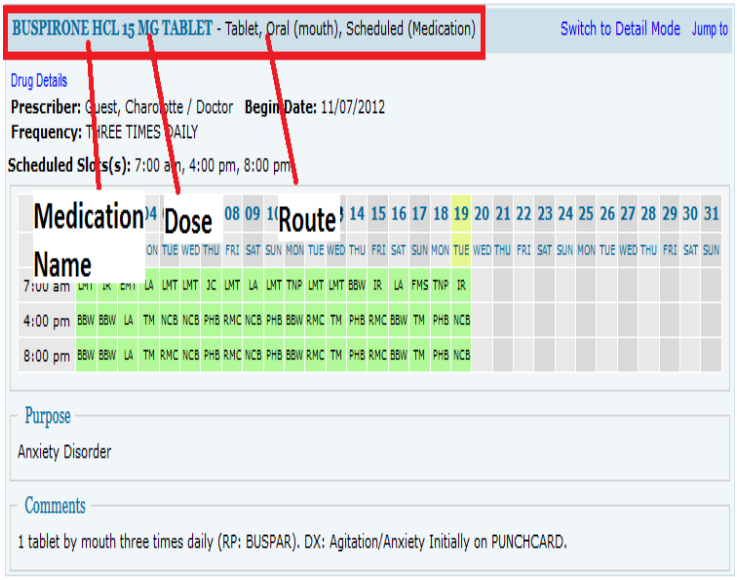


Figure 18

The section below this will provide you with (Figure 19):

- The *Prescriber*
- The *Begin Date*
- The *Frequency* (three times a day, weekly, daily, every other day, and so forth)
- The *Scheduled Slot(s)* ( time of adminsteration)

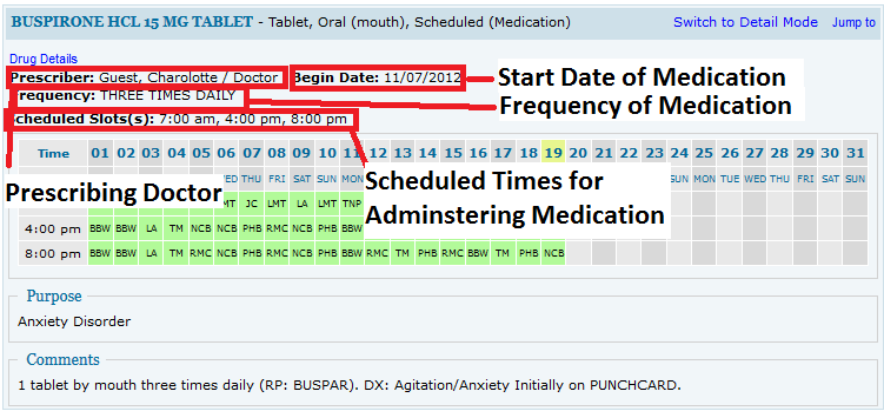


Figure 19

The core section of the block contains scheduled times that you are to administer the medication. You will see the initials of the employees who have administered in the past. You will click on the appropriate box, finding the time and date you are giving the medication. The current date will be highlighted in yellow. The box should be blank if the medication has not been administered (Figure 20).

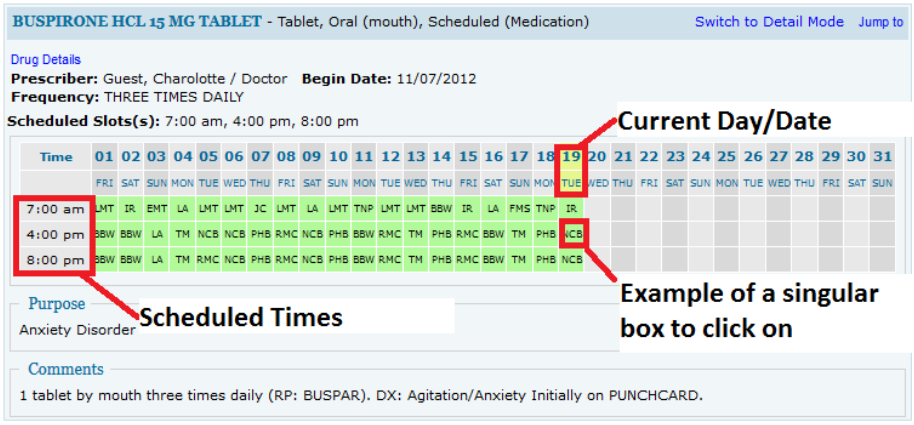


Figure 20

Finally you will find two more pieces of information regarding the medication. There is a *Purpose* section that explains what the medication is for. The section below *Purpose* is *Comments.* The *Comments* section contains a summary of the information already provided. However, it will often contain where the medication is located within the medication cart (Figure 21).

Once you have administered each medication and carefully made sure you have followed the directions, scroll to the bottom of the page and click "Save." **Make sure to do this**. In order to avoid confusion, it may be a good idea to have your co-worker check your *MAR* records. You could do this after you have administered medications

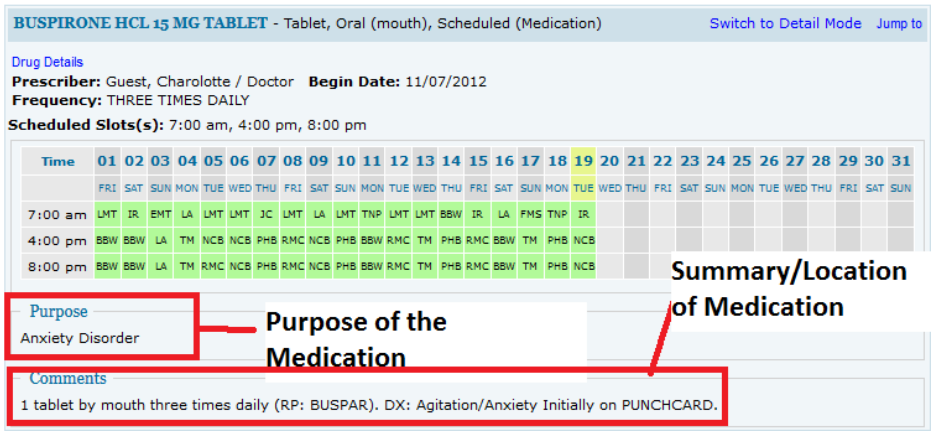


Figure 21

for the day. PRI usually designates a Support Professional to be responsible for reviewing the *MAR*.

The *MAR* can almost entirely guide you through passing medications. This is the most important function of Therap to be competent in. There are many ways in which you could make a mistake while passing medications. If you don't properly use the *MAR*, you could be miscommunicating information to your co-workers. Don't worry though, everything will all come together and understanding the interface will become second nature. What about Scheduled Treatments though?

## MAR SCHEDULED TREATMENTS

Documenting Scheduled Treatments is very similar to charting on Scheduled Medications. You only need to filter it differently. Also Scheduled Treatments are not stored in the medication cart. This means that a treatment could be something like an acne treatment located in the bathroom. A treatment could also be a cream that is kept in a client's bedroom. There are a variety of things that a treatment could be, but even if they aren't kept in the medication cart, they *are* just as important.

Who is responsible for recording treatments? Support Professionals are responsible for administering and charting on Scheduled Treatments for the clients that you have on your 1-1 list (this will be covered at on-site training). It is nice to have some tips for identifying what Scheduled Treatments a client needs though.

You access the treatments through the same page that you used to access Scheduled Medications. The filter parameters will just need to be tweaked.

- Click the "Filter" button.
- Select the correct group home
- Select "Scheduled Treatments" bar.

For the time interval, make sure to put your entire shift in the *From* and *To* Fields. This will cover all treatments on your shift. For example, if you work from 2:00 p.m. to 9:00 p.m., enter 2:00 p.m. in the *From* field and 9:00 p.m. in the *To* field. Finally, click the "Apply Filter" button (Figure 22).

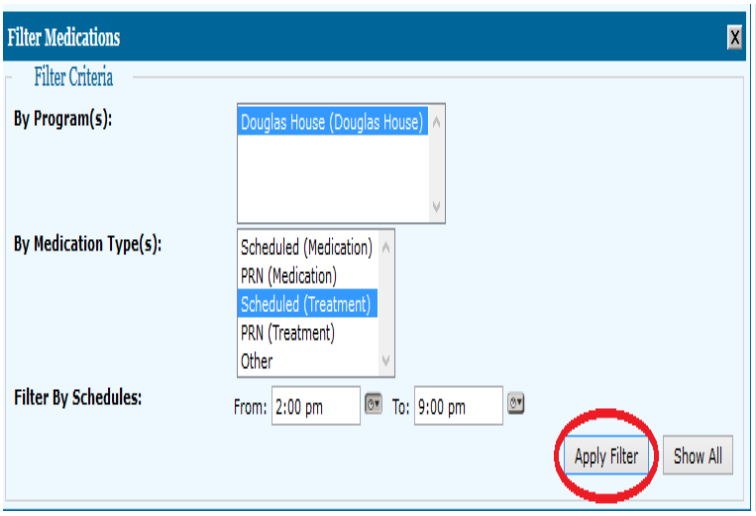


Figure 22

The blocks of information on Scheduled Treatments aren't very different from the Schedule Medication blocks. However, there is usually more content in the *Comments* section (Figure 22).

Scheduled Treatments can range from inserting overnight oxygen tubes, applying ointments/creams, applying prescribed shampoos, soaking feet in water, irrigating a catheter, exercising with residents, and much more. These treatments will be introduced at your on-site training.

After you mark the appropriate boxes on the *MAR* (Figure 21), make sure to click the "Save" button (located at the bottom of the client's *MAR* screen). This will assure that your information is recorded and you communicate that you have administered the treatment.

It's important to be able to recognize all of these components of the *MAR*. Doing so will contribute to accurately communicating with your co-workers. This should become very fluent and you will be able to confidentially use the *MAR*.

**Caution: Carefully concentrating is important, the speed at which you perform is not. One mistake could be extremely harmful to a client. Take your time and you should be fine.**

You can also communicate with employees throughout PRI. T-Logs are designated for information on a client. A Therap function called **SComm** allows you to contact PRI staff about other matters.

## SCOMM

**SComm** is essentially an e-mail service, but it's through Therap. SComm is a PRI wide messaging system. You will receive messages that contain the weekly newsletters, upcoming events, requests for help, and much more. It's a powerful tool to stay in touch with all of the members of the PRI community.

The SComm system is only within Therap though, so it means that you will not have a traditional "JoeSmith@email.com" e-mail address. Don't think of it like a common work e-mail service. It can only be used internally. Therefore, do not expect to interact outside of PRI employees with it.

You will often find that if you have received a *High-level* notification T-Log, you may receive a SComm message about it. Your House Nurse will often do this in order to assure that information gets to all employees.

There are two main functions of using the SComm system:

1. How to read messages.
2. How to compose messages.

## READING SCOMM MESSAGES

You will notice that on the homepage of Therap, on the right sidebar, you can access the SComm function. To read your SComm messages, click on the "Inbox" link (Figure 23).

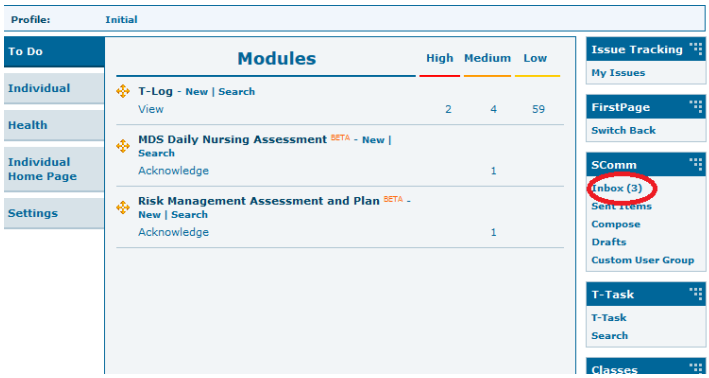


Figure 23

This will then bring you to a screen where all of your SComm messages will appear. By default your messages will simply display like any other e-mail system—unread messages at the top and read messages below them. However, you will often come to work and not have time to read all unread SComm messages. If you are in a hurry, you can simply filter your SComm messages. You prompt it to display the *High-level* SComm messages at the top of your list.

SComm messages function the same way as T-Logs-- as far as being classified with a *Notification Level*: *High*, *Medium*, or *Low* (Figure 24).

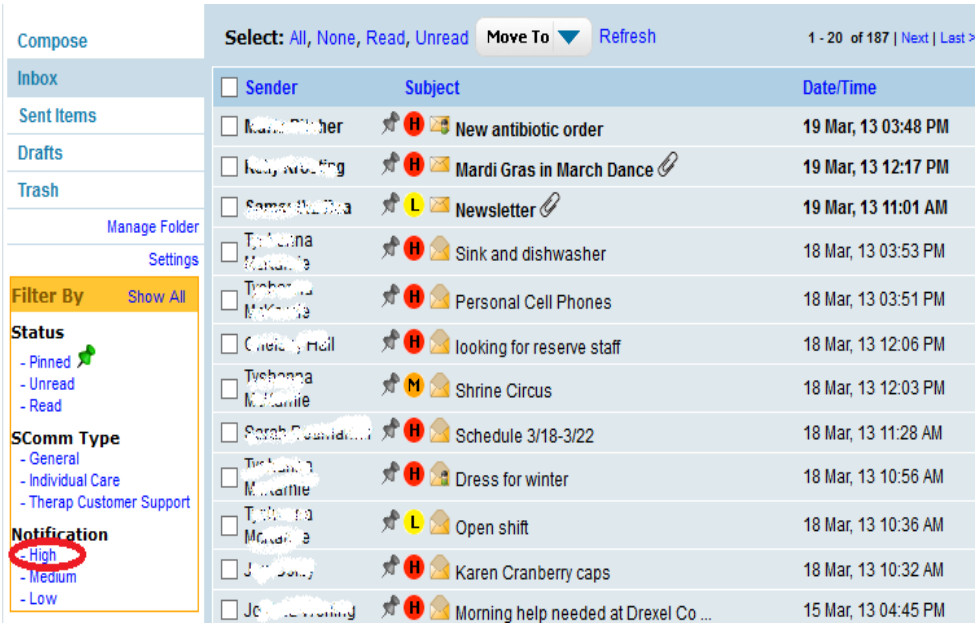


Figure 24

To display the *High-level* SComm messages, click the "High" link. This is to the left of your SComm Inbox (Figure 24). After doing this you will remain on the same page, but your SComms messages will automatically organize by *Notification Level* (*High-level* to *Low-level*). Look in the subject line and you will see an icon with the corresponding letter (H, M, or L).

It should be safe to assume that most people have used an e-mail service. Other than the notification filtering tip, you should be able to browse your SComm inbox. How do you efficiently compose SComm messages though?

## COMPOSING SCOMM MESSAGES

You may need to ask your staff members if they can cover a shift for you. You may have medical information to relay to staff. Whatever the case may be, it's useful to know how to compose a SComm message.

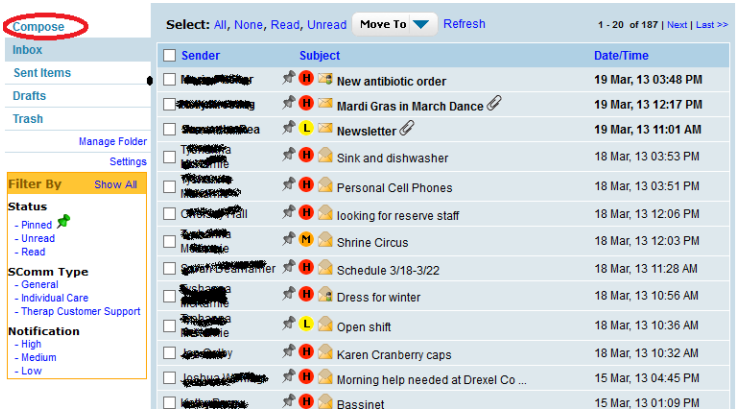


Figure 25

You can access the compose feature from multiple areas, but if you're within your inbox just click the "Compose" link. This link is located on the top-left side of your inbox (Figure 25).

The next screen will supply you with three icons that ask which type of a SComm message you're composing (Figure 26):

- A *General* SComm
- An *Individual Care* SComm
- A *Therap Customer Support* SComm


Figure 26

As a Support Professional, you will probably never compose a *Therap Customer Support* message. However, you will use the first two.

If you're composing a SComm message that pertains to a client, select *Individual Care*. Otherwise you should select *General.* If you select *Individual Care*, Therap will then ask you to select which client this SComm message relates to.

Then you will be brought to page that provides you with different ways of locating the recipient(s). If you had selected *General*, you would have simply been brought to this page right away (Figure 27).

There are multiple ways of finding the recipients(s) that you would like to compose to. You can search for them under the "User List" tab, which will simply give you a list of all employees in alphabetical order. If you never have met the person, yet know the employee title of the recipient, you can look them up under "User Title" tab. This will divide all of the employees into their respective titles (Program Manager, Dietician, VP of Operations, and so forth). You may also locate the recipient(s) by going under the "Programs" tab. This will break down the employees by the group homes they work at.

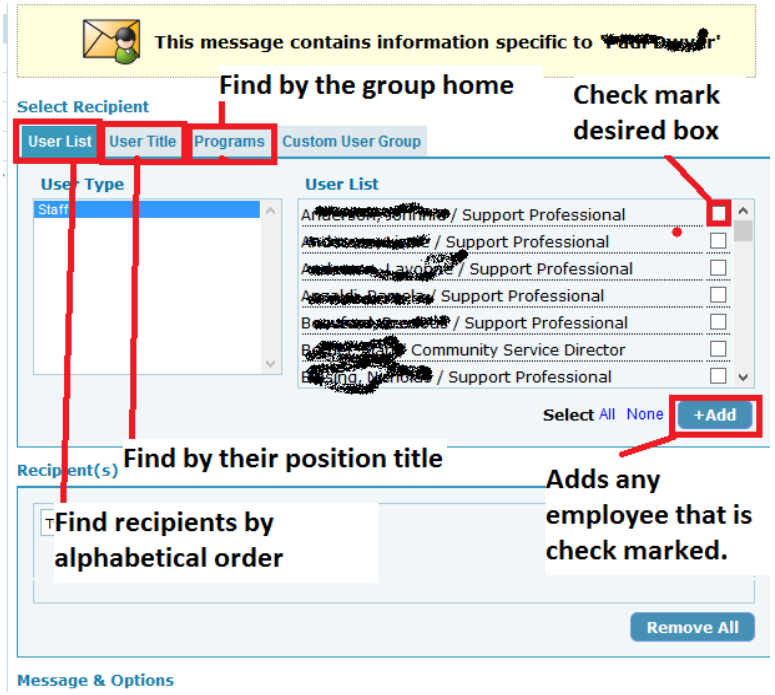


Figure 27

PRI doesn't use the "The Customer User Group" tab. You do not have to worry about this tab.

Whichever way you decide to locate the recipient(s), remember to check the box next to his or her name. Finalize the process by selecting the "Add" button. This button is located below the tabbed section (Figure 28).

After adding the recipient(s), simply scroll down and the compose box will be right below. This functions the same as any other e-mail format. However, remember to select the *Notification level* above the *Subject* field (Figure 28).

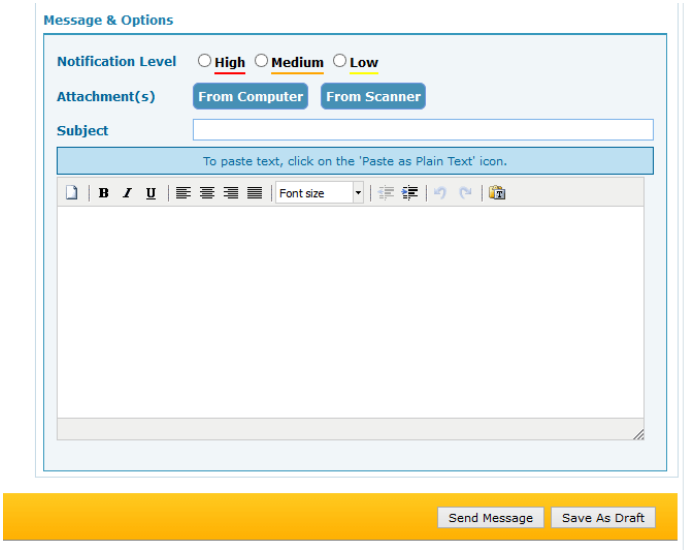


Figure 28

This concludes how to compose a SComm message. If you need any further assistance with this, please consult your Program Manager.

The SComm system is a rich interactive tool. It contributes to PRI's mission by providing another form of communication. Often you will receive SComm messages from employees giving away free furniture, pets, and so forth. You may receive a SComm message that is requesting your help. The point is, SComm messages aren't always regarding PRI business.

Trying to add recipients is one of the most frustrating parts employees run into. It's not that employees can't locate the recipients, it's that they often forget to click on the "Add" button (after checking the recipient box).

Hopefully you can see the great potential you possess. The SComm system can contribute to an even more efficient work environment.

## THERAP WRAP-UP

You now know about **T-Logs**, **Intake and Elimination**, **Medication Administration Records**, and **SComm**. These are the core components of Therap that you will be using, but there is more. You will learn the rest along the way. One of the more significant portions that wasn't covered is **ISP Data**. Your House Supervisor and QDDP will teach you everything you need to know about **ISP Data**. By this point you should be savvy with the layout of Therap.

You have learned so much and by now you're probably sick of reading this and perhaps would rather just start using Therap. Great! That's the best way to learn. This guide is a great reference if you run into any problems. Documentation components of Therap require practice to master. As you become more skilled at using Therap, your communication skills should grow alongside. PRI strongly supports that they work together.

I hope you can now see how powerful Therap is. Communicating effectively is the number one way to enhance a client's life. I hope you remember that **T-Log** entries, **Intake/Elimination** submissions, **MAR** information, and **SComm** messages are not just surface intranet concepts. They are deeply connected to promoting the mission of PRI. The hope is that you support PRI's mission too. Remember you should be, "Committed to developing person centered quality living experiences for individuals with disabilities."