## Supportive Therapeutic Observation Record

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| **Patient Name** |  | **Date of Birth** |  | |
| **NHS Number** |  | **Legal Status** |  |
| **Ward** |  | **Primary/Named Nurse** |  |
| **Responsible Clinician** |  | | |
| **Named nurse** |  | | |
| **Level /Exact intervals of observation**  **e.g. 15 mins (see table below)** |  | **Date implemented** |  |

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| *Rationale for observations:*  *Risk behaviour(s)(risk to self and or others):*  *Risk factors:*  *Interventions to reduce risk factors:*  ***NB: The patients care plan should accompany this supportive therapeutic record* sheet** |

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| **Within Arm’s Length Observation And Within Eyesight Observation** | The observation record should be completed and signed following each period of observation by **all colleagues undertaking the observations**. An entry should be made on the electronic record. |
| **Intermittent Observation** | The observation record should be signed at the exact interval’s observations are carried out and record to be completed following the period of observation. For intermittentobservations at least once during the hour period, attempts should be made to therapeutically engage with the patient. An entry should be made on the electronic record summarising the observation period. |

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| **Patient Name** | **Ward** | **Date of Birth** | **Hospital Number** |
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| **Date** | **Time** | **Observed activity/Risk Behaviour(s)/factors identified during observations** | **Name(s)/ Signature(s)/ designation of colleague carrying out observations** | **Name(s) /Signature(s) /designation of colleague receiving patient hand –over** |
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| Signature of Nurse in Charge at end of shift to confirm all supportive therapeutic observations have been completed during the shift | DATE  SIGN | SIGN |

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| **Patient Name** | | | **Ward** | **Date of Birth** | | **Hospital Number** | |
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| **Date** | | **Time** | **Observed activity/Risk Behaviour(s)/factors identified during observations** | | | **Name(s)/ Signature(s)/ designation of colleague carrying out observations** | | **Name/ Signature/ designation of colleague carrying out receiving patient hand –over** | |
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| Signature of Nurse in Charge at end of shift to confirm all supportive therapeutic observations have been completed during the shift | DATE  SIGN | SIGN |