



Care of an Orthopaedic Device

Application Date: _	Time:	Location of device
Applied by:	Dept.:	Sign/ print
Please circle which	device is to be implemented	
Plaster of Paris H	inged brace Cricket Splint Tra	action Neck Brace TLSO brace Other Please
specify		
the relevant area of the sk ntact and considered 'norm efore application of device Yes Apply device Discuss w application the plan of assessme For remo	in No	Please tick if the patient has; Red and Blanching skin Back or purple skin Broken skin And complete the Skin map below
	plan over leaf for the care of any wound assessment plan for any	

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Day	For removable devices, skin checked and device reapplied?	For PoP document skin state	How is the skin?	Is a replacement device/part needed?	Is Colour, Sensation and Movement present? (CSM)	Are complaints of pain disproportionate to injury? If yes, escalate and document	Is the affected limb off loaded?	Is device still indicated Yes/No	Signature
1		SKIT State					loadeu:	103/110	
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PATIENT STICKER



Upon changing the device, if the skin integrity of the patient has changed, please update the skin map and Waterlow where appropriate. Please also document this in the notes and update handover.

Any skin damage should be reported via the Datix system and also the patient should be referred to tissue viability.

N-Normal RB-Red and blanching RNB- Red non blanching S-Scuff P-purple B-Black BL-Blister If pressure damaged please grade if able

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