

File within 3rd spine

NHS number: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 CR number: \_\_\_\_\_

*Affix patient label*

**Inpatient splinting  
 - Care plan**

Care Plan commencement date	Care Plan completion date
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**Problem**

# Management	<input type="checkbox"/>	Risk of skin breakdown	<input type="checkbox"/>
Risk of soft tissue shortening	<input type="checkbox"/>	Poor alignment, limiting function	<input type="checkbox"/>
Oedema	<input type="checkbox"/>	Risk of reducing passive range of movement	<input type="checkbox"/>
Pain	<input type="checkbox"/>	Post-op protection and support	<input type="checkbox"/>
Joint instability	<input type="checkbox"/>		
Joint dislocation	<input type="checkbox"/>		

**Goals**

To maintain passive range of movement	<input type="checkbox"/>	To restrict range of movement	<input type="checkbox"/>
Reduce risk of soft tissue shortening and contractures	<input type="checkbox"/>	To maintain bone / joint alignment	<input type="checkbox"/>
To improve function	<input type="checkbox"/>	To immobilise	<input type="checkbox"/>
To reduce pain	<input type="checkbox"/>	For support / protection	<input type="checkbox"/>
To improve joint alignment	<input type="checkbox"/>		
To assist with oedema management	<input type="checkbox"/>		

Other individual goals:	Sign, Designation Date and Time

**Interventions**

<b>Type of splint:</b>			<b>Positions or range of movement:</b>
	<b>Left</b>	<b>Right</b>	
Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	
Hand	<input type="checkbox"/>	<input type="checkbox"/>	
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	
Knees	<input type="checkbox"/>	<input type="checkbox"/>	
Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Hip	<input type="checkbox"/>	<input type="checkbox"/>	
Foot	<input type="checkbox"/>	<input type="checkbox"/>	
Humerus	<input type="checkbox"/>	<input type="checkbox"/>	

Other individual interventions:	Sign, Designation Date and Time

affix patient label

**Wearing regime**

- |                         |                          |                     |                          |
|-------------------------|--------------------------|---------------------|--------------------------|
| 4 hours on, 2 hours off | <input type="checkbox"/> | Mobilising only     | <input type="checkbox"/> |
| 6 hours on, 3 hours off | <input type="checkbox"/> | Daytime only        | <input type="checkbox"/> |
| Overnight               | <input type="checkbox"/> | Remove for exercise | <input type="checkbox"/> |
| Continuous wear         | <input type="checkbox"/> | Remove for washing  | <input type="checkbox"/> |

**Precautions**

- |                                 |                          |
|---------------------------------|--------------------------|
| Monitor for signs of marking    | <input type="checkbox"/> |
| Monitor for signs of discomfort | <input type="checkbox"/> |
| Monitor for soiling / hygiene   | <input type="checkbox"/> |

**Other**

*Document all treatment outcomes on evaluation sheet*

**Application of splint:**

**Other individual interventions**

**Sign, Designation  
Date and Time**

Care Plan  
activated

Sign  
Print

Designation

Care Plan shared  
with patient

Sign  
Print

Designation

Initial:

Initial: