SENARAI SEMAK CREDENTIALING

PROSEDUR ORTOPEDIK

PREPARATION AND APPLICATION OF THOMAS SPLINT

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Assess patient and affected limb			
4	Inform and explain to the patient regarding procedure			
5	Give privacy to the patient			
6	Measure affected limb (circumference of upper thigh)			
7	Prepare equipment: - 7.1 Measure Thomas Splint 7.2 Apply calico 7.3 Apply padding			
8	Maintain correct alignment of the limb during the procedure			
9	Apply Thomas Splint to the affected limb correctly.			
10	Comfort patient			
11	Provide health education			
12	Documentation			

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Name of Assessor & Signature:

PREPARATION AND APPLICATION OF BOHLER BRAUN'S FRAME

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Assess patient and affected limb			
3	Inform and explain to the patient regarding procedure			
4	Prepare equipment:- 4.1 Apply calico/strap to the BBF 4.2 Apply padding on the BBF			
5	Give privacy to the patient			
6	Apply BBF to the affected limb in the correct position			
7	Comfort patient			
8	Provide health education			
9	Documentation			

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Name of Assessor & Signature:

APPLICATION AND CARE OF PATIENT WITH SKIN TRACTION AND THOMAS SPLINT

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure			
4	Assess patient and affected limb			
5	Prepare equipment and give privacy to the patient.			
6	Assist patient to lie down in supine position.			
7	Maintain correct alignment of the limb during the procedure.			
8	Apply skin traction kit correctly.			
9	Put Thomas splint accordingly			
10	Apply weight accordingly.			
11	Maintain principle of traction			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION AND CARE OF PATIENT WITH SKELETAL TRACTION WITH BBF / THOMAS SPLINT

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure to be done			
4	Assess patient and affected limb			
5	Give privacy to the patient.			
6	Measure circumference of the upper thigh			
7	Prepare equipment: - 7.1 Choose the correct size of Thomas splint And measure the circumference. 7.2 Apply calico and padding to the Thomas Splint			
8	Assist patient to lie down in supine position			
9	Maintain correct alignment of the limb during the procedure.			
10	Put the affected limb to the Thomas splint.			
11	Apply stirrup, traction cord and weight			
12	Maintain Thomas splint to the bar			
13	Maintain alignment of the limb - ASIS			
14	Check neurovascular status			
15	Comfort the patient and provide health education			
16	Documentation			

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Name of Assessor & Signature:

APPLICATION AND CARE OF PATIENT WITH FIXED TRACTION

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure			
4	Assess patient and affected limb			
5	Prepare equipment and give privacy to the patient.			
6	Assist patient to lie down in supine position.			
7	Maintain correct alignment of the limb during the procedure.			
8	Apply skin traction kit correctly.			
9	Put the pillow below the affected limb.			
10	Apply brace at the end of the bed			
11	Maintain principle of traction			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

CARE OF PATIENT WITH PLASTER OF PARIS

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
	BEFORE APPLICATION OF POP			
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure to be done.			
4	Check neurovascular status and record.			
5	Send patient to POP room			
	AFTER APPLICATION OF POP			
1	Receive patient.			
2	Clean the affected limb			
3	Support the affected limb with pillow			
4	Expose the POP			
5	Check neurovascular status and record			
6	Comfort the patient			
7	Provide health education			
8	Documentation			

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Name of Assessor & Signature:

APPLICATION AND CARE OF PATIENT WITH HALTER TRACTION

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check patient's X-ray			
3	Inform and explain to the patient regarding procedure.			
4	Asses of patient condition			
5	Prepare equipment: - 5.1 Halter kit 5.2 Weight			
6	Give privacy			
7	Check vital sign before the procedure			
8	Put patient on supine position and apply donut ring below occiput (make sure to assess skin integrity every 2 hours)			
9	Apply Halter Belt and put padding under chin			
10	Apply weight accordingly			
11	Elevate head of bed with bed elevator			
12	Comfort the patient.			
13	Provide health education			
14	Documentation			

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Name of Assessor & Signature:

ASSIST APPLICATION AND CARE OF PATIENT WITH HALOVEST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check consent			
3	Inform and explain to the patient regarding procedure to be done.			
4	Prepare equipment:- 4.1 Halovest set 4.2 Dressing set			
5	Give privacy			
6	Ensure patient to cooperate in procedure.			
7	Check vital sign before the procedure.			
8	Assist Doctor during the procedure.			
9	Apply keyhole dressing to the pin halo that has been applied.			
10	Check vital sign after the procedure and assess breathing pattern			
11	Comfort the patient.			
12	Provide health education			
13	Clear the equipment			
14	Documentation			

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Name of Assessor & Signature:

ASSESSMENT OF NEUROVASCULAR STATUS
WITH TRACTION
WITH CAST
POST – OPERATIVE

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure to be done.			
4	Check neurovascular status and record.			
5	Send patient to POP room/ OT/ apply traction			
	AFTER APPLICATION OF POP/ TRACTION/ OT			
1	Receive patient.			
2	Clean the affected limb			
3	Support the affected limb with pillow.			
4	Expose the POP (for patient with POP application).			
5	Check neurovascular status and record.			
6	Comfort the patient.			
7	Provide health education.			
8	Documentation			

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Name of Assessor & Signature:

PRE AND POST OP CARE OF PATIENT: AMPUTATION

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Pre Op: Follow Save Surgery Safe Life (SSSL) checklist 1.1 Vital sign (baseline) 1.2 Consent 1.3 Skin Preparation 1.4 Blood Investigation 1.5 NBM			
2	Post Op: Position supine for 6 hours			
3	General monitoring: 3.1 Vital sign 3.2 IVD 3.3 Analgesia 3.4 Wound 3.5 Radivac			
4	Elevate stump for 24hours – reduced oedema and good venous return			
5	Assess patient and affected limb – bleeding sign			
6	Monitor Phantom limb and sensation			
7	Physiotherapy for ambulation with walking frame/ wheelchair/crutches			
8	Refer OCCT for splint of amputation			
9	Provide health education			
10	Documentation			

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Name of Assessor & Signature:

PRE AND POST OP CARE: TRAUMA

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Pre Op: Follow Save Surgery Safe Life (SSSL) checklist: 1.1 vital sign (baseline) 1.5 Blood Investigation 1.2 Consent 1.6 NBM 1.3 Skin Preparation 1.7 Urine C&S 1.4 Prophylaxis 1.8 Assess neurovascular status			
2	Psychological Preparation - Reinforced patient regarding procedure to be done			
3	Inform and explain to patient regarding procedure to be done			
4	Post Op : 4.1 General monitoring : 4.2 Vital sign 4.3 IVD 4.4 Analgesia and antibiotic 4.5 Wound 4.6 Radivac			
5	Assess neurovascular status			
6	Teach patient for ROM and ambulation and refer physiotherapy as follow the protocols 6.1 Deep breathing exercise 6.2 Quadriceps exercise 6.3 Dorsi-flexion exercise for the ankle 6.4 Passive exersice 6.5 CPM for TKR 6.6 Early ambulation as tolerated (walking frame / crutches)			
7	Provide health education as protocols			
8	Documentation			

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Name of Assessor & Signature:

PRE AND POST OP CARE: NON-TRAUMA

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Pre Op: Follow Save Surgery Safe Life (SSSL) checklist 1.1vital sign (baseline) 1.5 Blood Investigation 1.2 Consent 1.6 NBM 1.3 Skin Preparation 1.7 Urine C&S 1.4 Prophylaxis 1.8 Assess neurovascular status			
2	Psychological Preparation - Reinforced patient regarding procedure to be done			
3	Post Op: General monitoring: 3.1 Vital sign 3.2 IVD 3.3 Analgesia and antibiotic 3.4 Wound 3.5 Radivac			
4	Assess patient and affected limb positioning as protocols: 4.1 TKR: maintain no flexion of the knee with knee brace 4.2 THR: maintain with abduction pillow 4.3 Others			
5	Assess neurovascular status			
6	Sent patient for check x ray as Dr ordered			
7	Follow protocol Post Op: 7.1 Total knee Replacement 7.2 Total Hip Replacement 7.3 ACL / PCL Reconstruction 7.4 Others			
8	Teach patient for ROM and ambulation and refer physiotherapy as protocols 8.1 Deep breathing exercise 8.2 Quadriceps exercise 8.3 Dorsi-flexion exercise for the ankle 8.4 Passive exersice 8.5 CPM for TKR 8.6 Early ambulation as tolerated (walking frame / crutches)			
9	Provide health education as protocols 9.1 Total knee Replacement 9.2 Total Hip Replacement			

	9.3 ACL / PCL Reconstruction 9.4 Others			
10	Documentation			

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Name of Assessor & Signature:

APPLICATION OF CRYO CUFF

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Inform and explain to patient regarding procedure to be done.			
3	Assess patient and affected limb			
4	Prepare equipment and check the cryo cuff functioning and complete set			
5	Give privacy to patient			
6	Apply cryo cuff			
7	Check neurovascular status			
8	Provide health education			
9	Documentation			
10	Clean the affected limb			
11	Check neurovascular status			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION OF CPM

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Inform and explain to patient regarding procedure to be done.			
3	Assess patient and affected limb			
4	Prepare equipment and check the CPM functioning and complete set			
5	Give privacy to patient			
6	Apply CPM. Follow the degree of extension and flexion as ordered			
7	Check neurovascular status			
8	Provide health education			
9	Documentation			
10	Clean the affected limb			
11	Check neurovascular status			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

IMMEDIATE MANAGEMENT OF PATIENT WITH SPINAL INJURY

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Preparation of Bed 2.1 Solid based bed/ suitable mattress 2.2 Sufficient pillows for positioning 2.3 Intravenous drip stand			
3	Psychological Support to patient			
4	Maintain spinal alignment - Log turning at least of 4 staffs managing			
5	Monitor Vital sign patient - Sign of spinal shock			
6	Care of Skin - Skin assessment			
7	Care of respiratory: - Encourage Deep Breathing Exercise			
8	Bladder Care: 8.1 CBD 8.2 Clean Intermittent Catheterization			
9	Bowel Care - As protocols			
10	Provide health education – to patient and carer			
11	Documentation			
12	Provide health education			
13	Documentation			

.....

Name of Assessor & Signature:

HEALTH EDUCATION AND EXERCISE

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Inform and explain to patient regarding procedure to be done.			
3	Assess patient			
4	Give privacy to patient			
5	Provide health education and teach patient the exercise: 5.1 Range of motion upper and lower limb 5.2 Static Quadriceps 5.3 Ankle Foot Pump Exercise 5.4 Deep Breathing Exercise			
6	Check neurovascular status			
7	Documentation			
8	Give privacy to patient			
9	Apply to Above Knee Back Slab			
10	Clean the affected limb			
11	Check neurovascular status			
12	Provide health education			
13	Documentation			

.....

Name of Assessor & Signature:

AMBULATION PATIENT

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Inform and explain to patient regarding procedure to be done.			
3	Assess patient			
4	Give privacy to patient			
5	Teach patient the exercise - Provide health education 5.1 With crutches 5.2 With walking frame 5.3 Wheelchair			
6	Documentation			
7	Maintain correct allignment of the limb during the procedure			
8	Perform procedure application of Above Knee Cast according 'Buku Panduan Praktikal Pemasangan Kast KKM'.			
9	Check neurovascular status			
10	Provide health education and POP Care			
11	Documentation.			

.....

Name of Assessor & Signature:

CARE OF PATIENT WITH CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check 2 identifier of patient			
2	Inform and explain to patient regarding procedure to be done.			
3	Check X-ray film			
4	Send patient to POP room			
5	Back From POP Room Clean the affected limb			
6	Support the affected limb with pillow.			
7	Expose the POP [to fasten dryness]			
8	Check neurovascular status and record.			
9	Comfort the patient.			
10	Provide health education.			
11	Documentation			

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Name of Assessor & Signature:

INTERPRETATION OF PLAIN X-RAY – UPPER LIMB, LOWER LIMB, SPINE

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT to ensure right patient			
2	Interprate plain x-ray			
3	Inform and explain to patient regarding finding x ray (with permission of doctor)			
4	Comfort the patient			
5	Provide health education			
6	Documentation			

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Name of Assessor & Signature:

APPLICATION OF ARM SLING

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR /BHT			
2	Check patient's X-ray			
3	Inform and explain to the patient regarding procedure.			
4	Asses of patient condition			
5	Prepare equipment:- Arm sling(kain anduh)			
6	Give privacy			
7	Apply arm sling			
8	Comfort the patient.			
9	Provide health education			
10	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF STUMP BANDAGE

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR /BHT and correct patient			
2	Inform and explain to the patient regarding procedure			
3	Asses of patient condition			
4	Prepare equipment:- 4.1 Crepe bandage 4.2 plaster			
5	Give privacy			
6	Apply stump bandage			
7	Comfort the patient.			
8	Provide health education			
9	Documentation			

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Name of Assessor & Signature:

APPILATION OF LIMB BANDAGE

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Receive instructions written by doctor.			
2	Register and check patient's MRN no.			
3	Check patient's consent			
4	Inform and explain to patient regarding procedure to be done.			
5	Assess patient and affected limb			
6	Prepare equipment			
7	Give privacy to patient			
8	Apply limb bandage from distal to proximal			
9	Check neurovascular status			
10	Provide health education			
11	Documentation			

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Name of Assessor & Signature:

PRINCIPLE AND CARE OF ORTHOSIS – KNEE BRACE, JUWETTE BRACE, SOMI BRACE

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR /BHT			
2	Inform and explain to the patient regarding procedure			
3	Asses of patient condition			
4	Prepare equipment: - - brace			
5	Give privacy			
6	Apply brace			
7	Comfort the patient.			
8	Provide health education			
9	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF SHOULDER STRAPPING

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Prepare equipment			
6	Give privacy to patient			
7	Apply Shoulder Strapping			
8	Check neurovascular status			
9	Provide health education			
10	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF VOLAR SLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Prepare equipment			
6	Give privacy to patient			
7	Apply Volar Slab			
8	Check neurovascular status			
9	Provide health education			
10	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF DORSAL SLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Prepare equipment			
6	Give privacy to patient			
7	Apply Dorsal Slab			
8	Check neurovascular status			
9	Provide health education			
10	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF ABOVE ELBOW BACK SLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Receive instructions written by doctor.			
2	Register and check patient's MRN no.			
3	Check patient's consent			
4	Inform and explain to patient regarding procedure to be done.			
5	Review X-ray film			
6	Assess patient and affected limb			
7	Prepare equipment			
8	Give privacy to patient			
9	Apply Above Elbow Back Slab			
10	Check neurovascular status			
11	Provide health education			
12	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF ABOVE ELBOW CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Receive instructions written by doctor.			
2	Register and check patient's MRN no.			
3	Check patient's consent			
4	Inform and explain to patient regarding procedure to be done.			
5	Review X-ray film			
6	Assess patient and affected limb			
7	Prepare equipment			
8	Give privacy to patient			
9	Apply Above Elbow Cast			
10	Check neurovascular status			
11	Provide health education			
12	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF BELOW ELBOW CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Receive instructions written by doctor.			
2	Register and check patient's MRN no.			
3	Check patient's consent			
4	Inform and explain to patient regarding procedure to be done.			
5	Review X-ray film			
6	Assess patient and affected limb			
7	Prepare equipment			
8	Give privacy to patient			
9	Apply Above Elbow Cast			
10	Check neurovascular status			
11	Provide health education			
12	Documentation			

.....

Name of Assessor & Signature:

APPLICATION OF BELOW ELBOW BACKSLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Inform and explain to patient regarding procedure to be done.			
2	Prepare equipment i. POP – 10cm (2 roll) 12 folded layer ii. Ortoban 7.5cm or 15cm iii. Crepe bandage – 7.5cm or 10cm iv. Arm sling			
3	Give privacy to patient.			
4	Position the patient.			
5	Measure the desired POP length.			
6	Prepare 10 to 12 layers of POP to make a slab.			
7	Apply the orthoban by simple spiral (2/3) from distal to proximal patient's hands.			
8	Soak the slab then place above the orthoban stretch and excessive ortoban folded upwards. (Ortoban must be a few centimeters long and wide from the slab).			
9	The slab is applied on the posterior (dorsal) hand. Start from Metacarpal bone to radial head.			
10	cover the slab in the patient's hands by using the crepe bandage / cotton bandage.			
11	The bandage on the patient's hand is in a neutral position.			
12	Neurovascular status assessment.			
13	Apply arm sling.			
14	Provides health education and plaster care.			
15	Make patient comfortable.			
16	Clean up equipment after procedure.			
17	Documentation of procedures.			

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Name of Assessor & Signature:

APPLICATION OF COLLE'S CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Inform and explain to patient regarding procedure to be done.			
2	Prepare equipment i. POP – 10cm (2 rolls) ii. Ortoban 7.5cm (1 roll) iii. Arm sling			
3	Give privacy to patient.			
4	Position the patient Propped upor lie down. Wrist joints in the position of palmar flexion (20°-30°),ulna deviation (15°) and pronation (20°).			
5	An assistant's hand holds the patient's thumb in the fully extended while the other hand holds another patient's finger by maintain the traction.			
6	Wrap 1 cm orthoban past the MCP joint up to 2 cm from the elbow joint.			
7	Soak the POP and wraps from the wrist with the direction of the bandage from the inside outto the distal. Keep the palms open and do not exceed orthoban.			
8	Wrap the patient's palms and through 1st web space between your thumb and index finger 2 times. Keep the proximal band up to 3 cm from the elbow joint. Do not exceed orthoban ends.			
9	At the same time, mold the POP to make the outer layer smooth, while maintaining 3 point molding.			
10	Fold on the end of the orthoban . Palmar creases and knuckles should be visible.			
11	For a second POP roll, wrap the same way as the first but only one rolling through 1st web space. The total number via 1st web space is three layers (1st roll – 2 layers and 2nd roll – 1 layer).			
12	Make sure the patient's wrist position is always in flexion and ulnar deviation position.			

13	Neurovascular status assessment.			
14	Apply arm sling.			
15	Provides health education and plaster care.			
16	Make patient comfortable.			
17	Clean up equipment after procedure.			
18	Documentation of procedures.			

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Name of Assessor & Signature:

APPLICATION OF BENNET CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Inform and explain to patient regarding procedure to be done.			
2	Prepare equipment i. POP – 10cm (2 rolls) ii. Ortoban 7.5cm (1 roll) iii. Arm sling			
3	Give privacy to patient.			
4	Position the patient Sit or lie down(according to patient's condition). Wrist joints on neutral position and thumb on abduction and extension (hand shake position).			
5	Wrap 1 cm orthoban past the MCP joint up to 4 cm from the elbow joint.			
6	Additional padding is placed on the fracture part.			
7	The assistant draws the patient's thumb in the abduction and extension position and holds the second finger to the fourth finger of the patient in a condition of hand shake position.			
8	Soak the POP and wraps from the wrist with the direction of the bandage from the inside out. Make sure the patient's palms are always open and do not exceed orthoban.			
9	Wrap the patient's palms and through the first web space between the thumb and the index finger 2 times. Keep the wrap around the thumb until the middle proximal phalange.			
10	Continue wrapping to the proximal part up to 4 cm (approx. 4 finger) from the elbow joint. Do not wrap over the end of the orthoban.			
11	At the same time, mold the POP to make the outer layer smooth.			
12	Fold on the end of the orthoban. Palmar creases and knuckles should be visible.			

13	Repeat wrapping POP with a second roll in the same way.			
14	Before POP hardens, should press the fracture part with the tip of his thumb until POP becomes hard.			
15	Neurovascular status assessment.			
16	Apply arm sling.			
17	Provides health education and plaster care.			
18	Make patient comfortable.			
19	Clean up equipment after procedure.			
20	Documentation of procedures.			

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Name of Assessor & Signature:

APPLICATION OF ULNAR GUTTER

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Check X-Ray film			
3	Inform and explain to patient regarding procedure to be done			
4	Assess patient and affected limb			
5	Prepare equipment			
6	Give privacy to patient			
7	Apply ulnar gutter			
8	Check neurovascular status			
9	Provide health education			
10	Documentation			

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Name of Assessor & Signature:

APPLICATION OF THUMB SPICA CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Check X-Ray film			
3	Inform and explain to patient regarding procedure to be done			
4	Assess patient and affected limb			
5	Prepare equipment			
6	Give privacy to patient			
7	Apply thumb spica cast			
8	Check neurovascular status			
9	Provide health education			
10	Documentation			

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Name of Assessor & Signature:

APPLICATION OF SCAPHOID CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Check X-Ray film			
3	Inform and explain to patient regarding procedure to be done			
4	Assess patient and affected limb			
5	Prepare equipment			
6	Give privacy to patient			
7	Apply scaphoid cast			
8	Check neurovascular status			
9	Provide health education			
10	Documentation			

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Name of Assessor & Signature:

APPLICATION OF HANGING CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Assess patient's circulation using 6P (Pain, Pallor, Pulseless, Paraesthesia, Poikilothermia, Paralysis)			
6	Place patient in comfortable position			
7	Prepare equipment			
8	Give privacy to patient			
9	Apply to Hanging Cast			
10	Clean the affected limb			
11	Check neurovascular status			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION OF U SLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Assess patient's circulation using 6P (Pain, Pallor, Pulseless, Paraesthesia, Poikilothermia, Paralysis)			
6	Place patient in comfortable position			
7	Prepare equipment			
8	Give privacy to patient			
9	Apply to U Slab			
10	Clean the affected limb			
11	Check neurovascular status			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION OF BELOW KNEE BACK SLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Assess patient's circulation using 6P (Pain, Pallor, Pulseless, Paraesthesia, Poikilothermia, Paralysis)			
6	Place patient in comfortable position			
7	Prepare equipment			
8	Give privacy to patient			
9	Apply to Below Knee Back Slab			
10	Clean the affected limb			
11	Check neurovascular status			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION OF ABOVE KNEE BACK SLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Assess patient's circulation using 6P (Pain, Pallor, Pulseless, Paraesthesia, Poikilothermia, Paralysis)			
6	Place patient in comfortable position			
7	Prepare equipment			
8	Give privacy to patient			
9	Apply to Above Knee Back Slab			
10	Clean the affected limb			
11	Check neurovascular status			
12	Provide health education			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION OF ABOVE KNEE CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Assess patient and affected limb			
4	Inform and explain to the patient regarding procedure			
5	Give privacy to the patient			
6	Prepare equipment: i) Stockinette size 10cm ii) Ortoban size15cm x 2-3 rolls iii) POP 15cm @ 20cm x 6-8 rolls iv) POP stand			
7	Maintain correct allignment of the limb during the procedure			
8	Perform procedure application of Above Knee Cast according 'Buku Panduan Praktikal Pemasangan Kast KKM'.			
9	Check neurovascular status			
10	Provide health education and POP Care			
11	Documentation.			

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Name of Assessor & Signature:

APPLICATION OF BELOW KNEE CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Assess patient and affected limb			
4	Inform and explain to the patient regarding procedure			
5	Give privacy to the patient			
6	Prepare equipment: i) Stockinette size 10cm ii) Ortoban size15cm x 1-2 rolls iii) POP 15cm @ 20cm x 3-4 rolls iv) POP stand			
7	Maintain correct allignment of the limb during the procedure			
8	Perform procedure application of Below Knee Cast according 'Buku Panduan Praktikal Pemasangan Kast KKM'.			
9	Check neurovascular status			
10	Provide health education and POP Care			
11	Documentation.			

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Name of Assessor & Signature:

APPLICATION OF CYLINDER BACK SLAB

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR / BHT			
2	Check X-ray film			
3	Assess patient and affected limb			
4	Inform and explain to the patient regarding procedure			
5	Give privacy to the patient			
6	Prepare equipment: i) Stockinette size 10cm ii) Ortoban size15cm x 1-2 rolls iii) POP 15cm @ 20cm x 3-4 rolls iv) POP stand			
7	Maintain correct allignment of the limb during the procedure			
8	Perform procedure application of Cylinder Back Slab according 'Buku Panduan Praktikal Pemasangan Kast KKM'.			
9	Check neurovascular status			
10	Provide health education and POP Care			
11	Documentation.			

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Name of Assessor & Signature:

APPLICATION OF CYLINDER CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Receive instructions with correct patient and correct procedure			
2	Check consent,inform and explain to patient regarding Procedure to be done.			
3	Check x-ray			
4	Registration of patient			
5	Assessment ,Examination of affected limb Check circulation,pain score			
6	Prepare equipments			
7	Perform Hand Hygiene, Wear Mask, Glove and Apron			
8	Perform procedure			
9	Apply POP according to PANDUAN PRAKTIKAL PEMASANGAN PLASTER KAST (KKM)			
10	Start 2.5cm above malleolus until 2/3 femur patient.			
11	Knee angle/Flex 15-30°			
12	Observation			
13	Health Education			

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Name of Assessor & Signature:

APPLICATION OF BOOT CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Receive instructions with correct patient and correct procedure			
2	Check consent,inform and explain to patient regarding Procedure to be done.			
3	Check x-ray			
4	Registration of patient			
5	Assessment ,Examination affected limb Check circulation,pain score			
6	Prepare equipments			
7	Perform Hand Hygiene, Wear Mask, Glove and Apron			
8	Perform procedure			
9	Apply POP according to PANDUAN PRAKTIKAL PEMASANGAN PLASTER KAST (KKM)			
10	Start above phalanges until midshaft of tibia fibula			
11	Plantar flexction 90® ankle			
12	Observation			
13	Health Education			

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Name of Assessor & Signature:

APPLICATION OF PATELLA TENDON BEARING CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected limb			
5	Prepare equipment			
6	Give privacy to patient			
7	Apply patella tendon bearing cast			
8	Check neurovascular status			
9	Provide health education			
10	Documentation			

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Name of Assessor & Signature:

APPLICATION OF BODY CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to patient regarding procedure to be done.			
4	Assess patient and affected area of body			
5	Prepare equipment			
6	Give privacy to patient			
7	Positioning of patient			
8	Apply Body cast			
9	Comfort patient			
10	Check neurovascular status			
11	Provide health education			
12	Documentation			

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Name of Assessor & Signature:

APPLICATION OF MINERVA JACKET

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
BEFORE APPLICATION OF POP				
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure to be done.			
4	Check neurovascular status and record.			
5	Send patient to POP room			
AFTER APPLICATION OF POP				
6	Receive patient.			
7	Clean the affected limb			
8	Support the affected limb with pillow.			
9	Expose the POP.			
10	Check neurovascular status and record.			
11	Comfort the patient.			
12	Provide health education.			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION OF HIP SPICA

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
BEFORE APPLICATION OF POP				
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure to be done.			
4	Check neurovascular status and record.			
5	Send patient to POP room			
AFTER APPLICATION OF POP				
6	Receive patient.			
7	Clean the affected limb			
8	Support the affected limb with pillow.			
9	Expose the POP.			
10	Check neurovascular status and record.			
11	Comfort the patient.			
12	Provide health education.			
13	Documentation			

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Name of Assessor & Signature:

APPLICATION OF SERIAL CASTING FOR CTEV / PONSETI CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
BEFORE APPLICATION OF POP				
1	Check patient's EMR			
2	Check X-ray film			
3	Inform and explain to the patient regarding procedure to be done.			
4	Check neurovascular status and record.			
5	Send patient to POP room			
AFTER APPLICATION OF POP				
6	Receive patient.			
7	Clean the affected limb			
8	Support the affected limb with pillow.			
9	Expose the POP.			
10	Check neurovascular status and record.			
11	Comfort the patient.			
12	Provide health education.			
13	Documentation			

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Name of Assessor & Signature:

WEDGING OF PLASTER CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Read written instruction by doctor			
2	Register patient particular in the procedure registration book			
3	Assestment / examination by reviewing x-ray i. Comfirm site / side and angulation of fracture ii. Check integrity of pop iii. Check rotational angulation iv) POP stand iv. Check amount correction needed			
4	Prepare patient i. Explain to relative/ patients procedure to be carried out ii. Comfirm with patient the affected limb iii. Place patient in comfortable position iv. Place linen protector under affected limb v. With help of an assistant hold and position the limb as required vi. Give sedation (if required)			
5	Performed procedure i. Review x-ray ii. Draw lines along longitudinal axis of proximal and distal fragment iii. Measure the angle of deformity iv. Correct the angulation, insert the wedge according to the angle of deformity v. Reinforce the wedge with padding and plaster vi. Send for post wedging x-ray			
6	Observed the circulation and sensation and			
7	Take necessary action if complication arises.			

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Name of Assessor & Signature:

REMOVAL OF HALOVEST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Read written instruction by doctor			
2	Register patient particular in the procedure registration book			
3	Assestment / examination by reviewing x-ray i. Check condition of wound			
4	Prepare equipment needed			
5	Prepare patient i. Place patient in a comfortable position ii. Explain to patient relatives/parents the procedure to be carried out			
6	Performed procedure i. Begin procedure with help of an assistant ii. Apply soft collar around patient neck (if needed) iii. Clean the affected area and surrounding skin iv. Take Swab C&S (if required) v. the nuts are loosened on the vest and uprights and then removed vi. Use Torque screwdriver to loosen the head pin while someone holding the ring vii. All the pin are loosened and the ring is lifted from the head iii. Dress the wound ix. Rest patient in comfortable position			
7	Observation i. Care of the wound ii. Follow up clinic			
8	Documentation			

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Name of Assessor & Signature:

REMOVAL OF EXTERNAL FIXATOR / ILLIZAROF

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Read written instruction by doctor			
2	Register patient particular in the procedure registration book			
3	Assestment / examination by reviewing x-ray i. Check deformity of limb ii. Check condition of wound			
4	Prepare equipment needed			
5	Prepare patient i. Place patient in a comfortable position ii. Explain to patient relatives/parents the procedure to be carried out iii. Place linen protector under affected limb			
6	Performed procedure i. Begin procedure with help of an assistant ii. Hold the injured limb with care iii. Clean the affected area and surrounding skin iv. Take Swab C&S if required v. Use T-Handle to remove Schan'z Pin with proper technique vi. Dress the wound vii. Rest patient in comfortable position			
7	Observation i. Care of the wound ii. Teach Crutch walking iii. Follow up clinic iv. Exercise the affected limb			
8	Documentation			

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Name of Assessor & Signature:

REMOVAL OF CAST

CHECKLIST

Clinic/A&E/Ward/OT :

Patient's Name : Date :

I/C no :

Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Received instruction			
2	Registration			
3	Prepare equipment			
4	Prepare patient			
5	Explain to patient, relatives/parent the procedure			
6	Place patient in comfortable position			
7	Place linen protector			
8	Hold and position the limb			
9	Inspect the status of cast eg.soft,broken or no orthoban inside			
10	Demonstration of cast cutter -how its work/safety			
Perform procedure				
11	Cut the plaster cast with cast cutter/saw following bthe correct technique			
12	Refer to Doctor if any abnormalities or complication detected			
Health Education				
13	Care of wound if any			
14	Arm sling/ cructch walking			
15	Encourage exercise			
16	Clinic follow up			
Documentation				
17	Record in the procedure book			

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Name of Assessor & Signature:

PERFORM CLOSED MANUAL REDUCTION(CMR)

CHECKLIST

Clinic/A&E/Ward/OT :
Patient's Name : Date :
I/C no :
Please tick (√) at the appropriate column

No	Action	Evaluation		Remarks
		Yes	No	
1	Check patient's EMR/ BHT			
2	Inform and explain to the patient regarding procedurebto be done			
3	Psychological Support to patient			
4	Give privacy to the patient			
5	Prepare equipment- i. POP ii. Drug iii. Nibp spo2 iv. Oxygen			
6	Check X-ray			
7	Check vital sign and neurovascular status before the procedure			
8	Maintain correct alignment of the limb during the procedure			
9	Assist Doctor during the procedure			
10	Check vital sign and neurovascular status after the procedure			
11	Provide health education – to patient and carer			
12	Clear the equipment			
13	Documentation			
Health Education				
13	Care of wound if any			
14	Arm sling/ cructch walking			
15	Encourage exercise			
16	Clinic follow up			
Documentation				
17	Record in the procedure book			

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Name of Assessor & Signature: