壓瘡(壓傷)的預防及居家護理

Prevention of pressure ulcers (compression injuries) and home care

一、 什麼是壓瘡(壓傷)：

1. What is the pressure ulcer (pressure injury):

皮膚或皮膚下面的軟組織受損，其通常位於身體骨頭突出處或與某些醫療器材有關。

The skin or the soft tissue under the skin is damaged, which is usually located at the protruding part of the body's bones related to certain medical equipment.

二、 造成壓瘡(壓傷)的原因：

2. Causes of pressure sores (pressure injuries):

1. 身體長期維持某特定姿勢，未定時翻身更換姿勢。

1. The body maintains a certain posture for a long time and does not turn over regularly to change postures.

2. 輔助物之壓迫，如：約束、背架或支架等。

2. Compression of auxiliary objects, such as restraint, back frame or brace, etc.

3. 引流管壓迫不當，如：鼻胃管或尿管膠布黏貼不當。

3. Improper compression of the drainage tube, such as improperly sticking the nasogastric tube or urinary tube tape.

4. 大小便失禁、腹瀉，未確實清潔身體及及時更換尿布，導致皮膚浸潤或因清潔不當造成皮膚破皮。

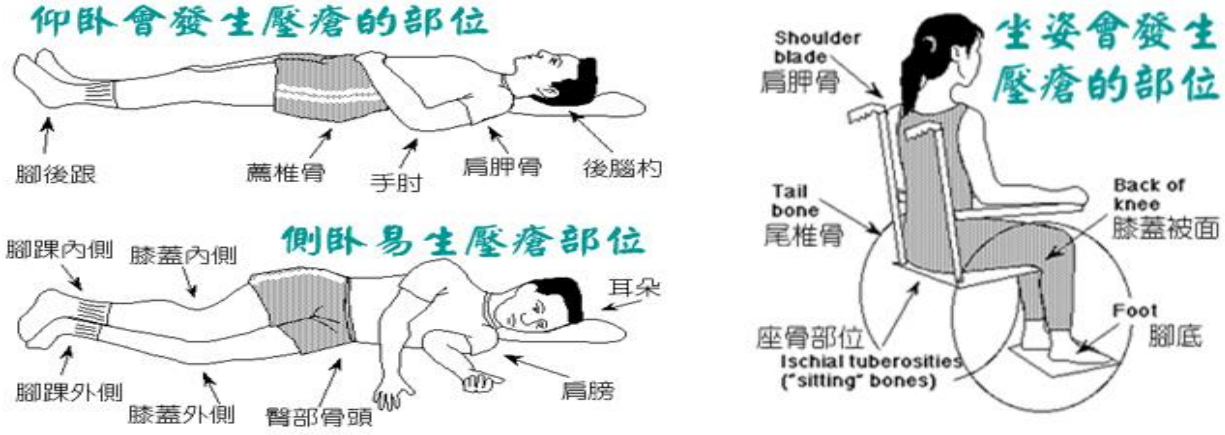
4. Urinary incontinence, diarrhea, failure to clean the body and timely replacement of diapers, resulting in skin infiltration or skin breakage due to improper cleaning.

5. 病人特定因素，如：糖尿病、營養不良、水腫、循環不良、皮膚脆弱或年老等。

5. Patient-specific factors such as diabetes, malnutrition, edema, poor circulation, fragile skin, or old age.

三、 常見壓瘡(壓傷)部位：

3. Common pressure sore (pressure injury) sites:



圖片來源： http://web.it.nctu.edu.tw/~hcsci/hospital/life/bedsore.htm

四、 照護注意事項：

4. Precautions for care:

1. 原則上每 1-2 小時翻身改變臥姿(如：左、中、右側)，並避免壓迫傷口處，但循環功能較差者，應勤翻身。每次翻身，可予骨突處背部按摩，觀察皮膚顏色及完整情形。

1. In principle, turn over and change your prone position every 1-2 hours (such as left, middle, and right), and avoid compressing the wound, but those with poor circulatory function should turn over frequently. Each time you turn over, you can massage the bony prominence back to observe the skin color and complete condition.

2. 長期臥床者建議使用氣墊床，但仍需按時翻身。若無氣墊床，則需選擇較柔軟床墊，禁止睡木板床。

2. People who stay in bed for a long time are recommended to use an air bed, but they still need to turn over on time. If there is no air bed, you need to choose a softer mattress, and it is forbidden to sleep on a wooden bed.

3. 翻身調整病人位置時，須抬高病人身體勿以拉拖方式，減少皮膚的拉扯而導致破皮。

3. When turning over to adjust the patient's position, the patient's body must be raised and not pulled or dragged, so as to reduce the pulling of the skin and cause the skin to break.

4. 避免將床頭抬高大於 30°，若需抬高病人，則以床單加墊，兩人共同抬高病人。

4. Avoid raising the head of the bed more than 30°. If it is necessary to raise the patient, use a bed sheet to padded, and the two people raise the patient together.

5. 保持床單及衣服乾淨、乾燥、平整、無皺摺。床上不可留有異物，避免病人躺在不平處，造成皮膚受壓損傷。

5. Keep sheets and clothes clean, dry, flat and free of wrinkles. No foreign objects should be left on the bed to prevent the patient from lying on uneven places and causing pressure damage to the skin.

6. 若大小便失禁者，宜使用看護墊代替紙尿褲。並隨時處理排泄物，宜以吸乾或輕拍方式擦拭，保持會陰部及肛門口周圍乾燥與清潔。

6. If you have incontinence, you should use nursing pads instead of diapers. Disposal of excrement at any time, it is advisable to wipe dry or lightly pat to keep the perineum and the area around the anus dry and clean.

7. 避免皮膚乾裂，可擦拭乳液等保護油，以增加皮膚柔軟及彈性。

7. To avoid dry and cracked skin, you can wipe off protective oils such as lotions to increase skin softness and elasticity.

8. 穿著易吸汗的棉質衣服並時常更換。

8. Wear cotton clothes that absorb sweat and change them frequently.

9. 宜加強觀察皮膚皺摺處(腋下、腹股溝、臀部、肛門口周圍等)，並保持乾燥及清潔。

9. It is advisable to strengthen the observation of skin folds (underarms, groin, buttocks, around the anus, etc.), and keep them dry and clean.

10. 冷熱水使用，宜注意溫度適當，避免對皮膚造成過度刺激。

10. When using hot and cold water, pay attention to the appropriate temperature to avoid excessive skin irritation.

11. 鼓勵早期下床活動，促進血液循環，使傷口癒合較快。

11. Encourage early getting out of bed to exercise, promote blood circulation, and make wounds heal faster.

12. 營養宜均衡，可多補充魚、肉、蛋、牛奶類等蛋白質含量高食物及蔬菜水果，促進傷口癒合。

12. Nutrition should be balanced. Fish, meat, eggs, milk and other high-protein foods, vegetables and fruits can be supplemented to promote wound healing.

13. 隨時觀察皮膚有無發紅、水泡等情形；若皮膚已產生水泡或有傷口、滲液及臭味時，請返院求醫。

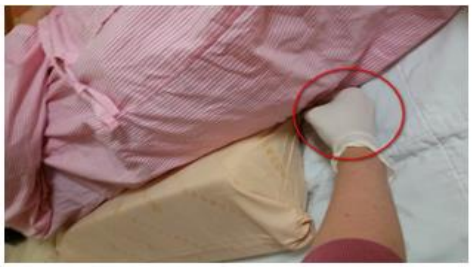
13. Observe the skin for redness, blisters, etc. at any time; if the skin has blisters or wounds, exudate, or odor, please return to the hospital for medical treatment.

備註：病人如有傷口請護理人員配合給予傷口換藥指導衛教單。

Remarks: If the patient has a wound, the nursing staff should cooperate in giving the wound dressing instruction and health education sheet.

五、 翻身擺位時之注意事項：

5. Points to note when turning over:

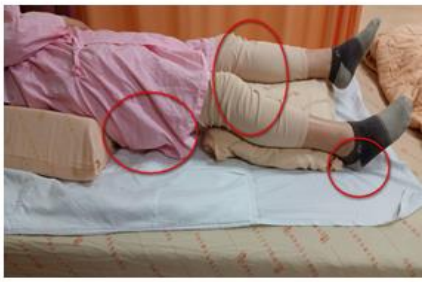


檢查骨突處懸空一個拳頭

利用枕頭及水袋將病人腳抬高

將肩膀拉出來

手部及足跟可墊水袋
注意：腳跟是否懸空



常見錯誤：未懸空一個拳頭
兩腳未平行、腳跟未懸空

參考資料

陳偉鵬等(2016)。臨床症狀護理(三版)。臺北:華杏。

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