

壓傷傷口的居家照顧(英文)

Domiciliary Care for Wounds from Pressure Injury

- 一、目的：維持傷口清潔乾燥，減少對傷口壓迫及刺激，避免壓傷傷口進一步惡化、感染，造成合併症，促進傷口癒合。

Purpose: Keep the wound clean and dry, reducing compression and irritation to the wound, avoiding complications resulted from further aggravation or infection of the wound from pressure injury to facilitate wound healing.

二、傷口處理方法

Approach for wound management

- (一) 每日觀察評估並紀錄傷口外觀、範圍大小、深度、顏色、味道、是否有異常分泌物等。

Daily observe, assess and record the appearance, range in size, depth, color, smell of the wound, and if there is any abnormal secretions, etc.

- (二) 傷口清潔步驟：

Procedure for wound cleaning:

1. 分別以乾淨的棉棒依順序由傷口中央往外進行環形擦拭：生理食鹽水→優碘→生理食鹽水。

Annularly wipe the wound with clean cotton swabs in a sequential order respectively from the center outwards: normal saline → Povidone-iodine → normal saline.

2. 清洗範圍須大於傷口基部半徑5公分以上，不可來回擦拭，將傷口之分泌物清除，直到清潔為止。

Cleaning area should be more than 5 cm of radius from base of the wound, wiping back and forth is not allowed; removing secretions from the wound until completely cleaned.

- (三) 同清潔傷口方式，採環形方式在傷口擦上醫生開立的藥物。

With the same manner as wound cleaning, annularly apply the prescribed drug by the physician on the wound.

- (四) 以消毒過的紗布覆蓋，並以紙膠固定。

Cover with sterile gauze, fixing with paper tapes.

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(五) 平時若紗布滲濕，應隨時立即更換。

Any gauze dressing leaked or dampened wet should be replaced immediately.

(六) 可配合使用親水性敷料、薄膜敷料等粘貼於皮膚發紅處。

Hydrophilic dressings and film dressings may also be applied to reddish sites of the skin.

三、注意事項 Precautions

(一) 傷口清潔前、後應立即洗手。

Be sure to wash hands immediately before and after wound cleaning.

(二) 棉棒擦拭過一次後即予丟棄，不可反覆使用，以免造成傷口感染。

To avoid wound infection, any used cotton swabs should be disposed, repeated use is not allowed.

(三) 勿隨便塗用不明藥物，以免傷口惡化。

To prevent aggravation of the wound, do not voluntarily apply any medications other than the prescription.

(四) 壓傷傷口過深，或已有發黑、異味之膿性分泌物時，應立即就醫！

Immediately seek medical attention in case of any deeper wound from pressure injury or any blackened and peculiar-smell purulent secretions exhibited!

四、壓傷的預防方法

Prevention of pressure injury

(一) 以中性肥皂和清水協助病人基本身體清潔，保持皮膚清潔乾燥，尤其是身體皺摺處更需每天清洗，並檢查全身皮膚有沒有發紅破皮現象發生。

Assist the patient to basically clean the body with neutral soap and clear water to keep the skin clean and dry, especially cleaning body folds every day, examining if there is any reddish or cracked skin over the whole body.

(二) 臥床不動病人，應至少1~2小時協助其翻身拍背，不要讓身體同一個部位長時間受壓，皮膚可抹水性乳液，並按摩易受壓或發紅部位，但不要使用在皮膚有破損的部位。

Assist the bedridden patient to turn over and hit lightly on the back at

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least once every 1 to 2 hours, avoiding compression on a specific area of the body for a much longer time, applying water-soluble lotion on the skin and massaging the sites liable to pressure or redness, but never apply on the sites with damaged skin.

- (三) 隨時保持身體、衣物、床單、坐墊的清潔乾燥及平整，以免皺摺形成壓力點。

Always keep the body, clothes, sheet and cushion clean, dry and neat to avoid any compressed site resulted from folds.

- (四) 大小便失禁病人應隨時協助清理，保持會陰部乾燥，儘量少使用紙尿褲，因易造成局部透氣不良，使皮膚過度浸潤。

Assist to clean the patient with fecal and urinary incontinence at any time, keeping the perineum dry, using disposable diapers as less as possible to avoid locally insufficient ventilation resulting in excess infiltration over the skin.

- (五) 床墊應平坦勿過硬，可使用減低壓力的床墊和椅墊，如氣墊床、水床、泡綿墊、水墊或空氣墊，可使壓力分布較平均。但局部的壓力仍可能造成壓傷，所以不要因使用墊子而忽略了間歇減壓的重要性。

Use a flat mattress with appropriate hardness, preferably using pressure-reducing mattresses or chair cushions such as air bed, water bed, foam cushion, water cushion or air cushion which may evenly distribute the pressure. Nevertheless, local pressure may still result in pressure injury, do not neglect the importance of intermittent pressure relief while using the cushions.

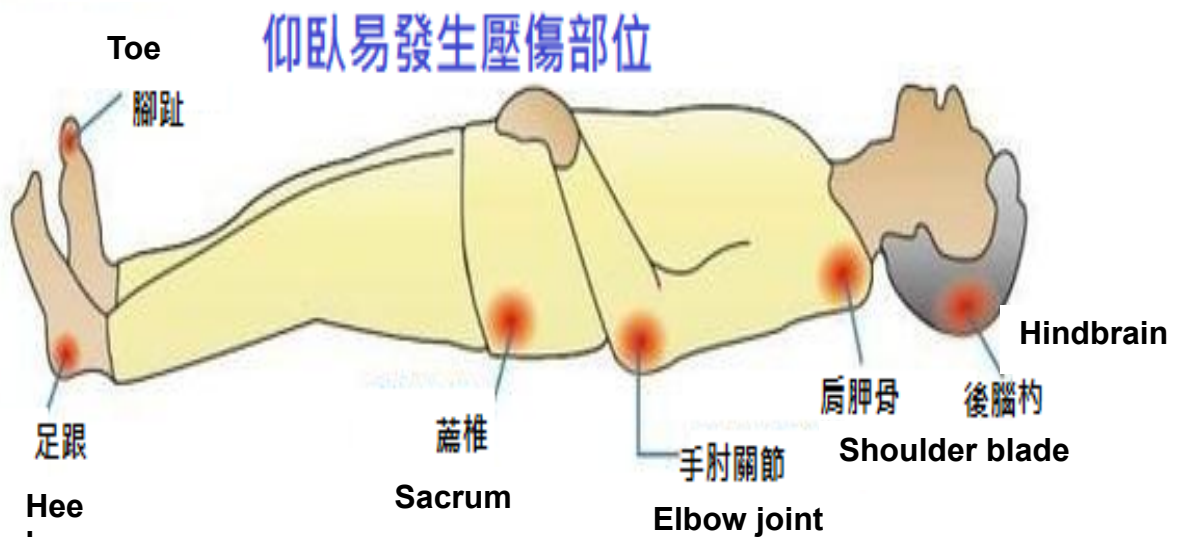
- (六) 姿勢及擺位注意事項：

Precautions for postures and positions:

1. 平躺：在頭部及雙膝下放置枕頭，給予支持。

Lying in supine position: use pillows under the head and knees to provide support.

Areas liable to pressure injury in lying supine

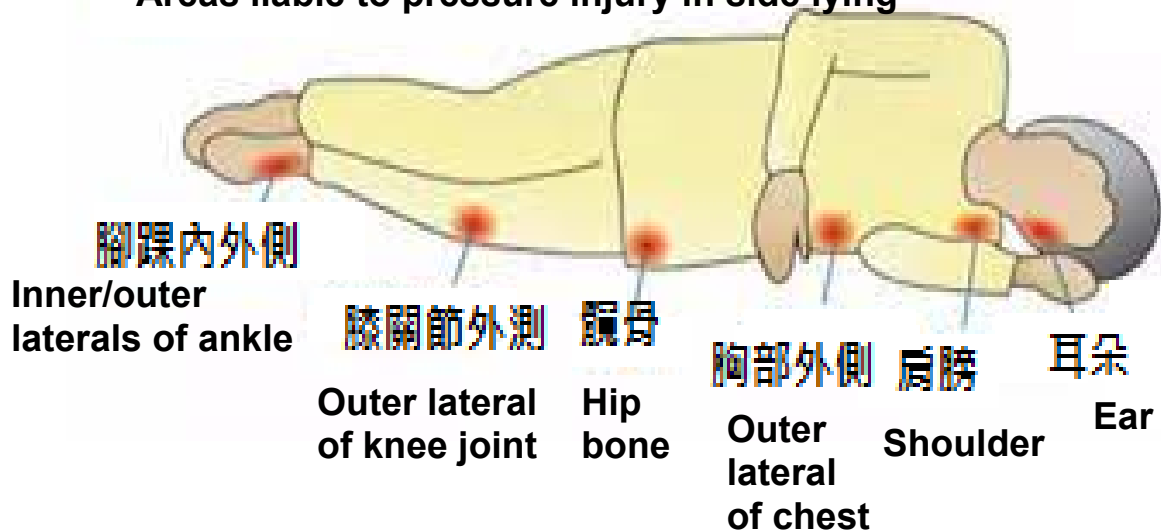


- 2.側臥：使用枕頭墊於背、腰處，使易受壓部份懸空，如尾骨、臀部兩側；肩膀及骨頭較突出處，則應注意其與床面之角度勿 >30 度，以免直接受壓，身體易受壓部位如下圖。

Lying on the side: pad the back and waist with pillows to suspend the sites liable to pressure such as the tailbone and bilateral hips; for the shoulders and areas with projected-bones, always keep the angle with the bed less than 30 degrees to avoid direct compression, areas liable to pressure are shown as the figures below.

側臥易發生壓傷部位

Areas liable to pressure injury in side lying



- (七) 坐於椅子上應至少每30分鐘將臀部抬起15秒，以減少局部壓力。坐姿時身體易受壓部位如右圖。

When sit on a chair, lift the hips for 15 seconds at least once every 30 minutes to reduce local pressure. Areas liable to pressure from sitting posture are shown as the right figure.



- (八) 使用約束帶時寬度須能插入一指，並隨時觀察肢體遠端皮膚，每2小時應鬆開5~10分鐘。

When restraining band is used, the space left should be one-finger width, observing distal-end skin of the extremities at any time, loosening for 5 to 10 minutes once every 2 hours.

- (九) 注意病人的身體營養狀況，應有足夠水份（2,500~3,000mL）、蛋白質（魚、肉、豆、蛋、奶類）及維他命C（如柳橙、奇異果等）之補充，避免吸菸，保持情緒樂觀，爭取積極的人生態度。

Pay attention to patient's nutritional status, providing sufficient supply of water (2,500 to 3,000 ml), protein (fish, meat, bean, egg, and dairy products) and vitamin C (e.g. orange, kiwi, etc.), avoiding smoking, keeping sound emotional management and striving for aggressive attitudes for life.

參考資料 Reference

- David, G. A., & Andrew J. M. (2021). Basic principles of wound management. *UpToDate*. Retrieved December 9, 2021, from <https://www-uptodate-com/contents/basic-principles-of-wound-management>
- Dan, B. (2021). Prevention of pressure-induced skin and soft tissue injury. *UpToDate*. Retrieved November 21, 2021, from <https://www-uptodate-com/contents/prevention-of-pressure-induced-skin-and-soft-tissue-injury>

護理指導評值 Nursing guidance evaluation:

◎是非題 True or false

1. () 壓傷傷口的居家照顧應注意保持傷口清潔乾燥，減少對傷口壓迫



及刺激，避免壓傷傷口進一步惡化、感染，造成合併症，促進傷口癒合？

In domiciliary care for the wound from pressure injury, always keep the wound clean and dry, reducing compression and irritation to the wound, avoiding complications resulted from further aggravation or infection of the wound from pressure injury to facilitate wound healing?

2. () 長期臥床不動病人，應至少 2~4 小時協助其翻身拍背？

Assist the long-term bedridden patient to turn over and hit lightly on the back at least once every 2 to 4 hours?

3. () 身體易受壓部位有背、腰處、尾骨、臀部兩側、肩膀、骨頭較突出處，應注意避免直接受壓？

Areas liable to pressure include the back, waist, tailbone, bilateral hips, shoulders, and areas with projected-bones, direction compression should be avoided?

◎選擇題 Multiple choice questions

4. () 傷口處理方法，下列何者錯誤？(1) 每日觀察並紀錄傷口外觀、範圍大小、深度、顏色、味道、是否有異常分泌物等；(2) 換藥時以乾淨的棉棒依順序由傷口中央往外進行環形擦拭：生理食鹽水→優碘→生理食鹽水；(3) 清洗範圍須大於傷口基部半徑五公分以上，應來回擦拭，將傷口之分泌物清除，直到清潔為止；(4) 勿隨便塗用不明藥物，以免傷口惡化

Which of the follows is incorrect in wound management? (1) Daily observe and record the appearance, range in size, depth, color, smell of the wound, and if there is any abnormal secretion, etc.; (2) In dressing change, annularly wipe the wound with clean cotton swabs in a sequential order respectively from the center outwards: normal saline → Povidone-iodine → normal saline; (3) Cleaning area should be more than 5 cm of radius from base of the wound, wiping back and forth is required to remove secretions from the wound until completely cleaned; (4) To prevent aggravation of the wound, do not voluntarily apply any medications other than the prescription.

5. () 壓傷的預防方法，下列何者錯誤？(1) 以中性肥皂和清水基本身體清潔，保持皮膚清潔乾燥；(2) 皮膚皺摺處更需每天清洗，並檢查全身皮膚有沒有發紅破皮現象發生；(3) 皮膚可抹凡士林，並按摩易受壓或發紅部位，但不要使用在皮膚有破損的部位；(4)

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隨時保持身體、衣物、床單、坐墊的清潔乾燥及平整，以免皺摺形成壓力點

Which of the follows is incorrect in prevention of pressure injury? (1) Basically clean the body with neutral soap and clear water to keep the skin clean and dry; (2) It is especially required to clean the body folds every day, examining if there is any reddish or cracked skin over the whole body; (3) Vaseline may be applied on the skin, massage the sites liable to pressure or redness, but never apply on the sites with damaged skin; (4) Always keep the body, clothes, sheet and cushion clean, dry and neat to avoid any compressed site resulted from folds.

6. () 壓傷的預防方法身體營養應注意病人的狀況，下列何者錯誤？(1) 足夠水份每天約喝 2,500~3,000 mL；(2) 多攝取蛋白質如魚、肉、豆、蛋、奶類；(3) 多補充維他命 C 如柳橙、奇異果；(4) 可吸菸、喝酒，以保持情緒樂觀

In prevention of pressure injury, which of the follows is incorrect in paying attention to patient's nutritional status? (1) Drink sufficient amount of water about 2,500 to 3,000 ml per day; (2) Ingest more proteins such as fish, meat, bean, egg, and dairy products; (3) Frequently supply vitamin C, e.g. orange, kiwi, etc.; (4) Smoking and drinking are acceptable, keeping sound emotional management.

(答對 5-6 題⇒完全了解；答對 3-4 題⇒部分了解；答對 1-2 題⇒完全不瞭解)
(Correct in 5 or 6 questions ⇒ completely understood; correct in 3 or 4 questions ⇒ partially understood; correct in 1 or 2 questions ⇒ not understood at all)

1.(O) 2.(X) 3.(O) 4.(3) 5.(3) 6.(4)

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