移工生活關懷

Taipei City Foreign Caregivers Manual

臺北市外籍看護照顧手冊

英文版
ENGLISH

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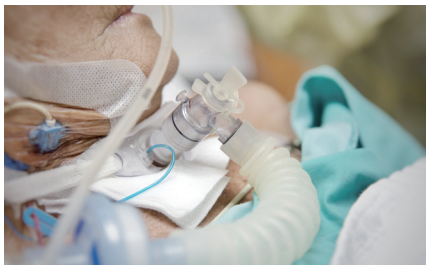

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Foreword
前言

The Art of Care
照顧的藝術

Care is a work of labor and toil with mind and body. Preparation of meal, feeding, assistance in displacement, assistance in bathing, accompanying the cared-for to visit a physician, communication with the patient / ward, and interaction with other family members of the patient are all parts of the care work. A caregiver is sometimes in a state of nervousness and confusion, most of the time afraid that there might be a possible mistake.

照顧是一件既勞心又勞力的工作。舉凡備餐、餵食、協助移位、協助沐浴、陪伴就醫、與被看護人溝通、與其他家庭成員互動等都是照顧的一環，看護工作者無時無刻都處於戰戰兢兢的狀態，深怕有個萬一。

As caregivers, we must have “patience,” “perseverance” and “concentration” as well as “kindness” and “sincerity” towards these works. During the process of taking care of the patients or wards, this will agitate a different spark. Therefore, “caretaking is also an art.”

身為看護工作者，對於照顧工作，我們必須具備三心二意，要有『耐心』、『恆心』、『專心』，以及『心意』、『誠意』，照顧過程中的每個環節都會激盪不同的火花，所以說「照顧，也是一種藝術。」

Nevertheless, in order to make yourself more proficient in caretaking and to accomplish the work with ease, you need to fully learn certain diseases and all kinds of care knowledge and skills.

然而，如何讓自己可以更得心應手的照顧，一個人也可以游刃有餘，那麼對於疾病或是各種照顧知識與技巧就需要充分了解，掌握內涵，如此照顧工作方能順利進行。

Furthermore, apart from busy taking care of the patient or ward, caregivers also have to pay attention to their own physical and mental state at all times. Once you have a physical or mental discomfort, you should let the employer know and avoid bearing the burden alone. It is important and necessary to learn self protection.

此外，除了忙於照顧外，看護工作者也要隨時注意自己的身心狀態，一旦發現自己有身體或心理不舒服，都要反應給雇主知道，避免獨自承擔，學習自我保護是重要，也是必要的。

The work of care is tedious and painstaking. However, it is also an important process for mutual support and care among people. It is an act of love. Because of you, families and the society become more stable and wonderful.

照顧工作繁瑣又辛苦，但也是人與人之間相互扶持和照顧的重要過程，是一種大愛的表現，因為有你，讓家庭和社會穩定和美好。

Hand Hygiene
手部清潔

教學影片

Purpose | 目的

To keep hands clean at all times, remove dirt, prevent caregiver and the patient from viral infection with the environment, and prevent the spread of germs to others. Washing of hands can achieve the effect of protection.

清潔雙手，去除污垢，預防看護者、被看護人與環境間交互感染，並傳播病菌，確實洗手可達到保護作用。

When to wash hands | 洗手時機

The caregiver must wash both hands before and after touching the person being cared for, including measuring body temperature, pulse, blood pressure and blood sugar, assisting in displacement,bathing, dressing, combing hair, feeding, sputum suction and wound care, or handling the urinary bag and the cystostomy opening as well as organizing surroundings or utensils of the person being cared for in order to truly protect each other and to avoid catching infection from each other.

接觸被看護人前後都必須洗手，包括為被看護人測量體溫、脈搏、血壓、血糖、協助移位、沐浴、穿衣、梳頭、餵食、 抽痰、傷口處理，或是處理尿袋、造廔口處理、整理被看護人周遭環境或用具等，以確實保護彼此，避免相互感染。

Preparation for necessary items | 用物準備

Liquid soap (or bar soap), paper towels (or hand towels).

洗手液（或肥皂）、擦手紙（或是毛巾）。

Step 步驟

▶▶▶ Steps for proper hand washing
洗手的正確步驟

step 1

Remove the watch and any accessories from hands. Steps for proper hand washing.

除去手錶及取下手上任何之飾品。

step 2

Roll up sleeves about 2-5 cm above the elbow joint.

將衣袖捲至肘關節上 2-5 公分。

step 3

Rinse your hands with clean water, and then press the liquid soap onto both hands and keep hands lower than the elbow.

以清水潤濕手部後，按壓洗手液於雙手並保持手部低於手肘。

step 4

Keep rubbing your hands until having lather, and each part of your hands should be rubbed for at least 5 to 10 times (or at least 30 to 40 seconds).

搓揉雙手至泡沫產生每個部位搓洗至少 5-10 下（時間至少 30-40 秒）。

step 5

Rinse off the liquid or bar soap from your hands under running water.

用流動水沖去手上之洗手液。

step 6

Dry your hands with paper towels or a clean hand towel.

用擦手紙或乾淨毛巾擦乾雙手。

02

Common home inspections

居家常用檢測

Common home inspections
居家常用檢測

The four indicators, including body temperature, pulse rate, respiratory rate and blood pressure, are referred to as the vital signs, which represent physical conditions of an individual at the time.

體溫、脈搏、呼吸、血壓此四項指標，稱之為生命徵象， 代表著每個人目前身體狀況。

Since these four item indicators are very important basis for the caregivers, it is recommended that each item should be measured at least once every day. In addition, exercise, bathing (sponge bath), feeding (tube feeding) and emotional situation should be avoided 30 minutes prior to the measurement of the aforesaid four items. In case of an occurrence of the aforesaidsituations, measurement should be conducted 30 minutes later to avoid affecting the measured values and causing errors on the data interpretation.

由於這四個項目指標，在照顧上是非常重要的依據，建議每個項目每天至少都要測量一次，且在測量前 30 分鐘，應避免運動、洗澡（擦澡）、進食（灌食）、及發生情緒激 動情形，若有上述情況發生，請間隔 30 分鐘後再行測量，以免影響測量值，造成數據上判讀之誤差。

Please remember to wash your hands before and after taking the measurement! Avoid catching infection from each other to protect yourself and the person being cared for by you!

記得測量前後，請記得洗手喔！避免相互感染，保護自己也保護被看護人喔！

Easy operating instructions on how to measure bodytemperature, pulse rate, respiratory rate and blood pressure are given as follows.

如何測量體溫、脈搏、呼吸、血壓，以下有簡易操作說明：

Body Temperature Measurement
測量體溫

教學影片

Preparation for necessary items｜用物準備

Thermometer (ear thermometer, earmuff or digital thermometer), a record book.

體溫計（耳溫槍、耳套或電子體溫計）、紀錄本。

Step 步驟

▶▶▶ When using the ear thermometer
以使用耳溫槍為例

step 1

Check first whether there is any ear wax in the ear; excessive ear wax will interfere with the infrared heat and affect the measurement.

先檢查耳朵有無耳垢，耳垢過多，會干擾紅外線熱能，影響測量。

step 2

Use a cotton swab to clean the earwax if there is any.

若有耳垢則用棉棒清潔。

step 3

Put on the earmuff and turn the power on.

套上耳套並打開電源。

step 4

When inserting an ear thermometer, pull the ear down and back for children under three years old or pull up and back for children over three years old. In this way, the ear thermometer can correctly detect the ear tympanic membrane to obtain the standard temperature.

放置耳溫槍時，三歲以下，要把耳朵往下往後拉，三歲以上要把耳朵向上向後拉。使耳溫槍能正確偵測到耳朵鼓膜，以獲得標準溫度。

step 5

Put the ear thermometer into the external auditory meatus, and press and hold the measuring button until hearing beeps, indicating that an ear temperature is obtained.

將耳溫槍置入外耳道，長按測量鈕，待聽到嗶嗶聲，便可得到耳溫。

step 6

Record the measured data, such as: 38.3 °C.

紀錄數據，如：38.3℃。

Step 步驟

▶▶▶ When using the digital thermometer
以使用電子體溫計為例

step 1

Turn on the digital thermometer and place the metal end of the thermometer under the armpit and hold it tightly.

打開電子體溫計，讓金屬端置於腋下夾緊。

step 2

When hearing two beeps, data shown on the screen is the axillary temperature.

當出現嗶嗶二聲，螢幕上之數據即為腋溫。

step 3

Record the measured data, such as: 38.5 °C.

紀錄數據，如：38.5℃。

Notes | 注意

1. It is very important to pull the auditory meatus straight for an accurate temperature measurement. For a baby less than three years old, the ear must be pulled back and down, and for a person more than one year old (including an adult), the ear should be pulled up and back.

   拉直耳道對測溫準確與否很重要，三歲以下，要把耳朵往下往後拉，三歲以上要把耳朵向上向後拉。

2. When ear temperature exceeds 38° C or axillary temperature exceeds 37.5° C, it indicates that the person being measured is having a fever. The patient or ward should drink lots of fluids, and the caregiver should immediately contact the employer to assess whether the patient or ward should seek medical treatment.

   當耳溫超過 38℃、腋溫 37.5℃以上，即表示開始有發燒情形，請予多補充水份，同時聯繫雇主，評估是否就醫。

Respiration Measurement
測量呼吸

教學影片

Preparation for necessary items｜用物準備

A watch with a second hand (or an electronic watch, a mobile phone, etc.), a pen, a record book.

使用有秒針的錶（或是電子錶、手機等）、紀錄本、筆。

Step 步驟

step 1

Measurement shall be performed at least once a day, and exercise, bathing (wiping), eating (feeding), and emotional agitation should be avoided 30 minutes before the measurement, If any of the above occurs, please take the measurement again after an interval of 30 minutes to avoid affecting the measurement value and causing errors in data interpretation.

每天至少都要測量一次，且在測量前 30 分鐘，應避免運動、洗澡（擦澡）、進食（灌食）、及發生情緒激動情形，若有上述情況發生，請間隔 30 分鐘後再行測量，以免影響測量值，造成數據上判讀之誤差。

step 2

Observe with your eyes the ups and downs of the chest and abdomen of the cared-for for one minute (each up and down is counted as one breath).

用眼睛觀察被看護人之胸部起伏一分鐘（上下起伏計算為一次）。

step 3

Carefully measure the depth, breathing rate, rhythm and sound of breathing.

仔細測量呼吸之深度、速率和節律及呼吸的聲音。

step 4

Record the measured data, such as: 15 breaths / minute

紀錄數據，如：15 次／分。

Notes | 注意

Observe whether the person being cared for has purple lips, difficulty breathing, dyspnea, or breathing noise.

觀察被看護人是否有嘴唇發紫、呼吸困難、呼吸費力、呼吸雜音。

Blood pressure and pulse measurements
測量血壓與脈搏

教學影片

Preparation for necessary items | 用物準備

An electronic sphygmomanometer, a record book, a pen.

電子血壓計、紀錄本、筆。

Step 步驟

step 1

In addition, exercise, bathing (sponge bath), feeding (tube feeding) and emotional situation should be avoided 30 minutes prior to the measurement of the aforesaid four items. In case of an occurrence of the aforesaidsituations, measurement should be conducted 30 minutes later to avoid affecting the measured values and causing errors on the data interpretation.

在測量前 30 分鐘，應避免運動、洗澡（擦澡）、進食（灌食）、及發生情緒激 動情形，若有上述情況發生，請間隔 30 分鐘後再行測量， 以免影響測量值，造成數據上判讀之誤差。

step 2

Assist the care recipient to adopt a comfortable posture, such as sitting or lying down. Roll up the sleeve of the arm of the patient or ward to the upper arm or pull the sleeve straight, then find the position of the brachial artery and make sure that the brachial artery position is at the same level as the heart.

協助被看護人採舒適的坐姿或臥姿，手臂可用小枕頭、小浴巾或被單支托。將被看護人衣袖捲至上臂或將袖子拉平順，找出肱動脈位置，使肱動脈位置與心臟同高。

step 3

Place the blood pressure monitor in a smooth place, and have the palm of the patient facing up; wrap the cuff around the upper arm, and lower edge of the cuff should be 2-3 cm away from the cubital fossa. You should be able to insert 2 straight fingers between the cuff and the arm for an accurate fit. If there is a mark '♂' (midpoint of force application of the inflatable bag) on the cuff, then you should let the mark aim at the brachial artery.

血壓計放於平穩之處，讓被看護人手心朝上，將壓脈帶纏繞在上臂，壓脈帶下緣位置須距肘關節窩 2-3cm 處。壓脈帶鬆緊以伸入兩平指為宜，若壓脈帶上有 ♂ 之記號（充氣囊之施力中點），則將之對準肱動脈。

step 4

Press the measuring button

按下測量鍵。

step 5

Make sure you have a correct reading, and then remove the cuff.

確定測量結果，取下壓脈帶。

step 6

Record the measured data, such as: 120/80 mmHg

紀錄數據，例如：血壓 120/80 mmHg、脈搏 70 下 / 分。

Notes | 注意

1. Please pay attention to the posture of the patient. The patient should have a proper support under the arm for the measurement.

   注意被看護人的姿勢，測量時手臂應有適當的支托。

2. Select an appropriate spot for the measurement, and it is better to have the same spot for every measurement.
   Both arms of the person being cared for should be measured for the first time. The arm with higher blood pressure value should be the arm for the following measurement. In case the difference between the diastolic blood pressures of both arms is more than 10 mmHg or the difference between the systolic blood pressures of both arms is more than 20 mmHg, the measurement should be performed one more time. The caregiver also should understand whether there is a problem of aortic stenosis or other problems. In addition, you should make sure if the mark on the cuff truly aligns with the point of maximal impulse of the brachial artery.

選擇適當的測量部位，最好每次測量同一部位。
首次測量被看護人血壓應雙手都量，之後以數值較高那側為主，若雙手舒張壓相差 10 mmHg 或收縮壓相差 20 mmHg 以上，應再確認一次，並了解是否主動脈狹窄或其它問題。另次監測時，確認壓脈帶監測，是否確實對準肱動脈最大搏動點。

3 When the arm for measuring blood pressure is exposed, the caregiver should keep the patient warm, and roll down the sleeve as quickly as possible after finishing the measurement so that the patient will not catch cold.

測量血壓，露出手臂時，要注意保暖，測量完畢後也要盡快整理衣袖，以免著涼。測量血壓，露出手臂時，要注意保暖，測量完畢後也要盡快整理衣袖，以免著涼。

4 Try to take the measurement on a naked arm. The patient can wear a thin underwear or long sleeve for the measurement in cold weather, but the clothing must be smoothed.

儘量測量赤膊的手臂，天冷時，可穿薄內衣或長袖測量， 但須將衣服撫平整。

5 Depending on situations, if it is necessary to repeat the measurement, it is better to have the patient rest for one to two minutes or allow the arm to have a little exercise prior to taking another measurement. In addition, the cuff should be loosed to press the air out of the air bag.

視情況，若需重複測量時，最好暫停 1-2 分鐘或活動一下手後再測，且壓脈帶要放鬆，並壓出氣囊內空氣。

6 In general, normal value of systolic blood pressure is 90-140 mmHg, and normal value of diastolic blood pressure is 60-90 mmHg (50-90 mmHg).

一般血壓正常值為收縮壓：90-140 mmHg; 舒張壓：60-90 mmHg。

7 When measuring blood pressure, the factors causing blood pressure measurement error include: pseudo high blood pressure and pseudo low blood pressure.

測量血壓時，造成血壓測量誤差的因素可分：血壓假性偏高、血壓假性偏低。

(1) Pseudo high blood pressure / 假性偏高

A. The arm position of the person being measured is lower than the position of the heart.

被測者手臂位置低於心臟。

B. Fail to use an appropriate cuff: The cuff is too narrow so that the measured value is higher.

未能使用大小合宜之壓脈帶：太窄時，測出的值較高。

C. Wrapping of the cuff is too loose or uneven (requiring more pressure in order to suppress the brachial artery).

壓脈帶包裹得太鬆或不平均
（則需要更大的壓力才能壓住肱動脈血流）。

D. Usually the measured value of blood pressure is higher when the person being measured is smoking, having an inflated bladder, after having a meal, after taking an exercise, or having emotional anxiety and tension at the time of the measurement.

被測者抽煙時、膀胱脹時、尿急時、或進餐後、運動完或情緒焦慮緊張時測量，測出的數值較高。

(2) Pseudo low blood pressure / 假性偏低

A. The arm position of the person being measured is higher than the position of the heart.

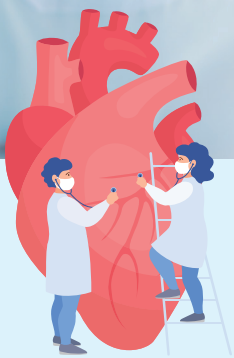
被測者手臂位置高於心臟。

B. The cuff is too wide so that the measured value is lower.

壓脈帶太寬，測出的值較低。

8 When the blood pressure value remains high, which is higher than 160/100 mmHg, accompanied by a change of consciousness, general weakness and slurred speech, or the blood pressure value continues to be lower than 90/60 mmHg along with icy cold limbs and dizziness, the caregiver should immediately notify the employer to take the patient to a hospital as soon as possible.

當血壓值持續偏高，大於 160/100 mmHg，或伴隨有意識改變、全身無力、口齒不清；血壓值持續偏低，小於 90/60 mmHg，或伴隨四肢冰冷、頭暈等不適症狀，請立刻告知雇主，儘速就醫。



9 The radial artery is located “at the wrist below the side of the thumb, and is the most common spot for measuring the pulse rate.”

橈動脈位於『手腕靠大拇指側的下方，是最常測量之脈搏點』。

10 In case the measured pulse rate exceeds 100 beats per minute or less than 50 beats per minute accompanied by chest tightness, cardiac discomfort or short of breath, the caregiver should appease the emotion of the patient or ward, supply oxygen and, at the same time, contact the employer as soon as possible, and provide assistance in taking the patient or ward to a hospital.

當脈搏跳動每分鐘超過 100 次或小於 50 次，伴隨有胸口悶、心臟不適感、呼吸急促，請予情緒安撫、提供氧氣，同時請盡快聯繫雇主並協助送醫。

11 In case the aforesaid discomfort condition of 2. occurs, it is necessary to measure carotid artery in order to ensure vital sign state.

如有 2. 不適情況，需測量頸動脈，以確保生命徵象狀態。

Blood Glucose Measurement
測量血糖

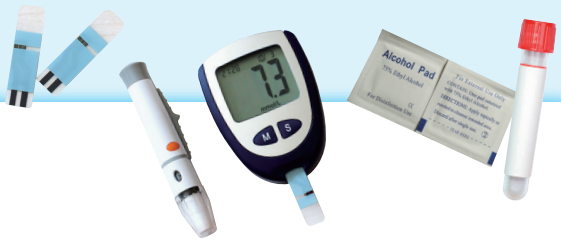
教學影片

Preparation for necessary items｜用物準備

Blood glucose meter, test strips, a lancing device, lancets (pocket or pen knife), alcohol swabs, a sharp container.

血糖機、試紙片、採血筆、採血針、酒精棉片、針頭收集筒。

Step 步驟



step 1

Turn on the blood glucose meter, and then take out one test strip and insert it into the blood glucose meter.

血糖機開機，取出試紙片並插入血糖機。

step 2

Put a lancet onto the lancing device and adjust a proper scale.

採血筆裝上採血針，調整適當刻度。

step 3

Select the outer end of a finger for taking blood, and blood should be drawn from different part of a finger in rotation.

選擇手指末端外側，需輪換不同部位採血。

step 4

Use the thumb to gently rub a spot, where blood is to be drawn, to make it congest with blood, and temporarily hold down the spot.

用大拇指輕揉預採血部位使其充血，並暫時壓住。

step 5

Use alcohol swab to disinfect the blood-drawing spot; take a drop of blood after the spot is dry to avoid affecting the blood glucose level.

用酒精棉片消毒採血部位。待乾後再採血，以免影響血糖值。

step 6

Keep the lancing device close to the blood-drawing spot and then jab at the spot with the lancet; squeeze a small amount of blood onto the test strip and wait for the data to show.

採血筆貼緊採血部位，扎針後，擠出適量血量滴入試紙片上，待數據出現。

step 7

Record the measured data.

紀錄數據。

step 8

Give the hypoglycemic agent or insulin to the patient or ward according to the prescription.

依照處方給予降血糖藥物或胰島素。

Notes | 注意

1. Measure blood glucose level at least once every day before a meal; in case of any unstable blood sugar conditions, number of measurement per day should be increased.

   每天至少餐前測量一次，若有發現血糖不穩現象，請增加測量次數。

2. Test strips should be stored in a dry place at room temperature.

   試紙片請放置常溫、乾燥處。

3. The lancet should be thrown into the sharp container after the blood is drawn. When the container is about 70% to 80% full, it should be brought to a medical facility for recycles. Please remember, a lancet can only be used once.

   採血針請於採血後，丟到針頭收集筒，7-8 分滿拿回醫療院所回收；切記僅能單次使用。

4. Do not squeeze hard if insufficient amount of blood is drawn; use a different test strip for taking the blood one more time.

   採血時若血量不足勿硬擠，請更換試紙片，再次進行採血。

5 Blood glucose value / 血糖值

(1) Normal person / 正常人

Have an empty stomach for eight hours before a meal, and the blood glucose value should be lower than 100 mg/dl; the blood glucose value should be lower than 140 mg/dl two hours after a meal.

飯前空腹八小時應低於 100 mg/dl；飯後兩小時，血糖值低於 140 mg/dl。

(2) Diabetic patient / 糖尿病患者

It is recommended to keep blood glucose level within 80-120 mg/dl on an empty stomach for three meals. In order to avoid low blood sugar at night, it is better to keep the blood sugar level within 100-140 mg/dl before going to bed.

建議三餐空腹血糖應控制在 80-120 mg/dl；為避免半夜低血糖，睡前血糖最好控制在 100-140 mg/dl。

6 Blood glucose abnormality treatment / 血糖異常處理

(1) Low blood sugar / 低血糖

A. Definition / 定義

If plasma glucose is lower than 70 mg/dl, it means blood sugar is too low. However, the following symptoms may occur to some people only when blood sugar is lower than 50 mg/dl. Therefore, special attention must be paid.

定義：如果血漿糖低於 70 mg/dl 以下就表示血糖太低，但有些人可能低於 50 mg/dl 以下才會出現下列症狀，所以應特別注意。睡前血糖最好控制在 100-140 mg/dl。

B. Symptoms / 症狀

Mild symptoms: Sensation of hunger, trembling in every limb, palpitation, looking pale, in a cold sweat, headache, dizziness, irritability, weakness, fatigue or numb lips.

輕度：當有飢餓感、四肢發抖、心悸、臉色蒼 白、冒冷汗、頭痛、頭暈、易怒、虛弱、疲倦、嘴唇麻等症狀。

Severe symptoms: Slow in reacting, abnormal behaviors, inability to concentrate, absentminded, slurred speech or loss of consciousness.

重度：反應遲鈍、行為反常、注意力不集中、精神恍惚、口齒不清、意識喪失。

C. Treatment / 處理

Treatment: Give the patient 10 to 15 grams of sugary juice, sugar water (sugar cubes would be the best) or one pouch of drink in aluminum foil when the patient is with clear minds; after 10 minutes, the caregiver should determine whether it is necessary to give sugar or sugar water to the patient one more time depending on conditions.

處理：意識清楚時先給 10-15 公克含糖的果汁或糖水（最好是方糖）或鋁箔包飲料 1 瓶，10 分鐘後視情況再決定是否須再給一次。

(2) If blood sugar level is already lower than 100 mg/dl before taking any exercise, it is suggested to supplement 15 to 20 grams of carbohydrate food (such as one slice of toast or two saltine crackers) prior to taking an exercise.

運動前的血糖已經低於 100 毫克／百毫升，建議先補充 15-20 克的醣類食物（例如一片土司或是兩片蘇打餅）後，才開始進行運動。

(3) In case an unconsciousness situation occurs without timely detection, please notify the employer to take the patient to a hospital immediately.

若無及時發現而發生意識不清狀況，請告知雇主立刻送醫。

(4) High blood sugar / 高血糖

If the measured blood sugar level is higher than 200 mg/dl in normal days, please notify the employer and contact the daily diabetes team to seek advice on care.

當平日測量血糖值高於 200 mg/dl，請告知雇主，聯絡平日的糖尿病團隊，尋求提供照顧建議。

03

Body Care
身體照顧

Instruction on feeding
餵食須知

Notes on meal preparation | 備餐須知

The most important part of meal preparation is cleanliness. Please prepare food by following instructions of the doctors. Different meals (such as: liquid, soft food, and food in small and broken bits) should be prepared according to doctors orders and patients physical conditions.

備餐首重清潔；製作食物請遵照醫護人員建議，依照疾病進展及復健狀況，準備不同餐點（如：流質、軟質、細碎）。

Feeding safety principles | 餵食安全原則

1. Pay attention to the patient's state of consciousness prior to feeding, and do not feed the patient if there is any abnormal condition.

   餵食前須留意病人的意識狀況，若有異狀請勿餵食。

2. 

   Pay attention to patient's head and neck posture prior to feeding. Postures such as lying down or head bending backwards should be avoided. The patient should sit upright with the head bending forward about 60 degrees when eating withthe mouth, and the head bending forward about 45 degrees when eating from the nasogastric tube.

   餵食前應注意被看護人的頭、頸部姿勢，避免平躺或頭部後仰，上半身宜坐正，由口進食頭部向前彎約 60 度，鼻胃管進食頭部向前彎約 45 度，維持食道通暢，避免吸入性嗆傷。

3. 

   The caregiver should start with small meals when feeding the patient, and give another mouthful of food after confirming that food is completely swallowed by the patient.

   餵食時，應以少量食物開始，並確認食物完全吞嚥後，才可以餵食下一口。

Common feeding problems: Dysphagia
常見餵食問題：吞嚥困難

Dysphagia means that it takes more time and effort to move food or liquid from your mouth to your stomach. Choking often occurs when taking liquid food.

吞嚥困難是指食物不易從口腔吞嚥到胃，尤其是流質食物，因此常有嗆到的狀況產生。

Stroke, Parkinson's disease, oral cancer, nasopharyngeal cancer and tongue cancer patients after surgery combined with radiation therapy are the group of afflictions prone to dysphagia.

中風、巴金森氏症、口腔癌、鼻咽癌、舌癌等癌症術後合併放射線治療者，是吞嚥困難好發族群。

To avoid any choking accident, which may lead to complications such as respiration, pneumonia, hence,the caregiver should pay attention to the head and neck posture, and food in sticky paste is more suitable for the patient. The patient should not have excessive oral intake per bite.

為避免造成嗆到意外，引發吸入性肺炎等併發症，除了注意頭頸部姿勢，食材應以黏稠糊狀為宜，且每口進食的份量不宜過多。

Food can be smashed using a food processor or food stirring rod, or food can be prepared using the thickening agent to facilitate eating.

食物可利用食物處理機或是食物攪拌棒打碎或使用增稠劑，方便進食。

Roll-Over Skills
翻身技巧

教學影片

Purpose｜目的

In order to avoid bedsores generation, frequent roll-over is an important key.

為了避免壓傷產生，勤翻身是重要的關鍵

Preparation for necessary items｜用物準備

Pillows, roll-over sheet, towels (make it a scroll).
枕頭、翻身中單、毛巾 (製成捲軸)。

Notes | 注意

1. Roll-over should be performed at least once every 2 hours (taking turns on lying down, lying on the left side and lying on the right side).

   至少每 2 小時翻身一次（正躺、左側臥、右側臥，三邊輪流）。

2

Use of assistive devices to support body: Make good use of pillows of various sizes at home, or roll towels into scrolls and place them as supports on the back, between legs or at the bony protrusion to maintain normal body position to prevent joint contracture and deformity as well as bedsores.

運用輔具支托身體：可善用家中的各種大小枕頭，或可將毛巾簡易製成大小捲軸，墊在背後、雙腿間或骨突處，維持正常體位，預防關節攣縮變形及壓傷。

3

Clap and massage the patient on the back when performing roll-over, which can promote circulation and loosen mucus to facilitate discharge of mucus. Do not clap or massage too hard to avoid injury.

翻身時搭配拍背和按摩，可以鬆動痰液利於排出及促進循環，切勿過於用力，以免受傷。

4

The caregiver should cup one hand when clapping the patient's back and clap on the upper part of the back (below the shoulder and above the ribs). The spine will be regarded as the midline, and the caregiver should pat or massage gently on both sides. Do not pat on bony protrusion and both sides of the waist to avoid injury.

拍背時，手成杯狀，拍打範圍為上背部（肩膀以下至肋骨以上），以脊椎骨為中線，輕拍兩側或輕柔按摩，切勿拍骨突處及腰部兩側，以免受傷。

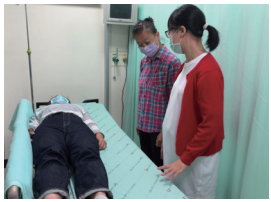
Step 步驟

Roll-over Steps
翻身步驟

Demonstration: Rolling over a patient's body from lying down onto the position of lying on the right side operated by a single person.

示範：單人操作由平躺轉右側臥 。

step 1



The caregiver should stand on the right side of the patient or ward. The caregiver also has to pay attention to the available distance from the edge of the bed to the right side of the patient to make sure there is enough space for the roll-over to avoid falling. If the available space from the edge of the bed is insufficient, the caregiver should move the patient in parallel to the left side of the bed and then roll over the body of the patient.

請看護者站在被看護人的右側，並留意被看護人右側床緣距離是否足夠，避免因翻身而跌落，若床緣距離不足，先將被看護人平行移動至左側再行翻身。

step 2

Bend the left leg of the patient or ward and bend the right hand and place it next to the ear; protect the person's head, and bend the left hand and place it in front of the chest; if the patient has stiffness and contractures in upper limbs, one of his/her hand can be located on the shoulder and the other on the hip.

將被看護人左腳彎曲、右手彎曲置於耳朵旁，保護頭部、左手彎曲置於胸前，若被看護人上肢僵硬攣縮，則可一手在肩一手在臀。

step 3

The caregiver should place the left hand on the shoulder of the patient and place the right hand on hip of the patient, and then use both hands simultaneously to roll the person's body into a position of lying on the right side.

看護者左手放在肩膀，右手放在臀部，兩手同時出力，翻成右側臥，也可使用翻身單協助翻身。

step 4

Put a rollover pillow on the back of the patient or ward to support the back and fix the right lateral decubitus. If there is a fracture, please use the turn over sheet to turn over

拿一個翻身枕置於被看護人背後，以支托背部，固定右側臥姿，如有骨折之情形，請使用翻身單翻身。

step
5

Pull out the shoulder of the patient or ward to reduce local pressure and increase comfort; do not pull the shoulder hard to avoid shoulder joint injury, if there are tubes, please confirm whether there is pressure and keep the tubes unblocked.

再將被看護人肩膀拖出，減少局部受壓，增加舒適感，切勿用力拉扯，避免肩關節受傷，如有管路，請確認是否有壓迫的情形並維持管路暢通。

step 6

Put a rollover pillow between two legs of the patient or ward; bend the leg in the upper position and use a pillow to support the leg; the leg in the lower position should be placed straight.

放置一個翻身枕在被看護人的兩腿之間，上位腿彎曲，並墊一枕頭支托，下位腿伸直。

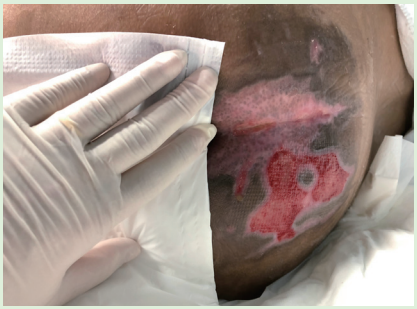
step 7

Finally, place pillows in all gaps of the person's body and the bony protrusions, which can be easily oppressed, to avoid causing bedsores.

最後，拿枕頭置於身體各處空隙及容易受壓迫之骨頭突起處，以避免造成壓傷。

Bedsore Care
壓傷照顧

教學影片



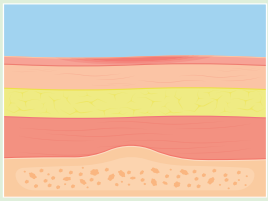
What are bedsores ? | 何謂壓傷 ?

Bedsores are injuries to the skin and tissue caused by sustained pressure, where arterial blood supply of the very sensitive areas is blocked. If the pressure continues for more than six hours, it may lead to tissue damage and dead skin cell. Bedsores also can be caused by moisture, uneven underclothes, or improper shearing force.

壓傷乃因身體局部承受外在持續的壓力，使得該區的動脈血流供應受阻，若壓力持續六小時以上，組織就會壞死。壓傷亦會因潮濕或衣褲不平整及不當的剪力皆會造成。

Bedsore grades | 壓傷分級

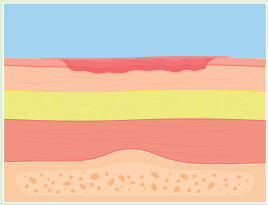
Grade 1 第一級



Skin of the pressure areas is permanently red but is not broken at all.

受壓部位皮膚發紅，但未破皮。

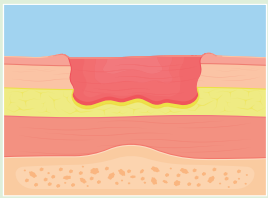
Grade 2 第一級



Partial-thickness skin loss of the pressure areas involving damage of the skin.

受壓部位皮膚有破皮且傷及皮膚。

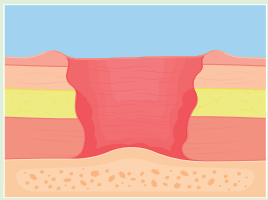
Grade 3 第一級



Full thickness skin loss of the pressure areas involving damage of skin.

受壓部位皮膚傷及真皮層。

Grade 4 第一級



Full thickness skin loss of the pressure areas involvingdamage of the muscular layer, or bones and skeleton.

受壓部位皮膚傷及肌肉層或骨骼。

Non-gradable grade: "All body black, please seek medical attention as soon as possible"

＊不可分級的等級：「全部發黑，請盡速就醫」。

Avoid shearing force | 如何避免壓傷

1. If the patient is unable to move on his/her own, a pillow should be placed beneath the knees if the patient is in a semi-lying position on the bed to avoid the shearing force when the patient is slipping down.

   無法自行移動的病患，若在床上採取半坐臥，應在膝蓋下放一個枕頭，以免病患向下滑產生剪力。

2. When the caregiver wants to move the patient up and down as well as to the left or to the right, dragging the patient should be avoided. The caregiver should use the bed sheet to help move the patient.

   想要上下或左右移動病患時，避免拖拉病患，要以床單輔助來移動。

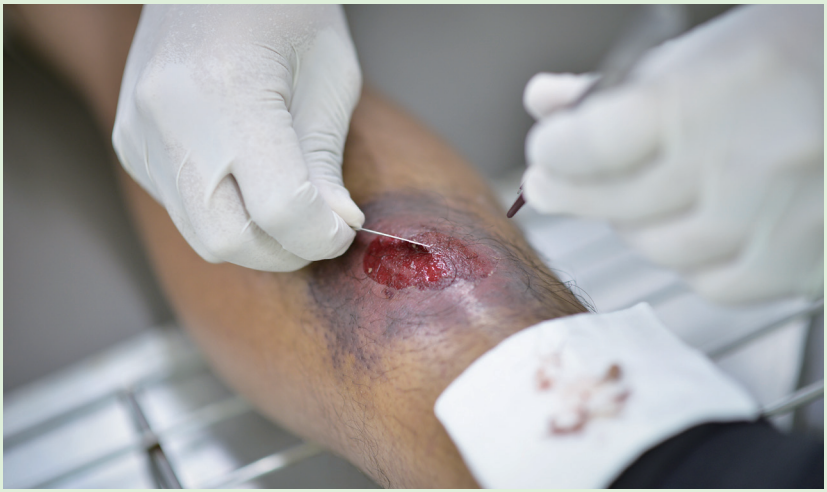
3. A pillow should be placed between the feet and the foot pedal to prevent the patient from slipping down.

   將枕頭置於腳和垂足板之間，以防病患向下滑。

High risk groups of bedsores | 什麼人容易壓傷

Dystrophy, anemia, edema, smoking, the elderly, unconsciousness, unable to roll over on their own, diabetes, and incontinence all belong to high risk groups of bedsores.

營養不良、貧血、水腫、抽菸、高齡者、意識不清、無法自行翻身、糖尿病、大小便失禁者，皆屬於壓傷的高危險群。



Bedsore wound care | 壓傷傷口的照顧

1. Closely watch skin conditions of the patient and make records:
Particularly the wound size, color and exudation. Length and width of the wound can be compared using the transparent paper by drawing marks of the wound size to measure length and width of the wound. Color and amount of the exudation also can be recorded, such as clean water, seriflux, pus, blood, etc. Follow the instructions of professionals to clean. If there is an upgrade or swelling, please notify family members promptly and assist in medical treatment.

密切觀察被看護人皮膚情形並做紀錄：特別是傷口的大小、顏色、與滲出物的情形。傷口的長寬可以用透

明紙比對，劃上傷口大小記號，再做長寬測量，亦可以將滲出物的顏色、量做紀錄。例如清水、漿液、膿液、血液…等。依照專業人士指示清潔，如有升級或是紅腫等情形請儘速通知家屬並協助送醫。

2. Protection before touching the skin of the patient or ward: The caregiver must thoroughly wash hands before and after performing physical care or changing bed linen and clothing. If there is any possibility of touching fluid or blood of the wound, the caregiver should wear gloves. Soap or lotion must not be applied to the skin lesion area. Crust of skin lesion area must not be stripped off arbitrarily.

接觸被看護人皮膚前的防護：為被看護人施行身體照顧或更換床單、衣物前後，皆須徹底洗手。若可能會觸及傷口的體液或血液，應戴手套。皮膚病變處不可使用肥皂、乳液；病變處的痂皮也不可擅加剝除。

3. Promote tolerance against pressure and damage to the skin / 促進皮膚對壓力及損傷的耐受力

(1) Balanced nutrition can prevent bedsores and promotehealing of bedsore wounds. Therefore, the caregiver should pay attention to eating conditions, and supplement nutrition when necessary.

均衡營養可預防壓傷及促進壓傷傷口的癒合，因此需留意被看護人的進食情形，必要時給予補充營養。

(2) Keep the skin clean and dry; apply lotion or ointment to the skin when necessary; massage the lotion or ointment to the skin to avoid skin dryness.

保持皮膚的清潔乾爽，必要時塗擦乳液、油膏，用按摩的方式避免皮膚乾裂。

(3) If the person being cared for is a patient of uncontrollable urination or defecation, the caregiver should pay special attention to the cleanliness of the skin to block skin irritation caused by urine and bowel movement. Vaseline can be applied to the skin around the anus after defecation when necessary.

若為大小便失禁者，應特別留意其皮膚清潔，以阻斷尿液糞便對皮膚的刺激，必要時可在排便後，塗擦凡士林於肛門周圍的皮膚。

(4) Massage can promote blood circulation of the skin, so it can be applied to the redness of the unpressurized skin. The skin blood circulation can be promoted by means of massage. You may consult professional nursing personnel for detailed massage steps.

對於未受壓發紅的皮膚，可藉按摩來促進皮膚的血液循環，詳細按摩步驟可請教專業護理人員。

4 Use appropriate assistive devices, such as air beds or air cushions, which can relieve pressure on the skin; do not use an air sphere, because it will stop the blood circulation of the pressure area.

使用適當的輔具，例如：氣墊床或坐墊，可以減輕皮膚受壓；不要使用氣圈，因其反而阻礙該部位的血液循環。

Wound Care
傷口照顧

教學影片

Preparation for necessary items｜用物準備

Sterile cotton swabs, sterile normal saline, sterile gauze, iodine solution or ointment, breathable paper tape.

無菌棉棒、無菌生理食鹽水、無菌紗布、優碘藥水或藥膏、透氣膠布。

Step 步驟

▶▶▶ Wound Handling Steps
傷口處理步驟

step 1

Prepare use items:
The caregiver should wash hands first, and then prepare items required for handling the wound, and also wear gloves.

用品準備：看護者洗手、準備傷口處理用物，並戴上手套。

step 2

Clean the wound:
Wash the wound using sterile normal saline and sterile cotton swabs (or gauze) to remove dirt and bloodstains.

清潔傷口：以無菌生理食鹽水及無菌棉棒（或紗布）沖洗傷口，去除髒污及血漬。

step 3

Wound care:
Dip a sterile cotton swab into the iodine solution and then disinfect from the wound center to the outer ring around the wound in a circular motion (do not wipe back and forth); 30 seconds later, dip a cotton swab into the normal saline solution to wipe clean with iodine solution.

傷口處理：依照醫生或專業人士指示上藥。

step 4

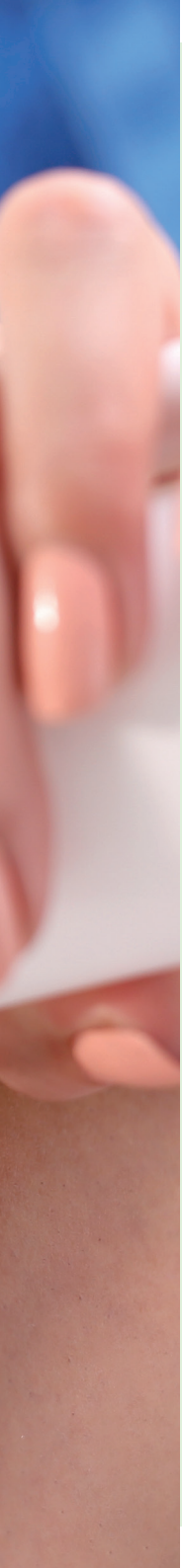
Bind up the wound:
Apply wound dressing over the wound and then stick the breathable paper tape on.

傷口包紮：蓋上敷料，敷料需大於傷口 2 公分， 貼上透氣膠布。

step 5

Observe and record the wound of the patient/ward for: especially the size, color, and exudates of the wound. The length and width of the wound can be recorded on transparent paper, marking the size of the wound, and then measuring the length and width, where the color and amount of the exudate can also be recorded. For example, water, serum, pus, blood...etc.

觀察被看護人傷口情形並做紀錄：特別是傷口的大小、顏色、與滲出物的情形。傷口的長寬可以用透明紙比對，劃上傷口大小記號，再做長寬測量，亦可以將滲出物的顏色、量做紀錄。例如清水、漿液、膿液、血液…等。



Notes | 注意

The caregiver should be gentle when changing or dressing of the wound, and the dressing can be damped first and then slowly removed. Lotion can be applied to tapes on the edge of the wound to avoid pain and further injury of the patient, hence this shows the attentive care of the caregiver.

換藥時應輕柔，傷口上的敷料可先沖濕後再緩慢撕下；傷口邊緣的膠帶，可抹乳液再行移除，避免增加被看護人疼痛感及二次傷害，同時也可展現看護工作者的細心。

Skin Care
皮膚照顧

教學影片

Skin is the largest and most important organ of a human body. It is a natural protective wall with functions of preventing rapid evaporation of moist, bacterial infection, regulation of body temperature, etc. Therefore, we need to take good care of it daily in order to maintain its normal operation so that it can continuously protect our health.

皮膚是人體最大且最重要的器官，是天然的保護壁，具有防止水分快速蒸發、病菌入侵、調節體溫…等功能，因此為了要維持其功能正常運作，我們需要天天好好的保護它， 使它可以不間斷的為我們的健康把關。

Routine care｜日常保養

1. Balanced with nutritious diet:
Including having adequate intake of calories, protein, proper vitamins, minerals, collagen and water to maintain tissue repair.

   均衡營養的膳食：包括攝取充足的熱量、蛋白質，適當的維生素、礦物質、膠原蛋白、水分等，維持組織修補功能。

2. Frequent use of moisturizer:
After taking a bath (or a sponge bath), apply lotion or body oil to the whole body to enhance skin tissue.

   充足保濕的使用：擦澡或洗澡後，予全身塗抹乳液，增加皮膚強度。

3 Increasing number of roll-over:
To reduce pressure of the body to avoid bedsores.

增加翻身的次數：減少局部身體受壓，造成壓傷。

4 Good cleaning habits:
Wash hands frequently, clean fingernails,taking a bath, use appropriate cleaning products, avoid alkaline soaps.

良好的清潔習慣：勤洗手、修指甲、愛洗澡，請選用合適的清潔用品，避免鹼性皂類。

5 Always have careful observations: always pay attention to bony protrusion and wrinkle areas to see whether there is any redness, infiltrations and other situations.

常常細心的觀察：請常注意骨突處及皺褶處，是否有發紅、浸潤…等情形。

Notes | 注意

Avoid using patent medicine:
If the patient has any uncomfortable symptoms, please consult a physician and do not give the patient any patent medicine which may lead to allergy symptoms, such as skin blisters, erythema and edema.

避免使用成藥：身體若有不適症狀，請諮詢醫師，避免私自使用成藥，導致過敏症狀，讓皮膚產生水泡、紅斑、水腫。

Constipation Care
便祕照顧

教學影片

What is constipation? | 何謂便祕？

Constipation refers to no bowel movements for at least 3 days or having a difficulty to defecate hard and dry stools.

三天以上沒解大便或大便乾硬有排便困難的情形，即稱之便秘。

Causes of Constipation? | 便秘的成因？

There are many causes of constipation, including small amount of fiber, small amount of water, lack of exercise, irregular bowel movements, relying on enemas or stool softeners, drug side.

引起便秘的導因很多，包括纖維量少、飲水量少、運動少、排便不規律、灌腸劑或軟便劑依賴、藥物副作用或疾病因素…等。

Constipation treatment？| 便秘的處理方式？

1. Abdominal massage:
It can stimulate gastrointestinal peristalsis and defecation. The massage should be performed in ante grade motion along the intestines, which is to perform the abdominal massage in a clockwise direction when facing the person being cared for.

   腹部按摩：必要時可使用腹部按摩刺激腸胃蠕動與排便，請於飯後兩小時或是飯前一小時使用，按摩方向，順行腸道位置，即面對被看護人時，順時鐘方向按摩腹部。

2 Stool softener:
Please follow instructions of the physician. Dose of stool softener should be reduced or temporarily stop using the stool softener when number of bowel movements is increased or diarrhea occurs. (Please consult the physician for drug dosage adjustments).

軟便劑：請依醫囑指示；當出現腹瀉情況或排便次數增加時，應減少軟便劑劑量或暫時停止使用。（藥物劑量調整請諮詢醫師）

3 Increasing water intake:
At least 2000 cc every day. Additional physician instruction: Except for patients having water restrictions.

增加水分的攝入量：每日至少 2000 cc。另醫師囑言：限水者除外。

4 Eating more high-fiber foods:
Such as vegetables, fruit, etc.

多攝取高纖維食物：如蔬菜、水果。

Fall Prevention
預防跌倒

教學影片

Fall is the main cause of accidental death for the elderly over 65 years old. Therefore, the primary focus of the elderly care is the fall prevention.

跌倒是 65 歲以上老人意外死亡的主因，所以照顧老人首重預防跌倒。

Since the elderly often has chronic diseases, such as hypertension, stroke and osteoporosis, even a minor fall can cause a major injury.

由於高齡長者常伴隨有慢性疾病，例如：高血壓、中風、骨質疏鬆症，即使輕微的跌倒也可能造成很大的傷害。

It is believed that by finding out those who fall easily (high risk group) and implementing fall prevention measures, the elderly or disabled persons can be helped in “walking safely.”

從找出跌倒高危險群並落實執行防跌措施，相信可幫助高齡或失能者獲得『行』的安全。

High-risk fall groups:
The caregivers must pay more attention to the elderly or a patient of the following types in the family.
跌倒高危險群：家中有以下類型的長者或病患，需多加留意。

1. Who is older than the age of 65 with instability of gait;

   年紀大於 65 歲，步態不穩。

2. Who has anemia, orthostatic hypotension or low blood pressure, had a history of falling down;

   有貧血、姿勢性低血壓或曾有跌倒病史。

3. Who has disturbance of consciousness (such as loss of orientation, restlessness, confusion, etc.) or has taken drugs which affect awareness or activity (such as diuretics, pain- killers, laxatives, sedatives, sleeping pills, cardiovascular drugs);

本身意識障礙（失去定向感、躁動混亂等）或服用影響意識或活動之藥物（如：利尿劑、止痛劑、輕瀉劑、鎮靜藥、安眠藥、心血管用藥）。

4. Who has symptoms of malnutrition, weakness, dizziness or sleep disorders;

營養不良、虛弱、頭暈或有睡眠障礙。

5. Who has limb dysfunction (such as limb weakness, joint pain, after having joint replacement surgery, stroke and dementia).

肢體功能障礙（肢體無力、關節疼痛、關節置換術後、中風、失智）。

Fall Prevention Measures｜預防跌倒之措施

1. Adequate light:
Keep bright sight and lights.

光線充足：保持視線與燈光明亮。

2. Dry floor:
Dry the floor immediately when it gets wet, and keep it dry at all times.

地面乾燥：弄濕時應立即擦乾，隨時保持地板面乾燥。

3. Unimpeded passage:
Items should be properly stored as much as possible in order to keep the aisles spacious.

通道的暢通：物品應盡量收置妥善，以保持走道寬敞

4. Wear non-slip shoes, and do not go barefoot.

應穿適當大小防滑鞋，切勿打赤腳。

5. Appropriate choice of furniture:
Chairs that are too low or too soft are not suitable for the elderly. Chairs with armrests are recommended.

選用合適的家具：太低、太軟的椅子不適合老年人，最好有扶手的設計。

6 Installation of non-slip and handrail facilities: Especially the stairs and bathrooms.

加裝防滑及扶手設施：尤其是樓梯、浴室。

7 Change of postures should be done slowly to avoid falls due to dizziness or postural instability. Try to use armrests to help balance the body as much as possible.

姿勢轉換時速度應放慢，避免因暈眩或姿勢不穩造成跌倒，盡量使用扶手協助平衡。

8 Use of assistive devices:
Some patients refuse to use any assistive device. The caregiver can encourage the patient to use a cane or walker and to not feel shy or feel that it is too much trouble. In case the patient still does not want to use it, alternative items are recommended, such as using an umbrella instead of using a cane. Please note that a non-slip pad should be added to the umbrella.

輔具使用：有些被看護人會拒絕使用，可以鼓勵被看護人，不要因害羞或怕麻煩，而不用枴杖或助行器，若被看護人仍無意願，建議可用替代性物品，例如：以雨傘代替拐杖，請注意要加防滑墊。

9 Fitting clothing:
Wearing clothes that are too large is prone to stumbling, and shoes should be non-slip ones.

穿著合身的衣著：衣褲太大易絆倒、鞋子應要防滑。

10 orthostatic hypotension, the patient should slowly sit up first and then sit on the bed edge before getting off the bed. The caregiver should help the patient/ward get off the bed when the he/she is feeling better.

有服用安眠藥、頭暈、血壓不穩或姿位性低血壓時，下床前，應先緩慢坐起後，坐在床緣，待不適改善後再由看護者扶下床。

11 Pull up the bed side rail on both sides at any time.

隨時將兩側床欄拉上。

12 In case the patient/ward is found restless, uneasy or unconscious, in addition to understand and eliminate the cause, the caregiver also can provide companionship or give proper protective constraints.

發現被看護人有躁動、不安、意識不清時，除應瞭解並去除原因外，可提供陪伴或給予適當的保護約束。

13 The caregiver must assist the patient to get off the bed for some activities or go to the toilet.

如廁或下床活動時請務必需有看護者在旁協助。

Safe Displacement
安全移位

教學影片

Purpose｜目的

In order to enhance physical and mental health of the patient, “safety action” is very important. Not only that the patient requires safe displacement, the caregivers also need to watch out for their own physical safety. The most often injury of a caregiver occurs when the caregiver is performing displacement of the patient due to bad posture. The chance of causing the patient to have an injury or fall also will be increased. The following provides simple steps and matters needing attention on how to perform a safe displacement.

為增進被看護人之身心健康，故『安全的行動』是非常重要的，除了被看護人需要安全的移動，看護工作者也需要 留意自己的身體安全，移位中是最常發生因為看護工作者的姿勢不良導致自己受傷，被看護人受傷、摔傷的機率也會增加。如何安全移位，以下有簡易操作步驟和注意須知。

Step
步驟

Displacement Steps
移位步驟

Demonstration: From the bed to the wheelchair
示範：由床上至輪椅。

step 1

The wheelchair first needs to be pushed to the bedside (on the healthy or normal side) and forms a 45°angle near the bed. The brake should be set first and then fold up the foot pedal.

輪椅需先推至床邊（放在健側），並與床成 45° 角，煞車應先固定，收起腳踏板。

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step 2

Stand by the side of the bed where the person being cared for is going to be moved to and facing the patient or ward.

站在被看護人所需移向的一側床邊，面對他。

step 3

Hold the patient's head and move the pillow to the side where he/she is going to be moved to; then safely move the him/her towards the caregiver.

托住頭，將枕頭先移動至要下床的床沿方向，將被看護人安全地移向看護者。

step 4

Help the patient up and sit by the edge of the bed, and wait until the he/she adapts to the situation and there is no dizziness and other symptoms. The caregiver should pay attention to the safety of the patient or ward at all times.

將被看護人扶起，協助坐於床緣，待身體適應，無頭暈等不適症狀，此時需隨時注意、保護被看護人的安全。

step 5

Face the patient and help him/her embrace the caregiver with both hands in order to protect his/her safety during displacement.

面對被看護人，協助被看護人將雙手環抱於看護者，以保護被看護人移位時的安全。

step
6

The caregiver can utilize the principles of body mechanics to safely move the patient to the wheelchair. The caregiver should encourage the patient to use the healthy or normal side to support the affected side. The caregiver should then lay down the foot pedal and move feet of the patient or ward to the foot pedal, and then use the fixing strap to fix the disabled person.

看護者可利用身體力學的原理，安全地將被看護人移到輪椅，鼓勵被看護人用健側支托患側，將踏板放下，雙腳挪到踏板上並使用固定帶固定失能者。

Notes | 注意

1. Unless an emergency situation, the primary focus of a safe displacement is the physical comfort and safety of the patient or ward. The patient should have a proper cover in order to protect his or her privacy and keep body warm.

   除非緊急狀況，安全移位是以被看護人身體舒適度及安全為最大考量，並予適當的覆蓋，以維護隱私與保暖。

2. The caregiver should pay attention to the physical condition of the patient before performing the displacement, and it should be performed progressively in order to avoid occurrence of orthostatic hypotension. Meanwhile, the caregiver also has to watch out for tubes to avoid dragging and empty the urine bag beforehand.

移位前須注意被看護人的身體狀況，以漸進式移位，避免發生姿勢性低血壓，同時亦須留意管路，避免牽扯和先行排空尿袋等。

3 Displacement is to change the lying position to a sitting position, or change the sitting position to getting out of the bed. Prepare the cared for to get out of the bed. The posture should be maintained at least 10 to 15 minutes for each changing step. In addition, the caregiver should pay attention to the state of consciousness and necessary time vital sign of the person being cared for when changing the posture, if there is any abnormality, please rest immediately and notify the employer

移位由平躺改為坐姿，或由坐姿接續下床。下床準備。各姿勢應維持 10-15 分鐘。另更換姿勢過程需留意被看護人意識狀態，必要時間生命徵象，如有異狀請立刻休息並通知雇主。

4 The action of carrying the patient should be done in a “gentle and steady” manner and use all kinds of assistive devices in a timely manner to support and fix head, neck, shoulder, back, hip, waist, upper limb and lower limb in order to avoid injury due to collision.

搬運動作應『輕、柔、穩』，並適時使用各種輔具，避免碰撞而發生受傷。

5 To ensure safety, bed rails should be pulled back and brake system of the wheelchair should be set after displacement is done.

移位後須拉上床欄及固定輪椅的煞車系統，以確保安全。

6 Adjust the bed height so as to level up the height of the wheelchair seat prior to performing displacement in order to avoid waist and back injury .

移位前調整床面高度與輪椅的坐面高度相同，可避免因工作造成腰背傷害。

Oral Hygiene Tips
口腔清潔技巧

教學影片

Purpose｜目的

To maintain oral hygiene, prevent the growth of bacteria, and avoid oral diseases.

維持口腔清潔，預防細菌滋生，避免產生口腔疾病。

Preparation for necessary items｜用物準備

Soft toothbrush (or mouth sponge cleaning rod, floss), a tongue depressor (wrap the front end with gauze), a cup for mouth rinsing, some clean water (or tea, lemonade), lip balm (or Vaseline), towels and a flashlight.

軟毛牙刷（牙線棒）、壓舌板（紗布包住前端）、壓舌棒、漱口杯、清水（或茶葉水、檸檬水）、凡士林、 毛巾及手電筒。

Step
步驟

step 1

Help the patient or ward to sit up or sit in a semi-lying position on the bed.

協助被看護人採坐姿或半坐臥。

step 2

Use the tongue depressor to pull the inner cheek away from the teeth and then conduct an oral examination with the flashlight.

手持壓舌板，撥開內頰，以手電筒檢查口腔。

step 3

Lay towels under the chin and in front of the chest; the cup for mouth rinsing should be placed under the chin of the patient to catch the oral effluent.

將毛巾舖於下頷及胸前，漱口杯置於被看護人下頷，以盛接口腔污水。

step 4

Damp the toothbrush or the oral sponge cleaning rod and have bristles of the toothbrush aligned with the area where the gums and teeth meet; turn the bristles up when brushing the upper teeth, and turn the bristles down for brushing the lower teeth.

Bristles and the teeth should form an angle of 45-60 degrees; gently press the bristles to the teeth so that bristles are somewhat in an arc shape to allow the sides of the bristles to have contacts with the teeth with considerable range.

牙刷或口腔海綿清潔棒沾水，將刷毛對準牙齒與牙齦交接的地方，刷上牙時刷毛朝上，刷下牙時刷毛朝下。刷毛與牙齒呈 45-60 度角，同時將刷毛輕輕壓向牙齒， 刷毛略呈圓弧，讓刷毛的側邊也與牙齒有相當大範圍的接觸。

step 5

Sequence to clean the oral cavity:
Inside and outside of oral cavity gums → inner cheek of oral cavity → upper jaw, lower jaw, and tongue.

清潔口腔之順序：
口腔內外面→牙齦→口腔內頰→上下顎及舌頭。

step 6

In the end, clean the whole mouth with clean wet gauze.

最後以清水沾濕的紗布，清潔全口。

step 7

Wipe mouth and face clean with a towel.

毛巾擦淨嘴和臉。

step 8

Apply lip balm or Petroleum jelly and assist the patient to have a comfortable lying position.

如有唇部乾燥情形可適時擦拭護唇膏，並協助舒適臥位。

step 9

"Record whether there are wounds and pustules in the mouth, and confirm the number of teeth. If there is any abnormality, please notify the employer and assist in the medical treatment."

紀錄口內是否有傷口、膿包，以及確認牙齒顆數，如有異常請通知雇主並協助送醫。

Notes | 注意

1. Brush each tooth back and forth for 10 times.

   每顆牙前後來回約刷十次。

2. Please remember to wash your hands before and after performing oral cleaning! Avoid catching infection from each other to protect yourself and the patient /ward.

   進行口腔清潔前後，請記得洗手喔！避免相互感染，保護自己也保護被看護人喔！

Denture Cleaning 假牙清潔

Purpose | 目的

To maintain cleanness of dentures; it is important to prevent the occurrence of discomfort and complications associated with dentures; and to clean dentures correctly, to protect and install dentures, to prevent dentures from deformation and damage.

維護假牙的清潔，預防假牙造成不適與合併症的發生是很重要的，同時正確的清潔，保護及裝取假牙、預防假牙變形與損壞。

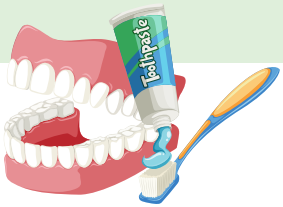
Denture Types: There are two types of dentures: fixed dental prosthesis and removable dental prosthesis.
假牙種類：有分為活動式及固定式兩種。

1. Removable dental prosthesis / 活動式假牙 :
Use clasps to clip onto thereal teeth; for people who are missing all of their teeth, the removable dental prosthesis is sucked onto the alveolus based on the principle of vacuum chucking. It is recommended that you should remind the elders to take out the dentures for cleaning every day.

是以鉤環扣著真牙齒，如果全口的牙齒已經脫掉，活動式假牙便以真空吸盤原理把假牙吸在牙槽上，建議您提醒長輩每天把假牙拿下來清潔。

2. Fixed dental prosthesis / 固定式假牙 :
Dentures are mounted on the teeth next to the missing tooth (or teeth) using the dental bridge, and they cannot be removed by a person on his/her own.

是以牙橋把假牙安裝在缺齒旁的牙齒上，是不能自行拿下來的。



Principles for proper denture cleaning
正確清潔假牙的原則

1. Oral cleaning should be performed before and after a meal every day since it can promote appetite and prevent occurrence of oral diseases.

   每日於進食前、後執行口腔清潔，可以促進食慾及預防口腔疾病產生。

2 All the bacteria adhered to dentures should be completely removed. However, the smooth surface of dentures must not be damaged. Therefore, the first thing to do is to take out the removable partial denture and clean it using a soft brush. Do not use toothpaste to clean the denture, because the abrasive in the toothpaste will rub the smooth surface off the removable partial denture. Gradually, the surface of dentures will no longer be smooth, and that stains and bacteria are easier to stack together. Therefore, only non-abrasive cleaner can be used to clean the removable partial denture. Of course, people will think that it may affect their health. In fact, there should be no special impact as long as proper cleaning is performed.

把所有黏附在假牙上的細菌徹底清除，但不可破壞假牙光滑的表面，因此首先把活動假牙拿下來，清潔時可用軟毛牙刷，但切勿用牙膏，因為牙膏裡的研磨料會磨去活動假牙光滑的表面，慢慢地會使表面變成磨砂般不再光滑，使污漬和細菌越加容易堆聚，因此清潔活動假牙時只適用非研磨性清潔劑，當然有人擔心會不會影響身體，其實只要清洗得宜是不應該有特別影響的。

Step 步驟

Cleaning steps of removable dental prosthesis
活動假牙清潔步驟

step 1

After the removable dental prosthesis is removed from the mouth, a toothbrush can be used to gently brush the dentures and remove larger particles of food.

活動假牙取下後，牙刷清潔輕刷假牙，及去除顆粒較大的食物。

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step 2

Put the dentures into a water cup or an immersion box for about 20 to 30 minutes. Water level of the cup or immersion box should cover the dentures completely, and water temperature should not exceed 60 degrees.

將假牙放入水杯或浸泡盒中，約 20-30 分鐘。浸泡水位蓋過假牙，水溫勿超過 60 度。

---

step 3

Before assisting the person being cared for to wear dentures, the caregiver should have dentures rinsed again with cooled boiled water.

協助被看護人佩戴前，再次用煮沸過之冷卻飲用水，沖洗後再協助佩戴。

Note： Denture material is intolerant to heat. Therefore, it is likely to cause damage or deformation to the denture material when encountering hot substances.
註 : 假牙材質怕熱，遭遇熱性物質容易造成假牙材質變形受損。

Body Cleaning Tips
身體清潔技巧

教學影片

Purpose｜目的

To keep the skin clean, remove dirt and odor, promote blood circulation, relax muscles and promote joint activities.

維持皮膚清潔，除汙去味；促進血液循環，放鬆肌肉，促進關節活動。

Preparation for necessary items｜用物準備

Shower gel (soap), towels (small towel, bath towel), clean clothing, lotion (or baby oil), an electric heater (to be used depending on conditions).

沐浴乳（肥皂）、毛巾（小毛巾、浴巾）、乾淨之衣物、乳液。

Principles｜原則

1. In general, the caregiver should give a sponge bath to the elderly in bed according to their preferences. Necessary items should be prepared in advance, and pay attention to the privacy of the elderly.

   一般來說，床上擦澡應尊重長輩喜愛的方式，需要的物品應事先準備齊全，注意長輩的隱私。

2. Watch out for bath water temperature; temperature of the bath water for the elderly should not be too hot. Water temperature can be higher during preparation, about 43-46°C.

   水溫宜留意，年長的長輩洗澡用水應避免過熱，準備時的溫度可較高，約 43-46℃。

3. Bathe the elderly from the cleanest spots to the dirtiest parts.

   從最乾淨的部位洗到最髒的部位。

4 Depending on conditions of the elderly, the elderly should be encouraged to wash their bodies on their own as much as possible if the elderly can do things by themselves. The caregivers only help the elderly wash the parts they cannot reach. However, considerations must be given for safety. Bath water should be replaced whenever necessary depending on water temperature and cleaning condition of the water during the cleaning process.

依長輩狀況，如果可自己活動，盡可能鼓勵長輩自己擦，我們協助其不及之處，但必須以安全為考量，清洗過程視水溫、污穢情形隨時更換水。

Sequence｜順序

In general, the order of cleaning the whole body is to start from hair and face, and then upper limbs → chest → abdomen lower limbs → back → perineum and hips. Each part of the body will be washed and wiped clean in turn in order to prevent cross infection caused by dirt and bacteria in each part of the body. Demonstration on face and body cleaning in turn is giving in the following:

一般全身清潔之順序是由上到下，前到後，按順序進行清潔和擦拭，以免身體各處之污垢病菌相互感染，在此示範臉部及身體之擦拭順序。

1. Face / 臉部
   Both eyes (from inner eyelid to outer eyelid) forehead→ nose → cheeks on both sides chin→ ears→ neck.

   雙眼（內眼瞼至外眼瞼）→ 額頭 → 鼻子 → 兩側臉頰 → 下巴 → 耳朵 → 頸部。

2. Body parts / 身體各部
   Upper limbs → chest → abdomen → lower limbs → back → perineum and hips

   上肢 → 胸部 → 腹部 → 下肢 → 背部 → 會陰部及臀部。

Step 步驟

step 1

After use items are properly prepared, the caregiver should assess the physical condition, dirt and odor of the patient or ward.

備妥各項用品後，評估被看護人的身體狀況及污垢異味等。

step 2

Clean body parts of the patient according to the cleaning sequence; damp a towel or put some shower gel onto a towel to clean the body; if shower gel or other cleaner is used, wash and clean the body more times to fully remove dirt and shower gel.

按清潔順序，以毛巾沾清水或沐浴乳擦拭身體，若使用沐浴乳等清潔劑，則需多用幾次清水擦拭，以充分去除污垢及沐浴乳。

step 3

Chest and abdomen cleaning:
When using a circular motion to clean female breasts, the caregiver must watch out for cleanness of wrinkle area at the bottom of breasts.

清潔胸部及腹部：女性個案乳房用環狀擦法，注意乳房底部皮膚皺褶處之清潔。

step 4

Upper limb cleaning:
Clean arms from finger tips towards the neck and shoulder; raise hands of the cared-for over the head and then clean the armpits; holding arms high can promote activities of muscles and joints. Watch out for cleanness of nails and spots between the fingers; use a bath towel to dry the body after finishing taking a bath.

清洗上肢：由手指端往頸肩端擦洗手臂，可將個案手高舉過頭，擦洗腋下，手臂高舉可促進肌肉關節的活動。注意指甲、指縫間的清潔。洗淨之後，用大毛巾擦乾。

step 5

Please note the sequence of using water when cleaning upper limbs, which is clean water → soap → clean water, until upper limbs are completely washed clean.

清潔上肢時應留意用水順序，為清水 →肥皂 → 清水，直到洗淨為原則。

step 6

Assistance in lower limb cleaning: Please note that the perineum must not be exposed. The caregiver should assist the patient/ward to clean both sides of hips, thighs and shanks, and dry these body parts. Put a large towel under the feet and help the patient/ward to bend knees and put feet in a washbasin to clean toes and spots between toes.

協助清潔下肢：需注意勿暴露會陰部，協助擦拭兩側髖部、大腿及小腿，並擦乾。舖大毛巾在足部，協助個案屈膝，將足部泡在臉盆，清洗趾部及趾間。

step 7

Back cleaning:
Help the patient roll over and have the back face the caregiver; apply continuous, long and vigorous rubbing to the back, and watch out for falling off the bed.

清潔背部：協助被看護人翻身背向你，使用連續、長而有力的擦撫動作，小心別跌下床。

step 8

Let the patient or ward lie down on the bed.

躺回平躺姿勢。

step 9

Perineum cleaning:
Put a rubber sheet or an under pad beneath the hips; if the patient/ward is capable of doing things on his/ her own.

清潔會陰部：墊橡皮中單或看護墊於臀部下面。

Notes | 注意

1. If bath water is found dirty during the cleaning process, please replace the water immediately.

   清潔過程，若發現水變髒，請立刻更換。

2. Maintaining indoor temperature / 維持室內溫度
   Close windows

   關閉窗戶。

3. Keeping body warm properly to prevent catching a cold / 適當保暖預防受寒
Please use towels to cover the finished body parts, and do not take off clothes for body parts that have not been washed.

擦拭完的部位請用浴巾覆蓋，未擦拭的部位請勿脫去衣物。

4. Maintaining privacy / 維護隱私
Private parts of the patient/ward should be properly covered.

需予適當的覆蓋。

5. It is recommended not to use cleaners often for dry and scaling skin. However, moisture of the skin needs to be enhanced. Therefore, lotion or baby oil can be applied to the skin after taking a sponge bath.

乾燥脫屑的皮膚，建議不要常使用清潔劑，但需加強保濕，擦澡後使用乳液。

6. Observe the condition of the skin during the time of taking a sponge bath.

利用擦澡時間觀察皮膚狀況。

7. The inner thighs and the perineum are the wrinkle areas. Please note that the areas must be kept dry.

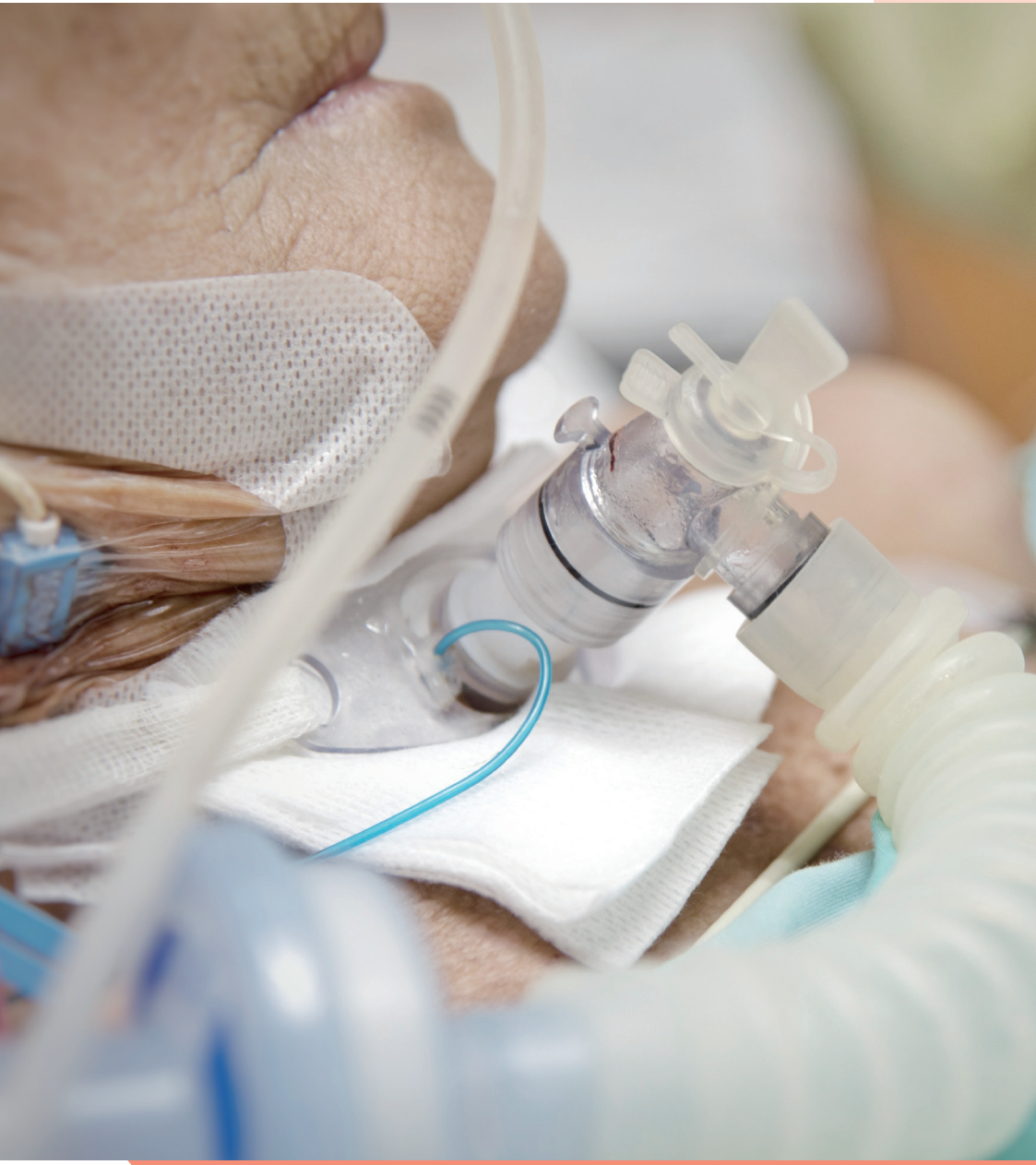
大腿的內側及會陰部，為皺褶區域，須特別注意擦乾。

8. If the patient/ward has wounds or has tubes affixed to body parts, the caregiver must perform tube cleaning and wound care after finishing a sponge bath.

若被看護人身上有傷口或是管路，請務必於擦澡後要執行管路清潔及傷口處理。

9. Under permitted physical conditions of the patient/ward, the caregiver can help the patient walk to the bathroom to take a bath, or even allow the patient to take a bath on his/her own so as to enhance self-care abilities and a sense of confidence of the patient or ward.

被看護人的身體狀況允許下，可協助被看護人至浴室洗澡，甚至可讓被看護人自行清洗，提升被看護人的自我照顧能力及信心感。



04

Tube Care
管路照顧

Nasogastric Tube Daily Care
鼻胃管日常照顧

教學影片

Purpose | 目的

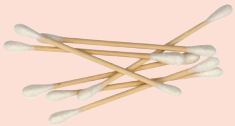
To fix a nasogastric tube to prevent the tube from slippage and to avoid nasal ulceration.

固定鼻胃管，可預防滑脫及避免鼻腔發生潰瘍。

Preparation for necessary items | 用物準備

Paper adhesive tape, clean gauze (for cleaning nasal cavity), small cotton swap.

紙膠、清潔的紗布（用於清潔鼻腔）、小棉棒。



Step 步驟

Check scales of the nasogastric tube
Use one of the following methods to determine whether the gastric tube is still in the stomach:

檢查鼻胃管刻度
以下列任一方式確定胃管是否仍在胃內：

step 1

The caregiver should check the mark of the nasogastric tube. If nasogastric tube prolapse occurs and exceeds 10 centimeters, notify the nurse to assist re-insert the tube. If the prolapse does not exceed 10 centimeters, the caregiver can gently advance the tube into the position at the original scale if there is no gastric tube whirling in the mouth, and then re-do the tube fixation. However, if the caregiver is unable to confirm or handle the current situation, please inform the employer and contact the home care nurse to assist in handling the situation.

檢查鼻胃管的記號，若超出且超過 10 公分時，請通知護理師重插；若刻度脫出未超過 10 公分，檢查口腔若無胃管纏繞，則可輕推進至原刻度位置，重新固定；若無法確認及處理目前情況時，請告知雇主並聯絡居家護理師協助處理。

step 2

The caregiver can use an empty syringe to draw back contents of the stomach into the syringe to make sure that the gastric tube is still in the stomach. Residue of food also should be checked. If the amount of residue of food is more than 50 cc, wait for half an hour or one hour to pour the residue of food back to the stomach (contents drawn out of the stomach without abnormality can be allowed to naturally flow back into the stomach).

以空針反抽，確定胃管仍在胃內，並檢查胃內殘餘食物量，若在 50 cc 以上，則延遲半小時或一小時再灌。（無異狀之反抽物，可讓其自然流回胃內。）

Daily cleaning | 日常清潔

1. Clean the oral cavity daily; before and after a meal, or in the morning and evening, the caregiver should clean the mouth of the patient with oral cotton swabs, and a toothbrush may be used to clean the mouth if the patient has clear consciousness.

   每日清潔口腔，進食前後或早晚以口腔棉棒清潔口腔，意識清楚的病人可以牙刷清潔之。

2. Clean nasal cavity with wet cotton swabs every day.

   每日用棉花棒沾水清潔鼻腔。

3. Adhesive tapes for fixation should be replaced every day. The nasogastric tube should be fixed towards the same direction and turn 90 degrees (1/4 of a lap) to prevent the tube from adhering to the stomach, and to avoid crush injury of the gastric mucosa caused by long-term ejection of food from the end opening of the tube. Nasal skin should be wiped clean prior to changing adhesive tapes, and be careful not to adhere tapes to the same skin location. If the skin of the cared-for is oily skin, please enhance cleaning work and then adhere tapes to prevent the tube from slippage due to difficult fixation.

   每日更換固定之膠帶，並將鼻胃管固定同一方向旋轉 90 度（1/4 圈），以防止鼻胃管黏附在胃壁上及胃黏膜長期受鼻胃管末端出口噴出之食物所壓傷，更換膠帶時需將鼻部皮膚拭淨再貼，並注意勿貼於同一皮膚位置。若皮膚為油性肌膚，請加強清潔後再黏貼膠布以免管路固定不易而發生滑脫。

4. The exposed parts of the nasogastric tube need to be properly protected to avoid slippage or dragging.

   鼻胃管外露部位需妥善保護，以免牽扯滑脫。

5. If the patient/ward is unconscious or is restless and uncooperative, the caregiver should watch out for the nasogastric tube being pulled out by the cared-for. The constraint gloves can be used when necessary to make appropriate, protective constraint for both hands of the cared- for.

意識不清或躁動不合作之病人，應預防鼻胃管被拉出，必要時可使用約束手套，將病人雙手做適當的約束保護。

6 If the nasogastric tube is made of silicone materials, it should be replaced every month. However, nasogastric tube of ordinary materials should be replaced every two weeks. On the day of replacing the tube, the caregiver should confirm the visiting time of the home care nurse to avoid replacing the tube after tub feeding, which may easily lead to vomiting.

使用矽膠材質每個月更換，普通材質每二週更換，更換管路當日，請確認居家護理師訪視時間，以避免灌食後更換鼻胃管，易造成嘔吐。

Tape fixation method for the nasogastric tube
鼻胃管膠帶固定法

1. Cut 2/3 of the tape into Y-shape.

   膠帶約 2/3 剪開成 Y 型。

2. Fold back the end of the tape (for easy tape replacement).

   末端回折（更換時方便）。

3. The front end of the tape is adhered to the nasal bridge. One tape is used to fix the nasogastric tube, and the other tape is used to fix the nasogastric tube in circular shape.

   前端黏貼於鼻樑，一條固定鼻胃管，另一條以環狀固定鼻胃管。

Perineum Washing and Urinary Catheter Cleaning
會陰沖洗及尿管清潔

教學影片

Purpose | 目的

To strengthen genitals cleaning and catheter disinfection in order to reduce odor, increase comfort and prevent infection.

加強清潔外陰部及消毒導尿管，減少異味，增加舒適感、預防感染。

Preparation for necessary items | 用物準備

Rinse cotton swabs, sterile cotton swabs, a rinse pot, breathable paper tape, saline solution, iodine, toilet paper, gloves; soap and towels are required for the male cared-for.

沖洗棉棒、消毒棉棒、沖洗壺、透氣紙膠、生理食鹽水、衛生紙、手套、尿管固定繩。

Step 步驟

Perineum Cleaning for Females
女性會陰清潔

step 1

Assist the patient/ward to raise hips, and place a rubber sheet beneath the area from waist to hips.

協助被看護人抬高臀部，放置橡皮中單於其腰臀以下部位。

step 2

Assist the patient to take off the trouser leg on the healthy side, and pull the trouser leg to the other side and use it to support the affected side.

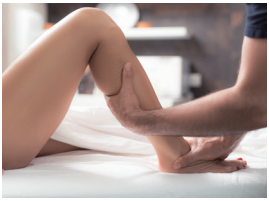
協助被看護人脫去健側之褲管，將脫下之褲子拉向另一側並支撐被看護人患側。

step 3

Place a bedpan beneath the area from waist to hips or use an under pad, or cleaning can be directly performed on a diaper.

放置便盆於被看護人腰臀以下部位或使用看護墊，亦可直接在尿布上清洗。

step 4



Elevate the head and neck and slightly bend the knee of the healthy side.

將被看護人頭頸部墊高，健側膝略彎曲。

step 5

Observe and record amount, color and odor of the perineal discharge of the patient.

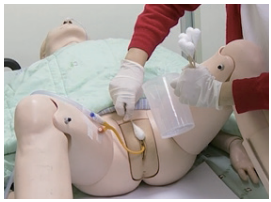
觀察、記錄被看護人會陰部分泌物之量、顏色以及氣味。

step 6

Clean the areas around labia and perineum by a moistened towel with soap.

以潤溼的毛巾沾肥皂清大小陰唇及會陰部周圍。

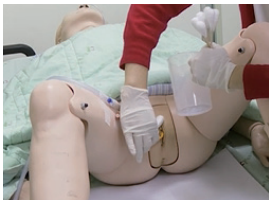
step 7



Use a rinse pot or the little cute rinse bottle for cleaning, and make the spout face the bed end:
Washing sequence if using rinse cotton sticks: urethral meatus → distal labia minora → proximal labia minora → distal labia majora → proximal labia majora.
If not using cotton sticks, don't forget to wash from top to bottom, and from inside to outside.

以沖洗壺或小可愛進行沖洗，壺嘴朝向床尾：
若使用沖洗棉枝，依序清洗：尿道口 → 遠側小陰唇 → 近側小陰唇→ 遠側大陰唇 → 近側大陰唇。
若沒有用棉枝，請記得：由上到下及由內到外的原則。

step 8



Clean from front to back, do not wipe back and forth.

由前到後清潔，不可來回擦拭。

step 9

Remove the bedpan or the under pad and dry hips; wipe the area from the perineum to the hips in an outward direction with toilet paper; do not wipe the area back and forth repeatedly.

移去便盆或看護墊並擦乾臀部，衛生紙由被看護人會陰部往臀部擦拭，不得來回反覆擦拭。

Step 步驟

Perineum Cleaning for Males
男性會陰清潔

step 1

Assist the patient/ward to raise hips, and place a rubber sheet beneath the area from waist to hips.

協助被看護人抬高臀部，放置橡皮中單於其腰臀以下部位。

step 2

Assist the patient to take off the trouser leg on the healthy side, and pull the trouser leg to the other side and use it to support the affected side.

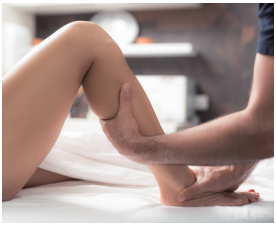
協助被看護人脫去健側之褲管，將脫下之褲子拉向另一側並支撐被看護人患側。

step 3

Place a bedpan beneath the area from waist to hips or use an under pad, or cleaning can be directly performed on a diaper.

放置便盆於被看護人腰臀以下部位或使用看護墊，亦可直接在尿布上清洗。

step 4



Elevate the head and neck and slightly bend the knee of the healthy side.

將被看護人頭頸部墊高，健側膝略彎曲。

step 5

Observe and record amount, color and odor of the perineal discharge of the patient.

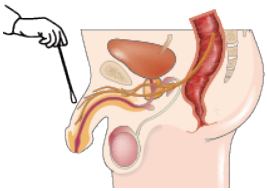
觀察、記錄被看護人會陰部分泌物之量、顏色以及氣味。

step 6

Wear clean gloves and properly open the package of cotton stick through the end of the package; damp the cotton stick in the rinse pot and then lather the cotton stick.

戴上清潔手套，正確打開棉枝包，由棉枝末端處將沖洗棉枝包打開，棉枝以沖洗壺沾溼再抹香皂。

step 7



Grasp the shaft of the penis with one hand and push the foreskin backwards and make an oral description of it; have the glans of the penis exposed, and then wash the glans with a cotton stick.

一手握住陰莖，做出包皮往後推的動作並口述，露出龜頭，龜頭以棉枝清洗。

step 8

Lather a wet towel and wash the penis, scrotum and anus with the towel.

以潤溼的毛巾沾肥皂清洗陰莖、陰囊及肛門。

step 9

Observe and record amount, color and odor of the perineal discharge of the patient.

觀察、記錄被看護人會陰部分泌物之量、顏色以及氣味。

step 10

Remove the bedpan and dry hips (use toilet paper to wipe the area from the perineum to the buttocks of the patient), and then take gloves off.

移去便盆並擦乾臀部（衛生紙由被看護人會陰部向臀部擦拭）脫除手套。

Cleaning of urinary catheter | 尿管清潔

1. Observe amount, color, odor and sediment of the urine.

   觀察尿液之量、顏色、氣味及沉澱物。

2. Change the fixing location of the catheter adhesive tapes; the catheter should be fixed using the fixation method of two horizontal taping lines and two vertical taping lines with the catheter in the middle (like a tic-tac-toe grid); the catheter should be fixed in the lower abdomen for males and inner thigh for females.

更換尿管膠布的固定位置，以井字固定法，男性固定於小腹，女性固定在大腿內側。

3. Please note that the catheter drainage position should be kept below the bladder when moving the catheter. If the patient needs to move, the catheter should be bent back.

移動尿袋時，注意尿袋引流位置保持在膀胱以下，如需移動，需反折尿管。

4. Opening of the urinary catheter should be closed at all times to avoid contamination.

尿袋開口隨時關閉，避免污染。

5. Check whether the catheter is unobstructed to avoid twisting due to compression.

檢查尿管通暢，避免受壓扭曲。

6 Observe or report possible abnormalities to the employer: Such as obstruction, urine leakage, occurrence of sediment, too little urine or catheter slippage.

觀察或報告雇主可能的異常狀況：如阻塞、滲尿、出現沉澱物、尿量過少或尿管滑脫等。

7 Put on clothes, and keep bed sheet flat and dry.

穿整衣褲，保持床單平整及乾燥。

Tracheostomy Tube Daily Care
氣切造口日常照顧

教學影片

Purpose | 目的

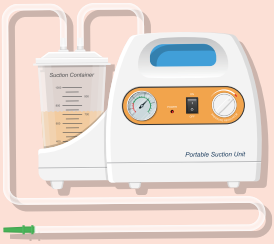
Cleanness and sterilization of the tracheostomy to reduce skin damage and infections caused by infiltration.

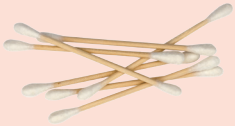
清潔、消毒氣切口，減少浸潤造成之皮膚損傷及感染。

Preparation for necessary items | 用物準備

A sputum suction machine, suction tubes, sterile cotton swabs, iodine, normal saline, Y-type gauze, tracheostomy tube holder.

抽痰機、抽痰管、無菌棉棒、生理食鹽水、Y 型紗布、氣切固定帶。





Step
步驟

step 1

Wash hands.

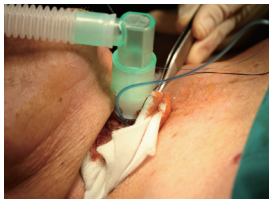
洗手。

step 2

Prior to conducting the racheostomy care, please let a family member or a caregiver who has received care guidance to perform sputum suction.

氣切造口護理前，請先由接受過護理指導之家人或護理師進行抽痰。

step 3



Remove the original Y-type gauze of the tracheostomy.

取下氣切口原有之 Y 型紗布。

step 4

Use the cotton swab moistened with normal saline solution to clean the areas surrounding the tracheostomy (cleanness)→ and then use the cotton swab with iodine to smear the area which has a width of 5 cm surrounding the tracheostomy from the inner side towards the outside (sterilization) → 30 seconds later, use the normal saline cotton swab to clean the same area one more time.

用生理食鹽水棉棒，清潔氣切造口周圍（清潔）→ 30 秒後再以生理食鹽水棉棒擦拭一圈。

step 5

Place the new Y-type gauze.

置放新的 Y 型紗布。

step 6

If the tracheostomy tube holder is loose or dirty, the tracheostomy tube holder needs to be replaced with a new one. If there is any abnormality in the tracheostomy, please inform the doctor or professional as soon as possible.

氣切固定帶若鬆掉、髒污，需重新更換新固定帶，氣切造口如有任何異常，請盡速告知醫師或專業人士。

Notes | 注意

1. The tracheostomy needs to be sterilized at least once a day(daily). Number of sterilization per day can be adjusted depending on conditions when the person being cared for has more sputum.

   氣切造口每日至少消毒一次，痰量多時依狀況調整。

2. The surrounding area of the tracheostomy needs to be kept clean and dry:
   If the Y-type gauze is damp or dirty, it must be replaced as soon as possible with a clean one.

   氣切造口周圍需保持清潔乾燥：Y 型紗布有潮濕或髒污，需立刻更換。

3. Watch for infection:
   When replacing the Y-type gauze, please observe whether there is any exudation or redness surrounding the tracheostomy.

   注意有無感染：更換 Y 型紗布時，請觀察造口周圍有無分泌物及發紅現象。

4. If there is no restriction on water intake, the patient/ward should take 2000-2500 cc water every day.

   若無水份限制，每日應給予 2000-2500 cc 的水份。

5. The patient should be encouraged to get out of bed for an exercise or sit ups. The caregiver should tap the back of the patient/ward at least 3 times a day.

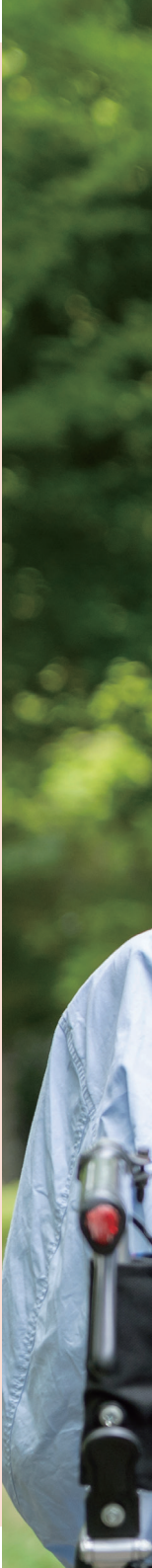
   鼓勵多下床活動或坐起，每日至少執行三次背部扣擊。

6. Do not tie the tracheostomy tube holder too tight or too loose. Width of 1 to 2 fingers should be fine. When changing the tracheostomy tube holder, the caregiver should fix one hand on the wings of the tracheostomy and pay attention not to pull the artificial airway.

   綁氣切固定帶時勿太緊或太鬆，寬度約 1-2 指即可；更換固定帶時，請一手固定於氣切造口蝶翼處，並注意勿拉扯到人工氣道。

7. Carry out oral care and cleaning everyday.

   每天都要進行口腔護理與清潔。



05

Other
其他

Social Resources.....社會資源

Social Resources
社會資源

After reading contents of the manual, you have learned some basic care skills.

看完了這本手冊的內容後，你已經學習了一些基本的照顧技巧了。

In fact, care skills and techniques are very diversified. The physical condition; type of disease and set ups of living place of each disabled person are all in different types. In case of further information regarding the caretaker manual or handbook, or if there is a need of individual guidance and learning, you may consult the following relevant units or apply for services.

但其實照顧技巧非常多元，且每位失能者的身體狀況、疾病類別及居家空間設置都不一樣，若手冊內資訊無法滿足你，或有個別化指導學習需求者，可向以下相關單位洽詢或申請服務。

In addition, making good use of various care services or social resources during the work of care also can help reduce your pressure in order to avoid increasing chance of injury to yourself and the person being cared for by you.

此外，照顧工作中善加利用各種照顧服務或社會資源，也可幫助自己減輕照顧壓力，避免增加自身和被看護人之受傷機率。

Emergency telephone number **緊急救護電話**	・Emergency telephone number 緊急救護電話		119
Taipei City Long-Term Care anagement Center **臺北市長期照顧管理中心**	・Western District ervice Station (Zhongzheng, Wanhua) 中、西區服務站 (大同、中山、萬華、中正)	02-2537-1099	分機 300~312
	・Western District ervice Station Zhongzheng, Wanhua) 東、南區服務站 (南港、內湖、信義、松山、大安、文山)		分機 200~225
	・Northern District Service Station (Beitou, Shilin) 北區服務站 (北投、士林)		分機 500~512
Taipei City Assistive Technology Resources Center **臺北市輔具資源中心**	・Taipei City Northern District Assistive Technology Center (National Taiwan University Hospital Assistive Technology Center) 合宜輔具中心 (士林、北投、中山、大同)		02-7713-7760
	・Taipei City Southern District Assistive Technology Center (The First Assistive Technology Resources Center) 西區輔具中心 (中正、萬華、大安、松山)		02-2523-7902
	・Taipei City Assistive Technology Center (Tongzhou Development Center) 南區輔具中心 (信義、文山、內湖、南港)		02-2720-7364

Family Caregivers Related Resources **家庭照顧者相關資源**	・Taiwan Association of Family Caregivers 中華民國家庭照顧者關懷總會	0800-507-272
	・Caregivers consultation and care services 臺北市家庭照顧者關懷協會	02-2739-8737
Foreign Caregivers Related Resources **外籍看護工相關資源**	・Taipei City Foreign and Disabled Labor Office 臺北市勞動力重建運用處	02-2338-1600
	・24-hour Protection Line for Foreign Worker 1955 外籍勞工 24 小時諮詢保護專線	1955

Data: Organized and supplied by Taiwan Association of Family Caregivers
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Taipei City Foreign Caregivers Manual
臺北市外籍看護照顧手冊

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服　務　電　話　02-2338 1600

服　務　網　址　http://www.fd.gov. taipei

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