居家外勞照顧技巧指導

(Skills Guidance for Home Care Workers)

（中、英文對照）

指導單位：行政院衛生署護理及健康照護處

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本資料僅供參考用，您需要諮詢您的醫療團隊，以確認正確及適合您個案的實際情況的技巧及程序。 本網站不對任何因參考本資料所衍生的任何後果負責。

Note: Both Chinese version and English version of this publication are intended for home care guideline only. Recommend to consult with your loacal medical staff and physician on the details of procedure needed for the individual case. This publication is not liable for any consequence as a result of practice referred to any information listed in the publication.

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一、居家個人衛生-口腔護理

Home hygiene - Oral Care

徹底清潔口腔，可防止口腔潰爛,避免口內病灶形成。

Clean oral thoroughly to prevent oral fester and to avoid forming lesions in the mouth.

一、原則及注意事項:

1.對可由口進食且有牙齒的個案，應協助其於餐後及睡前刷牙。
2.鼓勵下床到浴廁執行刷牙；若無法下床，則採半坐臥或側躺，以協助口腔清潔。
3.應先查看口腔有無破損，執行時動作應輕柔，勿造成口腔的傷害。
4.除使用溫水清潔漱口外，亦可採用綠茶(不加糖)或檸檬水。
5.若個案舌苔多厚，則以包紗布端之壓舌板固定，再用潔牙棒沾水清潔。
6.每日至少口腔護理一次，且須視個案狀況而增加次數。

I. Principles and Attention:

1. Case of be able to eat with teeth: should assist teeth brush both after meal and before going to bed.
2. Encourage to get out of bed to bathroom to implement brush; case of be unable to get out of bed; place half-seat-lies posture or side-lies-down posture to assist in mouth clean
3. Firstly, check any lesion in oral with gentle action, not to cause damage to the mouth.
4. In addition to using clean warm water for gargle, can use green tea (not sweetened) or lemonade as well.
5. Case of thick tongue moss: use gauze supported tongue-suppressing board to fix tongue position, and then use water rinsed clean-teeth-stick to clean.
6. Perform oral care at least once a day, and subject to increasing the number of cases as condition demands.

二、準備用物:

牙刷/潔牙棒、溫水(41-43°C) 、乾毛巾、彎盆、凡士林或護唇膏、壓舌板、紗布

To use of:

Toothbrush / clean-teeth-stick, warm water (41-43 ° C), dry towel, bending pots, Vaseline or lip balm ointment, tongue-compression board, gauze

三、方法:

1.以肥皂洗淨執行者的雙手。
2.準備用物(如上)。
3.協助個案採坐姿或側躺姿勢。
4.舖乾毛巾於個案頜下及胸前，將彎盆置於頜下將毛巾墊於個案的臉頰下以保持個案或床單的清潔。
5.若個案無法配合張口時，可以包妥紗布之壓舌板，將其上下牙齒撐開。
6.用潔牙棒沾上溫水，分別清潔牙齒內外、咬合面、口腔內頰及舌頭，清潔至乾淨為止。
7.若個案嘴唇乾燥，可用凡士林或護唇膏潤唇，勿使用甘油（會更乾燥）。

Method:

1. Wash hands with soap before implementation.
2. Prepare items as listed in category 2.

3. For case to adopt sitting posture or side-lies-down posture.

4. Pave dry towel below lower jaw and in front of chest, put bending pot below lower jaw and place towel below cheek to keep the case clean.
5. Case of unable to open mouth; place gauze supported tongue-suppressing board between top to bottom teeth to open the mouth.
6. Use warm water rinsed clean-teeth-stick to clean both within and outside teeth, including teeth bite face, oral and inner cheek, and tongue tip.
7. Case of dry lip; use Vaseline or lip balm ointment for dry relief, not to use glycerin which cause dry-lip worse.

二、居家個人衛生-洗頭

II. Home hygiene – head washing with shampoo

一、原則及注意事項：

1.協助個案每週到浴室洗頭 1-2 次；若無法下床，則執行床上洗頭技術。
2.洗頭時以指腹按摩，不可用指甲抓，以免傷害頭皮。
3.注意水或泡沫勿跑到眼睛或耳朵。

Principles and Attention:

1. Assist bathroom shampoo 1-2 times per week; case of be unable to get out of bed --- perform head washing technique on bed.
2. Massage pulp during shampoo, not to damage the scalp with nail.
3. Avoid water or foam flowing into the eyes or ears.

二、準備用物:

溫水(41-43°C)、水桶、水瓢、大毛巾、毛巾、洗頭槽、洗髮精、梳子、吹風機

To use of:

Warm water (41-43 ° C), buckets, water ladle, large towels, regular towels, washing trough, shampoo, combs, hair dryer

三、方法:

1.先測試水溫，溫度應維持在 41-43°C。
2.準備好洗頭槽。
3.協助個案平躺，頭移到床沿將洗頭槽放在頭頸部，其下接放預裝髒水的桶中。
4.以洗髮精搓洗頭髮，手指端搓擦頭皮，再用清水沖洗，可重複此步驟直到乾淨為主，注意水或泡沫勿跑到眼睛及耳朵。
5.以乾毛巾裹頭髮，移去用物。
6.安排舒適臥位後，擦乾頭髮再用吹風機將頭髮吹乾，吹乾後梳理整齊即可。

1. Method:
    1. Test the water temperature and it should be remained at 41-43 ° C.
    2. Have washing trough ready.
    3. Have case at supine (lying on the back or having face upward) posture, move case's head to the edge of bedside and place washing trough below head and neck, then place water bucket connected to the trough.
    4. Scrubbing hair with shampoo, use finger tip to rub scalp, then rinse with water, repeat this step until clean, not to have water or foam flowing into the eyes and ears.
    5. Wrap hair with a dry towel to dry hair, and remove others tool around.
    6. Arrange case with comfortable posture, use hair dryer to dry hair, and comb neatly.

三、居家個人衛生-清潔手腳

III. Home hygiene - clean hands and feet

清潔並清除手和腳之皮屑，會減輕身體的異味與發炎感染的機會。

Clean hands and feet and to remove the dander, which can reduce both, body odor and the chance of inflammation infection.

一、原則及注意事項：

1.淋浴或盆浴時，徹底以肥皂清潔每一隻手指、腳趾，尤其是指（趾）間，需搓揉至乾淨為止；若為床上擦澡，則於擦澡後再做足部護理，搓揉至乾淨為止完成。

2.搓洗動作應輕柔，勿強行撕下皮屑，以免造成傷口。

3.若有雞眼或硬繭，勿用刀片剪或用酒精強效藥物塗抹。

4.若有糖尿病病史者，應注意勿造成傷口。

5.可用乳液潤滑皮膚，並保持雙腳之乾爽，應穿乾淨棉質的襪子及舒適合腳的鞋子。

I. Principles and Attention:

1. During shower or bathing, clean every fingers, toes, thoroughly with soap, in particular, between fingers (toes), rub until clean; if bathing on bed, make a foot care after bath, rub until it cleaned up completedly.
2. Scrub or rub action should be gentle, not to forcibly torn off dander or skin to avoid skin wounded.
3. Do not use scissors or a blade with alcohol potent drug to handle chicken eye (abnormal skin bump or lump) or hard cocoon on the skin.
4. Case of diabetes, do not causing the wounded skin.
5. Treat skin with lubricant, and keep the foot dry and wear clean cotton socks and have comfortable shoes for the feet.

二、準備用物:

溫水(41-43°C)、臉盆、肥皂、毛巾、乳液、塑膠墊、指甲剪、銼刀

II. To use of:

Warm water (41-43 ° C), washbasin, soap, towels, emulsion, plastic mats, nail scissor, file

三、方法：

1.盆內水溫應維持在 41-43°C。

2.將塑膠墊置床上，將裝有溫水的盆子置於上。

3.將一側的手放入盆中，浸泡數分鐘，再以肥皂搓洗每一隻手指，尤其指縫，沖水洗淨後換另一側手，以相同方法執行。

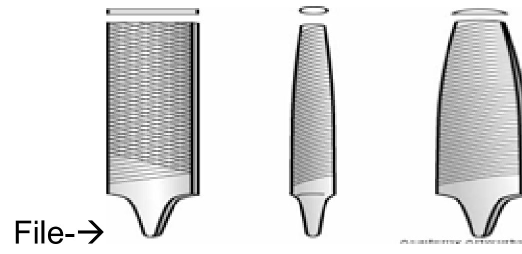
4.手部完成後，進行腳的浸泡與搓洗，方法同前，注意趾間清洗至無皮屑止。

5.修剪手指甲，應成弧形（圓）。

6.修剪腳趾甲，但不可傷及皮肉，修剪後用銼刀修平，以防兩端長入趾肉內。

III. Method:

1. Keep basin water temperature remained at 41-43 ° C.
2. Place plastic mats on bed, and place wash pot with warm water on bed as well.
3. Put one hand of case into the washbasin and soak a few minutes, then soap and scrub every finger, especially finger seam, flushing with water until clean and repeat this with the other hand.
4. After completion of the hand, do foot soaking and scrubbing, with the former method, have dander removed completely.
5. Trim fingernails to curved shape.
6. Trim toenails, but not to hurt the skin surface, pruning later with File (to prevent both nail ends to grow into underneath the skin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四、居家個人衛生-身體清潔
IV. Home hygiene – clean body

減少身體異味、維持身體的清潔舒適

Reduce body odor, maintain the body clean and comfortable

一、原則及注意事項：

1.個案可以下床，應每日淋浴或盆浴；若個案無法下床，則進行床上擦澡。
2.應從身體乾淨的部位開始清洗。
3.應注意水溫、隱私、安全、並預防跌倒。
4.關節彎曲、皮膚皺褶的地方，要特別清潔，例如:乳下、腋下、腹股溝處。
5.注意骨突處的皮膚有無發紅、長疹子或有傷口。
6.個案若有尿管、造口或傷口，則先擦澡再做護理。
7.執行床上擦澡時，動作應輕柔且隨時注意應常換水。

I. Principles and Attention:

1. Case of be able to get out of bed, arrange a shower or bath every day, case of be unable to get out of bed, practice sponging-bathe on bed.
2. Firstly, cleaning starts from the non-dirty area of body.
3. Pay attention to water temperature, privacy, security, and prevent fall-down.
4. Pay special attention on bending joints, the skin fold, such as: beneath breast, armpits, groin.
5. Take special note of skin redness, rashes or wound issues over bone splash area.
6. Cases of urine catheter, stoma or wound, perform sponging-bathe on bed firstly and nursing afterward.
7. Case of sponging-bathe on bed, all action should be gentle and supply with clean water for bathing all the times.

二、準備用物:

溫水(41-43°C)、臉盆、沐浴乳、大小毛巾、塑膠墊、乾淨衣褲

II. To use of:

Warm water (41-43 ° C), washbasin, bath emulsion, towels, plastic mats, and clean underwear

三、方法：

1.能自己擦洗的個案，則盡量讓個案自己擦洗。
2.先測試水溫，溫度應維持在 41-43°C。
3.將毛巾弄濕擰乾，沐浴乳適量抹在毛巾上，依序擦拭身體，再以溫水將肥皂充分擦淨，再用大毛巾擦乾身體，換上乾淨衣褲。
4.擦拭部位順序：臉部→胸部→上臂→腹部→腿部→背部→臀部→會陰部。
5.完成上述步驟後，手及腳的清潔依『居家個人衛生-清潔手腳』執行。
6.需要時可塗抹乳液於身體乾燥部位。

III. Method:

1. Let case to perform scrubbing and washing himself should case be able to perform himself.
2. Maintain water temperature at 41-43 ° C.
3. Wet the towels and twist dry a bit, add suitable amount of bath emulsifier on the tower, and scrub through the body in sequence, followed with warm water to remove soap, and then dry the body with towel, finally put on clean clothes.
4. Scrub position order: Face → chest → arm → abdominal → back legs → hip → perineum.
5. After completion of the above steps, clean up hands and feet based on the 『home hygiene - clean up hands and feet』procedure.
6. Emulsifier should be applied to dry body area.

五、居家個人衛生-會陰清潔及沖洗
V. Home hygiene – wash and clean the perineum

維持個案外陰部的清潔、去除異味、預防感染、促進舒適。

Keep genital clean, remove odor, prevent infection,
and promote comfort.

一、原則及注意事項：

1.個案可以下床，應每日淋浴或盆浴；若個案無法下床，則進行床上擦澡後再做會陰清潔及沖洗。
2.應注意水溫、隱私、安全、注意保暖並預防跌倒。
3.無法維持適當姿勢者，可請家屬協助固定雙腳。

I. Principles and Attention:

1. Case of be able to get out of bed, take a shower or bath every day, case of be unable to get out of bed--practice sponging-bathe on bed and clean and wash the perineum afterward.
2. Pay attention to water temperature, privacy, security, warmth and attention to prevent fall-down.
3. Case of be unable to maintain proper posture, ask family members to assist case's legs fixed on position.

二、準備用物:

溫水(41-43°C)、無菌沖洗棉花棒、沖洗尿壺、床上便盆、看護墊、清潔手套、衛生紙

II. To use of:

Warm water (41-43 ° C), sterile cotton bud (swab), chamber pot, bed pan, nursing pad, clean gloves, toilet paper

三、方法：

1.執行者先徹底洗淨雙手。
2.準備用物。協助個案平躺，脫去褲子或尿褲。臀下鋪看護墊，並放妥床上便盆。
3.協助個案採取適當姿勢：女性採屈膝仰臥式，男性採平躺雙腳微張開。
4.取出無菌沖洗棉棒。以靠近床頭之手持沖洗壺及無菌沖洗棉棒。
5.沖洗方法:

女性:將溫水緩緩沖洗會陰部，同時以另一隻手持沖洗棉棒分別擦拭依序：外陰部→大陰唇→小陰唇→尿道口→陰道口→肛門區。再以乾沖洗棉棒擦拭外陰部及肛門區。

男性：將陰莖提起→若有包皮須小心地將包皮往後推，露出尿道口→將溫水由尿道口向陰莖幹沖洗→以沖洗棉棒由尿道往外向陰莖幹做環狀擦拭→沖洗陰囊及肛門區→以乾沖洗棉棒擦拭陰莖、陰囊及肛門區。

6.溫水沖洗至會陰部乾淨為止。無菌沖洗棉棒擦拭方向須由上而下，一支棉棒只能使用一次。
7.去除床上便盆，並用衛生紙擦乾臀部，並脫去清潔手套。
8.協助個案穿好褲子或尿褲。

III. Method:

1. Wash hands thoroughly.
2. Prepare to use of items. Assist case in supine (lying down with face upward) position, take off case pants or diaper. Put nursing pad underneath buttock, and place bedpan properly.
3. Take appropriate posture for assistance: apply supine with knee-bending type for female case, apply supine with both feet slightly V-shape open for male case.
4. Take sterile cotton bud, use hand which close to bed to grasp flushing pod and sterile cotton bud (swab)
5. Flushing methods:

For Female: use warm water slowly washing perineum, and use the other hand hold sterile cotton bud to scrub according the sequence: Outside genitals -> big lip of vulva -> small lip of vulva -> urethral meatus -> vaginal orifice -> regio analis. And dry outside genitals and regio analis with

sterile cotton bud afterward.
For Male: lift the penis -> unfold penis wrapper carefully should case has the wrapper and reveal the urethral meatus -> use the lukewarm water to flush from urethral meatus to the penis -> use sterile cotton bud to dry from the urethra toward the extroverted penis with ring-like cleaning procedure -> flushing scrotum and the regio analis -> use sterile cotton bud to wipe penis, scrotum, and regio analis.
6. Clean perineum with warm water. Use sterile cotton bud to rub from top-down direction, and one cotton bud can be used only once.
7. Remove bedpan from the bed, use toilet paper to wipe the hip, and take off gloves.
8. Put on pants or diapers.

六、如何協助由口進食
VI. How to facilitate feed through mouth

對醫師指示可由口進食的個案，應協助其安全的由口吃東西，避免發生吸入性肺炎

As instructed by physician, help case to use mouth for food feeding safely to prevent aspiration pneumonia

一、原則及注意事項：

1. 當病人發生咳嗽時，請停止餵食，讓病人至少休息半小時再試，並讓醫護人員知道。
2. 餵食後需要採坐姿半小時後再臥床，以免食物逆流。
3. 應遵照醫護人員指示選擇食物的質地（如軟質、流質、一般飲食）。
4. 若發生嗆到情形，應立即以手挖、拍背或用抽痰管排出食物。

Ⅰ. Principles and Attention:

1. When case cough, stop feeding, let case rest at least half an hour and try again, and inform the medical staff as well.
2. After completion of feeding, have case take sitting posture for half an hour before lying on bed to avoid food reflux.
3. Follow the instructions of medical staff to supply the texture of food choices (such as the soft, liquid, the general diet).
4. Upon choking situation, use hand to dig choking material out, perform back-rap or use suction tube to remove food.

二、方法：

1.安靜的用餐環境，使注意力能集中在進食上。
2.協助坐起 60-90 度，以枕頭放頭後，毛巾放於臉頰下，維持舒適的進食姿勢。
3.食物放置個案面前，以促進食慾及消化液的分泌。
4.每次以一小口食物餵食，請個案進行兩次吞嚥，期間可用手協助個案下巴作吞嚥的動作。
5.餵食時每次一口且要緩慢、適量，確認已吞下後再餵下一口（中風個案應將食物放入口中偏健側）。
6.進食後應執行口腔清潔。
7.記錄進食量與種類及特別情形發生。

Ⅱ. Method:

1. Assure quiet dining environment, and case’s attention can focus on consumption.
2. Assist sitting posture at 60-90 degree angle, place pillow against back of head, put towel underneath cheek, maintain a comfortable feeding position.
3. Place food in front of case to promote appetite and secretion for digestion.
4. Perform small amount of food feeding each time, ask case to perform swallow-twice and use hand to assist case’s swallowing motion by chin movement.
5. Make sure to perform each feeding with slow and modest way; to confirm food being swallowed prior next feeding (for stroke case: food should be placed at contra lateral position).
6. Oral clean should be carried out after feeding.
7. Record quantity and type of consumption, and any special circumstances occured.

七、鼻胃管的照護
VII. Nasogastric tube care

1.每日應至少做一次口腔及鼻腔護理。
2.每日更換膠帶時，須將鼻部皮膚拭淨再貼，並注意勿貼於同一皮膚部位。
3.更換膠帶前，將鼻胃管固定同一方向旋轉 90°(1/4 圈)。
4.鼻胃管外露部位須妥當保護，以免牽扯滑脫。
5.每日注意鼻胃管刻度，若有脫出超過 10 公分以上，應通知居家護理師處理。
6.意識不清或躁動不合作之個案，應預防鼻胃管被拉出，必要時可使用約束手套將個案雙手做適當的約束保護。

1. Perform oral and nasal care at least one time per day.
2. Clean the nose skin area firstly when performing daily tape replacement, and not to affix the tape to the same skin location of previous taping area.
3. Rotate the nasogastric tube 90 ° (1 / 4 laps) following the fix orientation prior to replacing the tape.
4. Protect the exposed area of nasogastric tube, not to drag and casuse slip-away.
5. Pay attention to the reading scale of nasogastric tube, notify home nursing supervisor should tube emerging over 10 cm above.
6. Cases of restless sense of confusing or non-cooperation, prevent nasogastric tube to be pulled out by the case, and may restrict case's hands with bound gloves, if necessarily.

八、如何由鼻胃管正確灌入食物
VIII. How to inject food through nasogastric tube

一、原則及注意事項：

1.灌食前應先以下列方式確認胃管在正確的位置：

1).檢查鼻胃管的記號，應維持在護理師所做的記號處，若脫出 10 公分以上時，應通知護理師重插；若未超過 10 公分，檢查口腔若無為胃管纏繞，則可輕推進至原刻度位置，重新固定。

2).再以灌食空針反抽，若有反抽物，則就確定胃管仍在胃內。同時檢查胃內殘餘食物量，若在 50cc 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) 。

2.準備管灌食物:

1).若採自製，則可一次製作一天的量，放在冰箱每次取出約 250cc -300cc 的量加熱並將之完全灌完（若無法全部灌完，應速放回冰箱冷藏）。

2).若採商業配方，應依配方上沖泡調製方法使用。若為粉狀，每次只沖泡當餐的灌食量；若為罐裝，可直接隔水加熱後灌入，如當餐未完全灌完，則應立即放入冰箱中冷藏，下次取用時仍先請隔水加熱或倒出至杯中溫熱才可食用。

3.使用氣管內管或氣管套管的病人，灌食前應先翻身、拍背、抽痰，氣囊是否需打氣，應遵居家護理師之指示，以免食物灌入肺內。

4.藥物不可與食物攪拌後一起灌入，註明飯前、飯後或睡前使用之藥物應分開灌入。

I. Principles and Attention:

1. Make sure nasogastric tube located in the right position as decribed below before feeding:

1). Inspect mark on nasogastric tube and make sure it maintains at the nursing supervisor's marking position, if it emerges more than 10 cm notify the nurse/supervisor to re-insert the tube. If not more than 10 cm, perform oral examination to make sure no winding of nasogastric tube, then push lightly forward to the original marking location, and refix the tube.

2). Then use empty feeding syringe to do pull-out to make sure stomach material resided and nasogastric tube is inside stomach. At the same time to inspect food remnant in stomach, if more than 50 cc, then delayed half an hour or one-hour for feeding (should pull-out material without abnormality, let it naturally return to stomach).

2. Preparations of feeding food:

1) For self-made case, it can be produced one time for one day consumption usage, stored it in the refrigerator and take 250 cc-300cc each time to warm it up and feed to case all at once. (The unused amount need to stored into refrigerator right away).

2) For commercial formula case, prepare it according to the described formula. For powder form, just prepare the right amount for each serve; For canned form, use water bath heating over the can, it should be stored frozen in the refrigerator for any unused amount which should be heated by water bath over can or warm up in the cup for next feeding.

3. For endotracheal tube or use of tracheal case of patients, feeding should be preceded by body flipping, back rap, suction of phlegm, and check aerocyst condition. Procedures which should comply with home care supervisor’s to avoid food flowing into lungs.

4. Do not mix food and drug together for feeding, put annotation on medicine for before meal, after meal or before bed use, separately.

二、準備用物:

灌食空針、管灌食物、毛巾、衛生紙

Ⅱ. To use of:

Food feeding syringe, feeding food, towels, and toilet paper

三、方法：

1. 協助個案採半坐臥姿或坐姿；視需要墊上毛巾，以防食物滴落。
2. 洗淨雙手。
3. 灌食前先用灌食空針反抽，需有反抽誤以確定胃管仍在胃內，若抽出量在 50c.c.以上，則延遲半小時再餵食，無異狀之反抽食物，可讓其自然流回胃內。
4. 灌食空針接在胃管末端，將流質食物緩緩倒入，借重力流入胃內，灌食空針高度距腹部約 30~45 公分。
5. 灌食食物的溫度約 38~40℃。
6. 每次灌食量總量不可超過 500 cc，速度不可太快，以免引起個案腹瀉、噁心、嘔吐等不適症狀。
7. 灌食過程中應避免空氣進入，以減少個案腹脹不適。
8. 灌食過程中，若個案有異常情形，(例如：不停咳嗽、嘔吐、臉色發紫等)應立即停止灌食，並即刻通知護理師；若為非上班時間，無症狀緩解跡象，則應立移送醫。
9. 灌食時，若感覺不易灌入，可能是管口被食物阻塞，此時先用灌食空針反抽，再灌溫開水沖通鼻胃管。若仍然無法灌食，則與居家護理師聯絡處理。
10. 灌食後，以清水 30~50c.c.沖洗鼻胃管以防止食物殘留鼻胃管壁，將鼻胃管反褶塞入開口處或以栓子塞住。
11. 灌食後，繼續採半坐臥姿或坐姿，且勿翻身或抽痰，以免刺激引發嘔吐，約 30~60 分鐘後再平躺。
12. 將灌食用具清洗乾淨晾乾後，放置於清潔容器內，以備下次使用。
13. 紀錄此餐的灌食內容及量。

III. Method:

1. Place case at partly sitting prone position or the sitting posture; put a towel underneath case to prevent food dropping out.
2. Wash hands.
3. Use empty feeding syringe to do pullout from nasogastric tube to make sure stomach material resided and nasogastric tube is inside stomach. At the same time to inspect food remnant in stomach, if in more than 50 cc, then delayed half an hour or one-hour for feeding (let the pullout material naturally return to stomach should pull-out material without abnormality).
4. Connect feeding syringe to nasogastric tube end, put feeding material slowly into the feeding syringe and let it by gravity flow into the stomach, feeding height stay about 30 to 45 cm above the belly.
5. Maintain food temperature of about 38 ~ 40 ℃ for feeding.
6. Do not exceed 500 cc each time for feeding, and do not go to fast on feeding speed, so as to avoid diarrhea, nausea, vomiting and other uncomfortable symptoms.
7. Avoid feeding air into the syringe to reduce the cases of abdominal distention.
8. Any unusual circumstance, for example: non-stop coughing, vomiting, complexion turns purple, etc. during feeding processes should stop feeding immediately, and inform the nurse or home care supervisor right away; Case should be transferred to hospital in cases of non-working hours and no relief of symptomatic signs.
9. Whenever feeding is not flowing smoothly or too slow, it may be obstructed by feeding material in this case, try to use empty feeding syringe to do pullback and use warm water to flush nasogastric tube. Contact nurse or supervisor immediately should problem stay.
10. Once complete feeding, use clean water of 30 ~ 50 c.c. to wash nasogastric tube to prevent food residues, and bend the very end of nasogastric tube and fold it back, and squeeze it into the opening or engage with plug.

11. Maintain partly sitting prone position or the sitting posture at least 30-60 minutes after feeding, during this period not to perform body flip or phlegm suction to avoid vomiting, and assist sufine postion on bed afterward.

12. Clean and perform air-dry on feeding appliances, place these in clean containers for the next use.

13. Record feeding content and quantity.

九、尿失禁的照護
IX. Incontinence care

1. 固定時間帶個案如廁或使用便盆，給予充足時間及適宜的環境。
2. 個案如沒有飲水的禁忌症，應鼓勵白天飲水，傍晚後即減少飲水量。
3. 如果使用橡皮及布中單保護床墊，以防床褥墊弄污弄濕以避免個案的皮膚、衣服、床單被尿液浸濕。
4. 使用合適大小之紙尿褲，應注意黏貼鬆緊應合宜。
5. 一旦看護墊、紙尿褲、衣服或床單尿濕，應立即更換，給予會陰清潔及清潔擦乾皮膚。
6. 男性若使用尿套，應注意固定帶的鬆緊，若解尿於尿套，應隨時更換，避免逆流。
7. 紀錄如廁的時間及尿量，或是更換尿布次數。
8. 如果有尿量減少、超過 6 小時未解尿、頻尿、抱怨解尿疼痛、尿液顏色改變、發燒等不正常情形應立即告之家屬或居家護理師。

1. Assist case to go to toilet or use bedpan at fixed time, and provide sufficient time and comfortable environment.
2. For case without restriction on drinking water, encourge case to drink at day time, and reduce drinking water after evening
3. Use rubber and fabrics in the mattress for protection,do need to prevent mattress from dirty and urine wetting to avoid urine wetting on the skin, clothes, bed sheets.
4. Use appropriate size of paper urine trousers, do need to place adhesive tape with suitable tightness.
5. Immediately replace urine wetted nursing pad, paper urine trouser, clothes, or bed sheet, and clean the perineum, and clean skin and have skin dried.
6. Case of male urine wrap, pay attention to the tightness of elastic band. Replace urine bag if urination happened, to avoid reverse flow of urine.
7. Record time of urination, urine quantity, or the number of diaper replacement.
8. Inform family members or home care supervisor, should the following situation occur: reduction of urine quantity, urination unresolved for more than six hours, frequent urination, complaint of pain during urination, color change of urine, fever and other abnormal situation.

十、留置導尿管的居家照護
X. Urine catheter of home care

保持尿管通暢，降低發炎的機會

Maintain urine catheter at unobstructed condition, and reduce inflammation occurance.

1. 每日執行 1-2 次尿管護理（以清水確實清洗會陰部或尿道口）。
2. 每日至少柔捏尿管一次，避免折到或壓到，以保持暢通。
3. 解便後應立即予會陰沖洗。
4. 尿袋高度要低於膀胱位置（但不可置放於地面上），每日至少要倒尿三次，並紀錄尿量。
5. 尿袋開口須隨時關閉，勿受污染。
6. 每日更換膠布及固定位置，以減少皮膚刺激。
7. 無特殊水分限制者，應每日給水 2500cc-3000cc，每日尿量至少需維持 1500 cc。
8. 可予蔓越莓汁或果汁，以降低泌尿道感染機會。

如有發燒，尿量少於 500cc /日、血尿、滲尿、或尿管脫出、分泌物或小便有臭味、沈澱物增加等情形，請儘快與醫護人員聯絡。

1. Perform care of urine catheter 1-2 times per day (clean perineum or urethra mouth with clean water).
2. Gently pinch catheter at least one time a day, avoid bending or compressing on catheter and maintain at unobstructed condition.
3. Wash the perineum right after urination.
4. Place urine bag lower than bladder position (but do not place it on the ground), replace urine bag at least three times per day, and record urine quantity.
5. Close urine bag at any time to avoid contamination.
6. Change tape and its fixed position daily to reduce skin irritation.
7. For case without drinking limitation, maintain daily water supply at 2500cc-3000cc, daily urine output at least 1,500cc.
8. Provide case with cranberry juice or fruit juice to reduce infection of urinary tract.

Inform the medial staff should the following situation occurred: fever, urine output of less than 500 cc / day, hematuria, seepage of urine, or catheter emerged, secretions or fetid odor of urine, increasing sediment, and so.

十一、膀胱造瘻口照顧
XI. Take care of the bladder ostomy

1.每日更換 Y 紗及紗布，步驟如下：
   1)移除膀胱造廔口上的紗布。
   2)洗淨雙手。
   3)以無菌棉棒沾取生理食鹽水清潔造口周圍皮膚。
   4)用無菌棉棒沾優碘溶液，自膀胱造廔口為中心由內往外以環狀消毒法消毒皮膚，約直徑 5 公分範圍。
   5)用無菌 y 紗與無菌紗布覆蓋膀胱造廔口，並以紙膠固定。
   6)每天更換膀胱造廔管固定的位置，以減少紙膠對皮膚的刺激。
2.每天喝水 2000c.c.，每日尿量至少需維持 1500c.c.，以稀釋尿液及產生自然沖洗力，以預防泌尿道感染。
3.尿袋開口須隨時關閉，勿受污染。
4.尿管應避免受壓、扭曲，並應經常擠捏尿管，以避免阻塞。
5.尿袋高度要低於膀胱位置（但不可置放於地面上），每日至少要倒尿三次。
6.如果有發燒、造廔口發紅、小便有臭味、沈澱物增加、尿管滑出時應立即告之家屬及通知醫護人員。
7.每日應紀錄尿量、顏色及混濁度。

1. Replace Y gauze and gauze daily, the steps are as follows:
   1) Remove the gauze covered on bladder fistula.
   2) Wash hands.
   3) Use sterilized cotton swab rinsed with saline water to clean the skin around the stoma.
   4) Use sterilized cotton swab rinsed with iodine solution, to disinfect using ring-like disinfection method which use urinary bladder mouth as center location to move toward the outside to disinfect the skin, and extend approximately 5 centimeters in diameter range.
   5)Use sterile Y gauze and gauze to cover the urinary bladder mouth, and fixed it with paper tape.
   6)Replace tape and fixed position by daily basis to reduce skin irritation.
2. Drink plenty of water 2000 c.c. each day and maintain daily urine output at least 1500 c.c. which provide dilution of urine and induce natural flushing, so as to prevent urinary tract infection.
3. Close urine bag openings at any time to prevent contamination.
4. Gently pinch catheter frequently, avoid bending or compressing on catheter and maintain it at unobstructed condition.
5. Place urine bag lower than bladder position (but do not place it on the ground), replace urine bag at least three times per day, and record urine quantity.
6. Inform the medial staff should the following situation occurred: fever, redness on urinary bladder mouth, urine output of less than 500 cc / day, hematuria, seepage of urine, or catheter emerged, secretions or fetid odor of urine, increasing sediment, and so.
7. Record urine quantity, color and turbidity daily.

十二、膀胱訓練須知
XII. Bladder training notes

一、原則及注意事項:

1.晚上八點到隔日早上八點以前不做膀胱訓練，讓個案有好的睡眠，應將尿管打開。

2.紀錄每次自解狀況，包含時間、尿量。

3.若個案有發燒、解尿困難應通知醫護人員。

I. Principles and Attention:

1. Not to perform bladder training between 20:00pm to 8:00 am next day, let case has a good sleep; and urine catheter should be remained open.
2. Records case’s self urination every time and include time and urine quantity.
3. Notify the medical staff should fever occurred.

一、方法:

1.將尿袋裡的尿液排空。

2.將尿管對摺，並用管夾夾緊或用橡皮巾綁緊。

3.定時喝水：每小時喝 150-200 cc 或依指示攝取水份。

4.定時放鬆管夾：每三小時放鬆（打開）尿袋管 15 分鐘，再綁緊尿袋管。

5.尿管綁緊後，若時間超過 2 小時且未滿 4 小時個案就有尿意感或小便外滲，應鬆管夾，並告知醫護人員。

I. Method:

1. Empty urine in the urine bag.
2. Fold urine catheter and clamp tightly with tube clamp or rubber band.
3. Provide drinking water regularly: 150-200 cc per hour or otherwise instructed by medical staff.
4. Relax tube clamp or rubber band regularly:15-minute relax (open) for every three hours, then tighten it again.
5. For case to take 2-4 hours interval to have sensation to urinate or urination leakage after step 4, need to loose the clamp or rubber band of catheter tube and inform medical staff.

十三、氣切造口的居家照護-氣切護理
XIII. Home care - tracheotomy stoma care

維持氣切套管清潔及乾淨，避免感染

Maintain **tracheotomy** tube clean, to prevent infection

一、原則及注意事項：

1.氣管內管每日清潔 1-2 次，如果痰量多，則增加清潔次數。

2.Y 型紗布及氣切套管固定帶濕了或髒了，需馬上更換。

3.膠布浮貼於紗布上，避免直接貼於個案皮膚。

4.氣切固定帶之鬆緊約以二手指能插入為準。

5.取下氣管內管清潔時，不要超過 30 分鐘以上，以避免痰液形成結痂物堵住氣管徑。

I. Principles and Attention:

1. Clean Endotracheal tube 1-2 times daily, increase frequency of cleaning if phlegm(sputum) increase.
2. Replace Y gauze and fixing band (belt) of tracheotomy stoma casing if it becomes wet or dirty.
3. Avoid place elastic tape on to skin directly and place lastic tape fixed to Gauze in stead.
4. Keep two fingers margin in term of tightness for fixing band (belt)fixed for tracheotomy.
5. Not to take more than 30min. to perform endotracheal tube (inner tube) cleaning to avoid the formation of sputum scab to block gas tube.

二、準備用物:

清洗用的小刷子、無菌的 Y 型紗布、兩個杯子（分盛生理食鹽水及雙氧水）、優碘藥水、普通棉枝、氣切固定帶一條、4×4 紗布一塊

II. To use of:

Small cleaning brush, the Y-sterile gauze, two cups (for saline water and hydrogen peroxide, respectively), the gifted iodine syrup, ordinary cotton sticks, with a belt for fixed gas cut, a piece of 4 × 4 gauze

三、方法：

1.洗手。

2.固定外管後，將卡鈕上轉；輕拉出內管。

3.將內管置於雙氧水內浸泡數分鐘至痰液脫除，再用刷子清洗淨，放入生理食鹽水內。

4.拉出氣切口原有之 Y 型紗布。

5.棉花棒沾優碘環狀擦拭氣切口周圍後，再以生理食鹽水環狀擦拭。

6.置放新的無菌 Y 型紗布。

7.氣切繫帶若鬆了重新綁好、髒了應更換新的帶子。

8.消毒內管的方法:

＊方法一

1)用小刷子將氣管內管清洗乾淨。

2)將氣管內管浸泡於雙氧水 10-15 分鐘。

3)用生理食鹽水將氣管內管痰液沖洗乾淨。

4)將消毒好的氣切內管放回氣切管並扣緊。

＊方法二

1)用小刷子將氣管內管清洗乾淨。

2)用小鍋子裝冷水能淹過氣切內管的高　度，加熱至沸騰。

3)滾 5 分鐘，熄火。把氣切內管放入滾水中。
4)蓋上鍋蓋後自然冷卻即可。
5)將消毒好的氣切內管放回回氣切管並扣緊。

Ⅲ. Method:

1. Wash your hands.
2. Fix outer tube, and twist knob-button upward; lightly pulled out the inner tube.
3. Place inner tube in hydrogen peroxide soaked for a few minutes to remove sputum, and then use brush to clean it, and put it to the saline solution.
4. Pull out of the original Y-gauze from stoma connector.
5. Use cotton swab with iodine to wipe around the stoma, and then use cotton swab with saline water to wipe around the incision.
6. Replace Y-sterile gauze.
7. Place elastic belt(band) for stoma connector firmly without looseness and replace a new belt if it becomes dirty.
8. Disinfection of endotracheal tube (inner tube):

* A method

1) Use small brushes to clean endotracheal tube.
2) Soak endotracheal tube in hydrogen peroxide 10-15 minutes.
3) Use saline water to clean sputum in endotracheal tube.
4) Put disinfected endotracheal tube back into the tracheotomy tube and clasped.

* B method

1) Use small brushes to clean endotracheal tube.
2) Use a small pot with cold water filled to the height can cover tracheotomy tube height, heated to boiling.
3) Boil for five minutes and turn off power and put endotracheal tube in the boiled water.
4) Cover the pot with its cover and perform the natural cooling
5) Put disinfected endotracheal tube back into the tracheotomy tube and tighten it.

十四、氣切造口的居家照護--從氣切口抽痰

XIV. Home care –Phlegm (Sputum) suction through tracheotomy stoma

清除痰液、保持呼吸道順暢

Remove sputum, and maintain respiratory smoothly

一、原則及注意事項：

1.抽痰時，不可將抽痰管及戴上抽痰用無菌手套的手碰觸其他物品，或對著抽痰管咳嗽、講話…等。
2.抽痰管、抽痰用無菌手套只能使用一次，勿重覆使用。
3.抽痰之先後順序為，氣切管→鼻→口，抽完口鼻後不可再用該抽痰管回抽氣切管的痰液。
4.兩次抽吸應間隔 1-2 分鐘。
5.抽吸時若有面色發酣現象，應馬上停止並給氧氣。
6.可先協助個案翻身、扣背及姿勢引流，使痰液咳出；清醒者鼓勵做有效咳嗽（深呼吸、腹部用力咳出），若仍不易咳出再抽吸。
7.在進餐前 30 分鐘或進餐後 1 小時內請勿抽吸，以防嘔吐。
8.抽吸瓶液面不可超過 2/3 瓶，以免影響抽吸壓力及效果。

I. Principles and Attention:

1. Do not allow suction tube (phlegm tube) and sterile gloves to touch the other items, or put suction tube in front of coughing, speaking etc during suction.
2. Each suction tube and sterile gloves can be used only once, can not used repeatedly.
3. The operation sequence of suction is as: tracheotomy → nose → mouth, and do not reuse suction tube to perform tracheotomy suction after suction of nose and mouth.
4. Wait for 1-2 minutes for each suction operation.
5. Stop suction operation and provide oxygen if case's facial color turns luxurious during suction.
6. Perform body flip, pat back and posture drainage firstly, in order to facilitate case to cough sputum out; Encourage case to make effective cough (deep breathing, abdomen effort coughs), then perform suction again if no progress on coughing sputum.
7. Do not do suction 30 minutes before meal or one hour after the meal, to prevent vomiting.
8. Do not hold liquid level of suction bottles exceeding 2 / 3 of bottle which affect the suction pressure and suction effect.

二、準備用物:

抽痰機、抽痰管數條、抽痰用無菌手套、生理食鹽水瓶子（冷開水亦可）、清水瓶子

II. To use of:

Phlegm (Sputum) suction machine, a few of suction tube, sterile gloves, saline solution (cold water is also ok), water bottle

三、方法：

1.洗手。
2.打開抽痰管連接端之包裝，抽痰管先不要抽出。
3.抽痰管置包裝內，將連接端接到抽痰機的抽吸端。
4.一手戴上抽痰用無菌手套將抽痰管抽出，注意管子不可碰觸其他物品。
5.以另一手打開抽痰機，並調好抽吸壓力。(大人：150-200mmHg; 小孩:80-120 mmHg）。
6.先抽吸生理食鹽水（或冷開水），潤濕管子。
7.以輕柔動作插入適當深度（約相當於氣切套管的長度）。
8.以戴抽痰用無菌手套之手指旋轉抽痰管，施行間歇抽痰（大人每次不可超過 15 秒，小孩 5-8 秒）。
9.解除壓力後將管子抽出續抽吸清水以清潔管中 之痰液。
10.帶著抽痰手套的那隻手，順勢將抽痰管纏繞抓住後，再用另一隻手將抽痰手套脫下並包住使用過

之抽痰管後再丟棄。

III. Method:

1. Wash your hands.
2. Open connector side of suction pack, do not take out suction tube.
3. Have suction tube stayed in the pack, and connect suction connector with connection tube of suction machine.
4. Put on sterile gloves single-handedly and take suction tube out and wind around the palm, do not let suction tube touch other items.
5. Use the other hand to turn on the suction machine, and settle for right suction pressure. (Adults: 150-200 mmHg; children: 80-120 mmHg).
6. Do suction with saline water (or cold water) to wet the suction tube begin with.
7. Move gently to insert the suction tube with the appropriate depth (equivalent to the length of tracheotomy tube, our case is 2/3 of suction tube lenth).
8. Use hand which wear sterile gloves to rotate suction tube to perform intermittent suction (suction time no more than 15 seconds for adult, children 5-8 seconds).
9. Release suction pressure before lifting out suction tube and flush with clean water to push sputum out of tube and flow into bottle.
10. Wind the used suction tube around hand which held suction glove, and use the other hand to take off the gloves and wrap around the suction tube and have it discarded.

十五、蒸氣吸入、姿位引流、背部扣擊

XV. Steam inhalation, posture position and draining, back-rap

一、蒸氣吸入法：

1. 請依醫護人員的指示，如果醫師有開立藥物，則將藥物加在蒸氣吸入機裡小藥杯中，若沒有開立藥物，使用醫囑吸入液（0.45% 生理食鹽水）。
2. 接好管路，套好鼻導管或面罩，在臉頰旁墊上毛巾，以防水氣滴落。
3. 過程中鼓勵個案深呼吸。'

I. Steam inhalation:

1. Follow medical staff's instructions and based on doctor's prescription, put drugs into to the medical cup for steam inhalation device, if no doctor's prescription just use saline solution (0.45% saline water) for inhalation.
2. Connect inhalation tube and check oxygen mask or nasal catheter which is properly connected, put a towel next to the cheek to prevent water dropping.
3. Encourage case to exercise deep breathing, if possible.

二、姿位引流

做完蒸氣吸入後或翻身時，讓病人側躺，床頭搖平，床尾搖高。依醫護理人員的指示，使有痰的部位朝上，例如:左側胸壁有痰--右側臥，右側胸壁有痰--左側臥。

II. Posture position and phlegm draining

After steam inhalation or body flip, place case at side-lies-down posture, control head of the bed to swing evenly, elevate bed tail block. Accord with medical staff's instructions, place the chest with phlegm spot upward, for example: if phlegm resided in the left chest wall and take the right side-lies-down (right flank lies down) posture, and left side-lies-down (left flank lies down) posture for phlegm in the right chest wall.

三、背部扣擊：

1.協助個案採取適當姿勢（利用個案原左或右側躺之臥位）並予枕頭適當支托。
2.在個案下頷處放置衛生紙。
3.若為左側躺則站在面向病患測，將手掌彎曲成杯狀叩擊個案之右上背部。
4.雙手交替拍打或單手叩擊，平均每一側需扣擊 10 分鐘約 600 下(平均一秒鐘一下)。
5.避免直接叩擊心臟部位、胸骨、肩胛骨和胸側肋骨緣上一手掌寬度等區域。
6.執行完畢應給予個案充分之休息。
7.注意事項：
    1).如果醫護人員告知有禁忌，則不可執行拍背。
    2).拍痰宜避免直接在赤裸的皮膚上操作。
    3).至少在用餐前一小時才可執行此活動，應避免於飯後操作。
    4).每天至少早晚各一次拍痰的活動，且每次每側應至少 10 分鐘。

III. Back-rap:

1. Assist case with appropriate posture (use decubitus either left or right flank lies down) and use pillows to provide sufficient support.
2. Place toilet paper underneath chin.
3. Face toward case for left-flank-lies-down posture, curve palm into the cup shape and perform back-rap on right-upper-back position.
4. Stike (rap) in turn with both hand or use single-handed strike, strikes 10 minutes approximately 600 times (average one second per rap (strike)) for each side.
5. Do not strike(rap) on heart location, sternum, scapula and one palm-size above rib chest area.
6. Give case a sufficient rest after completion.
7. NOTES:

1) Medical staff, under special condition, may inform the prohibition on back-rap on the case which should be abided with.

2) Avoid to perform back-rap directly over bare skin.

3) Avoid this operation right after meal and implement this at least one hour before meal.

4) Medical staff’s instruction on the schedule of back-rap may vary depends on case situation, but to perform this operation every two-hour is typical for serious disable case. For others, perform twice per day at morning and evening with 10min. each side is typical.

十六、居家用氧須知
XVI. Home oxygen notes

1. 若是使用氧氣筒，則應距離電源、火源至少 5 英呎處，周圍的人不可以吸煙，不可有火燭，放置氧氣處應避開熱水器、瓦斯、蒸氣等電熱源，而不用氧氣時應關閉，通風設備要好。
2. 氧氣流量不可任意的調整。
3. 應注意潮濕瓶中的水量在合適的水量，並觀察鼻腔及口腔黏膜有無太過乾燥或損傷。
4. 若是使用氧氣製造機，可放在較空曠處（如陽台），以避免機器運轉之噪音及散熱之熱風。
5. 對於接受持續性氧療法者，家中應有備用氧氣筒。

1. Keep a distance at 5-in away from power and fire source for use of oxygen cylinder, no smoking for the surrounding people, free of material may cause fires, oxygen cylinder/generator should be away from water heaters, natural gas, steam and other electric-heating sources, close the oxygen cylinder when of no use and keep ventilation sufficiently.
2. Do not adjust oxygen flow without medical staff approval.
3. Pay attention to the humidified bottle which sufficient water quantity, and check nasal and oral mucosa regularly and avoid abnomal dry or wounded condition.
4. Place oxygen generator at open area (such as the Terrace), avoid machine noise and heating air.
5. Have backup oxygen tank/cylinder ready at home for case of continuous oxygen therapy.

十七、居家日常生活照護指導-皮膚照護
XVII. Home care guide their daily lives - skin care

一、原因：

人體局部組織受持久的物理性壓力，包括：壓力、剪力、摩擦力而導致有礙血液循環，造成局部缺血的現象，使該處組織產生壞死。

I. Reasons:

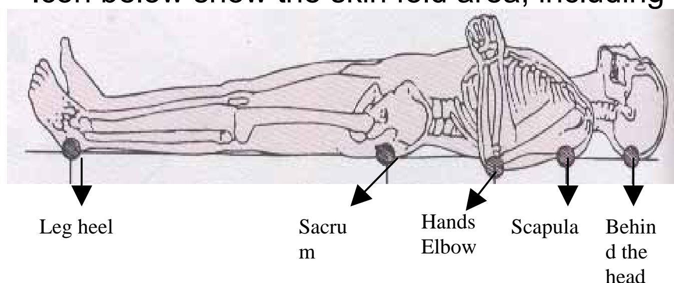
Local organization of human body are always suffered physically stress including: pressure, shear stress, and friction, which impede blood circulation, cause ischemia, and produce necrosis.

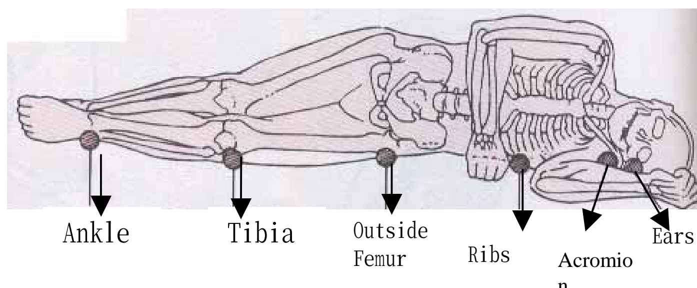
一、 常見部位

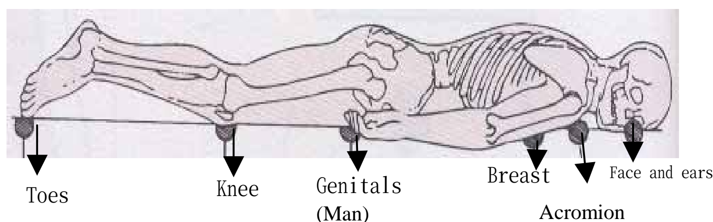
II. Common parts

如下圖示及皮膚皺摺處，包括乳房下、耳後、腹股溝。

Icon below show the skin fold area, including the breasts, ears, and groin.







三、原則及注意事項：

1. 每兩小時翻身一次，翻身時應注意衣服、被單、看護墊等之平整；對皮膚骨突受壓面，予輕拍或按摩促進血循。
2. 注意營養攝取，避免消瘦症或肥胖症。
3. 每日使用中性沐浴潔膚用品，以溫水擦拭或清洗個案的身體，可保持皮膚的乾淨，增強皮膚的抵抗力，並促進舒適。
4. 在皮膚乾燥處塗抹適當的保濕用品，如潤膚乳液、凡士林。
5. 需隨時留意衣服、被單或尿布墊之乾爽，以免皮膚浸泡於潮濕中，造成受損（衣服被單應選擇易吸汗之材質）。
6. 若不得已需約束，應對約束帶觸及皮膚處有　　軟墊防護，並每隔一段時間鬆開約束帶。

7. 需使用膠布，應選擇透氣者，且每日更換黏貼部位。
8. 如果有使用氣墊床，除避免尖銳物品置於床上外，應每日檢視氣墊床，若有漏氣的情形，可先自行檢查每個連接處有無鬆脫，若均無異樣，可連絡廠商到家裡進行維修處理。
9. 可將橡膠手套，裝入 6~7 分滿的自來水，用橡皮筋將橡膠手套的開口綁緊製成水球後，墊於個案的耳下、腳踩或腳跟下，以減少其壓迫的力量。

III. Principles and Attention:

1. Perform body flip every two hours, watch out clothing, linens, and nursing pad need to be smooth and flat during body flip; perform light pad and massage on the stress area of skin and bone bump.
2. Provide case with nutritional intake, avoid emaciated sickness disease or obesity.
3. Provide case with neutral quality of bath supplies for skin care, use warm water to wipe or clean body with skin-care supply, which can keep skin clean and enhance the skin's immunity and to promote comfort.
4. Apply dry skin with appropriate moisturizers, such as emollient (softening) lotion, Vaseline.
5. Always keep clothes, bed sheets or diaper at dry condition, not to have skin soak in the moist condition, which cause skin damage (chose clothes, bed sheet with good moisture absorbing quality).
6. For case required to be bounded with movement restriction, case’s bounded area should be protected with a soft cushion pad, and release bounding for a while from time to time to release bounding pressure.
7. Use tape of breathable type and change taping location daily.
8. Avoid to put sharp items on air-cushion bed, inspect air-cushion bed daily, check air supply connector and cable connection firstly upon leakage occured, contact manufacturers to deal with maintenance if leakage sustain.
9. Use rubber glove packed with 60-70% of water inside and seal it with rubber band to produce water balloons, use these water balloons as pads to place under ear and footstep or under heel, to reduce the stress of oppression.

十八、傷口的皮膚照護-正確的換藥
XVIII. Care of skin wound - the right medicine dressing (applying medicament)

正確並確實的換藥技術，可以有效預防感染。

The medicine dressing techniques need to be right and truly practice the medicine dressing techniques, which can effectively prevent infection.

一、原則及注意事項：

1.接觸傷口的物品或棉枝必須完全無菌，應注意物品之保存日期及換藥技術，一支棉棒只能使用一次。

2.換藥的次數與傷口狀況有關（分泌物多少、傷口大小），請與居家護理師討論換藥次數。

3.除了換藥外，還要勤於翻身及注意營養多吃魚豆蛋類及維他命 A、C。

I. Principles and Attention:

1. The goods and cotton swab which handling wound must be totally sterile should pay attention to the preservation date of goods and medicine dressing techniques, a cotton Swab can be used only once.

2. Dressing change related to wounds by situation (the amount of secretions, wound size), to discuss the number of dressing with home carer.

3. In addition to dressing change, we must also be diligent with body-flip and pay attention to nutrition and eat more fish, eggs, and vitamins A, C.

二、準備用物:

無菌棉棒、無菌生理食鹽水、無菌紗布、藥水或藥膏、透氣膠布

II. To use of:

sterile Swab, sterile saline water, sterile gauze, Disinfection liquid medicines or ointment, breathable tape

三、方法：

1.先用肥皂徹底洗淨執行者的雙手。

2.撕下舊敷料。敷料與皮膚沾黏時，先用生理食鹽水沖濕再撕下。

3.以棉籤沾生理食鹽水，從傷口的中間往外塗擦至傷口清潔止。

4.依醫護人員指示，以上述方式塗上藥水或藥膏。

5.蓋上敷料，貼上透氣膠布。

6.將傷口的情形紀錄下來，包括滲出液、有無異味、大小…。

III. Method:

1. Wash hand thoroughly with soap before the implementation.

2. Tear off the old dressing material. Use normal saline to wet the old dressing material if it adhered with skin heavily and then tear if off later.

3. Use cotton swab rinsed with saline water and clean wound area from the center to outbound location.

4. Follow medical staff’s instruction, use the similar way as stated above to dress wound area with disinfected liquid medicines or ointment.

5. Put gauge with related dressing material on the wound area and put breathable tape afterward.

6. Record information of wound, including effusion (effused fluid), smell/odor, size…

十九、居家日常生活照護指導-身體正確的姿勢與移動
XIX. Home care guide - correct body posture and movement

一、原因

1.使上身稍高時，可用各種墊子、大枕頭、棉被等放置於身下以墊高上半身，並於足部給予適當支托。

2.採半坐臥位時，需注意頭、背、腰和足部的支托。

3.側臥時，需利用枕頭增進病人的舒適，分散其體重，並維持合宜的姿勢，於頭部和腹部給予支托，同時注意足部的支托。

4.採半坐臥位時，在頭、肩 、上臂 、腿和腳踝的地方都特別加以支托。

5.一般的側臥，可於胸前放一大枕頭，然後於背面用大枕頭或大墊子、浴毯等頂住病人的背部；雙腿間夾放一個枕頭。

6.俯臥時，手臂的位置和肩部的支托很重要，可採一手伸直、一手屈曲或兩手屈曲的位置，肩下需墊一小枕，手臥捲軸。若為女性，尚需考慮分散其體重及維持女性適當之肢體位置，分散於肩下、腹部、大腿和小腿處支托，並於足掌上加支托板，以維持踝關節之正常功能位置。

I. Reason

1. Use all kinds of mattresses, large pillows, quilts etc. to place under beneath body to lift upper body higher and give foot area with appropriate support.

2. Pay attention to support head, back, waist and foot when place case at half-sit-lie posture .

3. Case of side lying (left-flank-lie or right-flank-lie), use pillow to improve comfort and spread case's weight, and maintain right posture, give sufficient support to head and abdomen and pay attention to support ankle area.

4. Case of sit-lying posture, use special support on head, shoulder, upper arm, leg, and ankle.

5. Case of side-lying posture, put a big pillow in front of chest and use big pillow or big mattress, or blanket to support case's back side; put a pillow clamped between legs.

6. Case of prone posture, arm location and shoulder support is very important, may have one hand unfold and flexture for the other hand, or have two hands both at flexure position, put a small pillow to support shoulder and use hand to hold scroll bar. For woman, needs to consider case's weight dispersion and appropriate body location, spread support over the shoulder, abdomen, thigh and calf, support carrier board on foot palm to maintain normal function of the ankle joint position.

二十、復健的居家照護-關節活動
XX. Rehabilitation of home care - joint activities

維持關節活動度，除了可以讓他感覺舒適外，也可以增加我們照顧時的方便。

To maintain joint activity to let case feel comfortable and also increase convenience for care.

一、原則及注意事項：

1.關節活動前，可適當的以熱毛巾或熱敷墊，熱敷各關節，使肌肉放鬆弛，會較容易進行。

2.可由手、肩到腳，從各部位的近端到遠端關節，注意每個可以活動的關節都要做。

3.做關節活動時遇到阻力請勿強行彎曲或拉直，以免造成骨折或傷害，每個關節皆採漸進式的角度增加。

4.關節運動要規律、持續執行，不要做做停停等於沒有效果，最好是每天早晚各一次，每個關節做3-5 次。

5.操作時注意自己的姿勢要正確，勿過度彎腰，以免造成自己酸痛。

I. Principles and Attention:

1. Prior to joint activity, apply hot towels or hot packs pad to improve fomentation of the joints and relax muscle tension, which can improve the movement.
2. Pay attention to each of movable joint activities, from the hand, shoulder to foot, from the proximal to a remote part of the joints.
3. Whenever encountered resistance during joint movement, do not bend or straighten by force, to avoid fractures or injuries, gradually increase the degree of angle for each joint movement.
4. Joint exercise is scheduled to be routine and continuous, stop the schedule from time to time can render no effect, the better way is to perform at both morning and evening every day, and exercise joint each 3-5 times.
5. Use correct posture for operation, do not bend overly and might cause sour and aches yourself.

廿一、排便訓練及甘油球灌腸
XXI. Defecation training and glycerol ball for enema

一、原則及注意事項:

1.飲食增加纖維的攝取，水果中有木瓜、香蕉、柳丁、梅子等亦可幫助排便。
2.每日應攝取 2000-2500C.C.的液體。
3.配合飯後胃結蠕動反射，以早餐飯後一小時內為佳。
4.要多活動，縱使臥床也必須協助多翻身、手腳全關節運動、腹部按摩，以助腸胃蠕動。

I. Principles and Attention:

1. Increase dietary with fiber intake, fruits of papaya, bananas, oranges, plums, etc. which help defecation.
2. Take 2000-2500 C.C. liquid base daily.
3. Better perform this training within one hour after breakfast, which in accord with gastric peristalsis reflex after meal.
4. Assist case to perform more activities even for case being restricted in bed, must help body-flip more often, full range of joint motion on hands and feet, abdominal massage to help the gastrointestinal motility.

二、排便訓練:

1.吃完飯後 30 分鐘，協助個案坐於馬桶或半坐臥於床上，由右上再向左後再向下順著大腸走向按摩 15 分鐘（深度 3 -5 公分）。
2.若仍未解便，以手指塗潤滑劑，深入肛門約 2 公分，輕柔快速坐環狀刺激，直到肛門放鬆為止，若肛門放鬆則採挖便。
3.大便訓練常配合甘油球或栓劑使用，栓劑在飯前 30 分鐘塞入，飯後 30 分鐘做腹部按摩及肛門刺激。

II. Defecation training:

1. Help case to sit on the toilet or sit-lying posture in bed, message from right-top to left along the large intestine for 15 minutes (message depth of 3-5 cm).
2. For case with unsuccessful bowel movement, use glove finger treated with lubricants to pinch into anal about 2 centimeters in depth, stimulate circularly with rapid gentle squeeze until reach the relaxation of the anus, then dig waist out of anal.
3. Stool (defecation) training always come with glycerol ball or suppository, insert suppository 30 minutes before meal, and do abdominal massage and anus stimulation 30 minutes after meal.

三、甘油球使用方法：

1.先帶上手套，塗潤滑劑深入肛門檢查有無硬便，有則先輕輕挖出，以免影響效果。
2.將栓劑或甘油球塞入肛門，栓劑須靠在直腸壁上以利藥物吸收，刺激腸蠕動，引發排便。

III. Glycerol-Usage:

1. Put on glove with lubricant and dig into anal to check; if stool is hard, then gently dig out hard stool firstly, so as not to affect glycerol ball usage.
2. Squeeze suppository or glycerol ball into anal, have suppository inclined to intestine wall to facilitate drug absorption, and stimulate peristalsis to trigger defecation.

廿二、居家日常生活照護指導-發燒的照護
XXII. Home care guide - fever care

發燒是身體疾病的警告訊息。

Fever is a warning message for illness.

一、原則及注意事項：

1.維持個案舒適姿勢臥位，以防體力消耗。

2.每 2-4 小時測量一次體溫，並紀錄。

3.體溫在攝氏 38℃以上時，先給予溫水拭浴及冰枕;39℃以上時，除冰枕及溫水拭浴並依醫師指示下給予退燒藥。

4.保持室內空氣流通，維持舒適的溫度 24～26℃，打開冷氣或電風扇。

5.去除過多的衣物，以利散熱。出汗應立即擦乾及更換乾爽衣物。

6.充分給予水份。例如水果汁、茶水及湯類皆可。

7.可使用淡鹽水漱口或執行口腔清潔。

8.與醫師或居家護理師聯繫，並依指示查看個案的皮膚、小便、大便、呼吸道、消化道有無異常。

I. Principles and Attention:

1. Maintain case at comfortable supine position to prevent physical exertion.
2. Measure and record body temperature every 2-4 hours.
3. Provide case with wiping bath with warm water and ice bath pillow for body temperature above 38 ℃; if above 39 ℃, in addition to the ice pillow and warm water bath, follow the instructions given by doctors to apply anti-fever medicine.
4. Maintain good indoor ventilation and a comfortable temperature of 24 ~ 26 ℃, open the air-conditioner or fan.
5. Remove any excessive clothing to facilitate heat dissipation. Wipe case and replace case with dry clothing for sweating.
6. Give sufficient drinking water, for example fruit juice, tea and soups etc.
7. Gargle with lightly salty water or perform oral cleaning.
8. Contact with a physician or home care staff, and follow the instructions to check case's anomalies of skin, urine, feces, respiratory, digestive anomalies.

二、方法：

1.溫水拭浴法:是在溫暖環境中(如浴室或房間)，以溫水(41-43°C)沾溼毛巾後，持續擦拭、拍打背部、手臂、腋下、鼠蹊部等，以增加皮膚表面血液循環，達到散熱目的。

2.冰枕之使用:冰枕內裝三分之二冰塊，加少許冷水，夾緊袋夾放入塑膠袋內，或是使用冰寶，以乾毛巾包裹放在頭下，每 2~3 小時檢測冰袋內冰塊（冰保之冰度是否退去），隨時更換。

II. Method:

1. Wiping bath with warm water:perform in the warm environment (such as bathrooms or rooms), rinsed towel with warm water (41-43°C), wiping continuously, stroking case's back, arms, armpits, groin etc, to increase blood circulation on skin surface to improve heat dissipation purpose.
2. Usage of ice pillow: fill two-thirds of pillow with ice cubes, add a little cold water, clamp and put it into plastic bag, or use the ice-bao, use wrapped dry towel to place it beneath head, check the ice bag every 2-3 hours (to assure good cooling condition sustained), to replace with ice cubes at any time when cooling condition is not enough.

廿三、糖尿病照護-測量血糖
XXIII. Diabetes Care - measure blood sugar

一、原則及注意事項:

1. 遵守血糖機廠商建議的使用原則。
2. 注意試紙使用期限，開封後應於 2 個月內用完。
3. 每次測量結果都應記錄下來。
4. 血糖測量次數依醫護人員指示。
5. 身體不舒服時，如：疲倦、心悸、冒冷汗、 發抖、嘔吐、食慾不好時，除要告知醫護人員外，並應立即檢查血糖。
6. 正常血糖值是 80-120mg/dl（禁食 8 小時以上）。

I. Principles and Attention:

1. Follow the operation instructions provided by meter manufacturers.
2. Pay attention to storage life-time of test paper which to be used up in two months after opening.
3. Record measurement results every time.
4. Measurement schedule should base on medical staff's instruction.
5. Whenver uncomfortable situation such as fatigue, palpitations, cold sweats, shaking, vomiting, poor appetite, in addition to inform home care supervisor, should measure blood sugar immediately.
6. Normal blood sugar level is 80-120 mg / dl (base on fasting more than eight hours).

二、測量血糖方法：

1. 先輕輕柔捏預針刺之指尖。
2. 以酒精消毒指尖。
3. 輕刺指尖後，擠出一滴足量之血滴於試紙上。
4. 依照廠商提供使用方式執行，讀取血糖值。
5. 使用後之針應刺回原針套上，放入固定收集盒。

Ⅱ. Measuring blood sugar:

1. Gently pinch fingertip of the target measurement.
2. Disinfect the target fingertip with alcohol.
3. Lightly pierce (prick) the fingertip, squeeze out of a drop of blood on the test paper.
4. Read out blood glucose levels based on operation instruction.
5. Put needles back to the original needle wrap (sheath) and save it to the specific collection box.

三、使用胰島素的方法:

1. 胰島素注射部位必須依照指示輪流注射。避免注射紅、腫、癢的部位。
2. 若有發抖、冒冷汗、心跳加快、無力、頭暈、嘴唇麻等症狀，應立即通知家屬及醫護人員；並依指示意識清醒者，立即喝半杯果汁或糖果，若意識不清醒或昏迷需送醫院。
3. 未開封之胰島素，可置冰箱下層，攝氏２～８℃冷藏，依瓶上有效日期保存，避免結凍。
4. 平日使用之胰島素，放在室溫陰涼處，避免陽光直接照射，可保存一個月。
5. 藥勿放在兒童觸手可及之處。外出旅遊時，放在皮包內，避免日曬即可。
6. 將針頭用針頭套子蓋好，並確定注射筒和針頭丟棄在硬的塑膠容器內，避免刺傷別人，及被人撿去重用。

Ⅲ. Use of insulin:

1. Follow instruction to place insulin injection on the various location. Avoid injecting into reddish, swollen, itchy parts of area.

2. Inform the family members and medical staff immediately in case of shivering, cold sweats, heart rate accelerated, weakness, dizziness, lip hemp symptoms; and follow instruction, for case of clear consciousness, provide a half cup of fruit juice or sweets immediately, or for case of sober awareness or unconscious case, rush case to the hospital right away.
3. For sealed insulin can be stored at lower chamber of refrigerator at 2 ~ 8 ℃ frozen condition, pay attention to the effective usage date for preservation and avoid frozen condition.
4. For regular use of insulin, it can be stored for one month at room temperature in the shade, and avoid exposure to direct sunlight.
5. Drugs should be out of children’s reach. When on touring, it’s ok to store in the bag and avoid exposure to sun.
6. Always use needle sheath (wrap) to cover , make sure injection tube and needles discarded in hard plastic containers, avoid to stab others and not to be reused.

廿四、糖尿病照護-飲食
XXIV. Diabetes Care - diet

糖尿病是由於患者對糖類的利用能力減低甚至無法利用，而造成血糖過高。糖尿病是可以靠飲食、運動、藥物三方面配合控制。糖尿病飲食，主要是供給個案足夠營養、維持理想體重、控制血糖於正常範圍內。

Patients with diabetes are due to the reduced ability or inability to the use of sugars, so as to cause high blood sugar. Diabetes can be controlled by three aspects control on diet, exercise, and medicine control. For case of diabetes diet, is to supply adequate nutrition, maintaining an ideal body weight, controlling blood sugar in normal range.

1. 定食定量，均衡攝食，選用植物油。
2. 選富含膳食纖維：糙米、燕麥、蔬菜等，使血糖升高較緩慢。烹調宜清淡：燉、烤、滷、清蒸、水煮、涼拌。
3. 避免吃富精製醣類或加糖食物：甜點、汽水、蜜餞、煉乳、罐裝果汁等會使血糖迅速升高，宜盡量避免選用。
4. 避免飲食太鹹，加工食品應少吃，避免飲酒。
5. 少吃油脂類：油煎、油酥、油炸及含油脂高的；少吃含高膽固醇：內臟、蛋黃、魚卵、蟹黃等（一週 2-3 個蛋為宜，若不吃蛋黃則不在此限）

1. Eat a fixed amount of food, take a balance food, use vegetable oil.

2. Select fiber-rich dietary: brown rice, oats, vegetables, which cause blood sugar to rise more slowly. Prefer light cooking: stewed, roasted, soy sauced, steamed, boiled, cold food in sauce.

3. Avoid to eat refined sugar or sweetened food: desserts, soft drinks, candied fruit, condensed milk, canned juice, which cause blood sugar to rise rapidly and advise not to use.

4. Avoid to eat salty and processed foods, and avoid drinking.

5. Restrict to eat greasy categories: pan fried in oil, crisp fries, deep fried in oil and high fat content; Restrict to each high cholesterol food: offal, egg yolks, eggs, crab egg, etc. (2-3 whold eggs a week ok, without restriction for removing egg yolks)

廿五、高血壓照護-量血壓

XXV. Care of hypertension - blood pressure measurement

一、原則及注意事項:

1. 室溫應適中，避免過冷或過熱。
2. 衣袖不可過緊。
3. 測血壓前 30 分鐘內勿運動、飲食、抽煙，同時避免焦慮、情緒不安及憋尿。
4. 測血壓需一次完成，若未完成則應鬆開壓脈帶，休息 2~3 分鐘再重新量一次。
5. 當氣溫有變化，性別、年齡、運動、情緒、洗澡、喝酒及體位不同，測量時間不同都會影響血壓的小幅度升高或降低，所以盡量在每天同時間，以同一血壓計測量。
6. 正常血壓值：收縮壓在 130mm Hg 以下，舒張壓在 85 mm Hg 以下。

I. Principles and Attention:

1. Maintain moderate room temperature to avoid too cold or overheating.
2. Do not use over-tight sleeves.
3. No exercise, meal, and smoking in 30 min. before blood pressure measurement, and avoid anxiety, emotional disturbance and suppressing urination.
4. Complete measurement in a single shot, otherwise loosen cuffs and rest 2-3 minutes before a new measurement.
5. Measurement reading varies with temperature changes, sex, age, exercise, emotional, bathing, drinking and different positions, different time. Perform measurement at the same time every day and use the same device for measurement.
6. Normal blood pressure: below 130 mm Hg in systolic blood pressure and below 85 mm Hg in diastolic blood pressure.

二、方法:

1.最好穿著寬鬆的衣服，並在安靜的環境下坐著休息至少 10-15 分鐘，量血壓前 30 分鐘切勿抽煙、喝咖啡或茶等刺激性飲料。
2.以坐姿測量血壓時，被量的人應舒適、輕鬆的坐好，將要受測量的上臂微彎伸向前外側，使與軀幹呈 45 度左右角度，再將前臂平放在可使上臂與心臟與一同水平的桌面，或墊子上，手心向上、手放輕鬆、勿握拳。
3.電子血壓計的測量方式比較簡單，手臂纏繞上氣袋，啟動後，勿移動測量手臂及勿說話，稍後測量結果便會以數字顯示。
4.若血壓值過高應立即通知家屬及醫護人員。
5.將血壓值紀錄於紀錄本。

II. Method:

1. Better wear loose clothing and sit and rest in a quiet environment at least 10-15 minutes, no smoking and drinking coffee or tea drinks, and other irritating drinks 30 minutes before blood pressure measurement.

2. Apply sitting posture to measure blood pressure with comfortable and easy ride, and the upper arm to be measued is extended forward flank outward and assume 45 degrees angles against the torso, evenly place the forearm on a table or support pad which can support the same level position with the upper arm and the heart, hold palm up and hand relax, not to hold wrist.

3. Measurement of the electronic device is not very complicated , wrap gas bag around arm, no movement and no talking during measurement, results is to be shown later on the display panel.
4. Immediately notify family members and medical staff if measurement result is too high.
5. Record blood pressure reading on the record book.

廿六、高血壓照護-高血壓之飲食原則

XXVI. Hypertension - diet for high blood pressure case

鈉的攝取量與高血壓有正相關，鈉攝取過量與高血壓的罹患率相對的提高；而肥胖也是造成高血壓的因素之一。

Sodium intake is associated with hypertension, excessive sodium intake cause incidence of hypertension increased; obesity is also one of the factors causing hypertension.

1.鈉最主要來源是食鹽，1gm 食鹽中含有 400mg 的鈉。調味品中的鈉含量的換算：

1 茶匙食鹽＝2 湯匙醬油	1 茶匙食鹽＝5 茶匙烏醋
1 茶匙食鹽＝5 茶匙味精	1 茶匙食鹽＝121/2 茶匙蕃茄醬

1. Salt is the most important source of sodium; 1 gm salt contains 400 mg of sodium. Sodium content conversion of seasoning :

1 teaspoon salt ＝ 2 teaspoons soy sauce	1 teaspoon salt = 5 teaspoons vinegar
1 teaspoon salt ＝ 5 teaspoons MSG	1 teaspoon salt ＝121/2 teaspoon tomato source

2. 避免食用的食品

1).奶類：如乳酪。

2).蛋豆魚肉類：如醃製、滷製、燻製、的火腿、香腸、燻雞、滷味、豆腐乳、魚肉鬆等，及罐頭食品和炸雞、漢堡、各式肉丸、魚丸等速食品。

3).五穀根莖類：如麵包、蛋糕、甜鹹餅乾、奶酥及油麵、麵線、速食麵、速食米粉、速食冬粉等。

4).油脂類：奶油、瑪琪琳、沙拉醬、蛋黃醬等。

5).蔬菜類：醃製蔬菜類如：榨菜、酸菜、醬菜等，或加鹽的冷凍蔬菜，如：豌豆莢、青豆仁等。

6).水果類：各類加鹽的罐頭水果及加工果汁。

II. Food to avoid

1). Dairy: e.g. cheese.

2). Bean, fish, and eggs categories: preserved, soy sauced, and smoked ham, sausage, smoked chicken, soybean sauce, fermented bean curd, dry fish meat etc., fast food like canned food and fried chicken, hamburgers, all kinds of meat balls, fish balls etc.

3) Category of five-grains and roots: such as bread, cakes, sweet and salty biscuits, milky crispy, and suture noodles, oily noodles, instant noodles, instant rice noodles, fast-food green bean noodles.

4). Grease categories: butter, margarine, salad dressing, mayonnaise, and so on.

5). Vegetables: pickled vegetables such as: mustard, pickled cabbage, pickles, salt or frozen vegetables, such as: pea pods, such as green beans kernel.

6). Fruits: all kinds of salt in processed and canned fruit juices.

廿七、高血脂之飲食原則
XXVII. Diet for Hyperlipidemia

1.維持理想體重，儘量少喝酒，適當生活型態，例如：戒菸、運動、壓力調適。
2.控制油脂攝取量，少吃油炸、油煎或油酥食物，及豬皮、雞皮、鴨皮、魚皮等。
3.炒菜宜用單元不飽和脂肪酸高者（花生油、菜籽油、橄欖油）；少用飽和脂肪酸含量高者（豬油、牛油、肥肉、奶油）。
4.烹調宜多採用清蒸、水煮、涼拌、烤、燒、燉、滷。
5.少吃膽固醇含量高的食物，如：內臟（腦、肝、腰子）蟹黃、蝦卵、魚卵。若血膽固醇過高；每週不超過 2~3 個蛋黃。
6.常選用富含纖維質的食物，如：未加工的豆類、蔬菜、水果及全穀類。

1. Maintain an ideal body weight, drink less wine, proper life style, such as: stop smoking, more exercise, stress management.
2. Fat intake control, less fried food, deep fried or oil-crispy food, and pigskin, chicken skin, duck skin, fish skin, and so on.
3. Better cooking with high-unsaturated fatty acids (peanut oil, canola oil, olive oil); less with high in saturated fatty acids (lard, butter, fat, cream).
4. Use more steamed, boiled, cold-with-source, roasted, burned, stewing, and soy souced.
5. Eat less with food high in cholesterol, such as: internal organs (brain, liver, kidney) crab eggs, shrimp eggs, roe. For high blood cholesterol; no more than 2 to 3 egg yolks per week.
6. Choice fiber-rich food more often, such as: unprocessed beans, vegetables, fruits and whole grains.

廿八、需緊急就醫情形
XXVIII. Case required emergency medical treatment

發生以下的情況時，應先通知雇主，並速送醫。

Inform the employer and speed to hospital in case of of following situation.

1.意識：突然改變、不清醒、叫不醒、昏迷狀況。
2.呼吸：每分鐘超過 30 次或每分鐘少於 12 次，呼吸非常費力、鼻翼搧動、胸部凹陷、呼吸暫停。
3.心跳：每分鐘超過 100 次以上或每分鐘少於 60 次以下。
4.體溫：超過 38.5˚C，且經過使用一般退燒處理（冰枕、退燒藥、溫水澡）仍無法降溫。
5.血壓：180/95 mm Hg 以上或低於 90/60 mm Hg 以下。
血糖：高於 400mg/dl 或低於 60 mg/dl。
6.鼻胃管:灌食前應檢查胃管之位置，並注意灌食中之反應，若有不良的管灌症候群，如管路阻塞或滑脫、咳嗽不止、呼吸急促、嘔吐、腹瀉、腹脹、便秘等，應速就醫。
7.氣切造口:當氣切造口處有感染、發炎、糜爛時、氣切造口管路脫出時、或氣切造口大量出血，將個案送返醫院就醫。
8.留置導尿管:
1)尿道口有滲尿情形，雖擠壓尿管未改善(擠壓的方法為：一手固定尿管的近端，一手往下擠壓)。
2)無尿液流出，且膀胱脹滿。
3)血流不止。
4)尿管滑出。
5)有尿路感染的徵象：混濁、沉殿。

1. Consciousness: a sudden change, not sober, unconscious, the state of coma.
2. Breath: more than 30 times per minute or more, or less than 12 times per minute, breathing very uneasily, nose wing uneasy movement, chest depression, apnea.
3. Heartbeat: over 100 times per minute or more, or less than 60 times per minute.
4. Temperature: More than 38.5 ˚ C, and through the use of general anti-fever treatment (ice pillows, anti-fever medicine, warm water bath) still cannot cool down.
5. Blood pressure: 180/95 mm Hg or more, or less than 90/60 mm Hg.
Glucose: more than 400 mg / dl or lower than 60 mg / dl.
6. Nasogastric tube: check location of feeding tube resided in case before feeding, and pay attention to response upon feeding, speed case to medical treatment in case of the followings : adverse possession irrigation syndrome, such as obstruction or slip out, more coughing, shortness of breath, vomiting, diarrhea, abdominal expansion, constipation.
7. Tracheotomy stoma: stoma area infection, inflammation, erosion, stoma connector and inner tube abnormally emerged out, or tracheotomy stoma massive bleeding, any of these rush to hospital for treatment.
8. Urine catheter:
1) urethra seepage and squeeze catheter without improvement (the squeezing method is as follows: one hand to hold the catheter, and other hand to squeeze it downward).
2) No outflow of urine and urinary bladder is full.
3) Bleed excessively
4) Catheter is slipped out.
5) Urinary tract infection symptoms: cloudy, precipitate.