

Taichung Armed Forces General Hospital
Leaflet of Inpatient Nursing Instructions

預防壓力性損傷之護理指導

Sir/Lady:

Nursing instructions for prevention of pressure injury

I. Purpose:

To prevent pressure injury due to blood flow obstruction and necrosis caused by compression or rubbing of the skin and subcutaneous tissue.

II. Precautions:

- (1) Common in patients who are bedridden for long periods, have poor limb mobility (including those with spinal cord injuries), are unconscious, suffer from incontinence, or have diabetes, fragile skin, weakness, or malnutrition.
- (2) Areas most prone to pressure injury: Primarily areas where bones protrude.
 1. Supine position: Occipital bone, scapula, elbows, bone, heels, and toes. (Figure 1)
 2. Lateral position: Auricles, shoulders, outer elbows, greater trochanter, outer knees, inner knees, ankles, and heels. (Figure 2)
 3. Prone position: Forehead, chin, chest, elbows, genital area, knees, and toes.
 4. Sitting position: Occipital bone, scapula, bone, sitting bone, and heels.
 5. Areas affected by various tubes:
 - (1) Oxygen nasal cannula: At the nostrils and where the tube goes around the ear.
 - (2) Nasogastric tube: At the patient's nostrils.
 - (3) Indwelling catheter: At the skin area where the catheter is fixed.
 6. Improper fitting of casts, neck collars, or back braces may create pressure points.
- (3) Change the patient's position every 1-2 hours (turning) and allow the patient to take a proper lying position or to use a pillow or other tools to support the body to prevent prolonged pressure. When lying supine, place a pillow under the lower legs to lift the heels off the mattress (Figure 3). When lying on the side, place a pillow between the legs to prevent the knees or ankles from pressing against each other (Figure 4), and place a thin pillow under the ankles and the outer sides of the knees to prevent skin friction with the mattress. Keep the bed sheets smooth and use an air mattress.
- (4) When elevating the head of the bed, ensure the foot of the bed is also raised to prevent the friction that makes the patient slide down.
- (5) If the patient's condition allows, encourage early out-of-bed activity. When sitting, lift the buttocks every 15 minutes.
- (6) Check if the cast, neck collar, back brace, or tube fixation is causing pressure on the skin.
- (7) Ensure adequate nutrition and hydration:

Consume a high-protein, high-calorie, and high-vitamin diet, such as fish, meat, eggs, dairy products,

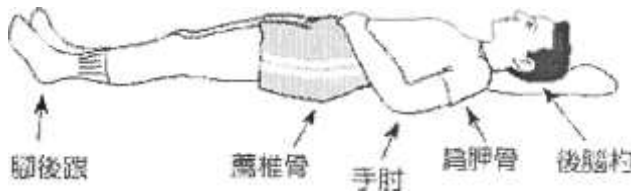
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beans, vegetables, and fruits. Weak patients and elderly individuals are prone to attention should be paid to hydration.

- (8) If redness or pressure injuries have already occurred, remove the cause and immediately notify the healthcare professional. The healthcare team will change medications and provide necessary treatment according to the condition of the wound.
- (9) Each time the patient is repositioned or the dressing is changed, check the pressure injury area and surrounding skin for shear damage. The worsening of the wound with development into the deeper site or surrounding skin inflammation may indicate the development of shear damage.

Figure 1

Areas with pressure injury



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Figure 2

Inner knee, areas with pressure injury



outer ankle/
outer knee, buttocks

Figure 4



If you are still unclear about something or have any questions, please contact the nursing station in the ward.