

Clinical Pearls for Proning

McGovern Medical School – Divisions of Critical Care, Pulmonary and Sleep @March
2020

1. First supine should be from 10am-4pm
 - a. If supine during 10am – 4pm does not allow for full 18 hours of prone, discuss with attending physicians whether patient should continue prone for > 18 hours or if patient should be placed into supine position prior to 18 hours
2. Equipment List
 - a. Manual and Rotoprone
 - i. Swiss Eye Mask
 - ii. Ocular Lubricant
 - iii. Tape for ET tube
 1. Initiate change before first prone ventilation phase
 2. Must be changed out every time patient is supine
 3. Biatain dressing will be placed down before tape is placed over cheeks
 - iv. Leads
 - v. Biatain dressings for shoulders, hips, ribs, knees, nipples, wrists, and cheeks
 - b. Manual Prone
 - i. Z-Flo Positioner (7x10) pads X3 for shoulders and face
 - ii. Pillows
 1. Extra if patient is female for under chest during prone
 - iii. Donut Pillows
 - iv. TAPS
 - c. Rotoprone bed
 - i. Extension tubing

3. Rotoprone Specifications
 - a. 400 pound max
 - b. 6'6" height max
4. Procedures and diagnostics (ie. X-ray, echocardiogram, HD, line placement, CT/MRI, etc.)
 - a. Should be done during the 6 hours in supine position unless change in patient's condition worsens and is needed STAT
 - b. Preferably during daytime hours
5. Cardiac leads should be changed during every supine position
6. Patient's body and head must be repositioned every 2 hours
 - a. Manual
 - i. Q2 turning with wedges and pillows
 - b. Rotoprone
 - i. Turn patient 30° to the left Q1hr for 15 minutes
 - ii. Turn patient 30° to the right Q1hr for 15 minutes
 - iii. If patient does not tolerate 30° start with 5° and incrementally increase until 30°
 - iv. For patient assessment if needed turn patient 30-60° for visualization and accessing lines/tubes/drains
7. Obtain ABG 4 hours after being placed in supine to assess oxygenation
 - a. Place patient back in Prone position if:
 - i. PaO₂ drops to less than 55mmHg
 - ii. MD discretion
8. Criteria for Prone Interruption
 - a. End of life decision
 - b. Cardiac Arrest
 - c. Untreated or Tension Pneumothorax
 - d. Arrhythmia with Hemodynamic Instability

- e. Massive Hemoptysis needing intervention
 - f. Possibility of stroke
9. Nutrition Support During Prone Positioning
- a. Post-pyloric enteral nutrition (EN) is preferred. If post-pyloric access becomes dislodged but patient is tolerating EN, can continue gastric feeding.
 - b. Position patient in reverse Trendelenberg at 15 degrees. EN should be held if bed is flat.
 - c. Hold EN when changing position and resume once HOB elevated.
 - d. Check gastric residual volume (GRV) if gastric access. Follow MICU Nutrition Protocol for GRV troubleshooting.
 - e. Paralytics during prone phase are not a contraindication to feeding, but tolerance should be monitored. For initiation of EN with paralytics, recommend trophic feeding (10-20 ml/hr) and advance to goal rate as tolerated.

References

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