PHASE 1: "Pre-Prone" Checklist

A SUPPLIES section is listed on page 2.
Items marked with an asterisk (*) are CONSIDERATIONS based on patient's status at the discretion of MD. A "CONSIDERATIONS" section is attached with details and rationale of those items.

√	Charge Nurse	√	MD
	Notify charge RT of decision to prone patient.		Ensure patient does not have any contraindications to prone positioning (see Rush Prone Policy).
	Assist bedside nurse in facilitating the prone positioning process.		Inform patient/family about decision to prone pt. and risks/benefits of prone position therapy.
	If manual prone positioning will be performed on an obese patient, it is advisable to accommodate for a ceiling lift in the room.		**Place invasive lines:** central line, arterial line, *HD line, and *dobhoff tube. **Ensure all invasive lines are placed on same side of patient** as they will be rolled to the opposite side. This is the preferred method, but it is not a contraindication if lines are present on both sides.
			Order STAT labs as appropriate, * Evaluate if CT or Bronchoscopy are needed prior to prone positioning.
			Utilize the **"Prone Patient" order set** for orders.
			*Determine if paralytic will be necessary.
√	Staff Nurse	√	Respiratory Therapist
	Notify staff RT about prone positioning order.		Perform a head, face, and oral mucosal skin assessment with RN and document findings in EPIC. **NOTE: Please evaluate neck mobility for turning with physician and/or RN.**
	Stop tube feeds if they are currently being administered.		Perform oral care and document it on EPIC.
	Coordinate with RT to titrate sedation based on ventilator synchrony. (Ensure rapid titration based on medication's parameters, bolus orders can be requested for rapid sedation). **NOTE: patient does not need to be sedated to a RASS of -5, ventilator synchrony is sufficient.**		1. remove ETAD device 2. place foam dressings on cheeks 3. wrap a polymem around pt's upper and lower lips 4. replace ETAD with soft endotracheal tube holder 5. Use surgical tape for additional securement
	*Initiate paralytic agent if ordered by physician (patient will need sedation to a RASS -5 prior to initiating paralytic.		**If out of soft endotracheal tube holders:** - follow steps 1-3 as above, then replace with a **new** ETAD and ensure securement is not too tight around neck (enough to fit 1 finger between neck and strap)
	Place the following based on the "Prone Patient" order set**:** indwelling foley catheter with temp. probe **(do not place foley stat lock at this time, secure with tape),** place internal fecal collector if patient meets criteria.		Assess ventilator parameters for optimization.
	Perform a full head-to-toe skin assessment with 2nd RN, perform CHG treatment to front of body, document findings in EPIC.		*If ordered: transport patient for a STAT CT and prepare for patient to have a bedside bronchoscopy
	Place foam dressings(mepilex) to the following areas: **small square –** facial cheeks, nipples **medium square** – bilateral knees. If bony areas are present apply to: clavicles, shoulders, pelvis. **Heel mepilex** – bilateral anterior side of ankles **If male, perform foley care with CHG and wrap penis with mepilex lite**		
	Consider placing *interdry* on skin folds.		
	Perform a baseline pupillometry assessment, rinse eyes with NS flush if needed and apply eye ointment.		

Supplies Needed

√	Staff Nurse	√	Respiratory Therapist
	Foam dressings (mepilex) minimun: 4 small square, 2-8 medium square (depends on pt's bony prominences, see pre-prone checklist above for placement) 2 heel, 1 mepilex lite		Soft endotracheal tube holder or ETAD device
	3-4 standard pillows		4 polymems
	1 fluidizer pillow or donut pillow		Surgical tape
	wedge		End tidal CO2
	CHG wipes		scissors
	Underpads (chucks)		
	ECG leads		
	Maxitube (blue sliding tube)		
	2 flat sheets		
	Regular tape		
	Foley stat lock		
	interdry if needed		
	Pupillometer if paralyzed		

PHASE 2: "Executing the Prone Position" Checklist

√	Charge Nurse	√	Respiratory Therapist
	Gather the "Turning Crew" which consists of at least 5 members including:		Remove headboard of the bed.
	1. 2 staff nurses – 1 on each side of the bed. Ideally 2 staff members on each side of the bed is preferred if staffing allows.		Pre-oxygenate the patient with 100% O2.
	2. RT – to be positioned at the head of the bed. **Role:** Control the airway, Countdown all turns		Make sure enough slack is present with the ventilator circuit and move the ventilator as close to the patient's bed as possible. **Before placing patient into prone position, ensure ventilator is moved to the opposite side of patient's invasive catheters. The ventilator will remain in this position for both pronation and supination.**
	3. Charge nurse - is "hands off" and is positioned at the foot of the bed. **Role:** Read out loud "Steps for manual pronation and supination" (see below).		**Provide thorough suction:** ET tube and oral cavity, and check cuff pressure.
	4. MD - Remains at bedside during the turn, monitors patient's vitals and informs team of any changes, remains at bedside until the patient is deemed stable after the turn. Aids with emergency interventions.		**Position your hands in the following manner to prepare for the turn:** one hand is used to stabilize the patient's occiput and neck, while the other hand is used to hold the ET tube and stabilize the front of the head.
	*** More members may be required depending on patient's size.**		Always on your count of 3, the team will proceed with all patient movements.

Steps for manual pronation

To be read out loud by Charge Nurse

	1	Ensure that lines/tubes found from the waist up are positioned toward the head of the bed, and lines/tubes from the waist down are positioned toward the foot of the bed, ensure enough slack is present.
	2	Maximally inflate the bed and place it in flat position.
	3	Place a Maxitube or a sliding sheet underneath the patient's current sheet.
	4	Remove patient's gown, ECG leads, and ECG electrodes. (At this time use pt's arterial line/SpO2 for pulse monitoring.) Tape arterial line's transducer to the side of the chest where the invasive lines are present.
	5	Tuck the patient's hand closest to the ventilator under the patient's buttock with the palm facing up. (This should be the opposite side of patient's invasive lines).
	6	Place underpads (chucks) on top of the patient's chest and pelvis.
	7	Place pillows on top of underpads in the horizontal position: on the patient's chest, pelvis, and knees.
	8	Place a flat sheet on top of everything, covering the patient up except for the patient's head.
	9	Roll the bottom and top sheets tightly together, encasing the patient like a "burrito". (Leave the Maxitube or sliding sheet unrolled since this will serve as your sliding sheet.
	10	At this time, RT removes patient's pillow and positions hands on patient's neck/occiput and ET tube as described above.
	11	If RT requests it, **on the RT's count of 3**, boost the patient up to the head of the bed.
	12	**On the RT's count of 3**, move patient horizontally to the edge of the bed **farthest** away from the ventilator.
	13	**On the RT's count of 3**, rotate the patient 90 degrees to the side-lying position with the ET tube facing the ventilator.
	14	**On the RT's count of 3,** while the patient is in side-lying position, slide the patient horizontally away from the ventilator**.**
	15	**On the RT's count of 3**, nurses opposite the ventilator side will pull the rolled-up sheets from beneath the patient, while the other nurses carefully turn the patient into the prone position.

Steps for manual supination

To be read out loud by Charge Nurse

	1	Follow steps 1-5 above, same for pronation and supination.
	2	Place arms down on patient's sides (remove from swimmer's position).
	3	Tuck the hand that is on the **opposite** side of the ventilator under the patient's hip/thigh, with the palm facing up, this arm should be the one on the opposite side of the patient's invasive lines.
	4	Place an underpad (chuck) on patient's buttocks.
	5	Follow steps 9-12 above, same for pronation and supination.
	6	Ensure patient's head/ET tube is facing the ventilator.
	7	**On the RT's count of 3**, move the patient horizontally to the edge of the bed **closest** to the ventilator.
	8	**On the RT's count of 3**,rotate the patient 90 degrees to the side-lying position with the ET tube facing the ventilator.
	9	**On the RT's count of 3**, while the patient is in side-lying position, slide the patient horizontally toward the ventilator**.**
	10	**On the RT's count of 3**, nurses on the ventilator side will pull the rolled-up sheets from beneath the patient, while the other nurses carefully turn the patient into the supine position.

PHASE 3: "Care of the Patient While Prone" Checklist

√	Staff Nurse	√	Respiratory Therapist
	Place a new set of ECG electrodes on patient's back and hook up ECG leads.		Auscultate breath sounds.
	Rest patient's head to one side using a fluidized positioner or donut pillow underneath.		Check for pressure points around ET tube and securement device.
	Place a wedge underneath shins to elevate toes off bed surface.		Check for significant changes in exhaled tidal volumes (pressure control modes) or increases in airway pressures (volume control modes).
	Place bed into Reverse Trendelenburg position (-10 to -20 degrees).		If changes are present, troubleshoot possible causes such as ET tube malposition or kinking, need for suctioning, cuff leak, chest tube malfunctions, etc.
	Level and zero invasive monitoring equipment (art line, PA catheter, etc).		If no mechanical problems found, pressure or tidal volumes may need to be adjusted for optimization.
	Ensure head is supported evenly with the neck in a neutral position.		Ensure head is tilted from side to side every four hours (opposite arm from ET tube's location will be placed upward, while other arm remains downward)
	Check that the ear is not compressed or folded. *consider placing foam dressings on ears.		Obtain ABGs as specified by MD.
	Place a new gown on patient, and sequential compression devices.		
	Check genitals of male patient to ensure they are not compressed between the legs.		
	Remove tape securement from foley and replace with foley stat lock on the back of the patient's thigh.		
	Position patient's arms into "swimmer's position" (opposite arm from ET tube's location will be placed upward, while other arm remains downward) and modify this position every four hours with the RT (manages the head turn).		
	Ensure eyes are closed and free from direct pressure, push fluidizer pillow down, molding it to allow eyes and bony prominences of the face to remain free from pressure. Additional foam dressings may be needed on the face based on patient's anatomy.		
	Perform assessment of pupils Q4h, pupillometry if patient is paralyzed, or document "unable to obtain" if it applies. Apply eye ointment per MD orders and rinse with NS flush PRN.		
	Activate the lateral rotation function of the bed if the function is available, or offload pressure points using additional pillows.		
	Label patient's monitor "**PRONE**" at the central station.		
	*Consider requesting a prokinetic agent if initiating tube feeds.		

PHASE 4: "Care of the Patient While Supine" Checklist

√	Staff Nurse	√	Respiratory Therapist
	Remove all foam dressings and perform a full head-to-toe assessment with 2nd RN. Document findings, place wound consult if needed.		Remove all facial protective dressings and assess skin with RN.
	Initiate tube feedings per dietitian consult recommendations.		Remove soft ET tube holder and replace with a new one
	Perform foley catheter care, oral care and CHG treatment.		Reposition ET tube.
	Perform pupillometry assessment and document findings, cleanse eyes with NS flush PRN, apply eye ointment per MD orders.		Adjust ventilator parameters as needed based on patient's tolerance back to supine position.
	Apply ice packs or wet gauze pads to face, eyes, and mouth/tongue for swelling.		
	Assess all central line dressings and replace as necessary.		
	***Coordinate with the interdisciplinary team to use this time for diagnostic imaging/procedures such as:** transporting to MRI, CT, obtain chest x-ray, ultrasound, echo, placement of additional lines, drains, bronchoscopy, etc.		

CONSIDERATIONS

- Placing an HD line prior to initiating prone therapy can allow CRRT to take place while patient is in prone position (preventing early supination before the 16-hr mark).
- Dobhoff tube placement is a safer alternative for enteric access while prone, allows for patient to have tube feedings throughout the duration of prone positioning, and until patient is deemed safe to swallow.
- Obtaining a chest x-ray prior to each prone positioning cycle will allow for verification of correct ET tube placement.
- Obtaining triglyceride levels prior to first prone cycle recommended if using propofol.
- Extension tubing may be considered depending on patient's size and location of items such as IV access location, etc.
- Evidence-based practice recommends the use of enteral feedings while patient is prone to help prevent electrolyte imbalances, protein/calorie malnutrition, balance of fluid status, promotion of skin healing, and glycemic control (refer to the Prone Policy for references), the use of paralytics and low dose vasopressors is not a contraindication. Prokinetic agents such as metoclopramide can help with gastric motility and absorption of feedings.
- Physical Therapy may be consulted for recommendations of optimal body alignment while patient is in prone position to prevent hyperextension of the neck and extremities.
- Bronchoscopies, additional placement of invasive lines, and electrocardiograms can all be performed while patient is in prone position.