



Prone Positioning in Critical Care

Aim: To provide guidance on nursing care for the prone positioning of patients in Critical Care

Scope: All adult patients in Critical Care

WHEN SHOULD WE TURN PATIENTS PRONE?

- Severe ARDS
- If a patient requires an $FiO_2 > 0.6$ and $PEEP > 5$ cmH_2O
- Worsening oxygenation and V/Q mismatch

Possible Contraindications

Absolute; Multiple trauma, open abdomen or chest, pelvic external fixation, Spinal/Vertebral instability

Relative; Raised Intra-ocular or intracranial pressure, 2nd or 3rd pregnancy trimester, frequent seizures, obesity, CVS instability, pelvic or chest fractures, recent abdominal surgery

The decision to turn a patient prone must be made by a Critical Care Consultant.

STANDARD CARE

1	Plan ahead - make sure that all necessary investigations have been carried out, timing of procedure to turn patient prone and back to supine position, gather all necessary equipment including re-intubation and airway trolley.
2	Ensure the completion of a pre proning checklist to maintain patient safety
3	Ensure appropriate number of staff are available (minimum 5), including staff competent in advanced airway skills. Allocate roles.
4	Complete a post proning checklist and debrief
5	Inform next of kin and provide information leaflet

Remember!

- Use a prone position skin bundle if available
- Inspect and document pressure areas every 2 hours.
- Liaise with physiotherapists about positioning and passive movements
- Protected eyes from pressure with eye pads or by taping closed
- Perform oral care as per unit protocol
- Place bed in reverse Trendelenburg position

Visualise!

- You must be able to suction the airway and visualise the ET and Tracheostomy tube at all times
- Arms in 'front crawl' swimming position and alternated 2 hourly at the same time as head reposition

Documentation

Please see your units full guidelines for more information