MedStar Health

MedStar Health Nursing.

Ceiling Lift Proning Checklist for Nurses

Pre-Pronation Care

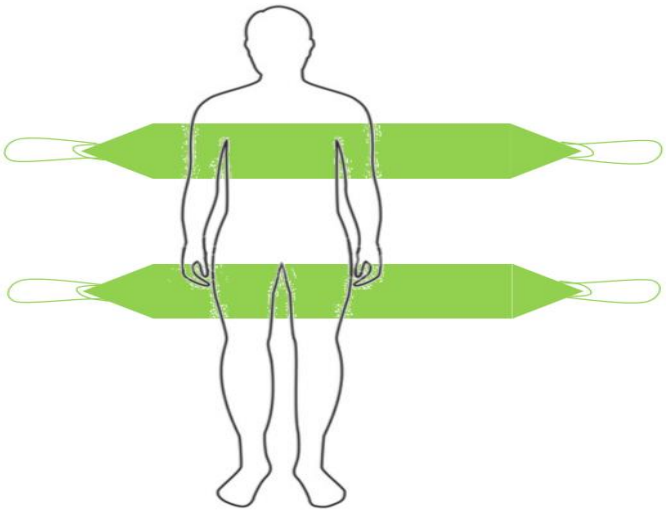
1. Check Physician Order (Proning Orderset).
2. Provide patient/family education for procedure and purpose of prone positioning.
3. Emergency equipment including code cart and intubation equipment should be outside patient room during pronation therapy.
4. The intensivist/designee should be present, if feasible, the **first time** the patient is placed in prone position and the **first time** the patient is returned to the supine position.
5. Plan for adequate clinical staff to assist in proning procedure:
    i. Ceiling lift: 3 clinical staff is recommended.
6. Ensure that patient is adequately sedated to prescribed RASS.
7. Consider an arterial line to obtain ABGs at baseline and 30 minutes after proning.
8. Place an Allevyn dressing on patient's cheeks under the Hollister ETT holding device to minimize onset of pressure injury while in the prone position.
9. Consider alternative ETT holding devices if pressure injury noted. Alternatives include traditional ETT taping.
10. Review fixation of invasive and curative devices.
11. Apply Allevyn dressings to other areas of the body associated with pressure injury formation (forehead, chin, upper chest, anterior iliac crest, knees, top of feet).
12. Apply Lacri-Lube to the patient's eyes and apply a cut-to-fit foam/Allevyn dressing over the patient's eyes.
13. Ensure tongue is in the mouth. If tongue is protruding or swelling is noted, insert bite block.
14. Ensure oral care, ostomy care, dressings changed, and drain/ostomies are emptied prior to proning.
15. Remove all ECG leads/stickers from the anterior chest and place on the patient's back with Black & Red leads on the patient's Left, White & Green leads on the patient's Right, and the Brown lead in the Middle.
16. Reposition invasive lines and tubing that are in the midline position. Re-assess fixation of invasive and curative devices, add IV tubing as needed. If there is a chest tube in place, place the chest tube on the side that the insertion site will be after pronation.
17. Ensure all central line dressing(s) are optimized to include; a CHG impregnated dressing that is clean, dry and securely intact and is not due to be changed within

the next 5-7 days. If the central line dressing is compromised (loose/moist/leaking) or is due to be changed before the clinician will have access, it is recommended to change the dressing prior to proning the patient and label with the date and time. Ensure that the central line tubing is secure to prevent any pulling, tugging or friction at the central line insertion site. Validate tubing is always current, labeled and dated.

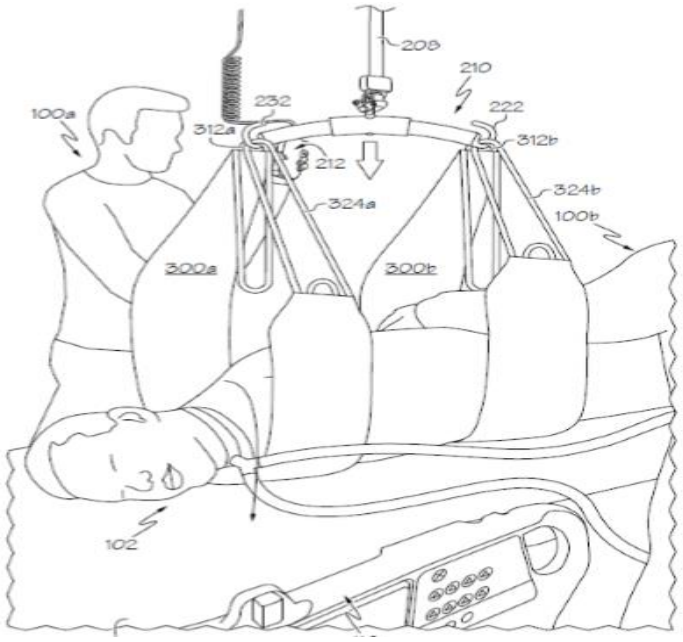
18. Consider applying a rectal bag on the patient at minimum to manage stool. If stool is liquid in consistency, collaborate with physician/APP to insert an internal Fecal Management System (i.e. Flexi-Seal), unless contraindicated.

Proning Procedure

1. Validate weight against ceiling lift capacity. Standard Arjo lifts accommodate 600 lbs. (bariatric 1000 lbs.) and Liko Lifts accommodate 550 lbs. (bariatric 1100 lbs.).
2. Perform hand hygiene and don proper PPE.
3. Review pre-proning care as noted above to ensure all measure were performed.
4. Assemble team (physician, optimally 2 other team members as needed including bedside nurse and RT if available), ensuring there is an adequate number of staff members to control lines, tubes and drains.
5. Place the patient on 100% FiO2 for 30 mins. prior to proning. Suction ETT, mouth, and nose.
6. It is important to plan which direction the patient will turn and adjust ventilator equipment, attached tubing, leads, and lines so there is enough slack during the movement.
7. While patient is still in supine position, place a moisture-wicking incontinence pad (Chux), a pillow or bariatric (Green) Ehob cushion over both the chest and hip, and a flat sheet on top of the pillows.
8. Turn the patient's head so that it is facing away from the ventilator with the ventilator tubing looped above the patient's head
9. Raise the bed to a proper working height and lower the siderails.
10. Place hand into pocket of MultiStrap™ and slide into the mattress surface to mitigate skin shear for proper placement.
11. Insert one Multistrap™ so the top is aligned with armpits and the patient is approximately 12 inches off the center. Adjust the position based on patient size. Place the second Multistrap ™ near the greater trochanter (see diagram below). Insert straps from side onto which patient is being turned leaving short end loops visible as below. The patient will turn in the direction of the long side of the straps.



12. Tuck patient's hand under each hip with palms up.
13. Wrap the edge of the sheets as closely as possible to the patient's body (like a burrito).
14. Maximum inflate the ICU bed.
15. Lower the slingbar and rotate so that it is parallel to the length of the patient. Attach the longer loop from the side onto which the patient is being turned and the short loop from the short side of the MultiStrap™ taking care to ensure the strap is seated properly on the slingbar.
16. One caregiver raises the slingbar until there is tension in the straps, then the team confirms that all the required loops are secure in the slingbar.
17. Ensure the team member at the head of the bed is responsible for initiating the turn maneuver via a verbal countdown, as well as securing the patients ETT and head throughout the maneuver. At this point, the patient is ready to be lifted.
18. On the count of three, the caregiver on the side the patient is being turned away from will operate the lift, while the other caregiver(s) monitor the lines and patient's response.
19. The caregiver at the head of bed will monitor and support the patient's head and airway.
20. Upon lifting, the patient will begin to rotate to the side. The lift movement is slow and controlled.



21. Lift the patient high enough so they are easy to slide, but do not lift the patient fully off the surface. Slide patient to opposite side from which you are turning so they are centered when proned. Team should continue manage tubing and lines as patient is being lowered.
22. When all caregivers indicate they are ready, the person at the patients back lowers the patient and guides them into the prone position.
23. Assess airway, invasive lines and tubing, and hemodynamic status.
24. Monitor oral secretions and suction as needed.
25. Place limb electrodes and V lead on patient's back
26. Position patient's head on prone pillow, Z-Flo or air waffle cushion, in a manner that minimizes pressure of holder and tube to face and enables visualization of ETT. The MultiStrap™ positioners can remain under the patient for returning patient to supine position.
27. Position patient's arms with one above the head and the other along the patient's body.
28. Place pillow under shins so toes are not touching mattress.
29. Return ICU bed to normal mattress setting and place patient in reverse Trendelenburg, at 10-20 degree angle.
30. Document procedure in MedConnect.
31. When returning the patient to the supine position, simply reconnect the MultiStraps™ to the bar in the same manner as when proning and follow the same procedures above to return to supine position.

Maintenance

1. Reposition head and arms every two hours.
    a. Head repositioning must be done with at least one other team member with the team member at the head of the bed initiating three count countdown and managing the airway and head movement. One a count of three, lift the patient's shoulders off the bed and rotate the head to the opposite side.
    b. Position patient's arms with one above the head and the other along the patient's body, alternating sides every two hours.
2. Assess for facial edema every 4 hours.
3. Monitor oral secretions with each position change.
4. Reposition the arms every two hours. Rotate the arm on the side of the ETT up, while the other rests by the patient's side (swimmer's position).
5. Turn the patient slightly lateral position every two hours. Place pillows on the same side that the patient's head is turned to minimize torqueing of the neck.
6. Ensure the neck and back are not hyper-extended.
7. Monitor face protection equipment at least daily for saturation and wipe-off each time the padding is removed. Face protection equipment should be changed at least every 72 hours.
8. Assess the central line site each shift to the best of the clinician's ability to visualize the insertion site. Assess that all central line(s) are secure, and that no tubing is laying on the floor to avoid risk of contamination. While proned, if any complications are observed to the insertion site or the dressing is overdue to be changed, document and notify the Provider.

Expectations of documentation

1. Document when patient starts proning, any reverse Trendelenburg positioning of the patient.
2. Document supination as well as the patient's response.
3. Document an integumentary assessment every time your patient returns to the supine position according to provider orders.

References

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