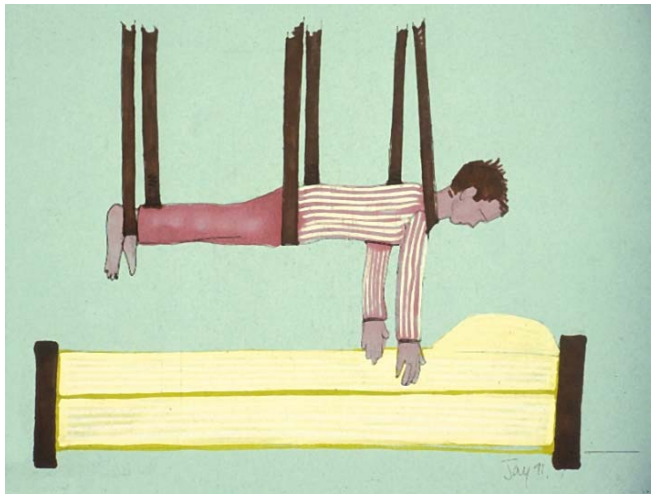
Prone Positioning: Examining a Key Supportive Strategy in ARDS Management



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ADVANCING NURSING THROUGH KNOWLEDGE & INNOVATION

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  - Eloquest Healthcare
- Baxter Healthcare Advisory Board

Polling Question

What is your position?

1. Bedside Critical Care
2. Bedside Progressive Care/Telemetry
3. Educator
4. Respiratory Therapy
5. Manager/Director
6. Clinical Nurse Specialist/Nurse Practitioner
7. Intensivist/PA
8. Quality

Objectives

- Discuss the physiologic rationale and the evidence for use of the prone position in patients with ARDS
- Identify evidence-based strategies for determining when to turn, how to turn, and how long to allow patients to remain in the prone position
- Outline strategies for preventing complications

Prone Positioning Incidence

Prone positioning was only used in 16.3% of patients with severe ARDS in the LUNG SAFE study

Bellaini G, et al. JAMA, 2016;315(8):788-800

European Prevalence Study (APRONET): Use of PP in mild 5.9%, moderate 10.3%, severe 32.9% ARDS

Guerin C, et al. Intensive Care Med, 2018;44(1):22-37

28% of ARDS COVID patients in the ICU are positioned prone.

Moore Z, et al. *J Wound Care*. 2020;29(6):312-320.

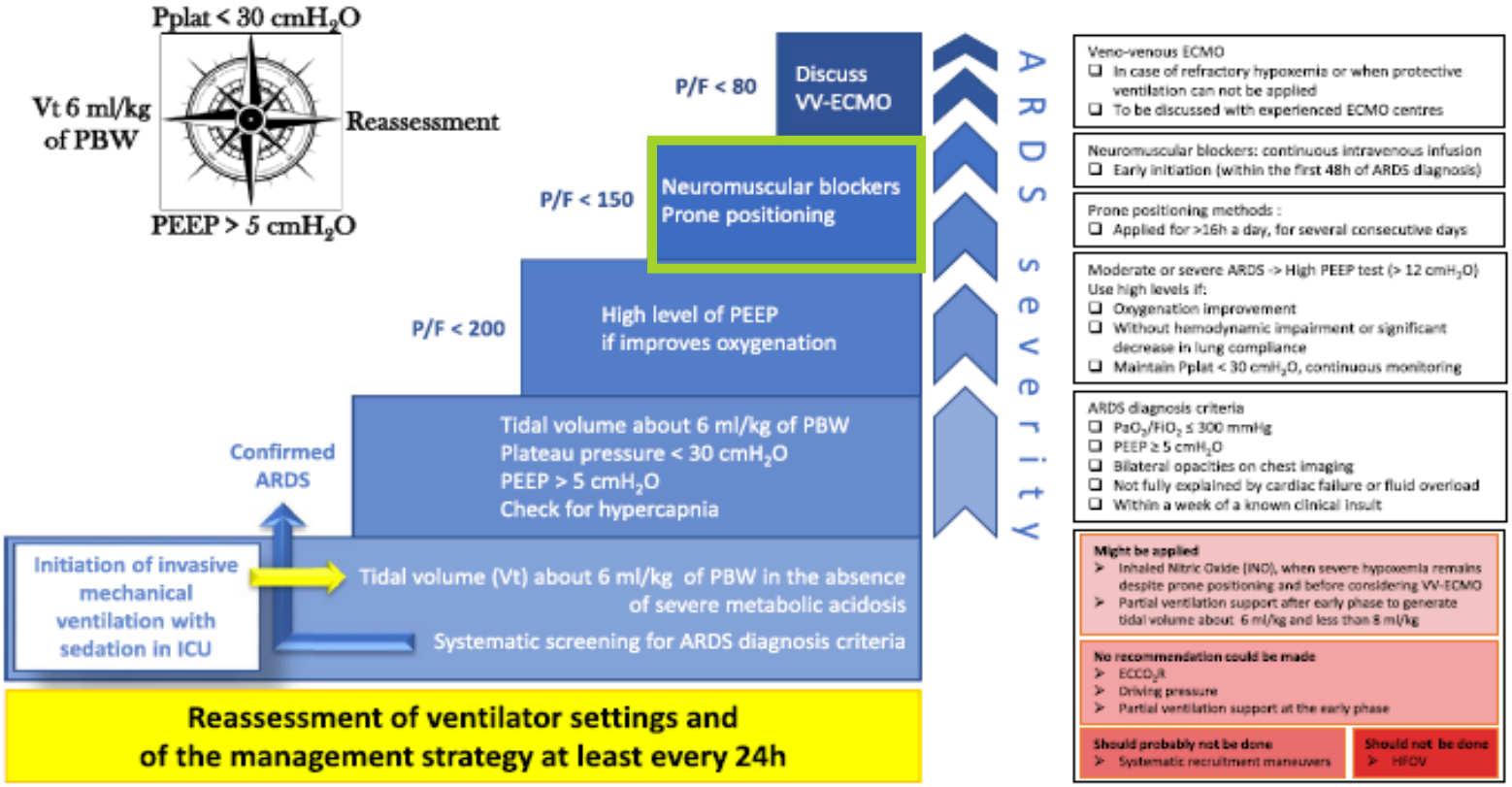
The Berlin ARDS Definition

TIMING	Within 1 week of a known clinical insult or new/worsening respiratory symptoms
CHEST IMAGING (X-RAY OR CAT SCAN)	Bilateral opacities—not fully explained by effusions, lobar/lung collapse, or nodules
ORIGIN OF EDEMA	Respiratory failure not fully explained by cardiac failure or fluid overload; need objective assessment (eg, echocardiography) to exclude hydrostatic edema if no risk factors present

	MILD	MODERATE	SEVERE
OXYGENATION	<200 PaO_2/FiO_2 or ≤300 with PEEP/CPAP ≥5 cm H_2O	<100 PaO_2/FiO_2 or ≤200 with PEEP ≥5 cm H_2O	≤100 PaO_2/FiO_2 with PEEP ≥5 cm H_2O
MORTALITY	27% (24% to 30%)	32% (29% to 34%)	45% (42% to 48%)

Ferguson ND, et al. *Intensive Care Med*. 2012;38(10):1573-1582.
Dharia A, et al. *ICU Director*. 2012;3(6):287-292.

Early management of ARDS in 2019

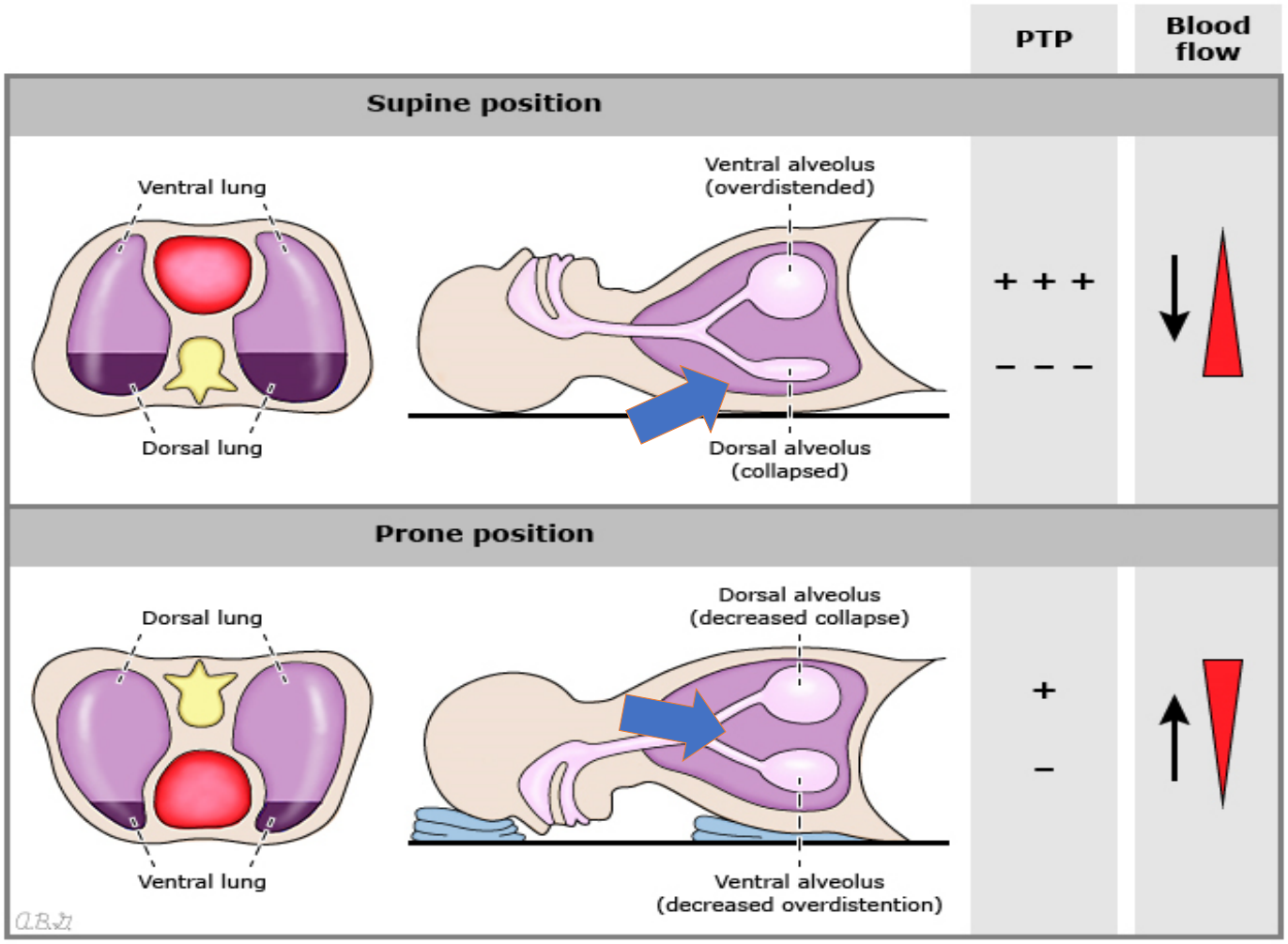


Papazian L, et al. Ann Intensive Care, 2019;9:69

Why Prone Positioning?

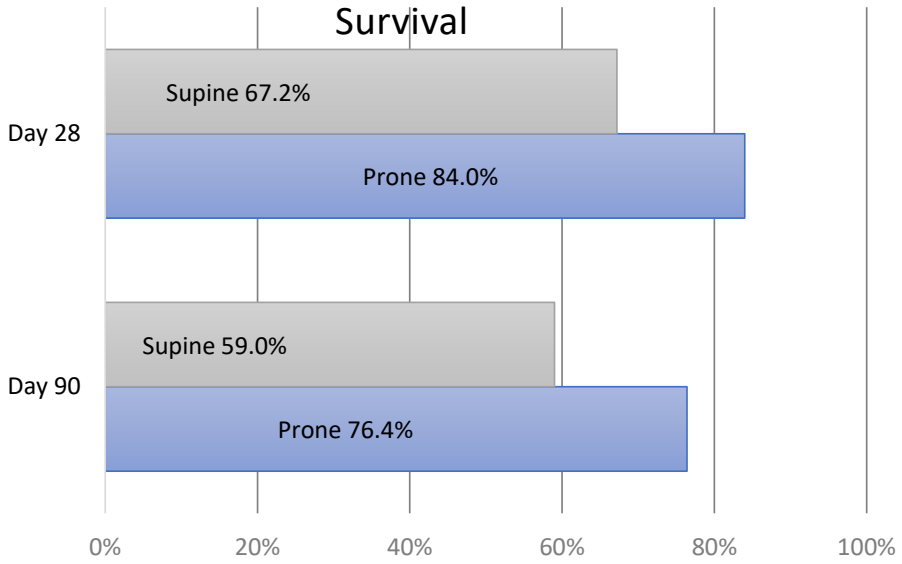
- Improves dependent aeration recruiting alveoli
- Reduces hyperinflation of nondependent regions dramatically
- Results in more homogenous lung aeration which reduces regional shear strain…less ventilator-induced lung injury (VILI)
- Decreases barotrauma and atelectrauma by recruiting and reducing overdistension that occurs with higher positive end-expiratory pressure (PEEP)
- ↓ PACO2 relates to net increase in recruitment /↓ in dead space
- Drains secretions

Fan E, et al. *Am J Resp Crit Care Med*. 2012;38(10):1573-1582.
Scholten EL, et al. *Chest*. 2017;151(1):215-224
Gattinoni J, et al. Semin Resp Crit Care Med, 2019;40:94-100.



https://www.uptodate.com/contents/prone-ventilation-for-adult-patients-with-acute-respiratory-distress-syndrome/print

Proning Severe ARDS Patients



In a randomized, controlled trial of 466 patients with severe ARDS, survival was significantly higher at 28 and 90 days in the prone position group

NNT=6

Guerin C, et al. *N Engl J Med*. 2013368(23):2159-2168.

Prone Positioning Meta-Analysis

9 randomized controlled trials / 2,242 patients

OUTCOMES	DECREASED 30-DAY MORTALITY	REDUCED 60-DAY AND 90-DAY MORTALITY	REDUCED 28-30-DAY MORTALITY
PATIENT POPULATION	ARDS patients with a PaO_2/FiO_2 ratio ≤100 mmHg	ARDS patients ventilated with PEEP ≥10 cmH_2O	ARDS patients who had duration of proning >12 hours per day (n = 1,067, RR = 0.73, 95% CI = 0.54 to 0.99; P = 0.04)

Hu SL, et al. *Crit Care*. 2014;18(3):R109.

Case Study

- Mr. Green is a 65-year-old male 90kg male 5 feet 10 inches. Patient has a 2-day history of fever and chills. His past medical hx is HTN, CAD. He presents to the ED with a fever 39.5°C complaining of inability to catch his breath.
- His initial vital signs:
  - HR 120/min
  - RR 40/min
  - BP 90/65
  - O2 sat of 92% on room air.
  - He is placed on 50% mask
  - ABG: (On 50% mask)
    - pH 7.20
    - PaCO2 28,
    - PaO2 60,
    - SaO2 93%
    - Bicarb 13
  - Extremely labored breathing
  - Lactic acid: 3.5
  - WBC's: 24,000 with a left shift
  - Platelets: 75,000
  - Electrolytes WNL
  - Chest x-ray shows bilateral infiltrates

What should happen next?

Polling Question

- What should be the next step in Mr. Green's care?
  1. Initiate non-invasive ventilation
  2. Initiate intubation
  3. Change to 100% non-rebreather
  4. Initiate HFNC

Case Study

- Intubated and transferred to the ICU
- Settings on mechanical ventilation
  - Vt 528, AC 28, FiO2 of 1.0, PEEP 8cm, Plat pressures 38cm H20
- ABG's: 7.34, 35, 70, 94, 18
  - P/F ratio is 70
- PEEP increased incrementally over next 12 hours to 14cm
- FiO2 at 80%
- Plateau pressures 35cm H2O mmHg

- ABGs:
  - Ph 7.35
  - PaCO2 34
  - PaO2 60
  - SaO2 91
  - Bicarb 20
  - P/F ratio 75

What should be our next step?

Polling Question

- What should be the next step in Mr. Green's care?
  1. Switch to HFOV ventilation
  2. Initiate ECMO
  3. Initiate prone positioning
  4. Switch to APRV ventilation

Who to Place in Prone Position?

- Patients with severe ARDS (PaO_2/FiO_2 <150 mmHg)
  - Per ATS/SCCM Mechanical Ventilation for ARDS guidelines, a strong recommendation for prone positioning for >12 hours /day
- Patients early in the course (12–24 hours)

Scholten EL, et al. Chest. 2017;151(1):215-224.
Bein T, et al. Intensive Care Med.2016;42:699-711).
Fan E, et al. Am J Respir Crit Care Med. 2017:195(9):1253-1263

Who Not to Place in Prone Position?

1. Patients with facial/neck trauma or spinal instability
2. Patients with recent sternotomy or large ventral-surface burn
3. Patients with massive hemoptysis
4. Patients with elevated intracranial pressure
5. Patients at high risk of requiring CPR or defibrillation

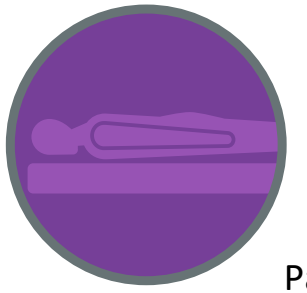
Scholten EL, et al. *Chest*. 2017;151(1):215-224.

Relative Considerations

- ENT: raised intraocular pressure or recent ophthalmic surgery, facial trauma, or recent oral maxillofacial surgery in last 15 days
- Cardiac: severe hemodynamic instability, unstable cardiac rhythms, ventricular assist device, intra-aortic balloon pump, recent sternotomy, new pacemaker < 48 hours
- Pulmonary: hemoptysis, unstable airway (double lumen endotracheal tube), new tracheostomy < 15 days, bronchopleural fistula, lung transplant
- Abdomen: second or third trimester pregnancy, grossly distended abdomen, ischemic bowel, abdominal compartment syndrome, recent abdominal surgery or stoma, extensive inguinal or abdominal soft tissue injury
- Musculoskeletal: chest wall abnormalities, kyphoscoliosis, or advanced arthritis
- Skin: burns on more than 20% body surface

Mitchell DA, et al. AACN Advanced Critical Care, 2018;29(4):415-425
Vollman K, et al. AACN Procedure Manual for High Acuity, Progressive, and Critical Care. 7th ed. St Louis, MO: Elsevier; 2017:142-163.

Patients Who Have Been Placed in the Prone Position Successfully



1. Patients with open abdomens
2. Patients with intracranial pressure monitoring
3. Patients with hemodynamic instability
4. Patients with pelvic fractures
5. Patients with external fixators
6. Patients with multiple traumatic injuries
7. Patients with use of extracorporeal membrane oxygenation (ECMO)
8. Patients with continuous renal replacement therapy (CRRT)

Patients with morbid obesity

Vollman KM. Crit Care Nurs Clin North Am. 2004;16(3):319-336.
Schiller HJ, et al. Chest. 1996;110:142S.29.
Goettler CE, et al. Crit Care. 2002;6(5):452-455
Mitchell DA, et al. AACN Advanced Critical Care, 2018;29(4):415-425

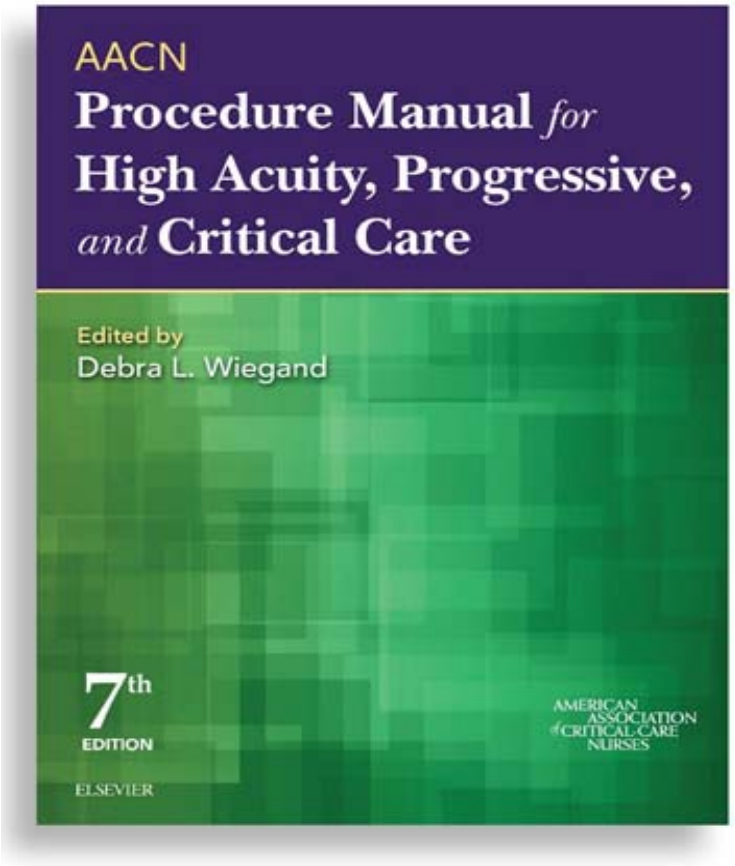
Pre-Prone Position Process

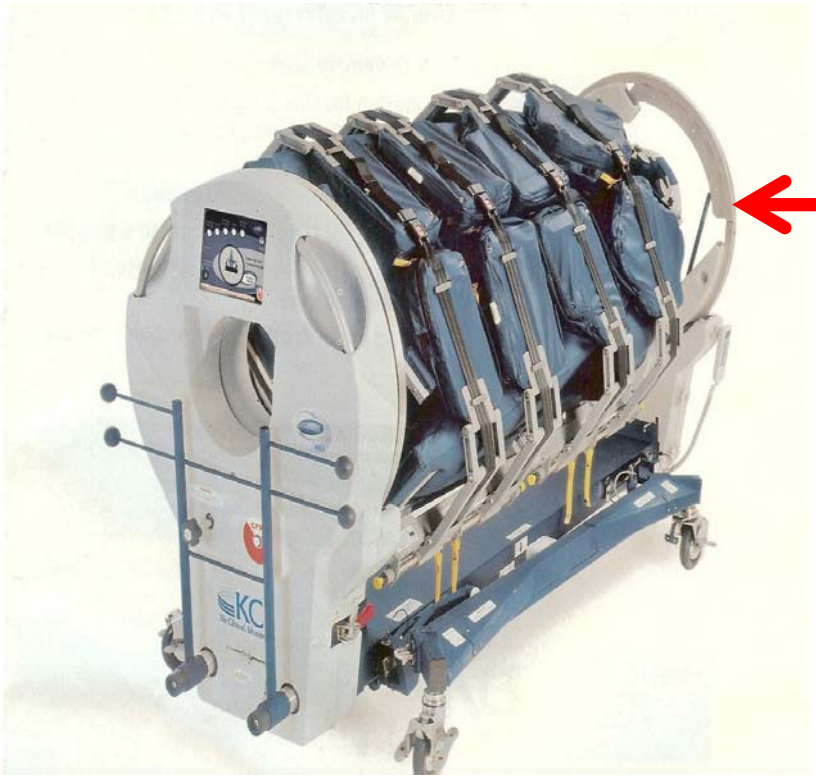
- Patient and family education
- Gather staff and supplies, obtain pre prone measurements
- Preoxygenate, empty stomach (1hr), suction endotracheal tube/oral cavity,
- Secure the endotracheal tube and lines (remove ET holders if in use)
- Position tubes inserted above the waist to the **top of the bed**
- Position tubes inserted below the waist to the **foot of the bed** (except chest tubes)
- Empty ileostomy/colostomy bags before the turn
- Placement of prophylactic dressings in high pressure/shear risk areas (forehead, chin, chest, elbow, pelvic, knees, dorsal feet)
- Ensure the tongue is inside patient's mouth and eyes are closed
- Develop an exit strategy for instability while in the prone position

Scholten EL, et al. Chest. 2017;151(1):215-224.
Dickinson S, et al. Crit Care Clin. 2011;27(3):511–523.
Vollman KM, et al. AACN Procedural Manual. 2016:142-163

AACN Procedural Manual-7th ed

- Chapter 18: Pronation Therapy
- Authors
  - Kathleen Vollman
  - Jan Powers
  - Sharon Dickinson





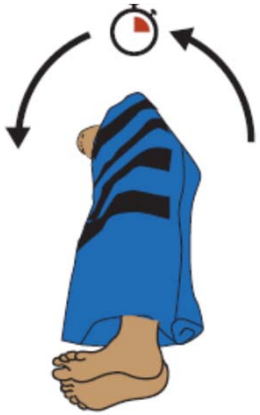
Rotoprone

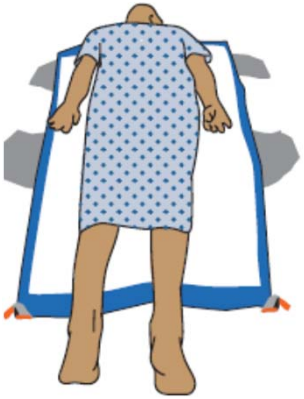
Prone positioner
No longer sold

Manual Proning

List Assisted Prone Positioning with Positioning Sheet

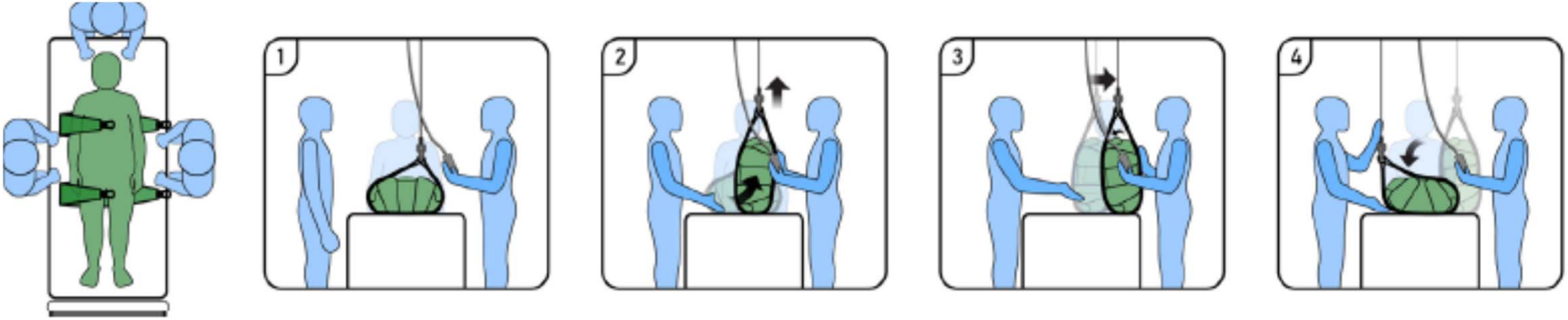
Disposable Slide Sheets





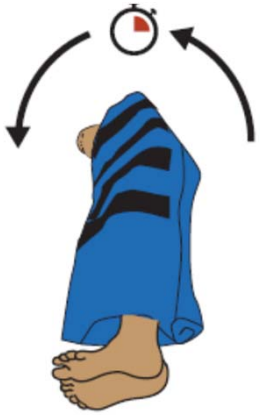
Prevalon AirTAP Patient Repositioning System

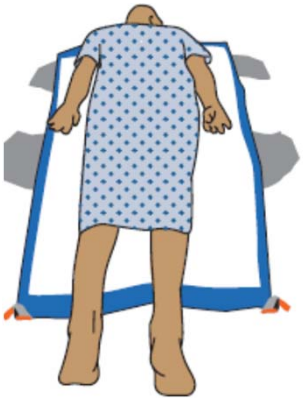
Lift Assisted Prone Positioning



Wiggermann N, et al. Human Factors 2020 in press

Burrito Method Using a Transfer System





Chest and/or pelvic support can be done by placing a pillow/wedge before completing the turn.

Positioning Schedule & Maintenance Care

- Consider every 16hrs uninterrupted (more frequent turn back may cause decruitment)
- Obtain post prone measurements
- Frequent oral hygiene and suctioning and as needed, restart feeding
- Move head slightly every hour or q 2-ensure ET tube is not kinked
- ROM of arms every 2 hours/change position of the arms (Swim position)
- Support feet in correct anatomical alignment
- If hemodynamic monitoring, level the zero-reference point at the right atrium
- Consider time periods in reverse trendelenburg to address facial edema and reduce risk of vomiting

Vollman KM, Dickenson S, Powers J. AACN Procedural Manual, Chapter 19;2016:142-163
Mitchell DA, et al. AACN Advanced Critical Care, 2018;29(4):415-425

Maintenance Care

Float the nasogastric tube to prevent pressure injuries

- Taping
  - Obtain 3 inches of 1 inch wide paper tape
  - Make two ¼ inch cuts 1 inch apart on each side of tape

Step 1: Cut tape

Step 2 : Secure to Nose

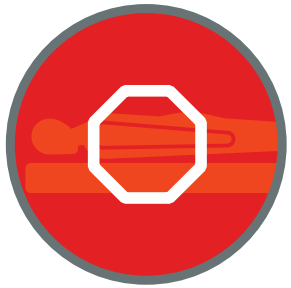
Images courtesy of Sharon Dickinson

Maintenance Care–Other Things to Consider

- Consider pillows, use of liter bags of IV fluids or fluidizer positioner to align the head and neck
- Use silicone preventive dressing under ECMO cannulas

Image courtesy of Sharon Dickinson

When to Stop Prone Positioning?



Research supports stopping prone positioning when PaO_2/FiO_2 has remained >150 mmHg 4 hours after supinating (with PEEP <10 cm H_2O and FiO_2 <0.6)

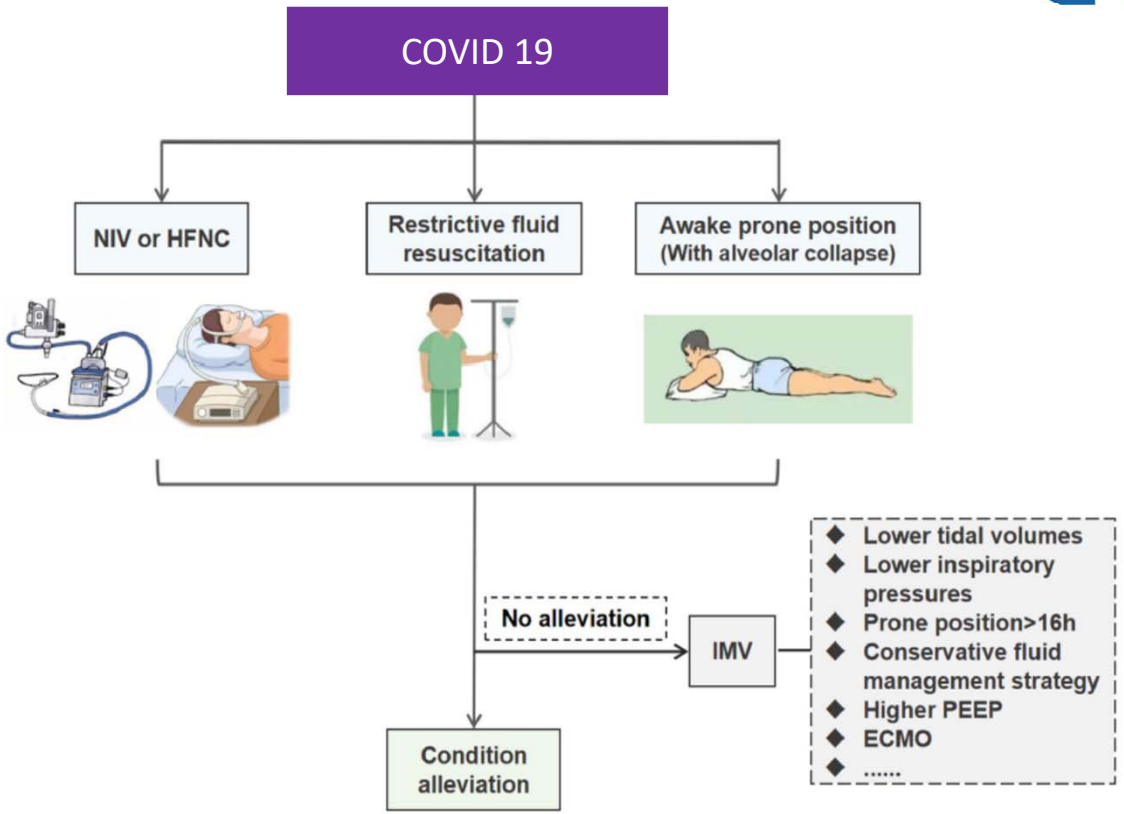
If there is no response after 48 hours, question whether prone positioning should continue

Scholten EL, et al. *Chest*. 2017;151(1):215-224.

Prone Positioning for Awake Patients

- Non-Intubated on NC, HFNC, & NIV
- Hypoxemic, non- hypercapnic
- Low saturations

Consider prone positioning 2-8 hrs. 2 to 3x daily



Ding L, et al. Crit Care, 2020;24:28
Sun Q, etal Annals of Intensive Care, 2020:10:33


What are the
Challenges & Issues

Polling Question

- What complications have occurred with use of the prone position at your hospital? Check all that apply
  1. Airway obstruction
  2. Accidental extubation
  3. Pressure injuries
  4. Loss of invasive lines
  5. Loss of tubes
  6. Cardiac arrest
  7. Hemodynamic instability
  8. Arrhythmias
  9. pneumothorax
  10. Ocular injuries
  11. Brachial plexus injuires

Adverse Events	No. of Trials Reporting the Outcome	Events/Prone	Events/Supine	Treatment Effect (Random-Effect Model) OR (95% CI)	p	Number Needed to Treat/Number Needed to Harm	Heterogeneity I² (%)	p
Ventilator-associated pneumonia	6	120/567	128/513	0.76 (0.44–1.33)	0.343	26	34.4	0.192
Pressure ulcers	6	294/698	218/646	1.49 (1.18–1.89)	0.001	12	0.0	0.617
Major airway problem[a]	9	255/1,104	180/1,063	1.55 (1.10–2.17)	0.012	16	32.7	0.167
Unplanned extubation	7	113/1,091	98/1,050	1.17 (0.80–1.73)	0.421	98	25.5	0.234
Selective intubation	2	12/642	5/615	2.73 (0.29–25.46)	0.378	95	55.9	0.132
Endotracheal tube obstruction	4	130/823	77/802	2.16 (1.53–3.05)	<0.001	16	0.0	0.580
Loss of venous or arterial access	4	36/407	22/397	1.34 (0.29–6.26)	0.712	30	75.5	0.007
Thoracostomy tube dislodgement or kinking	4	14/407	14/397	1.14 (0.35–3.75)	0.827	1,154	42.6	0.175
Pneumothorax	4	29/513	33/462	0.77 (0.46–1.30)	0.333	67	0.0	0.528
Cardiac arrest	3	104/718	119/675	0.74 (0.47–1.17)	0.197	32	30.3	0.238
Tachyarrhythmia or bradyarrhythmia	3	115/663	102/634	1.08 (0.78–1.50)	0.643	80	8.8	0.334

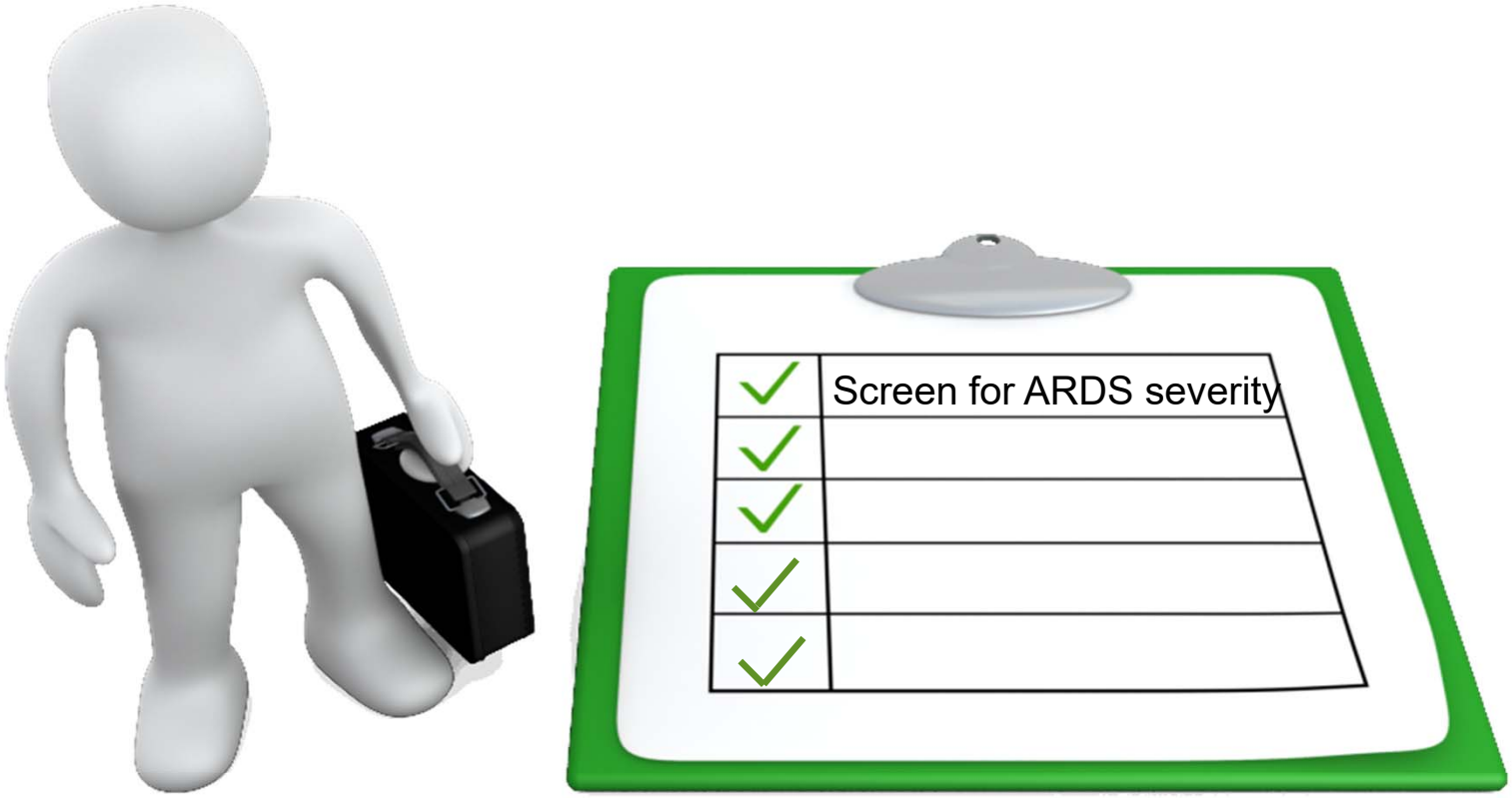
11.9% complication rate

Lee JM, et al. Crit Care Med, 2014;42(5):1252-1262

Potential Complications

- Temporary increase in oral and tracheal secretions occluding airway
- Endotracheal tube (ETT) migration or kinking
- Vascular catheter kinking
- Elevated intraabdominal pressure
- Increased gastric residuals
- Facial pressure ulcers, facial edema, lip trauma from ETT
- Brachial plexus injury (arm extension)
- Hemodynamic instability

Scholten EL, et al. *Chest*. 2017;151(1):215-224.


Screen for ARDS severity

Does your ICU have a process for assessing P/F ratios routinely?

	Mild	Moderate	Severe
Oxygenation	< 200 PaO_2/FiO_2 or ≤ 300 with PEEP/ CPAP ≥ 5 cm H_2O	< 100 PaO_2/FiO_2 or ≤ 200 with PEEP ≥ 5 cm H_2O	≤ 100 PaO_2/FiO_2 with PEEP ≥ 5 cm H_2O


Screen for ARDS severity
Prevent Pressure Injuries

Pressure Injury Risk in the Prone Patient

- Incidence
  - Prone position for ARDS increased odds of pressure injury
    - Ranges 1.22- 1.37 (95% CI 1.05 to 1.79)
    - PI 37% more common in prone pts
  - High rates being reported in COVID patients

Bloomfield R, et al. Cochrane Database Sys Rev, 2015, 11 CD08095.
Mora-Arteaga JA at al.. Med Intensiva, 2015, 39 (6), 359-372.
Munshi L, et al. Ann Am Thorac Soc, 2017, 14 S4, S280-S288.

Safety & Outcomes of Prolonged Prone Positioning for MV COVID 19 Patients

- Single center retrospective study MICU
- Mechanically ventilated patients with COVID 19
- Lung protective ventilation & prolonged prone positioning without daily supine unless FiO2 < 60% & PEEP < 10cm for ≥ 4 hrs
- 61 of 87 of MV COVID pts received prone ventilation
- Intubation to initial PPV was .28 days
- Total duration of PPV averaged 4.87 days before return to supine
- Measurement
  - Primary Safety Outcomes: Pressure injuries
  - Secondary Outcomes: hospital survival, ICU LOS, rates of facial & limb edema, HAI's, device displacement, lung mechanics and oxygenation

Douglas IS, et al. Critical Care Medicine, 2021 online

Safety & Outcomes of Prolonged Prone Positioning for MV COVID 19 Patients

Primary Outcome

- 71.7% developed ventral pressure injuries/22.6% on dorsal surface
  - Associated with duration and day 3 SOFA score/Median Braden score 11

Wound location	N (%)
Any Wounds	43 (70.49%)
Scattered	4 (6.56%)
Ventral wounds from PPV	40 (65.6)%
Chest	3 (4.92%)
Abdomen	9 (14.75%)
Perineum, groin and scrotum	15 (24.59%)
Dorsal Wounds	12 (19.67%)
Back	4 (6.56%)
Sacrum/buttocks	9 (14.75%)
Posterior neck	2 (3.28%)
Head and Neck	
Ears	17 (27.87%)
Face, Chin, Nose and Neck	27 (44.26%)
Axilla	2 (3.28%)
Extremities	
Lower extremities	12 (19.67%)
Upper extremities	16 (26.23%)

Secondary Outcomes

- 68.9% survived
- Prone duration 4.87 days
- PP applied for 30% of first 28 days
- 95.1% limb weakness
- 8.2% brachial plexus palsies
- Low HAI's

Douglas IS, et al. Critical Care Medicine, 2021 online

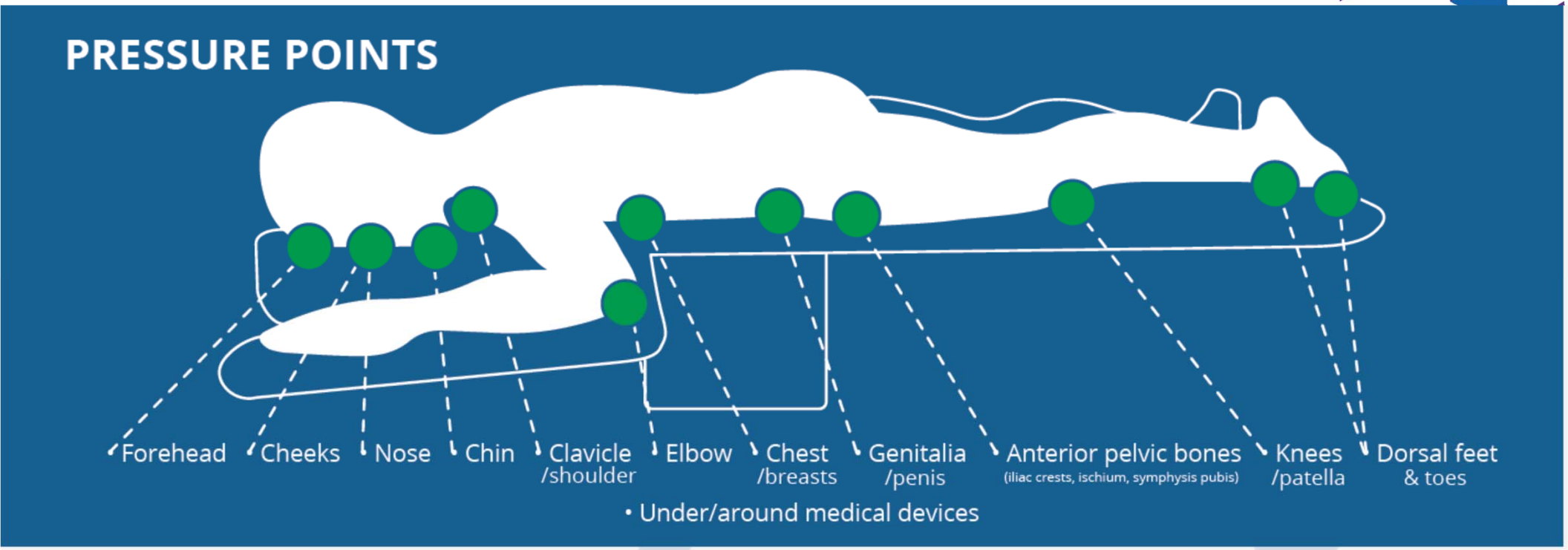
Pressure Injury Prevention: Prone Positioning

- Redistribution surface
- Positioning devices to offload pressure points (Do not use ring or donut-shaped positioning devices)
- Avoid shear and friction during the turning process
- Small micro turns while prone/swimmer position shifts q 2-4 hrs
- Assess skin with when doing small positioning shifts
- Placement of prophylactic dressings over all potential pressure injury risk areas

Green areas represent pressure sources while lying prone

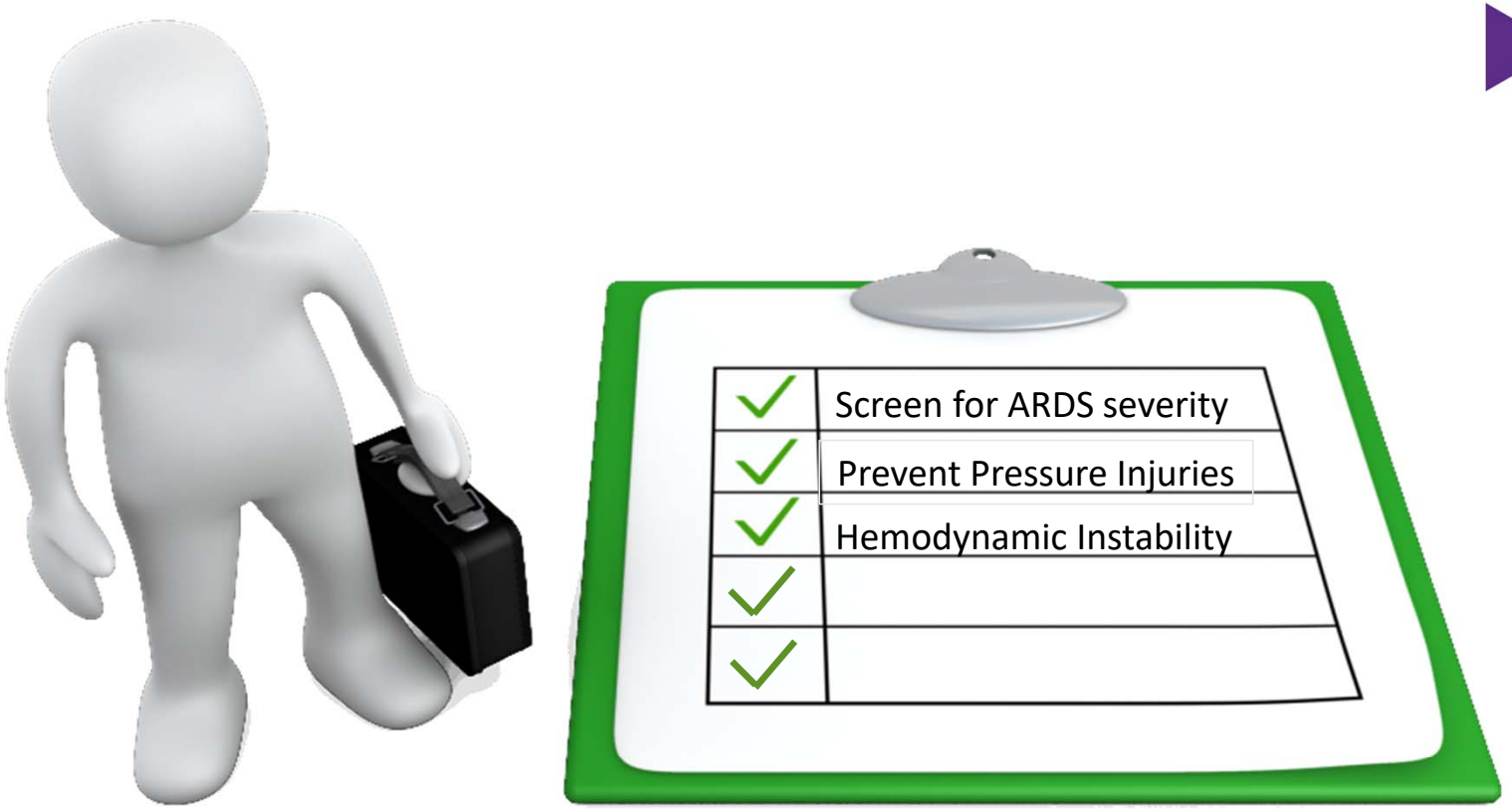
https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/posters/npiap_pip_tips_-_proning_202.pdf NPIAP 2020

Prophylactic Dressings for Prone Position PI Prevention



Upon returning to supine position, assess skin including under the dressings

https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/posters/npiap_pip_tips_-_proning_202.pdf NPIAP 2020

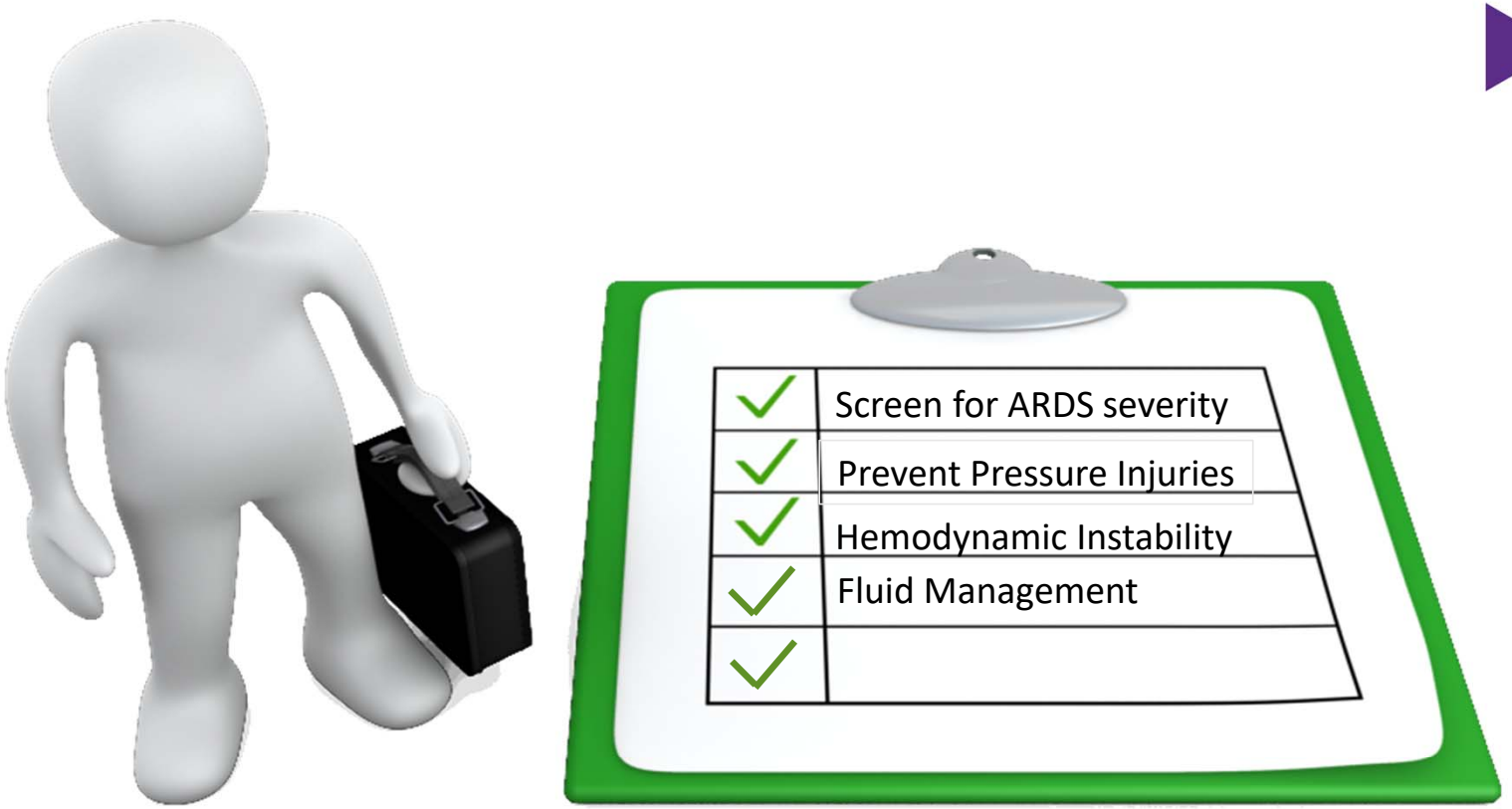

Screen for ARDS severity
Prevent Pressure Injuries
Hemodynamic Instability

The Role of Hemodynamic Instability in Positioning

- Lateral turn results in a 3%-9% decrease in SVO_2, which takes 5-10 minutes to return to baseline
- Appears the act of turning has the greatest impact on any instability seen
- Minimize factors that contribute to imbalances in oxygen supply and demand
- Factors that put patients at risk for intolerance to positioning:
  - Elderly
  - Diabetes with neuropathy
  - Prolonged bed rest
  - Low hemoglobin and cardiovascular reserve
  - Prolonged gravitational equilibrium

Right ventricular function improves in PP/ ↑ preload & CI

Winslow EH, et al. Heart Lung. 1990;19:557-561.
Price P. Dynamics. 2006;17:12-19.
Vollman KM. Crit Care Nurs Q. 2013;36:17-27
Ruste M et al. Ann Intensive Care, 2019;8:120
Zochios V, et al. J of Cardio & Vascular Anesth, 2018;32:2248-2251

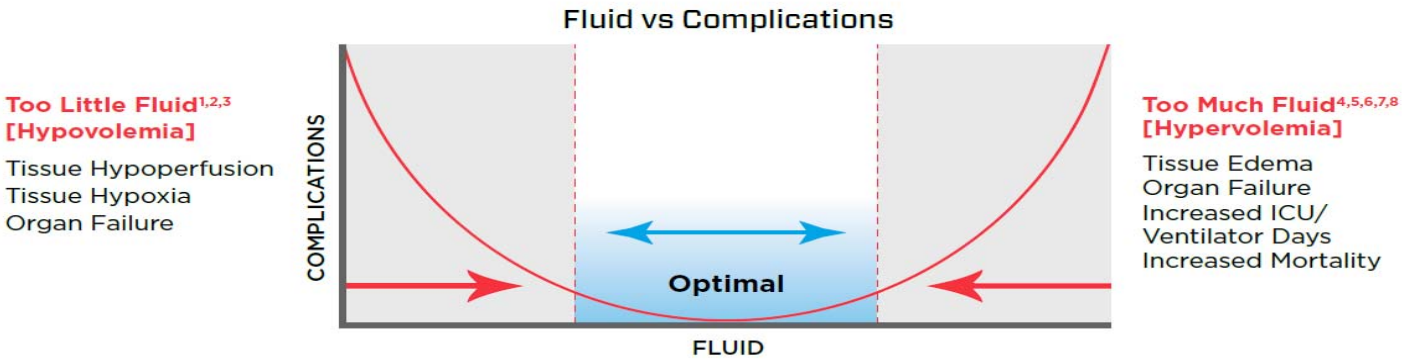

Screen for ARDS severity
Prevent Pressure Injuries
Hemodynamic Instability
Fluid Management

Polling Question

- Do you find fluid management in the ARDS patient a challenge?
  1. Yes
  2. No

We Need to Get the Fluids Just Right

FLUID IMBALANCE can lead to SERIOUS CONSEQUENCES

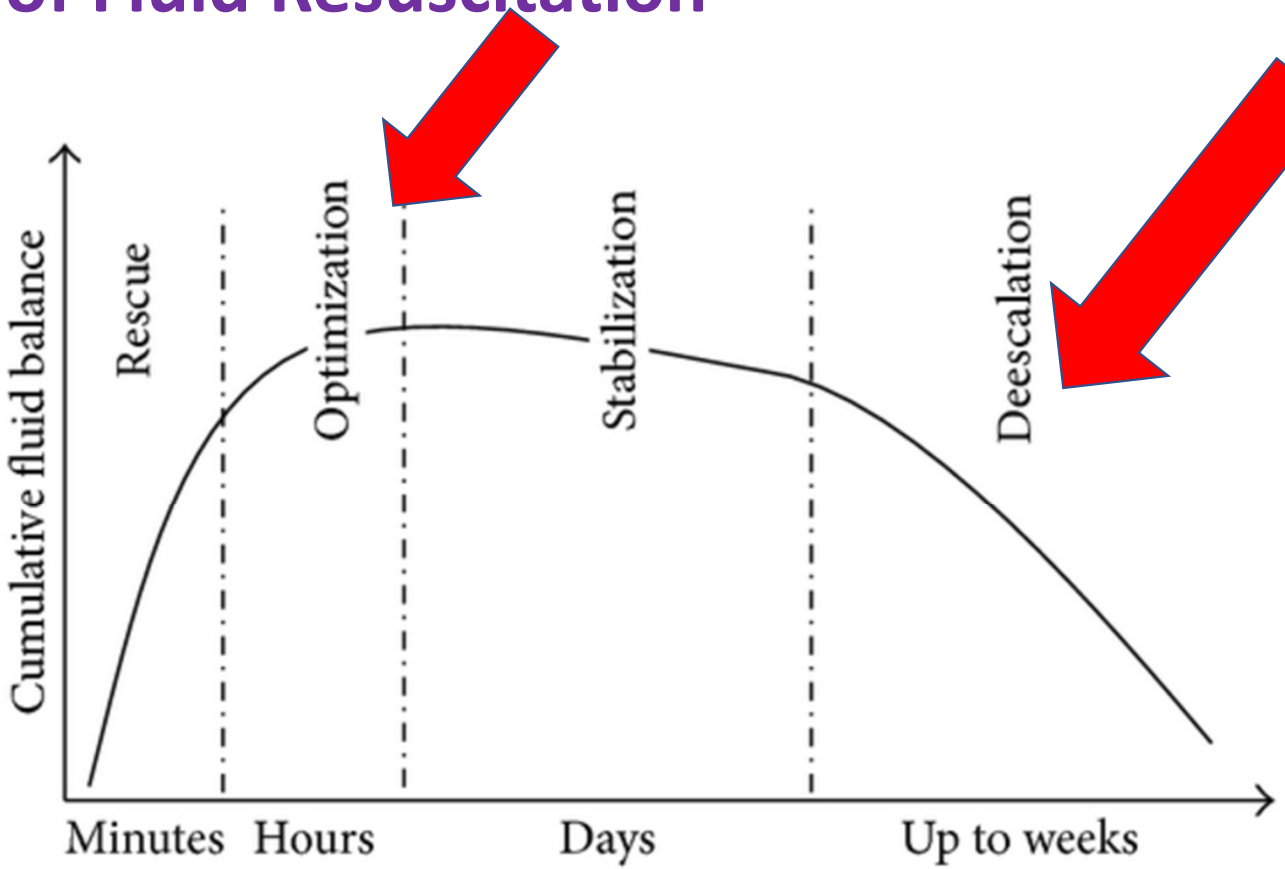


SEPSIS/SHOCK	VOLUME OVERLOAD IN SEPTIC PATIENTS IS ASSOCIATED WITH AN INCREASED RISK OF MORTALITY.[6,7]
SURGERY (ERAS)	CAREFUL MANAGEMENT OF INTRAOPERATIVE FLUIDS CAN GREATLY ENHANCE PATIENT OUTCOMES.[5]

References:

1. Shoemaker W et al. Tissue oxygen debt as a determinant of lethal and nonlethal postoperative organ failure. Crit Care Med 1988; 16:1117-1120.
2. Vermeulen H et al. Intravenous fluid restriction after major abdominal surgery: A randomized blinded clinical trial. Trials 2009; 10:50.
3. Rivers E et al. Early goal directed therapy in the treatment of severe sepsis and septic shock. NEJM 2001; 345:1368-1377.
4. Gustafsson UO et al. Enhanced Recovery after Surgery Society. Guidelines for perioperative care in elective colonic surgery: Enhanced Recovery After Surgery (ERAS) Society Recommendations. Clin Nutr. 2012; 31:783-800.
5. Corcoran T et al. Perioperative Fluid Management Strategies in Major Surgery: A stratified meta-analysis. Anesth Analg 2012; 114:640-651.
6. Boyd J et al. Vasopressin in Septic Shock Trial (VASST). Critical Care Medicine 2011; 39:259-265.
7. Vincent JL et al. Sepsis in European ICU: Results of the SOAP Study. Critical Care Med 2006; 34:344-353.
8. Kelm D et al. Fluid overload in patients with severe sepsis and septic shock treated with early goal directed therapy is associated with increased acute need for fluid-related medical interventions and hospital death. Shock 2015; 43:680-73.

4 Phases of Fluid Resuscitation



Malbrain *et al. Ann. Intensive Care* (2018) 8:66
https://www.researchgate.net/figure/Four-phases-of-hemodynamic-treatment-in-relation-to-cumulative-fluid-balance_fig1_287977953

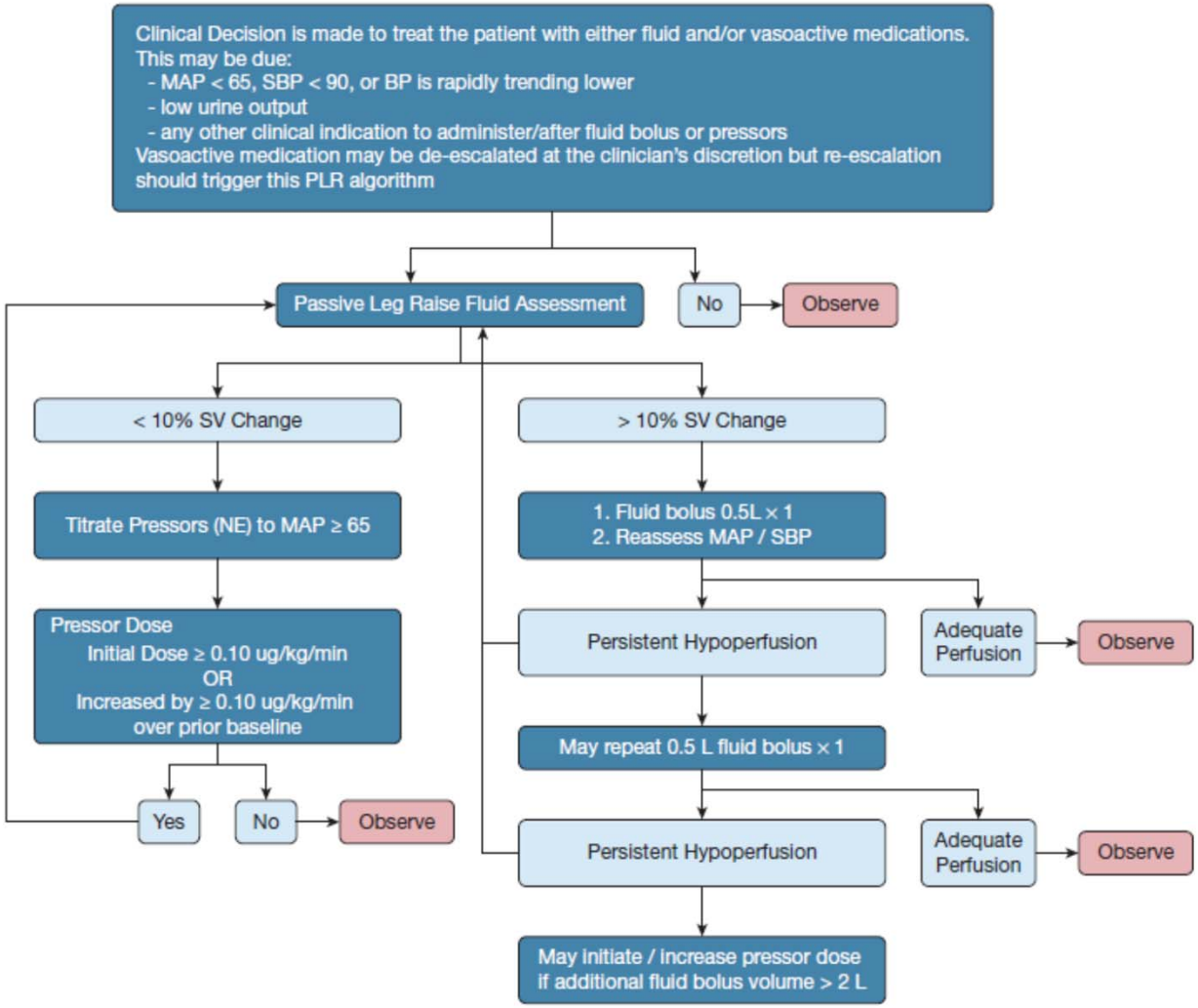
FRESH Trial

- 13 US and UK Hospitals
- Non-blinded RCT
- n = 124 patients
  - 83 treatment vs. 41 Usual Care
  - 2:1 enrollment
- Enrolled in the ER
  - Refractory septic shock
  - < 3L of fluid administered

- PLR with dynamic measure of SV change using Bioreactance
  - Used to guide decision of fluid vs. vasopressors for clinical hypoperfusion
  - Over the next 72 hours of care, or ICU discharge

Douglas I et al, *CHEST* 2020

Study Protocol



Douglas, Alapat, Corl et al, *CHEST* 2020;158(4):1431-1445

Primary Endpoint

- **Decreased 72-hour Fluid Balance** (p=0.02)
  - △ Treatment Group: 0.65 L +/- 2.85 L
  - △ Control Group: 2.02 L +/- 3.44 L
- Favoring Treatment Group: -1.37 L

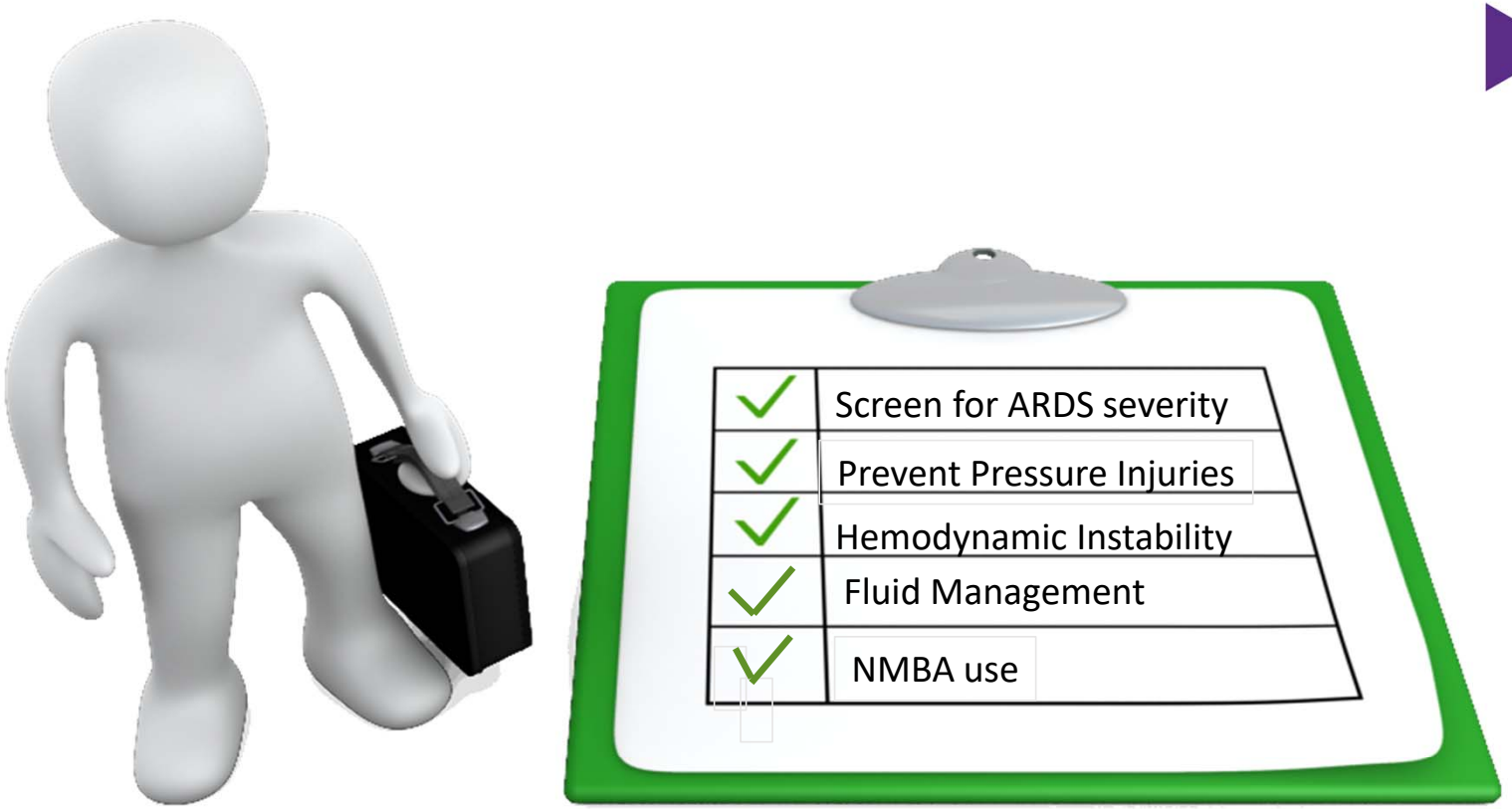
- 43% fluid responsive on initial PLR
- 33% fluid responsive between 48 – 72 hours
- 18% never fluid responsive

Douglas I et al, *CHEST* 2020

Secondary Endpoints

- **Renal Replacement Therapy (RRT)** p = 0.04
  - Treatment Group 5.1%
  - Control Group 17.5 %
- **Mechanical Ventilation** p = 0.04
  - Treatment Group 17.7%
  - Control Group 34.1%
- **ICU LOS** p = 0.11
  - Treatment Group 3.31
  - Control Group 6.22
- **Discharge Home** p = 0.035
  - Treatment Group 63.9%
  - Control Group 43.9 %

Douglas I et al., *CHEST* 2020

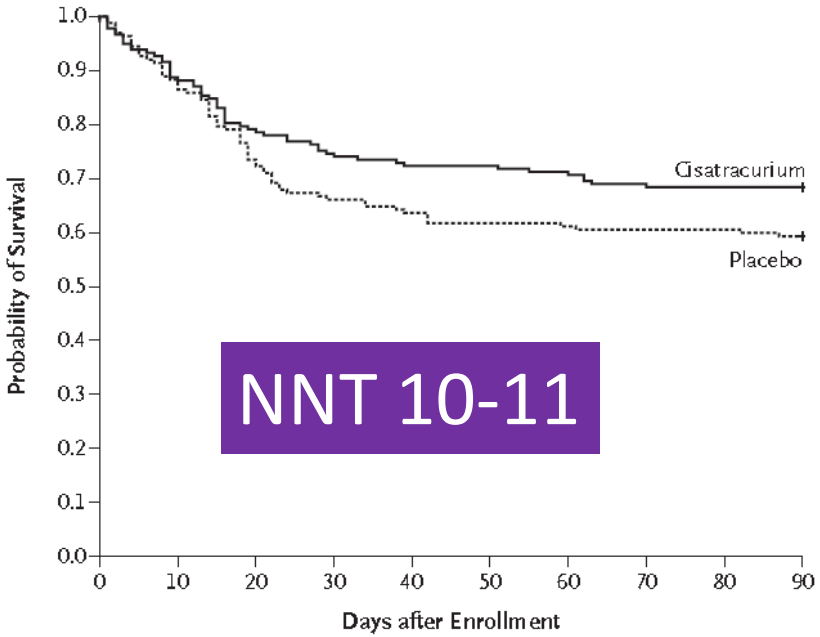

Screen for ARDS severity
Prevent Pressure Injuries
Hemodynamic Instability
Fluid Management
NMBA use

Neuromuscular Blockade in Early ARDS

- Multicenter, double blind trial
- 340 patients with ARDS within 48hrs of admitted to ICU
- ARDS defined as P/F ratio of < 150 ≥ PEEP 5cm & Vt of 6-8 ml/kg PBW
- Randomized to receive 48hrs of cisatracurium or placebo
- Study did not use train of 4

Results:

- After risk adjustment NMB group showed improved mortality at 90 days (31.6% vs. 40.7%)
- Also significant at 28 days
- ↑time off vent
- No difference in muscle weakness



NNT 10-11

Papazian L, et al. N Engl J Med. 2010;363(12):1107-16

ROSE Trial: Re-evaluation of Systemic Early Neuromuscular Blockade

- Protocol: moderate to severe ARDS < 48hrs / P/F ratio < 150 with ≥ PEEP 8 cm
- Cisatracurium for 48hr or usual care
- Protocol changed mid-study, removed RM

The ROSE trial at 90-day follow-up in patients with moderate-to-severe ARDS, 42.5% of the intervention group and 42.8% of the control group died before hospital discharge (between group difference -0.3%, 95% CI -6.4 to 5, *P*=0.93), -study stopped early.

Angus D, et al NEJM May 19th 2019

Prone Positioning used 15.8%. Equal use in both groups

Summary

- Use the prone positioning
- Implement early—don’t wait
- Develop a process or protocol to minimize complication risk
- Training all providers to mastery is critical


Jay '91
"HAPPY TURNING"

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ADVANCING NURSING THROUGH KNOWLEDGE & INNOVATION

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