Awake proning of COVID-19 patients in Step Down unit

1. Patients requiring any amount of oxygen supplementation or increased work of breathing qualify as candidates for awake proning
2. MD places order for awake proning
3. Patient educated on proning by bedside nurse and encouraged to empty bowel and bladder prior to proning
4. Prepare bed:
    a. Lay flat sheet down, pillow on chest and pelvis, so abdomen is not directly on bed
    b. Attention to patient comfort; angling pt towards the TV or window etc
    c. Primary nurse or RT at bedside with initiation of proning.
5. For any potential skin breakdown, apply wound prevention Mepilex etc
6. Secure IV's, foleys, lines, chest tube, drains and any other medical devices attached to patient
7. Place EKG leads on pt as per education sheet, ensure continuous pulse oximetry probe is attached to patient and functioning
8. Have patient turn on to abdomen, assist as needed, with caution to lines, drains, tubes etc
9. Place bed in reverse Trendelenburg position after patient is proned
10. Monitor patient for 2 minutes. If any hemodynamic instability, increasing respiratory distress or SpO2 drops by 4% or more, or below 90%, return the patient to supine and notify MD
11. Ensure call bell is easily accessible to patient before leaving room
12. Documentation:
    a. Document prone position, reverse Trendelenburg in "positioning" section of Adult PCS
    b. 1 hour after first proning session, observe and document (Nursing note):
        i. Patient comfort (physical comfort and dyspnea)
        ii. Respiratory rate
        iii. SpO2
        iv. Oxygen supplementation (device and FiO2)
    c. Subsequent checks every 4 hours
    d. Document supine position when patient returns to supine position, and full head to toe assessment including thorough skin assessment for breakdown
    e. Document any skin breakdown immediately!
13. Contact primary provider with any clinical status change or question regarding pronation