Prone ventilation is ventilation that is delivered with the patient lying in the prone position. Prone ventilation may be used for the treatment of acute respiratory distress syndrome (ARDS) mostly as a strategy to improve oxygenation when more traditional modes of ventilation fail (e.g., lung protective ventilation).

Propofol is a lipid-soluble, short-acting IV sedative administered continuously to provide sedation in mechanically ventilated ICU patients. It is available in a lipid emulsion that provides energy as lipid, and needs to be considered when prescribing EN.

Early enteral feeding: start within 24-48h once haemodynamically stable 1-3.

For medical patients with single organ failure – recommend avoid checking gastric residual volumes (GRVs) unnecessarily2 to lessen the risk of aerosol/droplet spread.

Continue to check GRVs for surgical patients, multi-organ failure (MOF) patients, patients who have vomited in last 24h and intestinal failure patients.

For patients undergoing prone position therapy* – start early enteral nutrition.3,4

See Figure 1 below for out-of-hours guideline for patients not at high risk of refeeding syndrome and Figure 2 overleaf for refeeding risk patients.

Consider prokinetic use on a case-by-case basis if intolerance is demonstrated or expected.

Consider a double-strength feed to limit fluid provision.

Consider a higher protein feed with lower energy content, if on high dose propofol.

Figure 1: Out-of-hours nasogastric tube feeding when using prone position therapy for 16h per 24h – for patients NOT at refeeding syndrome risk

Day 1
- Doublestrength feed 20ml/hr x 16h during prone position therapy
- Check GRV x 1 after finishes prone position therapy
- Continue to feed at 20ml/hr x 8hr unless GRV >250ml

Day 2
- Doublestrength 20ml/hr x 16hr during prone position therapy
- Check GRV x 1 after finishes prone position therapy
- Increase feed to 35ml/hr x 8hr unless GRV >250ml

Day 3
- Doublestrength feed 20ml/hr x 16hr during prone position therapy
- Check GRV x 1 after finishes prone position therapy
- Increase feed to 50ml/hr x 8hr unless GRV >250ml

Note:

I. Insert name of double-strength feed; use local GRV cut-off limit.
II. Day 1 gives 960kcal; Day 2 gives 1200kcal; Day 3 gives 1440kcal.
III. Concurrent Propofol* infusion will give extra kcal and fat. Monitor triglyceride level.

Consider a high protein lower energy feed if on high dose propofol, e.g. >15ml/hr.

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IV. Consider giving protein supplement as bolus through feeding tube from day 3 during period when NOT in prone position.

**Figure 2:** Out-of-hours enteral feeding when using prone position therapy for 16h per 24h – for patients AT HIGH RISK of refeeding syndrome

**Day 1**
- Doublestrength 10ml/hr x 16h during prone position therapy
- Check GRV x 1 after finishes prone position therapy
- Continue feed 20ml/hr x 8hr unless GRV >250ml

**Day 2**
- Doublestrength 20ml/hr x 16hr during prone position therapy
- Check GRV x 1 after finishes prone position therapy
- Increase feed to 20ml/hr x 8hr unless GRV >250ml

**Day 3**
- Doublestrength 20ml/hr x 16hr during prone position therapy
- Check GRV x 1 after finishes prone position therapy
- Increase feed to 30ml/hr x 8hr unless GRV >250ml

**Note:**
I. Day 1 gives 640kcal; Day 2 gives 960kcal; Day 3 gives 1120kcal.
II. Give intravenous Pabrinex I and II od x 3d, and NG multivitamin od x 7-10d, or per local Refeeding Syndrome Guideline.
III. These patients have a higher risk of cardiomyopathy – avoid hypophosphatemia.

**Once assessed by the dietitian:** follow the individualised patient specific care plan, or as per ICU Team.

**References:**

*Prone ventilation* is ventilation that is delivered with the patient lying in the prone position. Prone ventilation may be used for the treatment of acute respiratory distress syndrome (ARDS) mostly as a strategy to improve oxygenation when more traditional modes of ventilation fail (e.g., lung protective ventilation).

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