CHILD:

24 Hour Flowsheet

| F | atien | t ide | ntif | ica |
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| | Time | Initials |
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| | Strike a line till bugir ally assessifierit | data to indicate that it does no | or apply of | mas not been assessed. One | to maioato aco | UJJIIIUIII I | illiuliigs. | | |
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| ſ | RESPIR | ATORY | | | CARDIOVASCI | JLAR | | | |
| | ☐ Resp. even and unlaboured ☐ Respiratory distress: ☐ Mild ☐ Moderate ☐ Severe ☐ Nasal flaring ☐ Tracheal tug ☐ Head bobbing | AIR ENTRY □ Equal to bases □ Decreased to: □ RUL □ RML □ RLL □ LUL □ LLL □ Throi | uahout | ☐ Pink ☐ Pale | LI FILIN LI FAIC I | PERIPHE PULSES Left radia | RAL al / ulnar / brachial | Normal | NI.rooo, |
| | ☐ Indrawing: | ☐ See Nurses' Notes | -9 | See Nurses' Notes | See Nurses' Notes | Right rad | lial / ulnar / brachial | | |
| | ☐ Intercostal ☐ Subcostal ☐ Substernal ☐ Abdominal breathing | CHEST MOVEMENT ☐ Equal and adequate | | APICAL PULSE ☐ Regular ☐ Irregular | PERIPHERAL TEMPERATURE | P tibialis | oral / D pedis / s / popliteal | | |
| | ☐ Suprasternal retractions | ☐ See Nurses' Notes | | ☐ Murmur | Warm to: Extremities | Right fer | moral / D pedis / s / popliteal | | |
| ١ | ☐ See Nurses' Notes | CHEST DRAINAGE DEVICE [| □ N/A | See Nurses' Notes | | | eurovascular assessr | nont | L |
| | BREATH SOUNDS ☐ Clear to bases | ☐ Chest tube ☐ Blake drain | | | INTEGUME | | curovascular assessi | ПСП | - |
| | ☐ Crackles: | ☐ Pigtail | | Ckin alaas D Deviain | | | DDAINAGE [| | / A |
| | □ RUL □ RML □ RLL □ LUL □ LLL □ Throughout □ Wheezes: □ Inspiratory □ Expiratory □ Location: □ RUL □ RML □ RLL □ LUL □ LLL □ Throughout □ Stridor □ Grunting □ Referred upper airway sounds □ Cough: □ Dry □ Loose □ Productive □ Nasal congestion | ☐ LUL ☐ LLL ☐ cm H ₂ O s ☐ Underwater seal Drainage is: | suction Gerous | End date Type Irradiance | Pink Intact I Painful Drool Stomatitis/Mucositis See Nurses' Notes DRESSINGS IN Site: Dry and intact | Lesions ling s Grade | □ None □ Fresh □ Sanguinous □ Serosanguinou □ Purulent □ See Nurses' N | us otes /A | ld erd |
| | ☐ See Nurses' Notes | | | ☐ See Nurses' Notes | | | | | |
| | ☐ Flat ☐ Rounded ☐ Soft ☐ Firm ☐ Distended ☐ Shiny ☐ Tenderness: ☐ RUQ ☐ LUQ ☐ Guarding ☐ See Nurses' Notes ☐ See Stool Chart ☐ Ostomy site ☐ Drainage: ☐ Yes ☐ No ☐ See Nurses' Notes ☐ See Nurses' Notes ☐ Present: ☐ Hyper ☐ Hypo ☐ Absent ☐ Throughout ☐ Soft Development ☐ Soft Development ☐ Soft Development ☐ Soft Development ☐ Throughout ☐ Soft Development ☐ Soft Deve | BLADDER Self-voiding Diaper: Size Catheter: Size Intermittent Continuous See Nurses' Notes URINE Concentrated COLOUR Clear Clear Vellow Hematuria: Slight Moderate Marked See Nurses' Notes REPRODUCTIVE N/A Menses at present See Nurses' Notes | GAIT Stea Not Not Ami See DEVICE Trac Bra See Con Dro Dro Airb Airb NIE TONE | observed elchair | Alarms on and reviewe Identification Band on Allergy Band on | AT I SUBSTITUTE OF THE CKN With a \sqrt{a} | (safety check) I See Nurses' Note S & SCORE and insert actual score Braden Q Score Mobility | ERS attion closur n Car es | re re |
| | Nausea □ Vomiting □ Bottle Type □ Nipple Type □ See Nurses' Notes FEEDING □ N/A □ See Nur | □ NPO GASTRIC TUBE □ Meal Plan □ Insitu: □ □ Length □ Tube plac □ Straight dr rses' Notes □ Clamped | Location Cement von Zeinage | _ □ Type erified pH □ Intermittent suction □ Open barrel | Bedside safety check Patient plan of care upda Falls Risk Assessment so Family orientation/ Education to area/Diagno Mental Health Plan | ore | Activity Sensory percepti Moisture Friction and shea Nutrition Tissue perfusion | ır | |
| | ☐ Continuous ☐ Bolus ☐ Intermittent qh | ☐ Suction: ☐ | □ Contin □ Interm | | | 土 | Total Score | | |
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Signatures

and initials

24 Hour Flowsheet 0 – 3 MONTHS Patient identification

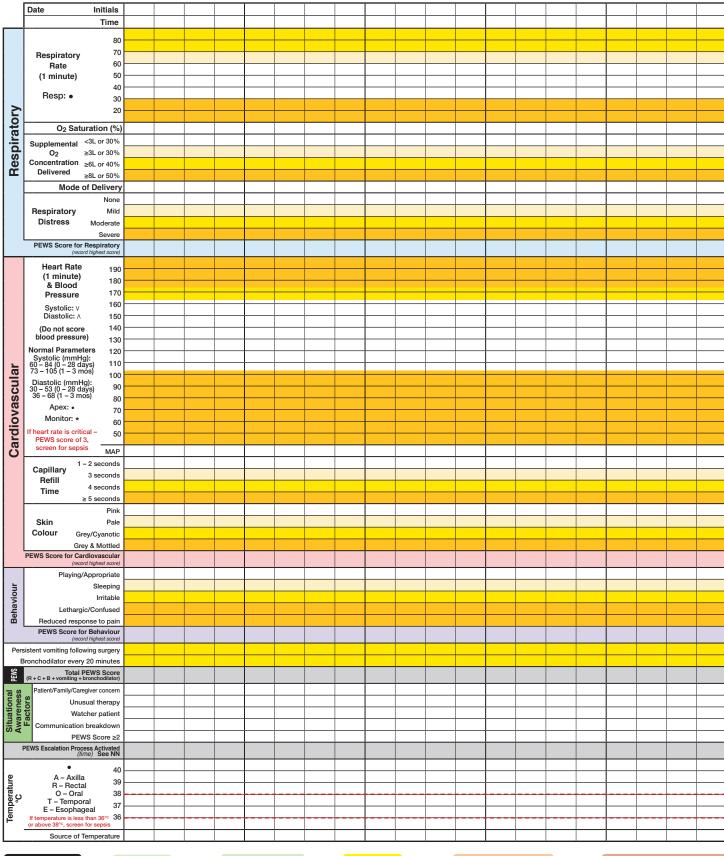
| Time | Problem/Focus | Nursing Documentation Notes |
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CHILD: **HEALTH** BC

Patient identification 24 Hour Flowsheet

0 - 3 MONTHS

PEWS Scoring Legend: 0 1 2 3





Score 0 - 1 Continue to monitor and document as per orders and routine protocols.

2 3 Increase frequency of assessments and documentation as per plan from consultation.

Score 4 and/or score pediatrician consult. MRP/delegate to communicate a plan of care. Increase assessments.

Reassess adequacy of resources and escalate to meet deficits.

Score 5 – 13 or score of 3 in any one category

Immediate assessment by MRP/delegate or pediatrician, or emergency room physician. MRP/delegate to communicate a plan of care. Increase nursing care with increasing interventions as per plan. Consider interval or external transfer to higher level of care.

Revised 11 2020

Score 2 or any one of 5 Situational Awareness Factors Review with more experienced healthcare professional. Scalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.

CHILD: **HEALTH** BC

Patient identification

24 Hour Flowsheet 0 - 3 MONTHS

Time To speech To pain 2 Irritable cry/Confused Cries to pain/Inappropriate 3 Moans to pain/Incomprehensible 2 Normal spontaneous/Obeys 6 Withdraws to touch/Localized 5 Vithdraws to pain/Withdraws Abnormal flexion Colour, Warmth, Right Arm & Sensation of Extremities Left Arm √= Normal NN = Nurse's Notes Location of pain Arousal Score Screen for sensis if PEWS score increases by 2, or temperature is > 38°C or < 36.0°C, or critical heart rate. (Indicate with a $\sqrt{}$ and document findings and actions in Nurses' Notes.) Regular Enteral / Gastric tube Checks IV Site to Source (touch, look, and compare q1h) Patient Safety Check q1h PRAM Score (asthma patients only) Phototherapy / Eye shields Incubator Temperatur Routine Repositioning q___ Foley care / Pericare Shower (S) / Bath (B) Mouth car Oximeter site probe change q4h Family presence

| PUPIL SIZE (mm) | | | | | | | | |
|-----------------|---|---|---|---|---|---|---|---|
| | | • | • | • | | | | |
| ı | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

| | MUSCLE STRENGTH GRADING SYSTEM | | | | | LEVI | EL OF AROU | SAL SCORE | | | | |
|-----|-------------------------------------|-----|---|-----------|-------|---------------|-------------|------------------------|-----------------------------|------------------------|----------------------------|-----------------------------------|
| 0/5 | No movement | 3/5 | Movement overcoming gravity, | | 1 | 2 | 3 | 4 | 5 | | | |
| 0,0 | 110 moromone | 0,0 | but not against resistance | ш | Awake | Normal sleep, | Difficult | Responds only | Does not respond | | | |
| 1/5 | Trace movement | 4/5 | Movement overcoming gravity and some resistance | gravity a | | | | and alert, oriented | easy to arouse to verbal | to arouse to verbal | to physical stimulation | to verbal or physical stimulation |
| 2/5 | Movement only (not against gravity) | 5/5 | Normal strength against resistance | 1 L | | stimulation | stimulation | | | | | |

CHILD:

HEALTH BC

COWS | Clinical Opiate Withdrawal Scale

CPAP Continuous Positive Airway Pressure

24 Hour Flowsheet 0 - 3 MONTHS

Patient identification

Calculated Maintenance Fluids _ mL/kg/hr Cumulative Total IN Bristol Stool Score Cumulative Total OUT _ mL/kg/hr | 12 hour balance Total Fluids _ Total Fluids mL/kg/hr 12 hour balance Urine Output _ _ mL/kg/hr Urine Output _ _ mL/kg/hr 24 hour balance Previous 24 hour balance Catheter Size # of Attempts Insertion Site ADMISSION WEIGHT PREVIOUS 24 HOUR TODAY'S WEIGHT Other Measurements (For example: height, abdominal girth, head circumference, photometer, peakflows) BiPAP Bi-level Positive Airway Pressure EVD External Ventricular Drain LLL Lower Left Lobe NN Nurses' Notes RLQ Right Lower Quadrant LLQ Lower Left Quadrant Degrees Celsius Gastrostomy Tube Nasal Prongs RML Right Middle Lobe CIWA-Ar Clinical Institute Withdrawal Assessment for Alcohol LUL Left Upper Lobe h Every _____ hours RUL Right Upper Lobe Right Centimeter(s) Jejunostomy tube LUQ Left Upper Quadrant NA Not Applicable RUQ Right Upper Quadrant

M Mask

MAP Mean Arterial Pressure

NG Nasogastric

NJ Nasojejunal

Kilograms

L Left

Room Air

RLL Right Lower Lobe VAC Vacuum Assisted Closure

CHILD: **HEALTH** BC

☐ Oral ad lib ☐ Breastfeeding ☐ NPO

FEEDING □ N/A □ See Nurses' Notes

☐ Bottle Type ___ ☐ Nipple Type ___

☐ See Nurses' Notes

■ Intermittent g

☐ Continuous ☐ Bolus

□ Nausea □ Vomiting □ Meal Plan □ Insitu: □ Location

Patient identification

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| Strike a line through any assessmel | nt data to indicate that it does n | ot apply o | or has not been assessed. Che | eck boxes 🗹 to indicate ass | sessment i | findings. | | |
|---|---|---|---|---|---|---|-----------------------------|-----------|
| RESPI | RATORY | | | CARDIOVASC | ULAR | | | |
| Resp. even and unlaboured Respiratory distress: Mild Moderate Severe Nasal flaring Tracheal tug Head bobbing Indrawing: Intercostal Substernal Abdominal breathing Suprasternal retractions See Nurses' Notes REATH SOUNDS Clear to bases Crackles: RUL RML RLL LUL LLL Throughou Wheezes: Inspiratory | AIR ENTRY Equal to bases Decreased to: RUL RUL Thro See Nurses' Notes CHEST MOVEMENT Equal and adequate See Nurses' Notes CHEST DRAINAGE DEVICE Insitu: Chest tube Blake drain Pigtail Site: Mediastinal | □ N/A | CENTRAL COLOUR Pink Pale Mottled Flushed Jaundiced See Nurses' Notes APICAL PULSE Regular Irregular Murmur See Nurses' Notes See Nurses' Notes | PERIPHERAL COLOUR Pink | PERIPHE PULSES Left radia Right rad Left fem P tibialis Right fer P tibialis See Ne | al / ulnar / brachial ial / ulnar / brachial ial / ulnar / brachial oral / D pedis / / popliteal moral / D pedis / s / popliteal eurovascular assessn DRAINAGE DRONE Fresh Sanguinous | ment r | 'A d |
| □ Location: □ RUL □ RML □ RLL □ LUL □ LLL □ Throughou □ Stridor □ Grunting □ Referred upper airway sounds □ Cough: □ Dry □ Loose □ Productive □ Nasal congestion □ See Nurses' Notes | ☐ Underwater seal Drainage is: t ☐ Sanguinous ☐ S ☐ Serosanguinous ☐ Chylous Air leak: ☐ Yes ☐ No ☐ See Nurses' Notes | Serous O | UMBILICUS N/A Clean Drying PHOTOTHERAPY N Start date End date Type Irradiance See Nurses' Notes | DRESSINGS IN I Site: Dry and intact VAC continuous/int at See Nurses' Notes | ermittent mm Hg | □ Type | otes /A | |
| GASTROINTESTINAL BOOMEN I Flat | BLADDER Self-voiding Diaper: Size Catheter: Size Intermittent Continuous See Nurses' Notes URINE N/A Dilute Concentrated COLOUR Clear Clear Vellow Hematuria: Slight Moderate Marked See Nurses' Notes | GAIT Ste Not Wh Am See DEVICE Tra Bra See | t observed eelchair | · · | S AT I CES CHECK | (safety check) 1 See Nurses' Note (S & SCORE | ention/ losurn n Care | / re b |
| ocation of bowel sounds: RUQ LUQ RLQ LLQ See Nurses' Notes | REPRODUCTIVE \(\triangle | | □ N/A □ Nurses' Notes reased/hypertonic creased/hypotonic | Alarms on and reviewed Identification Band on Allergy Band on | | Braden Q Score Mobility | | |
| | NUTRITION | | | Bedside safety check | | Activity | \dashv | _ |

GASTRIC TUBE ☐ N/A ☐ See Nurses' Notes

☐ Straight drainage ☐ Intermittent suction

Length _____

☐ Suction: ☐ Continuous

☐ Tube placement verified pH _

☐ Clamped ☐ Open barrel

■ Intermittent

Patient plan of care updated

Falls Risk Assessment score

Education to area/Diagnosis

Family orientation/

Mental Health Plan

Sensory perception

Friction and shear

Tissue perfusion

Moisture

Nutrition

Total Score