CHILD: HEALTH BC

24 Hour Flowsheet

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	U		71116

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CHILD:
HEALTH BC

24 Hour Flowsheet 4-6YEARS

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Patient	INDUITINGSTIN

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	CHILD :X

CHILD:
HEALTH BC

Patient identification

24 Hour Flowsheet 4-6YEARS

PEWS Scoring Legend:	0	1	2	3

	L	Date Initials														
		Time														
Γ		Respiratory 50														
		Rate 40														
		(1 minute) 30														-
		Resp: ● 20														_
ı		O ₂ Saturation (%)														_
ı	Respiratory	21			 						 	<u> </u>			 	\vdash
	ă∣	Supplemental														
ŀ	≒∣	Concentration ≥6L or 40%														
	S	Delivered ≥8L or 50%														
	<u>~</u>	Mode of Delivery														
İ	Ì	None														
		Respiratory Mild														
		Distress Moderate Severe														_
	L	PEWS Score for Respiratory														-
L		(record highest score)														
		Heart Rate 160 (1 minute)														
		& Blood														
		Systolic: V 130 Diastolic: A 120														
		(Do not score 110	-					-							₩	\vdash
		blood pressure) Normal Parameters						-			-				\vdash	\vdash
	ä	Systolic (mmHg): 90														
ľ	3	91 – 114 80 Diastolic (mmHg): 70														
	SC	50 − 80 70 Apex: • 60														
	Va	Monitor: * 50														
1	Cardiovascular	If heart rate is critical – PEWS score of 3,														
	ä	screen for sepsis MAP			<u> </u>	<u> </u>										<u> </u>
1	Ü	Capillary 1 - 2 seconds 3 seconds														
ı		Refill 4 seconds														
l		Time ≥ 5 seconds														
		Pink														_
		Skin Pale Colour Grey/Cyanotic														_
		Grey & Mottled														
İ	Ī	PEWS Score for Cardiovascular (record highest score)														
H	П	Playing/Appropriate														
	<u> </u>	Sleeping														
	Behaviour	Irritable														
	eha	Lethargic/Confused														_
	ш [Reduced response to pain PEWS Score for Behaviour														-
		(record highest score)														
	Per	rsistent vomiting following surgery														
	E	Bronchodilator every 20 minutes														
	PEWS	Total PEWS Score (R + C + B + vomiting + bronchodilator)														
	- I	Patient/Family/Caregiver concern														
5	SS	Unusual therapy														\vdash
2	ene	Watshar nation														\vdash
1	Awareness	Watcher patient													_	-
0) A														 	\vdash
		PEWS Score ≥2														
	Р	EWS Escalation Process Activated (time) See NN														
		40													<u> </u>	\vdash
9	<u>p</u>	A – Axilla R – Rectal 39														\vdash
1	S	O – Oral 38	 	 		 -	 	 	 	 				 	 	+
	°C	E – Esophageal														\vdash
15	<u>.</u>	If temperature is less than 36°C or above 38°C, screen for sepsis														
	•	Source of Temperature														
_	_		 				 			 				 	 	

Pediatric	
Early Warning	
System (PEWS)	
Escalation Aid	

Revised 09 2019

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

Score 4 and/or score increases by 2 after interventions consultation.

Score 4 and/or score increases by 2 after interventions consultation.

Notify MRP/delegate . Consider pediatrician consult. MRP/delegate or or score of 3 in any one category

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 or score of 3 in any one category

Immediate assessment by MRP/delegate or or score of 3 in any one category

Immediate assessment by MRP/delegate or or score of 3 in any one category

Immediate assessment by MRP/delegate or or score of 3 in any one category

	Strike a line through any assessment	t data to indicate that it does no	ot apply o	r has not been assessed. Che	eck boxes 🗹 to indicate as:	sessment	findings.				
Г	RESPIR	RATORY		CARDIOVASCULAR							
	Resp. even and unlaboured Respiratory distress: Mild Moderate Severe	AIR ENTRY ☐ Equal to bases ☐ Decreased to:			PERIPHERAL COLOUR Pink Pale Mottled Flushed	PERIPHE PULSES	RAL	Normal	NI		
	☐ Nasal flaring ☐ Tracheal tug☐ Head bobbing	RUL RMLRLL	uahout	☐ Jaundiced	☐ Jaundiced	Left radia	al / ulnar / brachial		L		
	☐ Indrawing:	☐ See Nurses' Notes	ugnout	See Nurses' Notes	See Nurses' Notes	Right rad	lial / ulnar / brachial		Ī		
	☐ Intercostal ☐ Subcostal ☐ Substernal	CHEST MOVEMENT		APICAL PULSE	PERIPHERAL	Left fem	oral / D pedis /		Ī		
	☐ Abdominal breathing ☐ Suprasternal retractions	☐ Equal and adequate ☐ See Nurses' Notes			TEMPERATURE Warm to: ☐ Extremities	Right fe	moral / D pedis / s / popliteal				
	☐ See Nurses' Notes	CHEST DRAINAGE DEVICE I	□ N/A	☐ See Nurses' Notes			eurovascular assessn	nont	rc		
	BREATH SOUNDS	Chest tube		2 000 Na1000 Not00				TOTAL	_		
	☐ Clear to bases☐ Crackles:	Blake drain			INTEGUME	NT					
	□ 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 □ See Nurses' Notes GASTROINTESTINAL	☐ Pigtail	Suction Gerous	Skin clear ☐ Bruisin☐ Petechiae ☐ Rash☐ Location☐ ☐ See Nurses' Notes☐ N/A☐ Clean ☐ Drying☐ PHOTOTHERAPY☐ NStart date☐ End date☐ Type☐ Irradiance☐ See Nurses' Notes☐ SCULOSKELETAL☐	Pink Intact Intact Painful Droo Stomatitis/Mucositi See Nurses' Notes DRESSINGS Site: Dry and intact VAC continuous/int	Lesions ling s Grade N/A ermittent mm Hg	None Fresh Sanguinous Serosanguinou Purulent See Nurses' No DRAIN N	otes /A	ld er		
	ABDOMEN Flat	BLADDER Self-voiding Diaper: Size Catheter: Size Intermittent Continuous See Nurses' Notes URINE N/A Dilute Concentrated COLOUR Clear Cloudy Amber Yellow Hematuria: Slight Moderate Marked See Nurses' Notes REPRODUCTIVE N/A Menses at present See Nurses' Notes	GAIT Ste Not Whith Am See DEVICE Trai Bra See Cor Dro Dro Airt Airb N/A	□ N/A ady □ Unsteady c observed eelchair □ Bedfast bulatory/walker Nurses' Notes S □ N/A ction □ Splint □ Cast ce □ Nurses' Notes ISOLATION ntact □ Contact plus plet plet and contact	Central edema:	S AT I	SAFETY RISK TO SELF/OTHI Suicidal Homicidal ideation Plan: Elopement risk BSTANCE USE Substance intoxica Withdrawal ERVENTIONS Restraints: Siderails Enc 1 Violence Preventior insitu (safety check) 1 See Nurses' Note KS & SCORE and insert actual score	llosur n Card	//		
	□ Bottle Type □ Nipple Type □ See Nurses' Notes FEEDING □ N/A □ See Nur □ Continuous □ Bolus	☐ Meal Plan ☐ Insitu: ☐ Length _ ☐ Tube pla. ☐ Straight dr rses' Notes ☐ Clamped ☐ Suction: ☐	Location Location Location Cement value va	☐ Type erified pH ☐ Intermittent suction ☐ Open barrel luous	Allergy Band on Bedside safety check Patient plan of care upda Falls Risk Assessment so Family orientation/ Education to area/Diagno	core	Mobility Activity Sensory perception Moisture Friction and sheat Nutrition Tissue perfusion Total Score	ır			
5	☐ Intermittent qh		_ milerm	IIIIGIII			1	_	=		

Time	Problem/Focus	Nursing Docume	entation	n Notes			
Signature	s						
Signature and initials							

CHILD: **HEALTH** BC

Patient identification

24 Hour Flowsheet **4 – 6 YEARS**

			Date Initials																								
		ı	Time																								_
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	- 1		P Size Right					\vdash																		\vdash	_
	- 1		P Leit					\vdash																	<u> </u>	\vdash	
	- 1		I B = Brisk Reaction Right L S = Sluggish																							\square	
	- 1		S F = Fixed Left					$oxed{oxed}$																	<u> </u>		
	- 1		Spontaneous 4																								
	- 1		E To speech 3																								ı
	- 1		Y To pain 2																								
	- 1		C = Closed None 1																								
	ı		Coos/Oriented 5							İ	Ì															\Box	_
	- 1		v E Irritable cry/Confused 4																								_
	- 1		R Cries to pain/Inapprepriate 2																							\Box	_
	- 1		Moans to pain/Incomprehensible 2					\vdash																		H	_
	Н	ca	None 1					\vdash																		H	_
	┥							\vdash																	-	\vdash	_
ı	-	0	Normal spontaneous/Obeys 6			-		\vdash																		\vdash	
ı	-	0	Withdraws to touch/Localized 5			-		\vdash								_										\vdash	_
l	-		O Withdraws to pain/Withdraws 4					\vdash		-	-														<u> </u>	\vdash	
l	-1		O Abnormal flexion 3 R					\vdash				_													<u> </u>	\vdash	
l	-		Abnormal extension 2																							\vdash	
ı	-	-	Flaccid 1																								
ŀ	اڃ	ļ	TOTAL SCORE GCS																								
١.	Spinal		Muscle Right Arm Strength																								
l,	윘		Refer to rating																								
	1		scale below Right Leg																								
	-1		Rate 0 – 5 Left Leg																								
	-1		Colour, Warmth, Right Arm																								
	_		& Sensation of Extremities Left Arm																								
	_		√ = Normal NN = Nurse's Right Leg																								
ı	_		Notes Left Leg																								
	-1		Bladder √ = Normal Function NN = Nurse's Notes																								
	_		Tunction TWV = TVUISC S TVOICS					_		_						_									=	=	_
			Time																								
Г		Pain	Tool: Pain Score																								
ı		(q4h 8 PRN)	Location of pain																								
ı			Arousal Score																								
İ			Sepsis Screen																								_
ı			Screen for sepsis if PEW	/S scor	re increa	ses by	/ 2. or	r tempe	rature	is > 38	°C or <	< 36.0°0	C. or cr	itical h	eart rat	te. (Ind	icate w	ith a ✔	and c	docume	nt find	inas ar	nd actio	ns in N	lurses'	Notes.)
ı	-	_	Time			Ť	,						Ĺ			Ė						T				Г	_
ı	-	Dogu	lar Enteral / Gastric tube			_		\vdash		_	_															\vdash	_
l								\vdash																		\vdash	_
			ks IV Site to Source (touch, look, and compare q1h)					\vdash		-	-	-	-	-	-	 			-	<u> </u>						\vdash	_
ı			Patient Safety Check q1h					_																			
	(I)		PRAM Score (asthma patients only)							<u> </u>	<u> </u>					<u> </u>				L						\square	_
ļ	Care		Phototherapy / Eye shields																								
ŀ	اڌ		Incubator Temperature																								
ı																											
ı		Rout	ine Repositioning qh																								
		Nurs	i ng Ambulation																								
ı		Care	Foley care / Pericare																								_
			Shower (S) / Bath (B)		\vdash	\neg																				\vdash	_
l			Mouth care					\vdash																		H	_
l		Ovi						\vdash								-				-						\vdash	_
		UXI	meter site probe change q4h			-				-	-					-				-						\vdash	
			Family presence		\vdash	_		-		-	-		_	_		<u> </u>				-		-				\vdash	_
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																										Ш	
Γ			PUPIL SIZE (mm)					MU	JSCLE	STRE	NGTH	GRAD	ING SY	STEM						LEV	EL OF	AROU	SAL SC	ORE			
ľ			_				/5	No move	ement		3/5	Moveme	ent over	coming	gravity,					2		3		4		5	
						\vdash						but not a Moveme				-	Awake	e T	Normal	sleep,	Diffic		Respo	nds onl	y Does	s not res	pond
1 2 3 4 5 6 7 8						Trace mo			4/5	and som	ne resist	ance	gravily		and a orient	ed	easy to to verba	al	to ar	erbal	to phy stimul	ation		erbal or p Iulation	nySI(
				2	2/5	Moveme (not agai	nt only	vitv	5/5	Normal	strength	agains	t resista	ınce			stimulat			ulation			\perp				

CIWA-Ar Clinical Institute Withdrawal Assessment for Alcohol

Centimeter(s)

COWS Clinical Opiate Withdrawal Scale

Continuous Positive Airway Pressure L Left

Patient identification

24 Hour Flowsheet 4 - 6 YEARS

	ulated Maint													1											
Date Time																									-
	-										1														
						1					1														
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Cun	nulative Total IN																								
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									\angle	\angle			\angle				\angle								
Br (docur	istol Stool Score nent in NN if abnormal)																								
Cum	ulative Total OUT																								
Total Fluids Urine Output					mL/kg/hr mL/kg/hr 12 hour balance				Total Fluids Urine Output				mL/kg/hr 12 hour balance												
TR	AVENOUS IN	ITIAT	TION		Othe	r Line	Pres	sent													our ba				
Tim			ion Site		$\overline{}$	Catheter Size # of Attempts					Signature						Previous 24 hour balance								
															ADMISSION WEIGHT						kį				
																		PREV	IOUS	24 HO	UR WE	IGHT			k
																			Т	ODAY	'S WE	IGHT			k
er	Measuremer	nts (For exa	ample:	: heigh	nt, abdo	ominal	girth, l	nead c	ircum	ferenc	e, phot	tomete	er, pea	kflows)									
												РМ													
										Al	BREV	IATIO	NS												
o	Bi-level Positive A	Airway P	ressure		EVD	Externa	ıl Ventric	ular Drair	ı LLL		BBREV		NS mL	Mil	liliters		NN	N	urses' N	lotes	RLO	Q Rigl	nt Lowe	r Quadra	nt

LUL Left Upper Lobe

M Mask

MAP Mean Arterial Pressure

LUQ Left Upper Quadrant NA Not Applicable

NG Nasogastric

NJ Nasojejunal

Jejunostomy tube

kg Kilograms

Date: _	
	ILD:XX ALTH BC

RUQ Right Upper Quadrant

Y Yes

Right Lower Lobe VAC Vacuum Assisted Closure

Right

Room Air

24 Hour Flowsheet

4 –	6 YEARS	

	Strike a line through any assessmen	t data to indicate that it does no	ot apply o	er has not been assessed. Che	eck boxes 🗹 to indicate as	sessment	t findings.					
Г	RESPIF	RATORY			CARDIOVASC	ULAR						
	Resp. even and unlaboured Respiratory distress: Mild Moderate Severe Nasal flaring Tracheal tug Head bobbing Indrawing: Intercostal Subcostal Substernal Abdominal breathing Suprasternal retractions See Nurses' Notes BREATH SOUNDS	AIR ENTRY □ Equal to bases □ Decreased to: □ RUL □ RML □ RLL □ LUL □ Throu □ See Nurses' Notes CHEST MOVEMENT □ Equal and adequate □ See Nurses' Notes CHEST DRAINAGE DEVICE II □ Insitu: □ Chest tube		CENTRAL COLOUR Pink	Warm to: Extremities	Right rad Left fem P tibiali Right fe P tibiali		Normal				
	Clear to bases	Blake drain			INTEGUME	NT						
	☐ Crackles: ☐ 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 ☐ See Nurses' Notes	□ LUL □ LLL □ cm H₂0 s □ Underwater seal Drainage is: □ Sanguinous □ S □ Serosanguinous □ Chylous Air leak: □ Yes □ No □ See Nurses' Notes	suction Serous	See nurses notes	MUCOUS MEMBRANE Pink Intact Painful Droo Stomatitis/Mucositi See Nurses' Notes PRESSINGS Site: Dry and intact VAC continuous/int at See Nurses' Notes	S Lesions ling s Grade N/A ermittent mm Hg	None Fresh Sanguinous E Serosanguinou Purulent See Nurses' N DRAIN Insitu Type	otes /A	ld erou			
	GASTROINTESTINAL ABDOMEN Flat	BLADDER Self-voiding Diaper: Size Intermittent Continuous See Nurses' Notes URINE Concentrated COLOUR Clear Clear Clear Vellow Mematuria: Moderate Marked See Nurses' Notes REPRODUCTIVE N/A Menses at present See Nurses' Notes	GAIT Ste. Not Whith Amm See DEVICE Trail Bra See Cor Dro Dro Airt Airb N/A TONE	t observed eelchair	HYDRATION Central edema:	S AT es IN IN INI INI CHEC with a	PSYCHOSOG SAFETY RISK TO SELF/OTH Suicidal Homicidal ideation Plan: Elopement risk BSTANCE USE Substance intoxica Withdrawal TERVENTIONS Restraints: Siderails Enc Violence Prevention insitu (safety check) See Nurses' Note KS & SCORE and insert actual score	ters attion/ closur n Care	/ re b e PI			
L	☐ See Nurses' Notes		L Dec	creased/hypotonic	Allergy Band on		Mobility					
				□ 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	core	Activity Sensory percepti Moisture Friction and shea Nutrition Tissue perfusion	ır				
	☐ Continuous ☐ Bolus ☐ Intermittent q h	☐ Suction: ☐	□ Contin □ Interm		I I I I I I I I I I I I I I I I I I I		Total Score					

Patient identification