Date: ____________

# CHILD HEALTH BC

## 24 Hour Flowsheet 7 – 11 YEARS

Patient identification

| Time | Initials |
|---|---|
| | |

*Strike a line through any assessment data to indicate that it does not apply or has not been assessed. Check boxes ☑ to indicate assessment findings.*

### RESPIRATORY

- ☐ 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**
- ☐ Clear to bases
- ☐ 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

**AIR ENTRY**
- ☐ Equal to bases
- ☐ Decreased to: ☐ RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL ☐ Throughout
- ☐ See Nurses' Notes

**CHEST MOVEMENT**
- ☐ Equal and adequate
- ☐ See Nurses' Notes

**CHEST DRAINAGE DEVICE** ☐ N/A
- ☐ Insitu: ☐ Chest tube ________ ☐ Blake drain ________ ☐ Pigtail ________
- Site: ☐ Mediastinal ☐ RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL
- ☐ ________ cm $H_2O$ suction
- ☐ Underwater seal
- Drainage is: ☐ Sanguinous ☐ Serous ☐ Serosanguinous ☐ Chylous
- Air leak: ☐ Yes ☐ No
- ☐ See Nurses' Notes

### CARDIOVASCULAR

**CENTRAL COLOUR**
- ☐ Pink ☐ Pale ☐ Mottled ☐ Flushed ☐ Jaundiced ☐ ________
- ☐ See Nurses' Notes

**PERIPHERAL COLOUR**
- ☐ Pink ☐ Pale ☐ Mottled ☐ Flushed ☐ Jaundiced ☐ ________
- ☐ See Nurses' Notes

**APICAL PULSE**
- ☐ Regular ☐ Irregular ☐ Murmur ☐ ________
- ☐ See Nurses' Notes

**PERIPHERAL TEMPERATURE**
- Warm to: ☐ Extremities ☐ ________
- ☐ See Nurses' Notes

| PERIPHERAL PULSES | Normal | Nurses' Notes |
|---|---|---|
| Left radial / ulnar / brachial | | |
| Right radial / ulnar / brachial | | |
| Left femoral / D pedis / P tibialis / popliteal | | |
| Right femoral / D pedis / P tibialis / popliteal | | |

☐ See Neurovascular assessment record

### INTEGUMENT

- ☐ Skin clear ☐ Bruising ☐ Petechiae ☐ Rash
- Location ________
- ☐ See Nurses' Notes

**UMBILICUS** ☐ N/A
- ☐ Clean ☐ Drying

**PHOTOTHERAPY** ☐ N/A
- Start date ________
- End date ________
- Type ________
- Irradiance ________
- ☐ See Nurses' Notes

**MUCOUS MEMBRANES**
- ☐ Pink ☐ Intact ☐ Lesions ☐ Painful ☐ Drooling
- ☐ Stomatitis/Mucositis Grade ________
- ☐ See Nurses' Notes

**DRESSINGS** ☐ N/A
- Site: ________
- ☐ Dry and intact
- ☐ VAC continuous/intermittent at ________ mm Hg
- ☐ See Nurses' Notes

**DRAINAGE** ☐ N/A
- ☐ None ☐ Fresh ☐ Old ☐ Sanguinous ☐ Serous ☐ Serosanguinous ☐ Purulent
- ☐ See Nurses' Notes

**DRAIN** ☐ N/A
- ☐ Insitu ☐ Location ________ ☐ Type ________

### GASTROINTESTINAL

**ABDOMEN**
- ☐ Flat ☐ Rounded ☐ Soft ☐ Firm ☐ Distended ☐ Shiny
- ☐ Tenderness: ☐ RUQ ☐ LUQ ☐ RLQ ☐ LLQ
- ☐ Guarding
- ☐ See Nurses' Notes

**BOWELS**
- ☐ Last BM ________
- ☐ See stool chart
- ☐ Ostomy site ________
- Drainage: ☐ Yes ☐ No
- ☐ See Nurses' Notes

**BOWEL SOUNDS**
- ☐ Present: ☐ Hyper ☐ Hypo
- ☐ Absent ☐ Throughout
- Location of bowel sounds: ☐ RUQ ☐ LUQ ☐ RLQ ☐ LLQ
- ☐ See Nurses' Notes

### GENITOURINARY

**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

### MUSCULOSKELETAL

**GAIT** ☐ N/A
- ☐ Steady ☐ Unsteady ☐ Not observed ☐ Wheelchair ☐ Bedfast ☐ Ambulatory/walker
- ☐ See Nurses' Notes

**DEVICES** ☐ N/A
- ☐ Traction ☐ Splint ☐ Cast ☐ Brace ☐ ________
- ☐ See Nurses' Notes

### ISOLATION

- ☐ Contact ☐ Contact plus ☐ Droplet ☐ Droplet and contact ☐ Airborne ☐ Airborne and contact ☐ N/A
- ☐ See Nurses' Notes

### NEUROLOGICAL

**TONE** ☐ N/A ☐ Nurses' Notes
- ☐ Increased/hypertonic
- ☐ Decreased/hypotonic

### HYDRATION

- Central edema: ☐ Yes ☐ No
- Peripheral edema: ☐ Yes ☐ No
- Skin turgor: ☐ Elastic ☐ Poor
- Skin: ☐ Dry ☐ Diaphoretic
- Mucous membranes: ☐ Moist ☐ Dry
- ☐ See Nurses' Notes

**FONTANELLES** ☐ N/A
- ☐ Closed ☐ Soft/Flat ☐ Depressed ☐ Full ☐ Bulging

### PSYCHOSOCIAL / SAFETY

**AT RISK TO SELF/OTHERS**
- ☐ Suicidal ☐ Homicidal ideation
- ☐ Plan: ________
- ☐ Elopement risk

**SUBSTANCE USE**
- ☐ Substance intoxication/ Withdrawal

**INTERVENTIONS**
- ☐ Restraints: ☐ Siderails ☐ Enclosure bed
- ☐ Violence Prevention Care Plan insitu
- ☐ ________ (safety check)
- ☐ See Nurses' Notes

### NUTRITION

- ☐ Oral ad lib ☐ Breastfeeding ☐ NPO ☐ Nausea ☐ Vomiting ☐ Meal Plan
- ☐ Bottle Type ________
- ☐ Nipple Type ________
- ☐ See Nurses' Notes

**FEEDING** ☐ N/A ☐ See Nurses' Notes
- ☐ Continuous ☐ Bolus
- ☐ Intermittent q________h

**GASTRIC TUBE** ☐ N/A ☐ See Nurses' Notes
- ☐ Insitu: ☐ Location ________ ☐ Length ________ ☐ Type ________
- ☐ Tube placement verified pH ________
- ☐ Straight drainage ☐ Intermittent suction
- ☐ Clamped ☐ Open barrel
- ☐ Suction: ☐ Continuous ☐ Intermittent

### QUALITY CHECKS & SCORES

Indicate completed check with a ✓ and insert actual score into box

| | | Braden Q Score | |
|---|---|---|---|
| Alarms on and reviewed | | | |
| Identification Band on | | | |
| Allergy Band on | | Mobility | |
| Bedside safety check | | Activity | |
| Patient plan of care updated | | Sensory perception | |
| Falls Risk Assessment score | | Moisture | |
| Family orientation/ Education to area/Diagnosis | | Friction and shear | |
| | | Nutrition | |
| Mental Health Plan | | Tissue perfusion | |
| | | Total Score | |



Date: ____________

# CHILD HEALTH BC

## 24 Hour Flowsheet 7 – 11 YEARS

Patient identification

| Time | Problem/Focus | Nursing Documentation Notes |
|---|---|---|
| | | |

| Signatures and initials | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |



Date: ____________

# CHILD HEALTH BC

## 24 Hour Flowsheet 7 – 11 YEARS

Patient identification

PEWS Scoring Legend: 0 | 1 | 2 | 3

- Date / Initials
- Time

**Respiratory**
- Respiratory Rate (1 minute) — 50, 40, 30, 20 — Resp: •
- $O_2$ Saturation (%)
- Supplemental $O_2$ Concentration Delivered — <3L or 30%; ≥3L or 30%; ≥6L or 40%; ≥6L or 40%
- Mode of Delivery
- Respiratory Distress — None; Mild; Moderate; Severe
- PEWS Score for Respiratory (record highest score)

**Cardiovascular**
- Heart Rate (1 minute) & Blood Pressure — Systolic: ∨ Diastolic: ∧ — (Do not score blood pressure) — Normal Parameters: Systolic (mmHg): 96 – 121; Diastolic (mmHg): 57 – 80 — Apex: • Monitor: * — 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50
- If heart rate is critical – PEWS score of 3, screen for sepsis
- MAP
- Capillary Refill Time — 1 – 2 seconds; 3 seconds; 4 seconds; ≥ 5 seconds
- Skin Colour — Pink; Pale; Grey/Cyanotic; Grey & Mottled
- PEWS Score for Cardiovascular (record highest score)

**Behaviour**
- Playing/Appropriate; Sleeping; Irritable; Lethargic/Confused; Reduced response to pain
- PEWS Score for Behaviour (record highest score)

- Persistent vomiting following surgery
- Bronchodilator every 20 minutes

**PEWS**
- Total PEWS Score (R + C + B + vomiting + bronchodilator)

**Situational Awareness Factors**
- Patient/Family/Caregiver concern; Unusual therapy; Watcher patient; Communication breakdown; PEWS Score ≥2

- PEWS Escalation Process Activated (time) See NN

**Temperature °C**
- • A – Axilla, R – Rectal, O – Oral, T – Temporal, E – Esophageal — 40, 39, 38, 37, 36
- If temperature is less than 36°C or above 38°C, screen for sepsis
- Source of Temperature

**Pediatric Early Warning System (PEWS) Escalation Aid**

| Score | Action |
|---|---|
| Score 0 – 1 | Continue to monitor and document as per orders and routine protocols. |
| Score 2 or any one of 5 Situational Awareness Factors | Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols. |
| Score 3 | Increase frequency of assessments and documentation as per plan from consultation. |
| Score 4 and/or score increases by 2 after interventions | Notify MRP/delegate. Consider 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 internal or external transfer to higher level of care. |

Revised 09 2019

Date: ______________

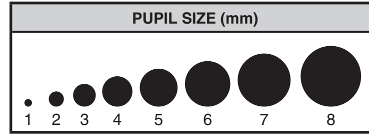
# 24 Hour Flowsheet
## 7 – 11 YEARS

Patient identification

| Date Initials | |
|---|---|
| Time | |
| **Neurological** — PUPILS — Size: Right | |
| Size: Left | |
| Reaction (B = Brisk, S = Sluggish, F = Fixed): Right | |
| Reaction: Left | |
| EYE — Spontaneous 4 | |
| To speech 3 | |
| To pain 2 | |
| C = Closed — None 1 | |
| VERBAL — Coos/Oriented 5 | |
| Irritable cry/Confused 4 | |
| Cries to pain/Inappropriate 3 | |
| Moans to pain/Incomprehensible 2 | |
| None 1 | |
| MOTOR — Normal spontaneous/Obeys 6 | |
| Withdraws to touch/Localized 5 | |
| Withdraws to pain/Withdraws 4 | |
| Abnormal flexion 3 | |
| Abnormal extension 2 | |
| Flaccid 1 | |
| TOTAL SCORE GCS | |
| **Spinal** — Muscle Strength (Refer to rating scale below, Rate 0 – 5): Right Arm | |
| Left Arm | |
| Right Leg | |
| Left Leg | |
| Colour, Warmth, & Sensation of Extremities (√ = Normal, NN = Nurse's Notes): Right Arm | |
| Left Arm | |
| Right Leg | |
| Left Leg | |
| Bladder Function (√ = Normal, NN = Nurse's Notes) | |

| **Care** | |
|---|---|
| Time | |
| Pain (q4h & PRN) Tool: ________ Pain Score | |
| Location of pain | |
| Arousal Score | |
| Sepsis Screen | |
| Screen for sepsis if PEWS score increases by 2, or temperature is > 38°C or < 36.0°C, or critical heart rate. (Indicate with a ✓ and document findings and actions in Nurses' Notes.) | |
| Time | |
| Regular Checks — Enteral / Gastric tube | |
| IV Site to Source (touch, look, and compare q1h) | |
| Patient Safety Check q1h | |
| PRAM Score (asthma patients only) | |
| Phototherapy / Eye shields | |
| Incubator Temperature | |
| Routine Nursing Care — Repositioning q____h | |
| Ambulation | |
| Foley care / Pericare | |
| Shower (S) / Bath (B) | |
| Mouth care | |
| Oximeter site probe change q4h | |
| Family presence | |

**PUPIL SIZE (mm)**




| MUSCLE STRENGTH GRADING SYSTEM | | | |
|---|---|---|---|
| 0/5 | No movement | 3/5 | Movement overcoming gravity, but not against resistance |
| 1/5 | Trace movement | 4/5 | Movement overcoming gravity and some resistance |
| 2/5 | Movement only (not against gravity) | 5/5 | Normal strength against resistance |

| LEVEL OF AROUSAL SCORE | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| Awake and alert, oriented | Normal sleep, easy to arouse to verbal stimulation | Difficult to arouse to verbal stimulation | Responds only to physical stimulation | Does not respond to verbal or physical stimulation |



Date: ______________

# 24 Hour Flowsheet
## 7 – 11 YEARS

Patient identification

Calculated Maintenance Fluids _______ mL/kg/hr

| Date Initials | |
|---|---|
| Time | |
| **Intake** | |
| Cumulative Total IN | |
| **Output** | |
| Bristol Stool Score (document in NN if abnormal) | |
| Cumulative Total OUT | |

| | | | |
|---|---|---|---|
| Total Fluids ________ mL/kg/hr<br>Urine Output ________ mL/kg/hr | 12 hour balance | Total Fluids ________ mL/kg/hr<br>Urine Output ________ mL/kg/hr | 12 hour balance |
| | | 24 hour balance | |
| | | Previous 24 hour balance | |

**INTRAVENOUS INITIATION** ☐ Other Line Present

| Time | Insertion Site | Catheter Size | # of Attempts | Signature |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| | |
|---|---|
| ADMISSION WEIGHT | kg |
| PREVIOUS 24 HOUR WEIGHT | kg |
| TODAY'S WEIGHT | kg |

**Other Measurements** (For example: height, abdominal girth, head circumference, photometer, peakflows)

| AM | PM |
|---|---|
| | |
| | |
| | |

**ABBREVIATIONS**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BiPAP | Bi-level Positive Airway Pressure | EVD | External Ventricular Drain | LLL | Lower Left Lobe | mL | Milliliters | NN | Nurses' Notes | RLQ | Right Lower Quadrant |
| °C | Degrees Celsius | GT | Gastrostomy Tube | LLQ | Lower Left Quadrant | MRP | Most Responsible Practitioner | NP | Nasal Prongs | RML | Right Middle Lobe |
| CIWA-Ar | Clinical Institute Withdrawal Assessment for Alcohol | HHHF | Heated Humidified High Flow | LUL | Left Upper Lobe | N | No | q ___ h | Every ____ hours | RUL | Right Upper Lobe |
| cm | Centimeter(s) | JT | Jejunostomy tube | LUQ | Left Upper Quadrant | NA | Not Applicable | R | Right | RUQ | Right Upper Quadrant |
| COWS | Clinical Opiate Withdrawal Scale | kg | Kilograms | M | Mask | NG | Nasogastric | RA | Room Air | Y | Yes |
| CPAP | Continuous Positive Airway Pressure | L | Left | MAP | Mean Arterial Pressure | NJ | Nasojejunal | RLL | Right Lower Lobe | VAC | Vacuum Assisted Closure |



Date: ______________

# 24 Hour Flowsheet
## 7 – 11 YEARS

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|---|---|
| | |

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- ☐ ________ cm $H_2O$ suction
- ☐ Underwater seal
- Drainage is: ☐ Sanguinous ☐ Serous ☐ Serosanguinous ☐ Chylous
- Air leak: ☐ Yes ☐ No
- ☐ See Nurses' Notes

### CARDIOVASCULAR

**CENTRAL COLOUR**
- ☐ Pink ☐ Pale
- ☐ Mottled ☐ Flushed
- ☐ Jaundiced
- ☐ ________
- ☐ See Nurses' Notes

**APICAL PULSE**
- ☐ Regular ☐ Irregular
- ☐ Murmur
- ☐ ________
- ☐ See Nurses' Notes

**PERIPHERAL COLOUR**
- ☐ Pink ☐ Pale
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☐ See Neurovascular assessment record

### INTEGUMENT

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- ☐ Petechiae ☐ Rash
- Location ________
- ☐ See Nurses' Notes

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- ☐ Clean ☐ Drying

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- Start date ________
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- Type ________
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- Site: ________
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**DRAINAGE** ☐ N/A
- ☐ None
- ☐ Fresh ☐ Old
- ☐ Sanguinous ☐ Serous
- ☐ Serosanguinous
- ☐ Purulent
- ☐ See Nurses' Notes

**DRAIN** ☐ N/A
- ☐ Insitu
  - ☐ Location ________
  - ☐ Type ________

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**ABDOMEN**
- ☐ Flat ☐ Rounded
- ☐ Soft ☐ Firm
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**BOWELS**
- ☐ Last BM ________
- ☐ See stool chart
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- ☐ Present: ☐ Hyper ☐ Hypo
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- ☐ Diaper: Size ________
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- ☐ ________
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- ☐ See Nurses' Notes

**REPRODUCTIVE** ☐ N/A
- ☐ Menses at present
- ☐ See Nurses' Notes

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**GAIT** ☐ N/A
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- ☐ Not observed
- ☐ Wheelchair ☐ Bedfast
- ☐ Ambulatory/walker
- ☐ See Nurses' Notes

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- ☐ Traction ☐ Splint ☐ Cast
- ☐ Brace ☐ ________
- ☐ See Nurses' Notes

### ISOLATION

- ☐ Contact ☐ Contact plus
- ☐ Droplet
- ☐ Droplet and contact
- ☐ Airborne
- ☐ Airborne and contact
- ☐ N/A ☐ See Nurses' Notes

### NEUROLOGICAL

**TONE** ☐ N/A ☐ Nurses' Notes
- ☐ Increased/hypertonic
- ☐ Decreased/hypotonic

### HYDRATION

- Central edema: ☐ Yes ☐ No
- Peripheral edema: ☐ Yes ☐ No
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- ☐ Full ☐ Bulging

### PSYCHOSOCIAL / SAFETY

**AT RISK TO SELF/OTHERS**
- ☐ Suicidal
- ☐ Homicidal ideation
- ☐ Plan: ________
- ☐ Elopement risk

**SUBSTANCE USE**
- ☐ Substance intoxication/ Withdrawal

**INTERVENTIONS**
- ☐ Restraints: ☐ Siderails ☐ Enclosure bed ☐ Violence Prevention Care Plan insitu
- ☐ ________ (safety check)
- ☐ See Nurses' Notes

### NUTRITION

- ☐ Oral ad lib ☐ Breastfeeding ☐ NPO
- ☐ Nausea ☐ Vomiting ☐ Meal Plan
- ☐ Bottle Type ________
- ☐ Nipple Type ________
- ☐ See Nurses' Notes

**FEEDING** ☐ N/A ☐ See Nurses' Notes
- ☐ Continuous ☐ Bolus
- ☐ Intermittent q________h

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- ☐ Insitu: ☐ Location ________
  - ☐ Length ________ ☐ Type ________
  - ☐ Tube placement verified pH ________
- ☐ Straight drainage ☐ Intermittent suction
- ☐ Clamped ☐ Open barrel
- ☐ Suction: ☐ Continuous ☐ Intermittent

### QUALITY CHECKS & SCORES

Indicate completed check with a ✓ and insert actual score into box

| | | Braden Q Score | |
|---|---|---|---|
| Alarms on and reviewed | | | |
| Identification Band on | | | |
| Allergy Band on | | Mobility | |
| Bedside safety check | | Activity | |
| Patient plan of care updated | | Sensory perception | |
| Falls Risk Assessment score | | Moisture | |
| Family orientation/ Education to area/Diagnosis | | Friction and shear | |
| | | Nutrition | |
| Mental Health Plan | | Tissue perfusion | |
| | | Total Score | |