Date: ______________

CHILD HEALTH BC

24 Hour Flowsheet
1 – 3 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

APICAL PULSE
- ☐ Regular ☐ Irregular
- ☐ Murmur
- ☐ ______
- ☐ See Nurses' Notes

PERIPHERAL COLOUR
- ☐ Pink ☐ Pale
- ☐ Mottled ☐ Flushed
- ☐ Jaundiced
- ☐ ______
- ☐ 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

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	

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

Date: ______________

CHILD HEALTH BC

24 Hour Flowsheet
1 – 3 YEARS

Patient identification

Time	Problem/Focus	Nursing Documentation Notes

Signatures and initials						

Date: ______________

CHILD HEALTH BC

24 Hour Flowsheet
1 – 3 YEARS

Patient identification

PEWS Scoring Legend: 0 | 1 | 2 | 3

Date		Initials																					
		Time																					
Respiratory	Respiratory Rate (1 minute) Resp: •	70																					70
		60																					60
		50																					50
		40																					40
		30																					30
		20																					20
		O_2 Saturation (%)																					
	Supplemental O_2 Concentration Delivered	<3L or 30%																					
		≥3L or 30%																					
		≥6L or 40%																					
		≥8L or 50%																					
		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): 85 – 109 Diastolic (mmHg): 37 – 67 Apex: • Monitor: * If heart rate is critical – PEWS score of 3, screen for sepsis	190																					190
		180																					180
		170																					170
		160																					160
		150																					150
		140																					140
		130																					130
		120																					120
		110																					110
		100																					100
		90																					90
		80																					80
		70																					70
		60																					60
		50																					50
		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 If temperature is less than 36°C or above 38°C, screen for sepsis	40																					40
		39																					39
		38																					38
		37																					37
		36																					36
		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 11 2020

Date: _____

CHILD HEALTH BC

24 Hour Flowsheet
1 – 3 YEARS

Patient identification

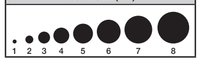
Neurological

Date / Initials																								
Time																								
Spinal	**PUPILS**	Size	Right																					
			Left																					
		Reaction (B = Brisk, S = Sluggish, F = Fixed)	Right																					
			Left																					
	EYE	Spontaneous	4																					
		To speech	3																					
		To pain	2																					
		None (C = Closed)	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																							
	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: _____

CHILD HEALTH BC

24 Hour Flowsheet
1 – 3 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 Urine Output _____ mL/kg/hr																								
12 hour balance																								
Total Fluids _____ mL/kg/hr 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: _____

CHILD HEALTH BC

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1 – 3 YEARS

Patient identification

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☐ Subcostal ☐ Substernal
☐ Abdominal breathing
☐ Suprasternal retractions
☐ See Nurses' Notes

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☐ Clear to bases
☐ Crackles:
☐ RUL ☐ RML ☐ RLL
☐ LUL ☐ LLL ☐ Throughout
☐ Wheezes: ☐ Inspiratory ☐ Expiratory
☐ Location:
☐ RUL ☐ RML ☐ RLL
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☐ 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
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☐ _____
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APICAL PULSE
☐ Regular ☐ Irregular
☐ Murmur
☐ _____
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Warm to: ☐ Extremities
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☐ 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

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Site: _____
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☐ Fresh ☐ Old
☐ Sanguinous ☐ Serous
☐ Serosanguinous
☐ Purulent
☐ See Nurses' Notes

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☐ Location _____
☐ Type _____

GASTROINTESTINAL

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☐ 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

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☐ Diaper: Size _____
☐ Catheter: Size _____
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☐ Amber ☐ Yellow
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☐ Traction ☐ Splint ☐ Cast
☐ Brace ☐ _____
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☐ Droplet
☐ Droplet and contact
☐ Airborne
☐ Airborne and contact
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NEUROLOGICAL

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☐ Decreased/hypotonic

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Peripheral edema: ☐ Yes ☐ No
Skin turgor: ☐ Elastic ☐ Poor
Skin: ☐ Dry ☐ Diaphoretic
Mucous membranes:
☐ Moist ☐ Dry
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PSYCHOSOCIAL / SAFETY

AT RISK TO SELF/OTHERS
☐ Suicidal
☐ Homicidal ideation
☐ Plan: _____
☐ Elopement risk

SUBSTANCE USE
☐ Substance intoxication/ Withdrawal

INTERVENTIONS
☐ Restraints:
☐ Sideralls ☐ 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		Mobility	
Allergy Band on		Activity	
Bedside safety check		Sensory perception	
Patient plan of care updated		Moisture	
Falls Risk Assessment score		Friction and shear	
Family orientation/ Education to area/Diagnosis		Nutrition	
Mental Health Plan		Tissue perfusion	
		Total Score	