



# Paediatric Observation Priority Score (POPS)

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AGE	SCORE	2	1	0	1	2
ANY	OXYGEN	< 90 on air	90 - 94 on air	95 > on air	90 - 94 on air	< 90 on air
ANY	BREATHING	Stridor / grunting	Audible wheeze	No distress	Accessory use / mild recession	Tracheal tug / severe recession
ANY	AVPU	Lethargic / confused	Responds to voice / sleepy	Alert	responds to voice / sleepy	Responds to pain
ANY	GUT FEELING	High level of concern/pale/ mottled	Low level concern	Well	Low level concern	High level of concern/pale/ mottled
Any	OTHER	Oncology Patient	Diabetic / first time seizure / Afebrile seizure	None	Ex- prem / less than 1 month old / known syndromes	Congenital heart disease / apnoea
0-1	PULSE	<90	90 - 109	110 - 160	161 - 180	180+
	RESPS	<25	25 - 29	30 - 40	41 - 50	50+
	TEMP	<35	35 - 35.9	36 - 37.5	37.6 - 39	39+
1-2	PULSE	<90	90 - 99	100 - 150	151 - 170	170+
	RESPS	<20	20 - 24	25 - 35	36 - 50	50+
	TEMP	<35	35 - 35.9	36 - 38.4	38.5 - 40+	40+
2-5	PULSE	<80	80 - 94	95 - 140	141 - 160	160+
	RESPS	<20	20 - 24	25 - 30	31 - 40	40+
	TEMP	<35	35 - 35.9	36 - 38.4	38.5 - 40	40+
5-12	PULSE	<70	70 - 79	80 - 120	121 - 150	150+
	RESPS	<15	15 - 19	20 - 25	26 - 40	40+
	TEMP	<35	35 - 35.9	36 - 38.4	38.5 - 40	40+
12->	PULSE	<50	50 - 60	60 - 100	101 - 120	130 +
	RESPS	<12	12 - 14	15-20	21- 26	26+
	TEMP	<35	35 - 35.9	36 - 38.4	38.5 - 40	40+

**POPS 0-1:** Is this child suitable for primary care?


**POPS 1-3:** Children must have a set of discharged observations performed.


**POPS 3 >** Inform senior doctor that patient is in dept.


**POPS 4-6:** Child must have repeat sets of observations every hour. Implement observation chart. Inform senior doctor.


**POPS 7>** Transfer child to resus for review by senior doctor.


## POPS is...


 A physiological and observational scoring system designed for use by Healthcare professionals of varying clinical experience.

 A checklist which quickly scores (between 0-16yrs) acutely ill children on a combination of physiological, behavioural and risk identifiers using easy to collect data.







 A visual aid which enables frontline staff to assess, identify, prioritise and treat acutely ill children and communicate the potential severity of illness.

 To reassure nurses not trained in Paediatric Care to be more confident in their abilities to assess children.

 To confidently identify children who are well and are safe for discharge or transfer to primary care.

 Will enhance and improve departmental communications and working relations.

## How POPS is used...

-  POPS system is an integral part of the triage and assessment process.
-  All children who present to ED except minor peripheral limb injuries will require clinical observations and must have a POPS Score calculated and recorded on the triage form.
-  Follow escalation pathway for the total POPS score recorded.
-  POPS is repeated according to pathway.
-  All actions relating to POPS score to be recorded in nursing documentation.
-  A repeat POPS score should be calculated prior to transfer to the ward or discharge and reported to assessing clinician.