To: **Telehealth Nurses Using Pediatric Telehealth Triage Guidelines: After-Hours**

From: Bart Schmitt, MD, FAAP
Sam Wang, MD, FAAP
Kelli Massaro, RN
Lisa Swerczek, RN

Contact email: pediatriceditorialteam@stcc-triage.com

Date: April 7, 2025

Re: **2025 Major Changes in the Pediatric Clinical Content: A Self-Study Guide for Nurses**

Yearly updates and new topics bring with them the responsibility to read and study the major changes in advance of implementation. Trying to learn new material while managing an actual call can be difficult. We hope this summary of changes will serve as a self-study guide, direct your reading and help you transition to the 2025 pediatric clinical content.

New Pediatric Guidelines

The 2025 version contains 380 guidelines. The 2025 update contains 16 new guidelines and 364 updated guidelines.

Read, or at least scan, all ***New*** **Pediatric Guidelines** listed below:

- Anorexia Nervosa
- Blood Pressure - High
- Child Neglect Suspected
- Contraception – Transdermal Patch
- Contraception – Vaginal Ring
- Coughing Up Blood
- Flank Pain
- Hallucinogenic Mushroom Use or Problems
- Hand Injury
- Medication Refill and Renewal
- Molluscum Contagiosum
- Mpox (Monkeypox) – Diagnosed or Suspected
- Mpox (Monkeypox) – Exposure
- Obesity or Overweight
- Tattoo Symptoms and Questions
- Weight Loss – Unintended

Title Changes to Existing Pediatric Guidelines

There are 5 existing guidelines that we have made minor changes to the title:

2025 Title	2024 Title
Avian Influenza (Bird Flu) Exposure	Avian Influenza Exposure
Bruises Not From Injury	Bruises
Eating Problems of Childhood	Eating Problems
Leg Swelling or Edema	Leg or Foot Swelling
Spells of Unknown Cause	Spells

See More Appropriate Guideline (SMAG) Prompts

- Updated with title changes as above.
- Added SMAGs for our new guidelines where appropriate.

New References

- Every year, new references from the pediatric literature are reviewed and incorporated into the clinical content. A new reference list is contained in the Supplemental Information folder.

New Search (Key) Words

- Every year, new search words are added to existing guidelines based upon repeated search testing.
- *Pediatric Specialty Clinics:* Last year, we added a unique search word for each specific specialty clinic for applicable topics. These unique search words link to the AH guidelines that those specialty clinics are most likely to use.
- If you are uncertain which guideline is best for your patient, please enter a search word. The keyword search system has become very selective and should meet your needs.
- Do not use the "No Guideline Available" guideline without first trying at least two search words.

Indexes for Pediatric Guidelines

There are 4 general indexes for the guidelines. In addition, there is also a Behavioral Health index that specifically lists pediatric behavioral/mental health guidelines. There is also an Infant (Baby) Index that lists topics for the first year of life. A Specialty Clinic Index may be helpful that lists the guidelines most commonly used by 23 specialty clinics in a children's hospital setting.

Indexes are contained in the Supplemental Information folder. Reviewing them may help you improve your guideline selection skills.

- Alphabetical Index
- Anatomical Index
- Behavioral Health Index (46 topics)
- Infant (Baby) Index (39 topics)

- Specialty Clinic Index
- System Index
- Type Index

Pediatric Care Advice (PCA) Handouts for Parent Education

- PCAs are handouts that cover the Care Advice that callers need to know about specific symptoms or common diseases.
- They are written at a 6th grade or lower health literacy level.
- Almost all after-hours triage guidelines have one or more matching PCA(s).
- They are completely compatible with the care advice in the triage guidelines.
- You can send the PCA to the caller at the end of your call.
- This process should reduce your call times. Reason: You can address the most pertinent Care Advice live and provide non-essential information via the PCA.
- Even more important, they help the caller with normal memory limitations and prevent repeat calls about forgotten advice.
- Ask your software vendor for information on how to access these PCAs.
- The existing PCA handouts will be updated for 2025 to match changes in the After Hours guidelines. These will be released in July of 2025. There will be at least 60 new ones. The Cough, Diarrhea and Vomiting topics all have separate handouts for 3 age groups: infants, age 1-5 and age 6-21.

Universal Changes

First Aid for Anaphylaxis:

An intranasal epinephrine product (neffy) was FDA approved in the fall of 2024. We have added Intranasal Epinephrine (neffy) to *First Aid advice* in all applicable allergic guidelines:

Epinephrine Intranasal:

- Give one spray into one nostril.
- If needed, give a second (repeat) dose in the same nostril with a new nasal spray 5 minutes after the first dose.

Benadryl Medicine for 6-12 Months Care Advice

We have removed this recommendation to give one dose of Benadryl for widespread hives treatment in infants under 1 year. It is not the current standard of care. We have also removed this exception in the Benadryl Drug Dosage Table.

Fever Does Not Cause Tachypnea:

Based on a 2022 article, we have re-emphasized that fever does not cause increased respiratory rates. This paragraph below was put in many of our respiratory guidelines and replaced an older version.

Fever Does Not Cause Tachypnea (Increased Respiratory Rates)

- Tachypnea should not be attributed to fever.
- Tachypnea is caused by lung disease (such as pneumonia or bronchiolitis) until proven otherwise. It's often the earliest sign of mild respiratory distress and often hypoxia.
- In infants, significant nasal congestion can lead to tachypnea which can be resolved by suctioning. In young infants, obligate nasal breathing can be a factor.
- It can also be caused by metabolic acidosis, such as DKA.
- Evidence: In a cohort of over 235,000 pediatric patients presenting to emergency and urgent care, there was no association between elevated temperature and changes in respiratory rate.
- Reference: Heal C, Harvey A, Brown S, et al. The association between temperature, heart rate, and respiratory rate in children aged under 16 years attending urgent and emergency care settings. Eur J Emerg Med. 2022 Sep 6;29(6):413-416.

If you are interested in reading this article, here is the link: The association between temperature, heart rate, and respiratory rate in children aged under 16 years attending urgent and emergency care settings - PMC

Go to ED Now (or PCP triage)

We have changed this disposition to include UCC, so it now reads "**Go to ED/UCC Now (or PCP triage)**. The resources in UCCs varies. Therefore, we also changed the universal care advice to caution the triager when selecting the appropriate site as follows:

Go To ED/UCC Now (or PCP Triage):
• If No PCP (Primary Care Provider) Second-Level Triage: Your child needs to be seen within the next hour. Go to the ED/UCC at _____ Hospital. Leave as soon as you can. Caution: See Sources of Care below when considering where to send the patient.
• If PCP Second-Level Triage Required: Your child may need to be seen. Your doctor (or NP/PA) will want to talk with you to decide what's best. I'll page the on-call provider now. If you haven't heard from the provider (or me) within 30 minutes, go directly to the ED/UCC at _____ Hospital.
Note to Triager:
• Use nurse judgment to select the most appropriate source of care.
• Consider both the urgency of the patient's symptoms AND what resources may be needed to evaluate and manage the patient.
• Do not send these patients to Retail Clinics. Retail Clinics have limited services and are not able to manage these patients.
Sources of Care:
• ED: Patients who may need surgery, need hospitalization, sound seriously ill or may be unstable need to be sent to an ED. Likewise, so do most patients with complex medical problems and serious symptoms.
• UCC is Open: Some Urgent Care Centers (UCCs) can manage patients who are stable and have less serious symptoms (e.g., minor illnesses and injuries). The triager must know the UCC capabilities before sending a patient there. If unsure, call ahead.

• Office is Open: If patient sounds stable and not seriously ill, consult PCP (or follow your office policy) to see if patient can be seen NOW in office.

Dosage Tables (changed for the 2022 release)

As a reminder, we made the long-acting antihistamine drug dosage tables (Cetirizine, Loratadine, Fexofenadine) inactive in 2022. Reason: Pharmaceutical companies continue to change their product concentrations and dosing intervals, making these tables difficult to keep current. If you have access to the older tables, please DO NOT use these as we are no longer updating them.
Our recommendation: Tell callers to follow the package dosage instructions. They are based on age and drug concentration. Let us know if this causes any problems for your call center.

Guideline Specific Changes

Avian Influenza (Bird Flu) Exposure
Major changes. Guideline rewritten to expand exposure to animals (other than birds) and animal products. This includes dairy cows, stray cats, and unpasteurized milk products. Please review the redline version for details.

Bluish Skin
Added *Triage Questions, Care Advice and Background Information* for Raynaud's Phenomenon:

Raynaud's Phenomena

Older children with episodes of painful bluish or pale hands may have Raynaud's phenomena. If this condition is suspected, they need to be evaluated by their PCP during regular office hours. Because the condition is due to vasospasm, these patients need to avoid vasoconstrictors such as decongestants (found in some cough and cold medicines), nicotine (including passive smoking) and caffeine.

Also, added information on harmless circumoral cyanosis, a common cause of bluish skin around the mouth (but not involving the lips) in Home Care.

Cough
Added *care advice* regarding albuterol if parent has inhaler at home prescribed for the patient and wants to use it with delayed dispositions:

Albuterol Inhaler Previously Prescribed for Cough:

- Triager Tip: Discuss only if caller brings up
- Patient has previously been prescribed albuterol for cough.
- Caller would like to use it for current cough.
- Tell caller: it is safe to give albuterol. Use it only as directed.
- It may or may not help your child's cough.

- If you find it helpful, call your doctor during office hours. Ask them about continued use.
- If it is not helpful after using it for one day, stop giving it.

Earache

We have changed the *care advice* to only recommend a one-time dose of olive oil drops only for severe otalgia not responsive to acetaminophen or ibuprofen. *Background Information* added regarding the use of olive oil ear drops for severe ear pain as follows:

Efficacy of Olive Oil or Herbal Ear Drops
• The evidence for the benefit of olive oil or herbal ear drops is weak.
• Olive oil ear drops were used as a placebo to evaluate the efficacy of Auralgan in improving pain. Auralgan had better improvements in pain; olive oil also showed some reduction in pain scores. However, all patients were also given acetaminophen prior to treatment. (Hoberman 1997).
• Another paper found that in both topical anesthetics and herbal extract topical drops, pain improved over the course of 3 days with and without oral antibiotics. The findings indicated that the pain was mostly (80%) self-limited and could be explained simply by the time elapsed. (Sarrell 2003).
• From the AAP 2013 Clinical Practice Guideline page e973: Oil eardrops: "may have limited effectiveness, but no controlled studies".
• For most otalgia, acetaminophen and ibuprofen are sufficient. However, if pain is very severe without signs of perforation, a trial of olive oil drops (3 drops) can be considered.

Eye with Pus
Last year, the criteria for bacterial conjunctivitis were tightened. It requires lots of pus in the eye that keeps recurring after being wiped away. This was to prevent the over-treatment of viral conjunctivitis that can have small amounts of eye discharge. Artificial tears are recommended for those patients.

A major change for 2025 is that the disposition for children younger than 2 years who meet the above criteria is now See Within 24 hours. This is a change from the previous criteria of 3 months. Reason: Bacterial eye infections and ear infections can occur together in this young age group. If that is the case, an oral antibiotic is indicated. The only way to be sure is to examine the eardrums.

If your call center has a standing order to call in antibiotic eyedrops for probable bacterial conjunctivitis, it will continue to apply to children age 2 and older.

Fever - 3 Months and Older

New *Triage Question* added as well as supporting *Background Information*:

Call PCP Within 24 Hours

[1] Fever AND [2] foreign travel to a developing country in the last month
R/O malaria or other travel-related infection
CA: 60, 1, 2, 3, 4, 5, 12, 8

Care advice also rewritten for the fever guideline as follows:

Fever Medicine:
• For fevers above 102 F (39 C), give fever medicine as needed.
• For lower fevers, medicine is not needed. Reason: Fever turns on your body's immune system. Fever helps fight the infection.
• Fever Medicines: Give acetaminophen (e.g., Tylenol) every 4 hours OR ibuprofen (e.g., Advil) every 6 hours as needed (See Dosage table). Using one product alone works fine for treating almost all fevers.
• Ibuprofen Caution: Ibuprofen is not approved until 6 months old. Also, do not use ibuprofen for children at risk for dehydration.
• Result: fever medicine usually lowers fever 2-3 degrees F (1- 1 1/2 degrees C). It takes 1 to 2 hours to see the effect.
• Avoid aspirin. Reason: risk of Reye syndrome.
• Pain: If your child also has pain, treat it as needed. It may be a sore throat or muscle pain from the infection. Fever itself does not cause any pain.

Influenza (Flu) – Suspected and Influenza Follow-up Guidelines
Due to the availability of home influenza tests, we have added some information about how to navigate this in our guidelines.

- If the home test is positive but has not been seen by a health care provider, the nurses should use the Influenza (Flu) – Suspected guideline.
- If the patient has already talked to or has seen a health care provider or is on Tamiflu with a positive home test, use the Influenza Follow-up guideline.

Measles – Diagnosed or Suspected
Due to the current outbreak in the US and the fact that measles patients should be seen in health care settings that have negative air flow rooms, we have changed the disposition of many of these patients to **Call PCP Now** or **Call PCP within 24 hours** to help prevent unnecessary exposure in office waiting rooms. Please continue to call ahead if referring a suspected or diagnosed patient to a health care setting. Also, please remind your callers to get their children vaccinated!

Sexual Abuse and Sexual Assault Guidelines
Both guidelines have major changes. Please review. These changes are based upon timelines for evidence collection and when to go the ED:

- Vaginal sexual abuse in a prepubertal girl (penis vaginal contact) within 3 days
- Vaginal sexual abuse in a postpubertal girl (penis vaginal contact) within 5 days
- Oral sexual abuse or assault within 24 hours
- Anal sexual abuse or assault within 3 days

If the timeline exceeds these limits, it is recommended to call the local agency.

This paragraph was added to Background Information:

Evidence Collection Based upon Local Jurisdictions (2025)

- Evidence (semen, DNA) collection timeframes can vary depending on local jurisdictions. Follow your local policies.
- Vaginal Evidence: For most organizations, the cutoff for evidence collection after penile-vaginal contact is within 3 days for pre pubertal children, and within 5 days for post pubertal children. The Canadian provinces of New Brunswick and Ontario use 12 days as the cutoff time for evidence collection from a sexual assault. Improving DNA testing technologies may extend this timeframe further.
- For any assault occurring after these time frames, it is recommended an initial call to the local authorities or child protection team to determine if the child should go to the ER or follow up with another agency.
- Oral Evidence: For penile oral contact, the potential time frame to collect evidence is within 24 hours.
- Anal Evidence: For penile anal contact, the potential time frame to collect evidence is up to 72 hours (3 days).
- The ED has the resources (trained staff and equipment) to perform a medical forensic history and evidence collection (semen, DNA, documentation of injuries including possible photography). The ED can also provide sexually transmitted infection testing, treatment, and prophylaxis. The ED can arrange counseling and address important psychological needs (an advocate is typically contacted). Further, law enforcement can assist in providing a report and in other ways if requested.
- If over 2 weeks has passed since the sexual assault, evidence collection and presence of physical findings will be very limited. For adults and emancipated minors, an alternate source of care (other than an ED) is referral to a rape crisis center where a counselor can help the victim get to the right resources.
- Source: Child Protection Team, Children's Hospital Colorado

Sleep Problems – Child Sleeps in a Crib

Safe sleep habits practices for newborns added in Home Care:

Safe Sleep for Newborns: On Back and In Crib

- Safe Position: Always put your baby down to sleep on their back. Reason: sleeping face-down on the stomach increases the risk of SIDS by 5 times. Cause of death: suffocation.
- Safe Place: Alone in a crib. Share a room with your baby, but do not share a bed. Reason: Bedsharing increases the risk of SIDS by 10 times.

- Safe Surface: Only put baby to sleep on a flat surface. Always use a firm mattress or pad. Avoid baby sleeping on an incline. Reason: Baby's neck will flex and may block their breathing.
- Safe Crib: Keep blankets, pillows, stuffed toys or other objects out of your baby's crib. Reason: These can get in baby's face and block breathing.
- Naps: Safe sleep is needed for every sleep, including naps.
- Age: First year of life. Exception: your baby has learned to easily turn over from front to back.
- Benefits: Safe sleep recommendations from AAP have reduced SIDS by more than half.

Tear Duct - Blocked

The option of a standing order for antibiotic eyedrops was removed from this guideline for 2025. The reasons include the avoidance of over-treatment and the need to check for an associated ear infection in this age group if criteria for bacterial conjunctivitis are met. That means lots of pus in the eye that keeps recurring after being wiped away.

Vomiting Guidelines
We have decided to see all patients with Severe Vomiting regardless of how the caregiver is managing it with this new question:

See HCP (or PCP Triage) Within 4 Hours
SEVERE vomiting (8 or more times/day OR vomits everything for over 8 hours)

Reason: These patients may need other interventions (such as Zofran) to stop the vomiting.

Vomiting with Diarrhea Guideline

Care advice added to treat mild diaper rash to help the nurse avoid using 2 guidelines for these patients.

Important Note Regarding Redlines Showing Changes from Previous Versions

The redline Word documents show the changes made from the previous year's version. The Major Redline folder may be a good resource for your staff as we have referenced most of those topics in this letter.

Here is a list of guidelines with MAJOR changes for 2025:

- 911 Questions
- Anaphylaxis
- Avian Influenza (Bird Flu) Exposure
- Eye with Pus

- Fever – 3 Months and Older
- Hives
- Influenza – Suspected
- Influenza Follow-up Call
- Measles – Diagnosed or Suspected
- PCP Calls
- Sexual Assault or Rape
- Sexual Abuse Suspected
- Tear Duct – Blocked
- Vomiting with Diarrhea
- Vomiting without Diarrhea

Evidence-Based Guidelines and Updates

Yearly changes in these pediatric telephone triage and advice guidelines are based upon the following resources and evidence:

- American Academy of Pediatrics (AAP) new clinical practice guidelines and policy statements (including updates in the AAP Red Book)
- Centers for Disease Control and Prevention (CDC) new guidelines or recommendations
- Food and Drug Administration (FDA) new regulations and advisories
- New Clinical Guidelines from other national organizations (e.g. AHA, ADA)
- Research findings reported in this year's pediatric literature
- Expert-based reviews of and recommendations for all specialty guidelines by pediatric specialists in that field. They are listed in specific guidelines after Background Information.
- Consensus-based recommendations from 2 Expert Panels of community pediatricians (based in Colorado and in St. Louis, Missouri)
- Quality improvement projects that evaluate Emergency Department Under-referral and Over-referral (from our Pediatric Call Center at Children's Hospital Colorado)
- Reviews and recommendations from the following call centers: Access Nurse 24 (Tennessee), Alberta Health Link, Canada; Arkansas Children's Hospital, Asante Health System (Oregon), Baylor Scott & White Health (Texas), Children's Hospital Colorado, Children's Hospital of Philadelphia, Cincinnati Children's, Cleveland Clinic, Cook Children's Hospital (Texas), Children's Mercy (Missouri), Denver Health, FoneMed, Johns Hopkins All Children's Hospital (Florida), Marshfield Clinic (Wisconsin), Mayo Clinic, Saskatchewan Health Authority (Canada), St. Louis Children's Hospital/BJC, Sitel (Canada); Triage 4 Pediatrics (Texas) and Triage Logic. Their contributions to our annual update process are immeasurable. See the Reviewer list for names of individual contributors to our update process.
- Reviews and recommendations from the following software vendors: ClearTriage and LVM Systems

- Observations and questions from users, such as you. Your feedback is always appreciated and continues to improve the quality of these guidelines.

The guidelines have undergone changes based upon review of the above-mentioned resources. Triage nurses are encouraged to review targeted guidelines using this self-study guide. We hope this summary of changes will help your transition and implementation of the 2025 pediatric guidelines.