UCOG UPDATES 2025

1. **UT FSED (Freestanding ED)**
    - Bypass indications
    - Special Stroke Considerations
2. **General Patient Care Guidelines**
    - Variances only given by State
    - OLMC cannot authorized procedures or treatments out of your scope
    - If patients have written dr orders that are out of protocol, they must consult OLMC
3. **Airway Management**
    - If hypoglycemia/hyperglycemia present → treat per HYPOGLYCEMIA / HYPERGLYCEMIA guideline.
    - AEMT - Adult Naloxone 0.4–2 mg (per dose) IV/IM/IO/IN for suspected narcotic overdose. May repeat as needed. Reference OPIOID OVERDOSE guideline
    - AEMT- Ped Naloxone 0.1 mg/kg (max 2 mg per dose) IV/IM/IO/IN for suspected narcotic overdose. May repeat as needed. Reference OPIOID OVERDOSE guideline
    - Paramedic- Consider chemical restraints per the BEHAVIORAL EMERGENCY guideline, as needed, to protect the patient and/or rescue personnel.
    - Paramedic- Peds If evidence of poor perfusion → give sodium chloride (NS) 20mL/kg IV once (max 1 liter)
4. **Blood Product Transfusion**
    - All New Protocol
5. **Death Determination/Termination of Efforts**
    - Ensure confirmation of patient's identifying information before ending care
    - There will always be patients and circumstances that deserve special consideration (pediatric drowning or pregnant patients for instance). OLMC should be consulted if there are ever any questions. Always be sensitive to the patient's desires, family concerns, and on-scene environment to insure an understanding by all who observe your actions that everything that could and should have been done to resuscitate the patient was done.
    - Pediatrics: Consider transporting pediatric arrests to the hospital after necessary on-scene interventions with ongoing resuscitative efforts en-route, unless it is an obvious death on scene.

6. **Family Centered Care**
    - New Children with Special Health Care Needs Section
7. **Pain Management**
    - Verbiage changes from Stop to Use Caution in giving medications if SBP <100mmHg in adults, SBP <70 + (age in years x 2) mmHg for pediatrics, SpO_2 <90% without oxygen, or GCS <14
    - For agitated/combative patients that meet the BEHAVIORAL EMERGENCY guidelines, pain management should NOT be used in conjunction.
    - If the patient's written emergency treatment plan has medications not in protocol → please consult with online medical control
    - Removed-Maximize dosing of a single agent before using additional agents
    - Acetaminophen 500-1000 mg PO/IV (infusion over 15 min), single dose only
    - Removed Paramedic Ped Ketamine IV/IO – 0.3mg/kg to a max of 20mg every 5 minutes to the desired effect or max dose of 40 mg.
8. **Pediatric Assessment**
    - If the patient's written emergency treatment plan has medications not in protocol → please consult with online medical control
9. **Procedural/Post ROSC Sedation**
    - All New Protocol
10. **Shock, Sepsis, & Fluid Therapy**
    - Consider shock in Adult patients with Shock Index >1, Shock Index= HR/SBP
    - Pediatric vital signs SBP <70 + (age in years x 2) mmHg for children, age-based tachycardia, and/or RR >20 BPM
    - If the patient has shock secondary to trauma or hemorrhagic shock (any source) → blood product is preferred over IV fluid.
    - AEMT- Ped Traumatic Shock Suspected Give fluid bolus of 20 mL/kg at a time (max 1L), reassess and repeat up to a maximum of 40 mL/kg total (Max 2L); Reassess for reversal of the signs of shock
    - If the patient remains hypotensive after 40mL/kg (max 2L) of NS → call OLMC
    - AEMT- Adult Non-Traumatic Shock Epinephrine (Push Dose) 10 - 20mcg as needed to maintain a SBP >100 mmHg after fluid bolus**.**
    - Paramedic- if traumatic or hemorrhagic shock suspected Adults & Peds Treat with blood product if available as per BLOOD PRODUCT TRANSFUSION guideline, if no blood products available → follow permissive hypotension / conservative fluid bolusing guidelines as in AEMT scope.

- FOR USE ONLY IN NON-TRAUMATIC SHOCK Epinephrine 0.05 - 1 mcg/kg/min IV/IO infusion for hypoperfusion. Titrate to maintain a SBP >100 mmHg.

11. Tracheostomy Management

- All New Protocol

12. Cardiac Patient Care Guidelines

- FSED Cardiac: Unless stabilization is needed, suspected cardiac emergencies, specifically STEMIs, should bypass the FSEDs and be taken to a facility with a Cardiac Cath Lab. At the same time, stable patients with a complaint of "chest pain" who do not have a STEMI, or serious arrhythmia, can easily be evaluated at an FSED.

13. Cardiac Arrest

- For Traumatic Arrest refer to the GENERAL TRAUMA MANAGEMENT guideline
- Anterior/Posterior pad positioning is now preferred for defibrillation.
- When using Mechanical CPR Check rhythm every 2 minutes. When an organized rhythm is present, check pulse (10 seconds only, use a verbal countdown)
- Amiodarone 5 mg/kg IV/IO (Max 300mg/dose) may repeat up to 3 more times at 150mg max dose per injection (Total Max 750mg = 300 + (3x150)) OR Rapid bolus – may repeat 2 more times every 5 min as needed with a max dosage of 15mg/kg during acute treatment**.**

14. Cardiac Chest Pain (ACS)

- Chest pain with cardiac origin is rare in children, consider other causes; Asthma, FBAO, Infection, or Trauma.

15. CHF/Pulmonary Edema

- CPAP is preferred if the primary concern is CHF or pulmonary edema

16. ROSC

- Updated guidance for post-ROSC management.
- Procedural sedation may be used if the airway is at risk of compromise. Intended to support airway protection and prevent agitation-related deterioration. Providers should review updated medication options and sedation criteria.

17. **Cardiac: Stable Tachycardia**

- Adenosine may now be administered for stable tachycardia in accordance with the updated cardiac protocol.

18. **Behavioral Emergencies**

- A new Behavioral Emergencies protocol has been added.
- Includes updated transport options and guidance.

19. **Fever Management**

- Ibuprofen and acetaminophen may be co-administered as part of the fever management protocol.

20. **Trauma in Pregnancy**
    - For pregnancies > 20 weeks, strongly consider transport to a trauma center.
21. **Obstetrics (OB) Protocol**
    - Delay cord cutting for 60 seconds or until the umbilical cord stops pulsating.
    - Oxytocin may be administered immediately after cord clamping, prior to placental delivery.
    - TXA added as an option for postpartum hemorrhage management.
22. **Overdose Protocol**
    - Minor updates made to guidelines for releasing patients after opioid overdose.
    - Providers should review new observation and refusal criteria.
23. **Stroke Protocol**
    - Updated criteria regarding when transport to a Freestanding Emergency Department (FSED) is appropriate.
24. **Toxic Exposure**
    - CHEMPACKs may now be requested through T-Dispatch.
25. **General Trauma Management**
    - Multiple updates implemented.
    - Please review the revised section for changes in assessment, interventions, and transport criteria.
26. **Amputations, Dental Emergencies, Crush Injuries, and Fractures**
    - These protocols have been combined into a single, streamlined protocol section.
27. **Snakebite Protocol**
    - Protocol name changed to: Envenomation.
28. **Traumatic Brain Injury (TBI)**
    - Updated oxygen saturation goal: ≥ 94%.
    - Previous target (90–94%) removed; maintain SpO_2 ≥ 94% for all TBI patients.
    - Pediatric patients: maintain MAP ≥ 60 mmHg.