

[HOSPITAL / HEALTH AUTHORITY NAME]

ACUTE EYE, ENT, AND DENTAL EMERGENCIES PATHWAY**Protocol 37: Rapid Recognition of Sight-, Airway-, Hearing-, and Dentition-Threatening Conditions; Immediate First Aid; Targeted Treatment; Specialist Escalation; Transfer; and Safe Disposition**

DRAFT FOR EMERGENCY MEDICINE, OPHTHALMOLOGY, OTOLARYNGOLOGY / HEAD AND NECK SURGERY, ORAL AND MAXILLOFACIAL SURGERY, DENTISTRY, ANAESTHESIA / CRITICAL CARE, PAEDIATRICS, STROKE SERVICES, INFECTIOUS DISEASES / MICROBIOLOGY, RADIOLOGY, NURSING, PHARMACY, AND TRANSFER SERVICES

STATUS: This is a draft clinical-governance document. It must be adapted to local ophthalmology, ENT, oral and maxillofacial, dental, anaesthesia, stroke, imaging, laboratory, pharmacy, procedural-sedation, infection-control, blood-product, transfer, and follow-up capability. Drug concentrations, doses, antimicrobial regimens, ocular-pressure treatment, airway procedures, nasal packing, dental blocks, tooth replantation, and specialist-transfer thresholds require local approval before implementation.

TIME-CRITICAL RULE: Treat the threat before completing the diagnosis. Begin immediate eye irrigation for chemical exposure; protect a suspected open globe with a rigid shield and avoid pressure; decompress a clinically obvious orbital compartment syndrome without waiting for imaging when vision is threatened and trained staff are available; activate stroke evaluation for acute retinal ischaemia; secure senior airway support early for stridor, drooling, floor-of-mouth swelling or expanding neck / oral haemorrhage; control severe epistaxis while resuscitating; and immediately replant an avulsed permanent tooth when appropriate or store it in a physiologic medium. Never replant an avulsed primary tooth.

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Nursing Services / Clinical Governance
Clinical leads	Emergency Medicine; Ophthalmology; Otolaryngology / Head and Neck Surgery; Oral and Maxillofacial Surgery; Dentistry; Anaesthesia / Critical Care; Paediatrics; Stroke Service; Radiology; Pharmacy
Applies to	Adults, children, pregnant patients, older adults, anticoagulated or immunocompromised patients, contact-lens users, postoperative patients, and persons with acute eye, ear, nose, throat, oral, dental, facial or neck presentations
Interfaces	Protocol 17 Altered Mental Status; Protocol 18 Stroke / TIA; Protocol 20 Headache / Intracranial Emergency; Protocol 29 Poisoning; Protocol 30 Anaphylaxis; Protocol 31 Major Trauma; Protocol 32 Head / Spinal Injury; Protocol 33 Thoracic / Abdominal / Pelvic Trauma; Protocol 34 Limb Injury; Protocol 35 Burns / Wounds / Bites; Protocol 48 Airway; local sepsis, antimicrobial, anticoagulant-reversal, safeguarding and transfer policies
Version / status	Draft 1.0 for local multidisciplinary validation
Review cycle	After any serious incident, missed time-critical diagnosis, medication or equipment change, guideline update, service change, or at least every 2 years
Required approval	Emergency Department; Ophthalmology; ENT; Oral / Maxillofacial Surgery; Dentistry; Anaesthesia / ICU; Paediatrics; Stroke Service; Radiology; Pharmacy; Nursing; Clinical Governance

1. Purpose

To provide a standardized emergency-department pathway for rapid recognition, immediate first aid, focused examination, targeted investigation, specialist escalation, transfer, observation, and safe disposition of acute eye, ear, nose, throat, oral, dental, facial, and neck emergencies while preventing avoidable blindness, airway loss, hearing loss, sepsis, haemorrhage, aspiration, disfigurement, and loss of dentition.

2. Scope

This protocol applies from pre-alert or first contact through discharge, observation, admission, emergency procedure, operative care, specialist transfer, rehabilitation, or death. It covers ocular chemical and traumatic injury, acute vision loss, painful red eye, orbital and postoperative eye emergencies; sudden hearing loss, ear trauma and foreign bodies; epistaxis, nasal trauma and foreign bodies; upper-airway and deep-neck infection, pharyngeal / oesophageal foreign bodies and neck swelling; dental pain and infection, dental trauma, avulsion, post-extraction bleeding, temporomandibular dislocation, and associated oral injury. Major multisystem facial trauma follows the trauma protocols in parallel.

3. Core policy statements

- Visual acuity is the eye vital sign. Measure and document each eye separately at the earliest safe opportunity, including baseline correction and the best obtainable result. A patient unable to read a chart must still be assessed using counting fingers, hand movements, light perception or no light perception.
- Airway, breathing and circulation take priority over detailed eye, ENT or dental examination. Stridor, drooling, muffled voice, trismus, floor-of-mouth elevation, rapidly expanding swelling, uncontrolled oropharyngeal bleeding, severe epistaxis and inability to handle secretions require immediate senior escalation.
- Eye irrigation, airway stabilization, haemorrhage control and permanent-tooth preservation must not wait for registration, imaging, formal visual testing, laboratory results or specialist arrival.
- Do not apply pressure, patch, manipulate, measure intraocular pressure, remove an embedded object or perform ocular ultrasound when an open globe is suspected. Use a rigid shield, not a pressure dressing.
- Acute painless monocular visual loss from retinal artery occlusion is an ocular stroke until proved otherwise. Activate an urgent stroke-centre pathway and assess for giant-cell arteritis where clinically relevant.
- Pain relief is essential but must not obscure serial airway, visual, neurological or neurovascular assessment. Do not discharge topical ocular anaesthetic unless an ophthalmology-approved local pathway explicitly permits it.
- Antibiotics do not replace drainage, removal, replantation, endodontic care or surgical source control. Use antimicrobial therapy for defined indications and according to local resistance patterns.
- Every patient discharged with a condition capable of delayed visual loss, airway deterioration, rebleeding, infection spread or tooth loss must receive written red flags, a named follow-up pathway and a defined review interval.

4. Definitions and severity framework

Category	Examples and operational response
Immediate resuscitation	Airway obstruction, severe respiratory distress, uncontrolled haemorrhage, anaphylaxis, septic shock, major facial / neck trauma, caustic exposure with airway injury, or cardiac / neurological instability. Resuscitation and senior airway / surgical support now.
Immediate sight-saving action	Chemical eye injury, suspected open globe, orbital compartment syndrome, acute retinal artery occlusion, acute angle closure with severe pressure elevation, rapidly progressive orbital infection with optic-nerve compromise, or postoperative endophthalmitis. Start first aid and specialist escalation simultaneously.
Same-day emergency specialist care	Retinal detachment symptoms, new field defect, severe keratitis / corneal ulcer, hyphema, sudden sensorineural hearing loss, septal haematoma, posterior or refractory epistaxis, deep-neck infection, button battery, avulsed permanent tooth, alveolar fracture or spreading odontogenic infection.
Urgent review within 24 hours	New flashes / floaters, uncomplicated contact-lens red eye after serious disease is excluded, corneal abrasion with risk factors, auricular haematoma, uncomplicated displaced dental injury, persistent ear / nasal foreign body, and postoperative pain or visual / hearing change.
Routine / ambulatory care after exclusion of danger	Minor conjunctivitis, uncomplicated self-limited upper-respiratory symptoms, stable chronic dental pain without swelling or systemic features, superficial oral ulceration, and minor injuries with normal function and reliable follow-up.

5. Roles and accountability

Role	Minimum responsibility
Triage / receiving nurse	Identify sight, airway, haemorrhage, sepsis, button-battery, dental-avulsion and postoperative red flags; begin immediate irrigation, compression, positioning, oxygen, monitoring and escalation within scope.
ED clinician	Lead ABCDE, document visual acuity / airway status, perform focused examination, start time-critical treatment, obtain appropriate imaging and specialist advice, reassess, and make a safe disposition decision.
Senior ED / resuscitation lead	Attend threatened airway, orbital compartment syndrome, open globe, severe visual loss, uncontrolled bleeding, deep-neck infection, major facial trauma, septic shock and complex transfer.

Role	Minimum responsibility
Ophthalmology	Guide or provide definitive eye examination, pressure-lowering therapy, intravitreal treatment, retinal / globe surgery, canthotomy support, and follow-up timing.
ENT / head and neck surgery	Guide airway planning, nasendoscopy, epistaxis control, drainage of deep-space infection, foreign-body removal, ear / nasal trauma care and operative escalation.
Dentistry / oral and maxillofacial surgery	Provide definitive dental source control, replantation / splinting, management of alveolar or mandibular injury, deep odontogenic infection, oral haemorrhage and follow-up.
Anaesthesia / ICU	Support difficult-airway planning, controlled intubation, procedural sedation, haemodynamic resuscitation and critical care.
Nursing / pharmacy / radiology / transfer team	Deliver irrigation, monitoring, medication verification, equipment readiness, imaging prioritization, procedural support, packing / wound care, documentation and treatment continuity during transfer.

6. Pre-alert, preparation, and triage

Pre-alert question	Why it matters
Is vision suddenly reduced, is there severe eye pain, chemical exposure or penetrating injury?	Triggers immediate irrigation, eye protection, visual-acuity documentation and ophthalmology / stroke escalation.
Is there stridor, drooling, voice change, trismus, floor-of-mouth or neck swelling, or inability to swallow saliva?	Identifies a threatened airway and need for resuscitation, anaesthesia and ENT / maxillofacial attendance.
Is bleeding active and where is it coming from?	Determines resuscitation, suction, compression, packing, reversal review and operative / interventional escalation.
Is a button battery, magnet, sharp object or caustic substance involved?	Requires urgent removal or decontamination and avoidance of harmful blind or irrigation attempts.
Was a permanent tooth avulsed and when?	Replantation success is time dependent; locate the tooth and preserve periodontal-ligament viability.
Recent eye, ENT or dental procedure, intravitreal injection or surgery?	Pain, visual loss, fever, bleeding or swelling may represent a serious postoperative complication.
Diabetes, immunosuppression, anticoagulation, sickle-cell disease, pregnancy or single functioning eye?	Lowers the threshold for specialist review, admission, antimicrobial treatment and monitoring.

TRIAGE OVERRIDE: Chemical eye exposure goes directly to irrigation. A patient with threatened airway or uncontrolled haemorrhage goes directly to resuscitation. A suspected open globe receives a rigid shield and no pressure. An avulsed permanent tooth is handled immediately while the rest of the assessment continues.

7. The first 10 minutes

1. Perform ABCDE. Sit an airway-threatened patient upright when tolerated, give oxygen, attach monitoring, obtain IV access and call senior ED, anaesthesia and the relevant surgical service early.
2. For chemical eye exposure, instil topical anaesthetic when available, remove contact lenses and begin copious irrigation with water or isotonic fluid immediately. Continue until ocular-surface pH is physiologic and remains stable after a pause.
3. For suspected open globe or intraocular foreign body, stop pressure-producing examination, place a rigid shield, keep nil by mouth, control pain and vomiting, update tetanus status, obtain urgent ophthalmology advice and arrange thin-section CT orbits when appropriate.
4. For suspected orbital compartment syndrome with reduced vision, relative afferent pupillary defect, tense proptosis and restricted movements, call ophthalmology while preparing immediate lateral canthotomy / inferior cantholysis by a trained clinician. Do not delay a clinically necessary decompression for imaging.
5. For sudden painless monocular visual loss, document last-known-well time, perform a focused neurological assessment, activate the retinal-ischaemia / stroke pathway, and assess for giant-cell arteritis in an appropriate patient.
6. For severe epistaxis, lean the patient forward, suction the mouth, apply firm continuous compression to the soft lower third of the nose, resuscitate as needed and prepare topical vasoconstrictor, cautery or packing according to findings and competency.

7. For stridor, drooling, severe trismus, floor-of-mouth elevation or rapidly expanding neck / oral swelling, avoid repeated provocative examination, maintain spontaneous breathing where possible and plan a controlled airway with senior anaesthesia and ENT / maxillofacial staff.
8. For an avulsed permanent tooth, handle only the crown, gently rinse gross contamination without scrubbing, replant immediately when safe and within competency, or store in Hank balanced salt solution, cold milk, saline or the patient's saliva. Never replant a primary tooth.
9. Provide analgesia, antiemetic therapy when indicated, and repeat airway, vision, pupils, bleeding, pain and neurological findings after every major intervention.

8. Focused assessment and investigations

8.1 Eye assessment

Domain	Minimum assessment
Vision	Visual acuity in each eye separately with usual correction; near card if distance chart unavailable; counting fingers / hand movements / light perception when necessary; colour desaturation and visual field by confrontation when feasible.
Pupils and neurology	Size, shape, reactivity, relative afferent pupillary defect, ocular alignment, diplopia, ptosis, cranial nerves and focal neurological deficit.
External and anterior segment	Lids, lashes, lacrimal system, conjunctiva, cornea, anterior chamber, pupil and lens. Use fluorescein and slit lamp when available after open globe has been reasonably excluded.
Pressure and posterior segment	Measure intraocular pressure only when open globe is not suspected. Examine red reflex and fundus when feasible; absence of a view may itself be important.
Trauma / exposure	Mechanism, projectile, high-velocity metal work, chemical name and time, irrigation already performed, contact lenses, eye protection, tetanus status, surgery or intravitreal injection.
Symptoms	Onset and progression of pain, photophobia, redness, discharge, flashes, floaters, curtain / field loss, haloes, nausea, headache, temporal pain or jaw claudication.

8.2 ENT, oral, and dental assessment

Domain	Minimum assessment
Airway / neck	Voice, stridor, stertor, drooling, ability to swallow secretions, trismus, tongue / floor-of-mouth elevation, neck movement, swelling, crepitus, tenderness and skin change.
Ear / hearing	Otoscopy, pinna and mastoid, canal, tympanic membrane, otorrhoea / haemotympanum, bedside Weber / Rinne when reliable, facial nerve and vestibular / neurological findings.
Nose	Bleeding side and rate, compression response, septum, foreign body, septal haematoma, deformity, clear fluid after trauma and signs of posterior bleeding.
Mouth / throat	Dentition, gingiva, palate, tonsils, uvula, posterior pharynx, floor of mouth, tongue, salivary ducts, lesions, swelling, pus, odour, bleeding and foreign body; avoid forceful examination when the airway is unstable.
Dental trauma	Identify primary versus permanent tooth; fracture, displacement, mobility, tenderness, pulp exposure, occlusion, alveolar-segment movement, missing tooth / fragment and aspiration risk.
Systemic context	Fever, rigors, dehydration, diabetes, immunosuppression, bleeding disorder, anticoagulants, recent surgery / extraction, antibiotics, allergy and social / safeguarding concerns.

8.3 Targeted investigations

- Tests are syndrome directed. Obtain glucose, full blood count, renal function, inflammatory markers, coagulation, group and screen / crossmatch, cultures and pregnancy testing when they will change treatment; do not delay first aid or source control.
- Use thin-section non-contrast CT orbits for suspected globe injury, orbital fracture or radiopaque foreign body; add contrast when orbital infection, vascular injury or abscess is suspected. Avoid MRI when a metallic intraocular foreign body is possible.
- Use contrast-enhanced CT neck for deep-space infection, abscess or occult neck pathology only when the airway is stable enough for imaging. Airway control and surgical review take priority.
- Use CT angiography for selected penetrating neck / facial trauma, major bleeding, vascular injury or stroke syndromes. Follow local trauma and stroke pathways.
- Dental / maxillofacial imaging may include panoramic, periapical or occlusal radiography and CT for alveolar, mandibular, midface or deep-space disease. Search for an aspirated or ingested missing tooth / fragment when clinically indicated.
- Audiometry should be obtained urgently for suspected sudden sensorineural hearing loss, but treatment and ENT referral should not be delayed when timely audiometry is unavailable.

9. Eye emergencies

9.1 Chemical eye injury

Step	Required action
Immediate irrigation	Start immediately with clean water, normal saline, lactated crystalloid or an approved ocular-irrigation solution. Do not wait for a preferred fluid, pH paper, consent formalities or ophthalmology.
Facilitate	Use topical anaesthetic, remove contact lenses, retract lids and sweep the fornices for retained particulate material after an open globe is excluded. Brush off dry powder before irrigation when appropriate.
Endpoint	Check pH of both eyes when possible. Continue irrigation until pH is approximately physiologic and remains stable after irrigation is paused; severe alkali or retained-particle injuries may require prolonged irrigation.
Avoid	Do not attempt chemical neutralization with another chemical. Do not delay irrigation for detailed history or visual acuity. Do not use a pressure patch.
After irrigation	Record vision, pupils, limbal ischaemia, corneal clarity / epithelial defect, conjunctival injury and intraocular pressure if safe. Give analgesia, tetanus care when indicated and urgent ophthalmology review.
Escalation	Immediate transfer for reduced vision, corneal haze, limbal blanching, persistent abnormal pH, large epithelial defect, elevated pressure, severe pain, alkali / cement / ammonia exposure or inability to examine reliably.

9.2 Suspected open globe, penetrating injury, or intraocular foreign body

- Suspect after high-velocity metal-on-metal work, projectile, sharp-object injury, major blunt trauma or explosive injury. Findings may include peaked / irregular pupil, shallow or deep anterior chamber, uveal prolapse, positive Seidel test, dense subconjunctival haemorrhage, low pressure, reduced vision or visible foreign body.
- Stop the examination once suspicion is established. Place a rigid eye shield, avoid all pressure, keep nil by mouth, elevate the head when safe, provide systemic analgesia and antiemetic therapy, and minimize coughing / straining.
- Do not remove a protruding object, patch the eye, measure pressure, evert the lids, perform ocular ultrasound or give eye drops that require pressure on the globe unless directed by ophthalmology.
- Update tetanus prophylaxis and give systemic antimicrobial prophylaxis according to the locally approved open-globe regimen and ophthalmology advice. Obtain urgent thin-section CT orbits; do not use MRI if metal is possible.
- Arrange emergency ophthalmic surgery or transfer. Protect the fellow eye and maintain treatment continuity during transport.

OPEN-GLOBE SAFETY: A normal-looking eye does not exclude penetration. When mechanism and findings are concerning, shield and refer rather than repeatedly manipulating the eye.

9.3 Orbital compartment syndrome

- Consider after orbital / facial trauma, retrobulbar injection, surgery, anticoagulant-associated haemorrhage or spontaneous bleeding. Red flags are rapidly falling vision, relative afferent pupillary defect, proptosis, a tense orbit, severe pain, restricted ocular movement and markedly raised pressure.

- This is a clinical diagnosis. Call ophthalmology and senior ED / maxillofacial support immediately. When vision is threatened and specialist arrival would cause harmful delay, a trained clinician should perform lateral canthotomy with inferior cantholysis according to the local procedure standard.
- Do not delay decompression for CT when the diagnosis is clinically clear. After decompression, reassess vision, pupils, pressure and orbital tension, then image and treat the cause. Failure to improve may require further cantholysis or operative decompression.

9.4 Acute angle closure and dangerously elevated intraocular pressure

Feature	Operational approach
Recognition	Severe unilateral eye / brow pain, red eye, blurred vision or haloes, headache, nausea / vomiting, corneal haze, shallow chamber, poorly reactive mid-dilated pupil and high intraocular pressure.
Immediate care	Urgent ophthalmology contact; analgesia and antiemetic; begin locally approved pressure-lowering treatment unless contraindicated. Common classes include a topical beta blocker, alpha agonist and systemic carbonic-anhydrase inhibitor.
Escalation	Add hyperosmotic therapy or other agents only with senior / ophthalmology guidance and appropriate renal, cardiac and fluid-status assessment. Miotics may be ineffective at very high pressure and should follow the approved pathway.
Definitive care	Laser iridotomy or another definitive ophthalmic procedure is usually required. Assess the fellow eye and medication / anatomical precipitants.
Safety	Check contraindications such as asthma, bradycardia / heart block, severe renal or hepatic disease, electrolyte disturbance, pregnancy and drug allergy before treatment; do not discharge until ophthalmology has defined the plan.

9.5 Sudden visual loss, flashes, floaters, or field defect

Presentation	Priority response
Acute retinal artery occlusion / amaurosis fugax	Treat as acute retinal ischaemia: establish last-known-well time, activate stroke-centre evaluation, obtain vascular / cardiac work-up and assess for giant-cell arteritis. Routine ocular massage or anterior-chamber paracentesis is not standard ED therapy.
Possible giant-cell arteritis	Age usually over 50 with new headache, scalp tenderness, jaw / tongue claudication, constitutional symptoms, polymyalgia or visual symptoms. Obtain inflammatory markers and platelets, but start urgent high-dose systemic corticosteroid treatment when suspected; do not delay for biopsy or imaging.
Retinal tear / detachment	New flashes, sudden shower of floaters, curtain / shadow or field loss. Same-day dilated retinal assessment; urgent transfer when local examination is unavailable, especially with field loss or reduced central vision.
Vitreous haemorrhage	Painless floaters / haze or reduced vision with poor fundal view. Urgent ophthalmology to exclude retinal tear / detachment; review diabetes, anticoagulation and trauma.
Optic neuritis / compressive optic neuropathy	Reduced vision, colour desaturation, afferent defect and pain on movement or neurological features. Urgent ophthalmology / neurology and appropriate imaging; consider demyelination, inflammation, infection and compression.
Acute postoperative / post-injection visual loss	Pain, marked redness, hypopyon, reduced vision or severe floaters after surgery / intravitreal injection suggests endophthalmitis or other surgical emergency. Immediate ophthalmology; intravitreal treatment is time critical.

9.6 Painful red eye, keratitis, abrasion, and foreign body

Condition	Key management
Microbial keratitis / corneal ulcer	Severe pain, photophobia, reduced vision, corneal infiltrate / opacity or epithelial defect, especially in contact-lens users. Immediate ophthalmology or same-day transfer; obtain cultures when advised and begin intensive topical antimicrobial therapy per local eye protocol.
Uveitis / scleritis	Photophobia, deep pain, ciliary flush, cells / flare, reduced vision or pain with eye movement. Urgent ophthalmology. Do not start topical steroid or cycloplegic therapy without an approved diagnosis / pathway.
Corneal abrasion	Exclude open globe and retained foreign body; document vision; fluorescein examination; remove contact lenses. Provide oral / topical non-anaesthetic analgesia and locally approved topical antibiotic when indicated. Do not routinely patch, particularly in contact-lens injury.
Superficial foreign body	Remove only if clearly superficial and within competency after open globe is excluded. Evert lids, irrigate and use magnification. Refer embedded, central, rust-ring, organic, high-velocity or incompletely removed material.
Conjunctivitis	Check vision, pain, photophobia, cornea and contact-lens use before diagnosing. Severe pain, reduced vision, corneal involvement, vesicles, neonate, immunocompromise or hyperpurulent discharge needs urgent specialist / microbiology input.
Herpes zoster ophthalmicus	Vesicular V1 rash, tip-of-nose involvement, red eye or visual symptoms. Start systemic antiviral therapy promptly when indicated and arrange urgent ophthalmic assessment.

9.7 Blunt eye trauma, hyphema, and eyelid injury

- Exclude open globe, orbital compartment syndrome, retinal injury and associated head / facial trauma. Document vision, pupils and ocular movements before analgesia or sedation when possible.
- Hyphema requires rigid shield, head elevation, activity restriction, avoidance of aspirin / NSAIDs when clinically appropriate, review of anticoagulation and urgent ophthalmology. Measure pressure only after open globe is excluded. Sickle-cell disease / trait increases risk and changes pressure-management thresholds.
- Use CT for suspected orbital fracture, entrapment, optic-nerve injury or intraorbital foreign body. Nausea, bradycardia, severe pain on eye movement or limited upgaze in a child may indicate trapdoor entrapment and requires urgent surgery.
- Eyelid lacerations involving the margin, canaliculus, levator, medial canthus, full thickness, tissue loss or orbital fat require specialist repair. Protect the cornea and avoid blind probing.
- Patients with a single seeing eye, paediatric injury, suspected non-accidental injury or inability to cooperate require a low threshold for specialist examination and safeguarding review.

10. Ear and hearing emergencies

10.1 Sudden hearing loss

- Distinguish conductive from sensorineural loss at first contact using history, otoscopy and bedside tuning-fork tests when reliable. Wax or middle-ear fluid does not safely explain every sudden loss.
- Assess bilateral or recurrent loss, severe vertigo, headache, neurological deficit, trauma, ototoxic exposure and vascular risk. Activate stroke / neurological pathways for focal findings or an acute central vestibular syndrome.
- Arrange urgent audiometry and ENT assessment. For suspected idiopathic sudden sensorineural hearing loss, initial corticosteroid therapy may be offered within 2 weeks after contraindications, risks and route are considered; intratympanic and hyperbaric options are specialist decisions.
- Do not order routine head CT or broad laboratory panels solely for uncomplicated presumed sudden sensorineural hearing loss. Arrange MRI or auditory-brainstem assessment for retrocochlear disease according to ENT guidance.
- Provide clear follow-up because salvage intratympanic therapy is time dependent when recovery is incomplete.

10.2 Ear infection, trauma, foreign body, and auricular haematoma

Condition	Emergency-department approach
Necrotizing / malignant otitis externa	Severe persistent otalgia, granulation tissue or cranial neuropathy in diabetes / immunocompromise. Urgent ENT, cultures, imaging and systemic antipseudomonal therapy; admit or transfer.
Mastoiditis / complicated otitis media	Postauricular swelling, protruding pinna, fever, severe pain, neurological signs or facial weakness. IV antibiotics, urgent ENT, imaging and drainage assessment.

Condition	Emergency-department approach
Auricular haematoma	Fluctuant swelling after trauma. Urgent drainage and compression by trained staff / ENT to prevent cartilage necrosis and deformity; review for associated injury and safeguarding.
Tympanic-membrane perforation	Keep ear dry, avoid instrumentation and ototoxic drops, assess hearing / vertigo / facial nerve. ENT review for marked hearing loss, vertigo, penetrating injury, contamination or persistent perforation.
Temporal-bone / basilar-skull injury	Haemotympanum, CSF otorrhoea, facial weakness, severe hearing loss or vestibular symptoms. Follow head-trauma pathway; CT and urgent ENT / neurosurgical input. Do not pack a suspected CSF leak.
Ear foreign body	Urgent removal for button battery, penetrating object, severe pain, bleeding or infection. Do not irrigate a battery, vegetable matter or when perforation is possible. Limit repeated attempts; early ENT for deep, smooth, impacted or uncooperative cases.

11. Nose emergencies

11.1 Epistaxis

1. Assess airway and haemodynamic status. Sit forward, suction blood from the mouth and apply firm uninterrupted compression to the soft lower third of the nose for at least 5 to 10 minutes. Do not repeatedly release to check.
2. Use a topical vasoconstrictor and local anaesthetic when appropriate. Clear clot gently and identify the site with good lighting and suction after initial control.
3. Cauterize only a clearly identified anterior site and avoid simultaneous bilateral septal cautery. If bleeding prevents localization, use appropriate nasal packing; use resorbable material when increased bleeding risk or anticoagulant / antiplatelet therapy is present when available.
4. Reassess after packing. Persistent brisk bleeding, posterior bleeding, haemodynamic compromise, airway risk, major comorbidity or transfusion requirement needs urgent ENT, admission and possible endoscopic arterial ligation or interventional radiology.
5. Do not reverse anticoagulation or antiplatelet therapy routinely before first-line measures. Consider reversal for life-threatening or uncontrolled bleeding after risk-benefit discussion and according to the anticoagulant-reversal protocol.
6. Provide packing care, medication instructions, avoidance advice, removal / review timing and return precautions before discharge. Consider recurrent unilateral bleeding, mass, hereditary haemorrhagic telangiectasia or safeguarding concerns.

11.2 Nasal trauma, septal haematoma, foreign body, and CSF leak

Problem	Required response
Septal haematoma / abscess	Bilateral or unilateral boggy septal swelling, obstruction and pain after trauma or infection. Same-day ENT drainage and antimicrobial therapy; delay risks cartilage necrosis and saddle-nose deformity.
Nasal fracture	Exclude septal haematoma, CSF leak, ocular / facial injury and uncontrolled bleeding. Imaging is not routinely required for isolated uncomplicated fracture. Arrange timely ENT / maxillofacial review when deformity or obstruction may need reduction.
Nasal foreign body	Remove promptly if visible and safe. Button batteries and paired magnets are immediate emergencies. Avoid blind instrumentation and repeated attempts; use ENT support for posterior, sharp, impacted or uncooperative cases.
Suspected CSF rhinorrhoea	Clear unilateral drainage after skull-base trauma, often positional or salty. Avoid nasal packing, instrumentation and forceful nose blowing; follow head-injury pathway and obtain urgent ENT / neurosurgical advice.

12. Throat, upper-airway, and deep-neck emergencies

Presentation	Immediate approach
Epiglottitis / supraglottitis	Severe sore throat, odynophagia, drooling, muffled voice, stridor, tripod positioning or toxic appearance. Keep calm and upright; avoid forceful tongue-depressor examination; call senior anaesthesia and ENT; secure a controlled airway in the safest location and give IV antimicrobials after the airway plan is established.
Ludwig angina / floor-of-mouth infection	Brawny submandibular swelling, elevated tongue, drooling, dysphagia, trismus or voice change. Airway first; early awake / controlled advanced-airway planning; IV broad-spectrum antimicrobials, sepsis care and urgent maxillofacial / ENT source control.
Deep-neck-space infection	Neck swelling, fever, severe pain, reduced movement, trismus, cranial neuropathy, chest pain or toxicity. Senior airway review, IV antimicrobials and contrast CT only if stable; urgent drainage / transfer. Consider descending mediastinitis and vascular complications.
Peritonsillar abscess	Unilateral severe sore throat, uvular deviation, trismus and “hot potato” voice. Assess airway, hydrate, provide analgesia, drain by trained clinician / ENT and give appropriate antimicrobials. Admit if airway, sepsis, dehydration, bilateral disease or unreliable follow-up.
Retropharyngeal abscess in a child	Fever, neck stiffness / torticollis, drooling, voice change, stridor or posterior-pharyngeal swelling. Minimize agitation, obtain senior airway and paediatric ENT support, IV antimicrobials and imaging only when stable.
Pharyngeal / oesophageal foreign body	Complete obstruction, drooling, inability to swallow, sharp object, button battery, multiple magnets or airway symptoms require immediate ENT / endoscopic removal. Do not use blind finger sweeps or unproven food-bolus remedies.
Expanding neck / oral haematoma or active bleeding	Activate trauma / major-haemorrhage care, reverse anticoagulation when indicated, obtain senior airway control before anatomy is lost, and involve ENT / maxillofacial / vascular services immediately.

AIRWAY WARNING: Repeated examination, forced supine positioning, sedation without a rescue plan, or transfer before airway stabilization can precipitate complete obstruction in epiglottitis, deep-neck infection, floor-of-mouth swelling and expanding haematoma.

13. Dental and oral emergencies

13.1 Dental pain and odontogenic infection

- Identify the source and determine whether infection is localized or spreading. Red flags are fever / sepsis, rapidly progressive swelling, trismus, dysphagia, drooling, floor-of-mouth elevation, neck extension, orbital involvement, dehydration, immunocompromise or failed treatment.
- Definitive dental treatment or drainage is the priority. Antibiotics are not indicated for most uncomplicated pulpal or periapical pain without systemic involvement. Use them for systemic illness, spreading infection, deep-space involvement, high-risk host or when source control cannot be obtained promptly, following the local antimicrobial guideline.
- Use an NSAID alone or combined with acetaminophen as first-line analgesia when not contraindicated. Reserve opioids for exceptional severe pain when non-opioid treatment is inadequate or contraindicated, using the lowest effective dose and shortest duration.
- Do not incise an anatomically uncertain deep swelling in the ED. Obtain dental / maxillofacial consultation and image when spread, bone involvement or airway risk is suspected.
- Arrange a specific definitive dental appointment; “see a dentist” without access, timing or red flags is not a safe discharge plan.

13.2 Traumatic dental injury and avulsion

Injury	Immediate management
Avulsed permanent tooth	Handle the crown only. If dirty, rinse gently for a few seconds in milk, saline or clean water without scrubbing. Replant immediately when safe and within competency, confirming correct orientation, or store in HBSS, cold milk, saline or saliva. Urgent dental / maxillofacial care for flexible splinting, pulp planning, antibiotics and tetanus assessment.

Injury	Immediate management
Avulsed primary tooth	Do not replant because of risk to the permanent successor. Control bleeding, assess aspiration / intrusion / alveolar injury and arrange dental review.
Luxation / displacement	Assess occlusion and alveolar segment. Reposition and splint only when trained and according to dental guidance; urgent dental review. Severe mobility, displacement, aspiration risk or interference with bite needs same-day care.
Crown fracture without pulp exposure	Recover fragments, cover exposed dentine with an approved temporary material when trained, provide analgesia and arrange prompt dental repair.
Pulp exposure / root or alveolar fracture	Urgent dental / maxillofacial management; protect exposed pulp, avoid repeated manipulation, use imaging and splinting according to the injury.
Missing tooth / fragment	Account for all material. Examine lips / cheeks and obtain imaging for embedded fragments; evaluate aspiration or ingestion when not located.

13.3 Oral bleeding, post-extraction haemorrhage, and jaw problems

Problem	Management
Post-extraction bleeding	Sit forward, suction, remove loose clot only when needed to identify the socket, and apply firm gauze pressure. Use local haemostatic material, suturing or topical tranexamic acid according to local competency; review anticoagulants and systemic bleeding.
Tongue / oral laceration	Control bleeding, inspect for foreign body and tooth fragments, assess airway and salivary ducts. Repair gaping, through-and-through, function-threatening or uncontrolled wounds with dental / maxillofacial support.
Temporomandibular dislocation	Inability to close the mouth after yawning, procedure or trauma. Exclude fracture and dystonia; provide analgesia / procedural sedation as required and reduce using an approved trained technique. Recurrent or complicated cases need maxillofacial follow-up.
Mandibular / alveolar fracture	Malocclusion, step, sublingual haematoma, mobile segment, numb lower lip or open fracture. Follow facial-trauma pathway, give analgesia, soft diet / nil by mouth as appropriate, antimicrobial and tetanus care for open injury, and urgent maxillofacial consultation.
Oral ulcer / lesion with concerning features	Persistent, indurated, bleeding, unexplained, immunocompromised or airway-affecting lesions require urgent dental / ENT / maxillofacial follow-up and biopsy pathway; do not repeatedly treat presumed infection without diagnosis.

14. Special populations and contexts

Population / context	Additional safeguards
Children	Use age- and weight-based treatment; minimize repeated traumatic attempts at eye / ear / nasal foreign-body removal; protect against amblyopia; never replant primary teeth; consider non-accidental injury and safeguarding.
Pregnancy	Prioritize maternal airway, vision and sepsis treatment. Do not withhold urgent imaging or necessary specialist therapy; select medications with obstetric / pharmacy input and use fetal assessment when clinically indicated.
Older adults / frailty	Atypical infection and giant-cell arteritis are more common; review falls, cognition, anticoagulation, hearing / vision baseline, medication burden, supervision and capacity for follow-up.

Population / context	Additional safeguards
Diabetes / immunocompromise	Lower threshold for admission and imaging in orbital cellulitis, necrotizing otitis externa and odontogenic / deep-neck infection. Infection may progress rapidly with limited early signs.
Anticoagulated / bleeding disorder	Use local haemostatic measures early, obtain relevant drug / timing history and laboratory tests, and reverse only for severe or uncontrolled bleeding according to protocol. Resorbable nasal packing is preferred when available.
Sickle-cell disease / trait	Hyphema and elevated ocular pressure require urgent ophthalmology because optic-nerve injury can occur at lower pressures and some pressure-lowering drugs may be unsuitable.
Contact-lens user	Painful red eye or epithelial defect is microbial keratitis until excluded. Remove lenses, do not patch, retain lenses / case for culture when requested and arrange same-day eye assessment.
Recent procedure / single seeing eye	Any new pain, visual or hearing change, discharge, swelling or bleeding after surgery / injection needs urgent specialist contact. Use a very low threshold for transfer when the affected eye is the only seeing eye.
Communication disability / language barrier	Use interpreters, hearing / visual aids and carers appropriately; document baseline function and adapt consent, examination and discharge instructions.

15. Medication and procedure safety

- All eye drops, nasal vasoconstrictors, systemic pressure-lowering agents, sedatives, local anaesthetics, antibiotics and haemostatic agents must follow approved concentrations, contraindications, age / weight dosing and independent checks where required.
- Confirm that open globe has been excluded before tonometry, ocular ultrasound, forceful lid manipulation or pressure patching. Confirm that tympanic-membrane perforation is not suspected before irrigation or potentially ototoxic ear drops.
- Procedural sedation for foreign-body removal, drainage, reduction or repair requires a trained airway-capable team, monitoring, recovery criteria and consent according to Protocol 50.
- Use local anaesthetic with appropriate maximum-dose calculations. Avoid injecting into infected tissue when ineffective or unsafe, and aspirate before injection when required by the technique.
- Document medication time, route, concentration, response and adverse effects. Send a current medication list and administered treatment with every transferred patient.

16. Monitoring and reassessment

- Repeat and trend airway findings, voice, secretion handling, swelling, respiratory effort, oxygenation, bleeding, haemodynamics, pain, visual acuity, pupils, ocular movements, pressure when appropriate, hearing / neurological findings and oral intake.
- Reassess after irrigation, canthotomy / cantholysis, pressure-lowering therapy, packing, cautery, drainage, tooth replantation, reduction, analgesia and antimicrobial therapy. Document both benefit and complications.
- Escalate for any fall in vision, new afferent pupillary defect, worsening proptosis, rising pressure, increased pain, new field loss, airway noise, reduced secretion handling, increasing trismus, recurrent bleeding, sepsis, facial weakness, neurological deficit or inability to maintain hydration.
- Observation is active care, not a holding state. Assign a named clinician, review interval, outstanding tests, treatment endpoints and a maximum decision time.

17. Consultation, transfer, and disposition

Disposition	Minimum triggers / criteria
Immediate operating / resuscitation pathway	Threatened or lost airway, orbital compartment syndrome, open globe, uncontrolled haemorrhage, major facial / neck trauma, septic shock, caustic airway injury or rapidly progressive deep infection.
Urgent specialist transfer	Sight-threatening eye disease without local ophthalmology; retinal ischaemia requiring stroke-centre care; sudden sensorineural hearing loss without timely ENT / audiology; posterior epistaxis; button battery; deep-neck or odontogenic infection needing surgery; complex dental trauma.

Disposition	Minimum triggers / criteria
Admission / monitored observation	Persistent airway or bleeding risk, systemic infection, IV treatment, recurrent haemorrhage, inability to swallow, significant comorbidity, postoperative complication, unreliable examination, safeguarding concern or lack of safe follow-up.
Discharge	Dangerous diagnoses reasonably excluded; symptoms and bleeding controlled; vision / airway / neurological function stable; oral intake and pain manageable; treatment supplied; reliable supervision; specific follow-up arranged; written return precautions provided.
Special follow-up	Ophthalmology, ENT, audiology, dental / maxillofacial, stroke, rheumatology, infectious diseases, anticoagulation, safeguarding, occupational health or rehabilitation as indicated.

18. Documentation and handover

- Record exact onset / last-known-well time, mechanism or exposure, first aid before arrival, baseline visual / hearing status, recent procedures, medications, allergies and relevant comorbidities.
- Document visual acuity in each eye, pupils, fields, movements, pressure when safe, slit-lamp / fluorescein findings, ENT airway signs, oral / dental map, occlusion, bleeding source, neurological findings and serial change.
- Record all irrigation fluids and times, pH trend, shields, medications, pressure-lowering treatment, packing / cautery, foreign-body attempts, dental-tooth handling and storage medium, procedures, consultations and accepting clinician.
- Use structured handover. Include unresolved airway / visual / bleeding risk, treatment response, pending tests, nil-by-mouth status, packing or shield precautions, transport requirements and specific deterioration actions.
- Photographs may support documentation only with consent and secure approved storage; they do not replace a written examination. Preserve forensic evidence and chain of custody when assault or occupational injury is suspected.

19. Governance, audit, and learning

Suggested indicator	Target / review question
Time to irrigation after chemical eye arrival	Immediate; every avoidable delay reviewed.
Visual acuity documented before disposition	Each eye separately in all feasible eye presentations.
Open-globe safety bundle completed	Shield, no pressure / tonometry, nil by mouth, antiemetic, tetanus / antimicrobial review, urgent ophthalmology.
Time to decompression in orbital compartment syndrome	Immediate when clinically indicated; imaging must not cause harmful delay.
Retinal artery occlusion routed to stroke evaluation	Yes, with last-known-well time documented.
Airway red flags escalated to senior anaesthesia / ENT	Immediate and documented.
Epistaxis compression duration and packing care documented	Yes for treated active bleeding.
Avulsed permanent tooth replantation / storage time documented	Yes, including medium and dental contact time.
Antibiotics prescribed for uncomplicated dental pain without systemic infection	Audit for avoidable prescribing.
Unplanned return, visual loss, airway deterioration, rebleeding or missed foreign body	Multidisciplinary case review.

- Review missed sight-threatening diagnoses, delayed airway intervention, failed transfer, secondary haemorrhage, medication error, repeated traumatic foreign-body attempts, inappropriate antibiotic / opioid prescribing, lost avulsed teeth and unplanned reattendance through clinical governance.
- Run multidisciplinary simulation for chemical-eye irrigation, open-globe protection, orbital canthotomy, epistaxis, difficult upper airway, button-battery removal pathway and dental avulsion. Include nursing, pharmacy, imaging, transfer and equipment deployment.
- Update referral contacts, drug / equipment stocks and transfer agreements after every service change or identified failure.

20. Minimum equipment and readiness

Capability	Minimum readiness requirement
Eye examination and first aid	Distance / near acuity charts, pinhole, penlight, fluorescein, cobalt-blue light or slit lamp, topical anaesthetic, pH paper, irrigation tubing / lens, eyelid retractors, rigid shields and tonometer with infection-control supplies.
Eye emergency procedures	Lateral canthotomy / cantholysis set, magnification, sterile instruments, approved pressure-lowering medicines, systemic open-globe antibiotics and immediate ophthalmology contact / transfer plan.
ENT airway and bleeding	Suction, oxygen, difficult-airway cart, video laryngoscopy, flexible nasendoscopy when service provides it, headlight, nasal speculum, topical vasoconstrictor / anaesthetic, cautery, resorbable and non-resorbable packing, balloon devices and major-haemorrhage support.
Ear / foreign body	Otoscope, microscopy or magnification when available, appropriate hooks / forceps / suction, irrigation equipment with contraindication checklist, topical preparations and paediatric restraint / sedation pathway.
Dental / oral	Dental mirror, light, suction, local anaesthetic equipment, temporary dental material, physiologic tooth-storage medium, haemostatic material, splinting access through dental service, bite / occlusion documentation and maxillofacial instruments.
Imaging / laboratory	24-hour CT access or defined transfer route; urgent blood tests, cultures, crossmatch, pregnancy testing and access to audiometry / dental imaging directly or by referral.
Training and contacts	Current 24-hour ophthalmology, ENT, maxillofacial, dental, anaesthesia, stroke, radiology and transfer contacts; annual competency review for irrigation, eye shielding, canthotomy, nasal packing and dental avulsion first aid.

21. References and evidence base

- Royal College of Ophthalmologists. Emergency Eye Care Commissioning Guidance and Emergency Eye Care in Hospital Eye Units and Secondary Care.
- Royal College of Ophthalmologists. The Management of Angle-Closure Glaucoma: Clinical Guideline, 2021.
- American Academy of Ophthalmology. Retinal and Ophthalmic Artery Occlusions Preferred Practice Pattern, 2024.
- American Heart Association. Management of Central Retinal Artery Occlusion: A Scientific Statement, 2021.
- American Academy of Otolaryngology-Head and Neck Surgery Foundation. Clinical Practice Guideline: Nosebleed (Epistaxis), 2020.
- American Academy of Otolaryngology-Head and Neck Surgery Foundation. Clinical Practice Guideline: Sudden Hearing Loss (Update), 2019.
- National Institute for Health and Care Excellence. Hearing Loss in Adults: Assessment and Management (NG98), current version.
- International Association of Dental Traumatology. Guidelines for the Evaluation and Management of Traumatic Dental Injuries: Fractures and Luxations, Avulsion of Permanent Teeth, and Injuries in the Primary Dentition, 2020.
- American Dental Association. Evidence-Based Clinical Practice Guideline for Pharmacologic Management of Acute Dental Pain in Adolescents, Adults, and Older Adults, 2024; Paediatric Acute Dental Pain Guideline, 2023.
- American Dental Association. Evidence-Based Guideline on Antibiotic Use for Urgent Management of Pulpal- and Periapical-Related Dental Pain and Intraoral Swelling, 2019.
- American Academy of Pediatric Dentistry. Acute Management of an Avulsed Permanent Tooth and endorsed IADT traumatic-dental-injury guidance.
- Local protocols for difficult airway, procedural sedation, sepsis, antimicrobial therapy, anticoagulant reversal, major haemorrhage, stroke, trauma, imaging, safeguarding and specialist transfer.

Annex 1. One-page eye, ENT, and dental emergency workflow

Step	Action
1. Identify the threat	Airway? Severe bleeding? Sudden vision / hearing loss? Chemical eye exposure? Penetrating injury? Orbital tension? Button battery? Avulsed permanent tooth?

Step	Action
2. Act immediately	ABCDE; irrigate eye; rigid shield; decompress threatened orbit; activate stroke; compress nose; call airway team; preserve / replant permanent tooth.
3. Measure function	Visual acuity each eye, pupils / fields / movements; voice / secretion handling / stridor; hearing / neurology; occlusion and dental map.
4. Examine safely	No pressure or tonometry if open globe possible; no provocative throat exam in unstable airway; no repeated blind foreign-body attempts; no replantation of primary teeth.
5. Investigate selectively	CT orbits / face / neck, CTA, blood tests, cultures, audiometry and dental imaging only when indicated; do not delay treatment.
6. Treat the cause	Pressure lowering, antimicrobials, drainage, cautery / packing, foreign-body removal, tooth stabilization, analgesia and source control with specialist guidance.
7. Reassess and decide	Trend vision, airway, bleeding, pain and neurological status; admit / transfer danger; discharge only with named follow-up and written red flags.

Annex 2. Eye emergency assessment record

Required field	Entry
Onset / last known well / mechanism	_____
Usual correction / baseline eye disease / surgery	_____
Visual acuity right	Without correction: _____ With correction / pinhole: _____
Visual acuity left	Without correction: _____ With correction / pinhole: _____
Pupils / RAPD	Right: _____ Left: _____
Fields / colour / ocular movements	_____
External / cornea / chamber / fluorescein	_____
Intraocular pressure if safe	Right: _____ Left: _____ Time: _____ Device: _____
Fundus / red reflex	_____
Treatment / response / ophthalmology advice	_____
Disposition / follow-up	_____

Annex 3. Chemical eye irrigation record

Required field	Entry
Chemical / concentration / exposure time	_____
Contact lenses removed	Yes / No / Not present
Initial pH right / left	Right: _____ Left: _____ Time: _____
Topical anaesthetic	Drug / time: _____
Irrigation start	Time: _____ Fluid: _____ Device: _____
Volume / duration	_____
Particulate material removed / fornices swept	_____
Repeat pH and stability after pause	Right: _____ Left: _____ Time: _____
Post-irrigation vision / cornea / limbus / pressure	_____

Required field	Entry
Ophthalmology contact / destination	_____

Annex 4. Open-globe and orbital-compartment checklist

Check	Complete / finding
Mechanism and eye protection documented	_____
Visual acuity / pupils documented without pressure	_____
Rigid shield applied; no patch / tonometry / ultrasound	_____
Nil by mouth; analgesia and antiemetic given	_____
Tetanus and systemic antimicrobial plan	_____
Thin-section CT orbits / MRI contraindication reviewed	_____
Ophthalmology contacted and accepting clinician named	_____
Orbital compartment signs assessed	Vision / RAPD / proptosis / tension / movements / pressure
Canthotomy / cantholysis time and response if performed	_____
Transfer precautions and escort	_____

Annex 5. Acute vision loss and painful red-eye escalation matrix

Finding	Action
Sudden painless monocular visual loss	Stroke / retinal-ischaemia pathway now; ophthalmology and giant-cell-arteritis assessment.
Curtain, shadow, new field loss, flashes with many floaters	Same-day retinal examination / transfer.
Painful red eye with reduced vision, corneal opacity, contact lens or photophobia	Same-day ophthalmology; treat microbial keratitis / angle closure / uveitis as appropriate.
Pain and visual loss after eye surgery / injection	Immediate ophthalmology for endophthalmitis or surgical complication.
Proptosis, RAPD, tense orbit, falling vision	Immediate orbital decompression pathway.
Eye trauma with irregular pupil, uveal tissue or high-velocity mechanism	Rigid shield and open-globe pathway.
Minor red eye with normal vision, no pain / photophobia and clear cornea	Treat likely benign cause only after danger is excluded; provide review and red flags.

Annex 6. Epistaxis treatment record

Required field	Entry
Onset / side / estimated loss / recurrence	_____
Airway / haemodynamics / anticoagulants	_____
Compression start / stop	Start: _____ Stop: _____ Duration: _____
Topical vasoconstrictor / anaesthetic	_____
Bleeding site identified	Anterior / posterior / not seen: _____
Cautery	Agent / side / time: _____
Packing	Type / side / insertion time / balloon volume: _____
Blood tests / transfusion / reversal	_____

Required field	Entry
ENT contact and escalation plan	_____
Packing review / removal and discharge advice	_____

Annex 7. Threatened-airway and deep-neck infection checklist

Check	Complete / finding
Stridor / drooling / voice / secretion handling / trismus	_____
Tongue / floor of mouth / neck swelling / progression	_____
Patient kept calm, upright and monitored	_____
Senior ED, anaesthesia and ENT / maxillofacial called	Times: _____
Primary and rescue airway plan agreed	_____
Imaging deferred until airway considered safe	Yes / No / rationale: _____
IV access, sepsis care and antimicrobials	_____
Drainage / theatre / transfer destination	_____
Transport airway equipment and escort	_____

Annex 8. Dental trauma and avulsion record

Required field	Entry
Time / mechanism / loss of consciousness	_____
Primary or permanent dentition	_____
Tooth / teeth involved	_____
Avulsed tooth found and handled by crown	Yes / No / Not applicable
Extra-oral dry time	_____
Storage medium	HBSS / milk / saline / saliva / dry / other: _____
Replanted by / time	_____
Occlusion / mobility / alveolar injury	_____
Missing fragments / aspiration evaluation	_____
Tetanus / antibiotics / analgesia	_____
Dental / maxillofacial contact and follow-up	_____

Annex 9. Minimum discharge instructions

Condition	Return immediately for
Eye injury / red eye	Reduced or distorted vision, increasing pain, new flashes / floaters / curtain, vomiting, worsening redness / swelling, pus, severe headache or inability to open the eye.
Epistaxis / nasal packing	Bleeding through mouth or packing, breathing difficulty, faintness, fever, increasing pain, packing displacement or inability to obtain scheduled removal.
Ear / hearing	Sudden or worsening hearing loss, facial weakness, severe vertigo, fever, mastoid swelling, persistent bleeding / drainage or severe pain.

Condition	Return immediately for
Throat / dental infection	Difficulty breathing or swallowing, drooling, voice change, increasing trismus, floor-of-mouth / neck swelling, fever, confusion, dehydration or rapidly increasing pain.
Dental trauma	Tooth loosening or darkening, increasing pain / swelling, fever, bite change, splint failure, bleeding, numbness or inability to attend the scheduled dental visit.

Every discharge must state medication dose and duration, eye / ear / wound / packing / dental care, activity and diet restrictions, driving / work limitations when vision or hearing is affected, the exact follow-up service and time, and a 24-hour return route.

Annex 10. Local configuration checklist

Local element	Complete before approval
24-hour ophthalmology contact and transfer destination	Name / number: _____
24-hour ENT / head and neck contact	Name / number: _____
Oral / maxillofacial and emergency dental access	Name / number / hours: _____
Stroke-centre pathway for retinal artery occlusion	Destination / activation: _____
Approved chemical-eye irrigation equipment and pH range	_____
Open-globe antimicrobial and tetanus regimen	Document / version: _____
Acute-angle-closure medication pack and contraindication guide	_____
Orbital canthotomy competency, kit and escalation standard	_____
Epistaxis packing / cautery devices and removal pathway	_____
Threatened-airway / deep-neck imaging and theatre pathway	_____
Dental avulsion storage medium and splinting referral	_____
Approved dental analgesic / antibiotic guideline	Document / version: _____
Procedural sedation and paediatric foreign-body pathway	_____
Staff training, simulation and next review date	_____