ONC-SOP-007: Urgent triage of patients with cancer

Standard operating procedure (SOP) · ONC-SOP-007 · Version 0.1 · Draft for local review

Supports: 51.8

At a glance

- Every patient who arrives for urgent or emergency care is triaged by clinical urgency within the time set by the facility, using a recognised triage tool.
- Oncology red flags are checked at triage: fever with low white cells, spinal cord compression, superior vena cava obstruction, severe bleeding, acute confusion and severe pain.
- The most urgent patients are seen first, and the triage category and time are recorded.
- Patients whose triage category is not confirmed are re-triaged at set intervals while they wait.
- Stop and act at once if: a red flag is present, or a patient's condition changes while waiting.

1. Purpose

To make sure that every patient with cancer who arrives for urgent or emergency care is sorted by clinical urgency, within a set time, and that the most urgent are seen first (51.8).

2. Scope

Item	Coverage
Applies to	Triage nurses, emergency and oncology staff, and any staff who see patients with cancer who arrive for care
Patients	Adults with active or recent cancer, and patients with a cancer-related emergency, presenting to any part of the facility
Locations	Emergency department, oncology day unit, ward areas, outpatient reception and the on-call service

3. Definitions

Term	Meaning in this SOP
Triage	The process of sorting patients by clinical urgency so that the most urgent are treated first
Recognised triage tool	A triage system with validated categories, such as the Manchester Triage System or the Emergency Severity Index, used as set by the facility
Red flag	A sign that needs immediate action, listed in Section 6
Time to triage	The time from arrival to a documented triage category

4. Background

Patients with cancer can deteriorate quickly from complications of their disease or treatment, and some complications are time-critical. Recognising them at triage, and not treating them as routine, changes outcomes. Patients on chemotherapy with fever can be deeply unwell within hours, even when they look well.

5. Responsibilities

Role	Responsibility
Triage nurse	Carries out triage within the set time, uses the tool, checks red flags, and re-triages waiting patients
Triage doctor or senior clinician	Reviews patients in the highest categories and any patient with a red flag
Oncology on-call clinician	Advises on cancer-specific emergencies and agrees the immediate plan
Service manager	Keeps the triage tool, the training and the audit in place

6. Red flags at triage

A patient with any of these signs is placed in the highest urgency category and the senior clinician is informed immediately:

- Fever of 38.0 degrees Celsius or above, or signs of infection, in a patient on chemotherapy or with a low white cell count (follow ONC-SOP-003).
- Signs of sepsis: fast breathing, low blood pressure, confusion, mottled skin or low urine output (follow ONC-SOP-008).

- Weakness or numbness in the legs, new back pain with bladder or bowel change, which may mean spinal cord compression.
- Swelling of the face and neck or arms, with breathlessness, which may mean superior vena cava obstruction.
- Severe or uncontrolled bleeding, or vomiting blood.
- Acute confusion, drowsiness or seizure.
- Severe pain that is not controlled, or pain with a new neurological sign.
- Breathlessness at rest or chest pain.
- Vomiting or inability to take fluids, with signs of dehydration or high calcium.

7. Procedure

7.1 At arrival

1. Record the arrival time and the reason for attendance.
2. Check the red flags in Section 6 at the first contact, before any queue.
3. Triage the patient using the recognised tool within the facility's set time. Record the category and the time of triage.
4. Inform the triage doctor or senior clinician of any patient in the highest categories immediately.

7.2 While waiting

1. Re-triage every patient who is waiting at the set interval for their category, and at any change.
2. Give the patient and family clear information about the wait, the reasons for it and what to do if the condition changes.
3. Record each re-triage with the time and the result.

7.3 Patients who leave before being seen

1. Record the time the patient left, and whether they were advised to stay.
2. Telephone the patient, where contact details exist, within the same working day to check on them and offer a follow-up.

8. Decision points

Situation	Action
Patient with a red flag is in a low category	Upgrade the category at once and inform the senior clinician
Patient does not speak the language	Use a professional interpreter during triage. Do not rely on a family member for triage questions
Patient deteriorates while waiting	Bring the patient to the resuscitation or acute area immediately and inform the senior clinician
Triage tool cannot be used, for example during a major incident	Use the facility's major incident triage system and record the patient's category

9. Escalation

- Red flag without a senior review within the set time: escalate to the consultant on call.
- Delay in triage beyond the set time for a high category: the service manager reviews the cause the same day.
- Adverse outcome after a delay: report under INC-SOP-001 within 24 hours.

10. Monitoring

The service manager audits 30 triage records each month for patients with cancer, and reports results to the emergency and oncology governance meeting each quarter.

Measure	Target
Patients triaged within the set time	At least 95 percent
Highest-category patients seen by a senior clinician within the set time	100 percent
Red flags recorded at first contact	100 percent
Waiting patients re-triaged at the set interval	100 percent

11. Records

- Triage record with category and times.
- Re-triage record.
- Red flag checklist.
- Record of patients who left before being seen.

12. Training

All triage staff complete training on the recognised tool and on cancer red flags at induction, with a practical assessment, and refresh the training every year.

13. Related documents

Code	Document
ONC-SOP-003	Neutropenic fever response
ONC-SOP-008	Sepsis recognition in patients with cancer
ONC-SOP-005	Palliative care integrated with active cancer treatment
ED-SOP-001	Triage on arrival and waiting rules
INC-SOP-001	Root cause analysis of serious incidents

14. Evidence

This SOP is based on the reference sources listed below and on the requirement of criterion 51.8 of the ASF standards. The triage tool and the set times must be confirmed against the facility's chosen tool at each review.

E-learning for this document

- No course linked yet. Request an emergency triage course from the academy (see the Standard 51 request list).

References

1. Mackway-Jones K, Marsden J, Windle J, editors. Emergency Triage: Manchester Triage System. Current edition.
2. Emergency Severity Index (ESI) Implementation Handbook. Agency for Healthcare Research and Quality (AHRQ). Current edition.
3. NICE. NG12: Suspected cancer: recognition and referral. Current edition.
4. Facility triage policy and set triage times (to be inserted by the unit at adoption).

Change history

Version	Date	Change
0.1	2026-10-26	First draft for review. Not yet approved by the ASF Expert Committee.

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