NHS North West

# NORTH WEST GUIDELINE

# Clinical Escalation and Conflict of Clinical Opinion

## Document Control:

| Role | Name | Contact |
|---|---|---|
| Owners | Regional Guideline Steering Group | |
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## Version control:

| Title | |
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| V0.1 | Copied over adapted version of University of Southampton guideline to new template |
| V1.0 | Ratified guideline |
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## Compliant with:

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## Authors

Please list all authors here:

| | |
|---|---|
| Danielle Freemantle<br>Alexander Heazell | Maternity Workforce Lead and former National Each Baby Counts Learn and Support Local Development Lead |
| Alexander Heazell | Regional Lead Obstetrician, NW England. |
| Chloe Hughes | |
| MaryJo Waldron | |
| Natasha MacDonald | |

## Acknowledgements:

## Conflict of Interest:

All members of the guideline development group should consider whether there are any conflicts of interest and declare them here.

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# Contents



# 1 Summary / Introduction

Problems with clinical escalation (raising concerns to other, more senior clinicians, about a clinical situation) have frequently been linked to poor outcomes including stillbirth and intrapartum related hypoxic injuries. This is closely related to problems with communication between members of the multidisciplinary team working in maternity care.

This guideline has been adapted for use in the North-West of England following introduction in other regions of the UK. The guideline aims to provide a **structured process** to support effective clinical escalation and to provide **tools to ensure effective communication** about clinical scenarios between professionals. It should be used with tools such as Maternity Early Warning Score (MEWS) or Newborn Early Warning Track and Trigger (NEWTT2) to identify deterioration.

## 2 Purpose

The document is intended to support all clinicians (including maternity support workers, midwives, nurses, obstetricians and sonographers) working in the maternity setting who are concerned about an evolving clinical situation or deterioration to be able to effectively clinically escalate and to resolve conflicts of opinion if a difference of opinion arises.

The document defines clinical escalation, who to consider escalating to and summarises the escalation process via a 'Clinical Escalation flowchart'. The 'Clinical Escalation flowchart' summarises the key steps and techniques to support effective escalation. The techniques are part of the Each Baby Counts Learn & Support Clinical Escalation Toolkit (RCOG 2022a).

Clinical escalation has often been identified as contributing to poor outcomes (RCOG 2019). The Independent Maternity review Ockenden report (2022) recommends that all staff working in maternity services must be able to escalate concerns and that effective clinical escalation is fundamental to safe and effective care in our maternity services. Providing effective and holistic maternity care can also provide challenges for professionals and women or birthing people. If the decisions around management or care causes concern or a difference of opinion this can result in a conflict of clinical opinion between team members. Theme 3 of the NHS England short-term plan states that providers should "ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit."

The term escalation is sometimes used in relation to high acuity levels where location of staff, additional staff or unit closure is considered – these acuity concerns are different from clinical escalation. This document focuses on clinical escalation and conflicts of opinion.

## 3 Scope

The purpose of this document is to describe the process for the escalation of clinical concerns for an evolving situation or deterioration in mother or baby's condition, and to support staff in resolving conflicts of professional opinion in a timely manner. It summarises key steps and techniques that can be applied to aid effective escalation. This flowchart should be used in conjunction with relevant associated clinical guidelines. It is not intended for use with or instead of existing operational maternity policies or guidelines e.g., Safe staffing levels in the Maternity service

## 4 Responsibilities

All obstetric consultants, trainees, midwifery, and clinical maternity support staff. All obstetric anaesthetic staff and theatre teams. All neonatal unit staff. shift co-ordinators and midwifery managers.

## 5 Clinical Escalation Flowchart

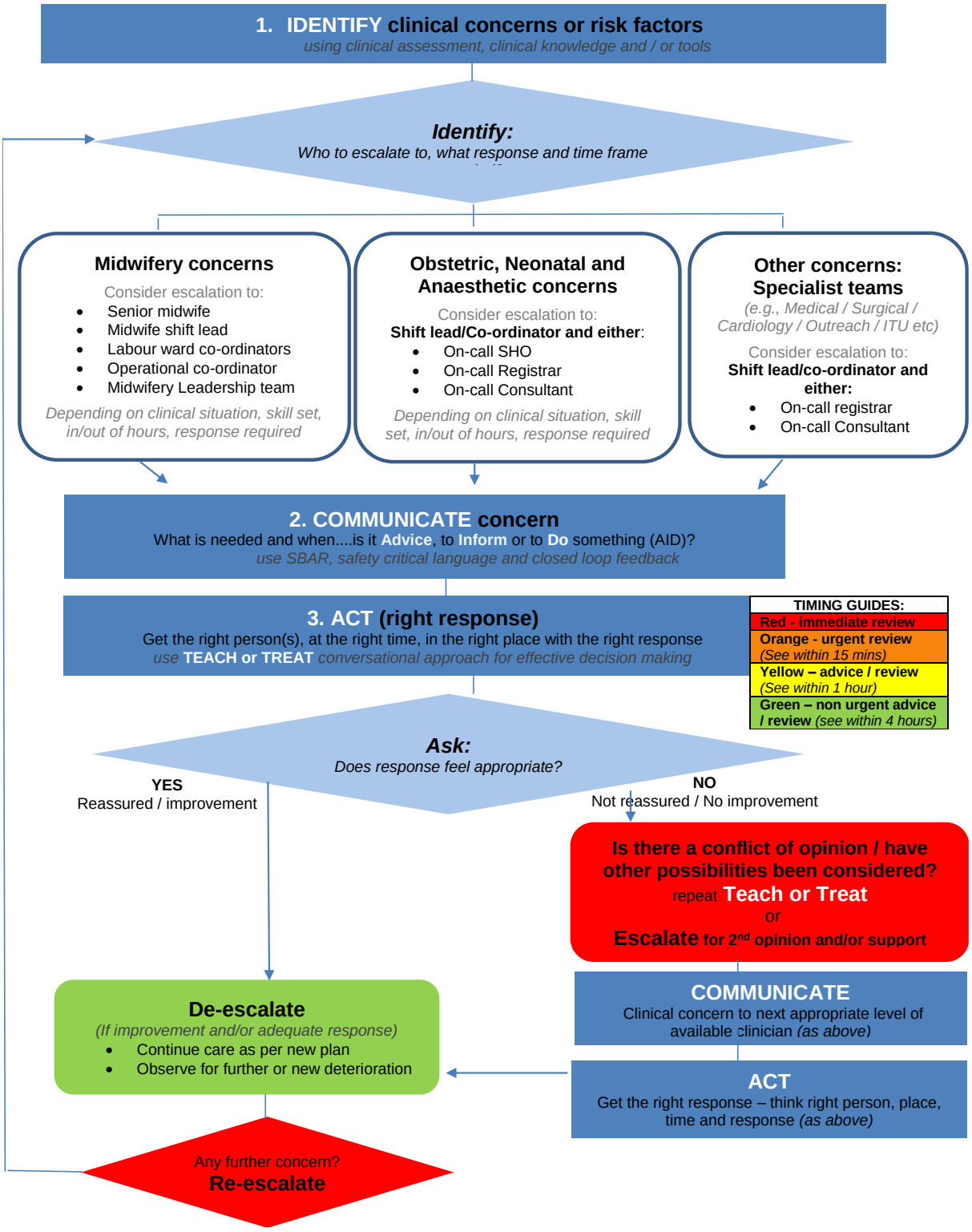
On the next page is a flowchart to outline the process of clinical escalation.

This is based around three key events – identifying a clinical concern or issue, communicating

that concern and taking appropriate action.

The clinical escalation process makes use of tools described in detail in Section 6.

## IDENTIFY - COMMUNICATE - ACT



# 6 Clinical escalation process and techniques to support escalation

The following details support an understanding of clinical escalation and the techniques that can be used.

## 6.1 Clinical escalation process

The Each Baby Counts Report (RCOG 2019) recognises that effective clinical escalation is a three-step escalation process:

1. ***IDENTIFY*** ***clinical concern(s) or risk factors*** *(evolving clinical situation or deterioration)*
2. ***COMMUNICATE*** ***concern(s)****; giving and receiving of the message; hearing and understanding*
3. ***ACT*** ***(getting the right response)****. Getting the right person, place, time and response.*

Effective clinical escalation involves key actions, and these are summarised in figure 1. There are also barriers to effective escalation, and these are summarised in figure 2.

**Figure 1. Effective clinical escalation involves the following key actions**

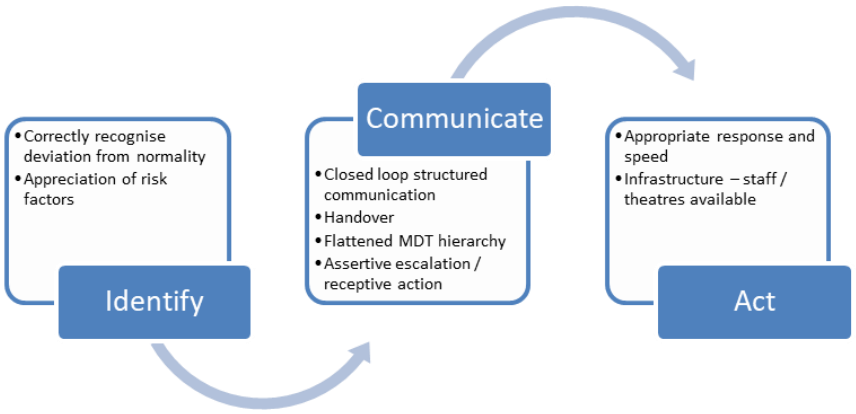
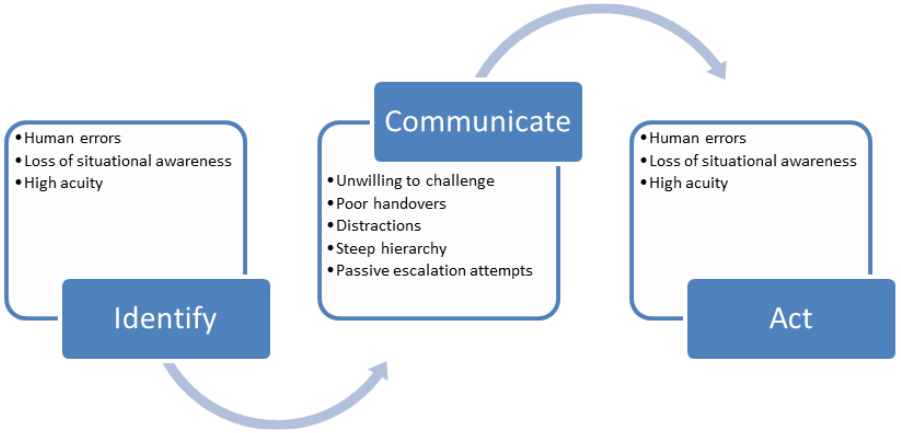



**Figure 2. Barriers to effective clinical escalation**

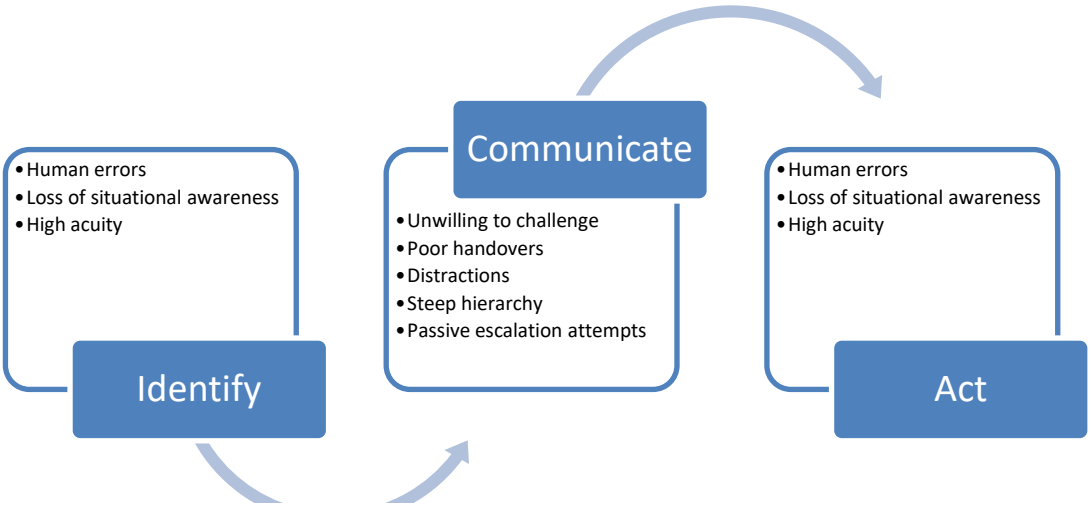


### 6.2 Techniques to support effective clinical escalation

The Each Baby Counts Learn and Support programme (RCOG, 2022a) developed three behavioural tools and techniques to build the right culture, behaviours and conditions that enable effective clinical escalation. These techniques promote improved communication, civility, teamworking and psychological safety with teams. They support an environment of constructive conflict or friction; whereby individuals within teams can understand and compassionately challenge the perceptions of others and contribute to decision-making. The techniques are aligned to the three-step escalation process of **IDENTIFY-COMMUNICATE-ACT**.

**IDENTIFY concerns AND who to escalate to during the shift *('Team of the shift' checklist)***


**Figure 2. Barriers to effective clinical escalation**




The first step in the escalation process involves clear identification of a concern. Several trigger tools exist that help with identification of deterioration, an evolving clinical situation or risk factors e.g., MEWS/NEWTT2, Partograms, Fetal monitoring classification tools, risk assessments etc.

At the point of identification of a concern an individual becomes consciously aware of this and that they will need to perform an escalation activity. This involves:

- Knowing who to escalate to
- Feeling psychologically safe to escalate
- Consideration of time frames
- Knowing how to escalate - *this can include using an emergency buzzer, alerting a colleague about deviation from normal, bleeping another staff member, making a phone call (senior midwife, call 999), putting out a 2222 emergency call or simply having a conversation about care plans and deciding management*.

- Deciding to escalate

The transient nature of teams in maternity services means that team members do not always know each other, understand individual strengths or work together regularly (Barber et al 2022). **Team of the shift** is a framework or checklist (appendix 1) that can be used at the beginning of a shift. It supports all team members to feel welcome, to introduce themselves by name and role, to understand skills sets and development or learning needs, to know what is expected of them and rules of engagement, to identify emergency team roles and, who to escalate to during the shift.

## COMMUNICATE: Advice-Inform-Do and SBAR


The second step in clinical escalation involves communicating the concern to the **right person**(s), **what is needed** and **when**. High clinical acuity and complex human factors can be a barrier to effective escalation and, to the ability to simultaneously triage multiple escalations as they occur. Communication therefore needs to support this.

The **Advice-Inform-Do** (AID) tool **is used to start the escalation conversation** before conveying key information using the Situation Background Assessment Recommendation Response (SBARR) framework to ensure key critical information is included and misunderstandings avoided (adapted from the Institute for Healthcare Improvement 2022). AID enables the recipient to i) promptly recognise an escalation ii) quickly understand what is needed/expected iii) maintain situational awareness when multiple escalations may be occurring.

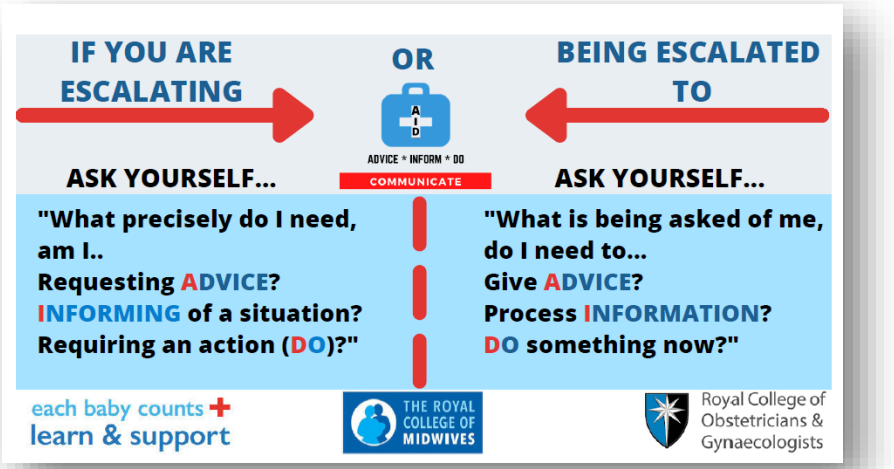
The communication of clinical escalation can be either 'pushed' (by the person escalating) or 'pulled' (by the person being escalated to). It relies on assertive escalation and receptive action

This can be used **when escalating**:

- **A**dvice – Can I ask your Advice
- **I**nform – Can I Inform you/let you know
- **D**o – Can you come and do something (e.g., review a CTG)

It can also be used in reverse **when being escalated to:**

- **A**dvice – Are you asking me for Advice about…?
- **I**nform – Are you (just) Informing me about….?
- **D**o – Do you need me to come and do….




## SBARR: Situation Background Assessment Recommendation and Response

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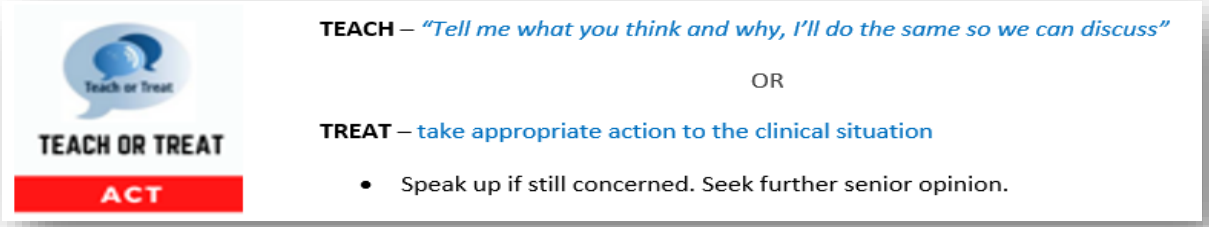
| **S** | **Situation:** What is the situation you are calling about?<br>• Identify self, unit, patient, room number.<br>• Briefly state the problem, what is it, when it happened or started, and how severe. | I need your ADVICE<br>I need to INFORM you<br>I need you to DO (ie come and see urgently) |
| **B** | **Background:** Pertinent background information related to the situation could include the following:<br>• The admitting diagnosis and date of admission<br>• List of current medications, allergies, IV fluids, and labs<br>• Most recent vital signs<br>• Lab results:<br>• Other clinical information | |
| **A** | **Assessment:** What is your assessment of the situation? | |
| **R** | **Recommendation:** What is the recommendation or what does he/she want? Examples:<br>• I need your ADVICE<br>• I need to INFORM you<br>• I need you to DO | |
| **R** | **Response**<br>**Are you happy with the response? Do you need to re escalate or de escalate**<br>**Think TEACH or TREAT** | Plan following Escalation |

## 7 ACT: Teach or Treat


The third step in effective clinical escalation involves **'act'** (acting in the right way or **getting the right response**). This involves making appropriate decision(s). Effective decision-making is important for safe care.

It is important to lead effective decision-making in teams and for team members to feel safe to contribute or to challenge where time permits and when they do not agree with a decision or understand the reason for a decision. An appropriate conversational technique to get the right response is **'Teach Or Treat'**. This avoids the decision-maker or team lead giving their own opinions at the outset because a different team member may be reluctant to air or contradict the leader (Global Air 2021). It is a safe way to open conversations in a non-confrontational way, exposes different perceptions and allows ongoing development or education, shared learning and the supports shared mental models.

**Teach Or Treat** works by enabling either the team lead or clinician with concern(s) to ask to 'teach or treat'. The conversation as follows:




## 8 Conflict of clinical opinion

If proposed decisions around management of care causes concern or differences of opinion between healthcare professionals, teams or the person being cared for these can usually be resolved by careful discussion and explanation using the techniques previously described.

If a conflict of clinical opinion persists then a second opinion should be offered or sought by any member of the team. In more rare or difficult cases, the senior clinician may seek legal advice.

If there is a conflict of clinical opinion despite the above measures or in an emergency, then any member of staff at any level can contact the On-Call Obstetric Consultant and/or Maternity Bleep holder. [N.B This will need adapting to each units on call structure]. If at any time the midwife directly caring for the patient is concerned with the decision of the midwife co-ordinator or middle-grade doctor, they may call the on-call Consultant directly to discuss issues of care. Depending on the situation it may also be appropriate for the midwife to contact the maternity bleep holder or the senior leadership team for support and advice.

If there is a conflict of clinical opinion with the consultant, the clinical team should again seek a Teach or Treat type conversation to explore the decisions made by that consultant. This may help the team to understand the rationale underlying certain clinical decisions / plan. If, ongoing conflict is apparent, the registrar and co-ordinator together should consider seeking a second consultant opinion irrespective of the time of day or night. This potentially could be a challenging situation, so establishing psychologically safe work environments and using

Teach or Treat as a method to open conversations can be essential. Depending on the situation it may also be appropriate for the midwife or obstetrician to escalate to the Midwifery bleep holder, the PMA or the leadership team for support and/or advice.

If a Maternity Support Worker (MSW) has concerns and has escalated this to a midwife with responsibility for providing care then any MSW can refer directly to the midwife shift lead or bleep holder or Midwifery Leadership team for ongoing advice or support.

It is important to maintain accurate and contemporaneous documentation of advice, reviews or plans of care. It is also important to ensure that the woman is informed and involved with any actions and the rationale for decisions.

Remember:

- It is always beneficial to first **discuss your concerns with the individual** managing the situation, to enable open discussion and mutual appreciation of the full ongoing circumstances.
- Consideration should be given around **whether it is appropriate to have the conversation in front of the woman or birthing person and their birth partner.**
- It may be necessary to hold a private conversation with a colleague(s) and if the concern is non-urgent, asking to make time to discuss further.
- It is important to build and **maintain a psychologically safe environment** for all; ensuring people feel *included*, safe to *learn*, safe to *contribute* and safe to *challenge*. To do this people need to feel accepted and respected and, encouraged to contribute and challenge.
- If at any time you are concerned with how a situation is being managed clinically or you want to discuss with another member of the team; you can get advice from other key members of staff at any time day or night.
- As per professional standards of practice for midwives and doctors if you express a reasonable concern in good faith, you will not be penalised.

## 9 Implementation – communication and training plans

The clinical escalation leads for each Trust will be expected to cascade to all relevant staff groups. All medical, nursing and midwifery staff caring for women and newborns to be supported by clinical leads to implement the contents of the guideline. In addition, the guideline will be included in local staff induction programmes.

The author is responsible for ensuring the effective dissemination of this guideline. Methods of dissemination may include:

- Present the guideline at relevant meetings
- Communication board in birth environments and ward areas for discussion at handover
- Training materials e.g., laminated flowcharts

## 10 Roles and responsibilities

This guideline applies to all clinical staff employed in North-West maternity units who provide clinical care to women and newborns. Staff have a responsibility to ensure that they are aware of this guideline and its contents. They should clearly document their rationale if they have not

complied with the recommendations detailed in this guideline. It is the responsibility of department managers, consultants, team leaders and education leaders to ensure staff are aware of this guideline.

## 11 Monitoring / Audit

The purpose of monitoring is to provide assurance that the agreed approach is being followed. This ensures that we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Key aspects of this policy will be monitored:

| | |
|---|---|
| Element to be monitored | HSIB cases, Clinical Events cases, and Adverse Event Reporting (AER) involving issues with clinical escalation |
| Lead (name/job title) | Risk Team |
| Tool | Risk case review log |
| Frequency | Yearly |
| Reporting arrangements | To report via risk meetings |

Where monitoring identifies deficiencies, actions plan will be developed to address them.

## 12 Details of attachments (e.g. list of appendices)

Appendix 1 – Team of the Shift framework

# 13 Appendix 1 – TEAM OF THE SHIFT framework

## IDENTIFY – COMMUNICATE - ACT

TEAM OF THE SHIFT
TEAM WORK, CIVILITY, PSYCHOLOGICAL SAFETY

**Date:** **Shift:** DAY / NIGHT

**Co-Ordinator name:**

It can be helpful to use this framework or checklist to implement **Team of the Shift Huddle** at the start of each handover.

Set the scene before you start

- *Reduce distractions*
- *Close the door*
- *Ensure privacy and confidentiality.*
- *Manage immediate safety issues - delegate prior to commencing team of the shift and handover*

| **IMPLEMENTATION CHECKLIST**<br>*Start promptly. 5-10 mins for Team of the Shift then clinical handover* | **RECORD below**<br>✓ *or X and comments* |
|---|---|
| **Welcome incoming team**<br>• Ask how everyone is (anyone hungry, angry, late, tired or distracted)<br>• Let people know who they can talk to if they wish to talk privately | |
| **Identify team members - introductions**<br>• First name and job title<br>• Role for the duration of the shift<br>• Support/development needs | |
| **Identify emergency team**<br>their roles and if there are any potential emergencies anticipated | |
| **Identify who to escalate to** and any escalation buddies | |
| **Clinical handover** | |
| **Thank outgoing team** - promote kindness and civility<br>• What went well?<br>• Celebrate and recognise success<br>• Is everyone ok?<br>• Do colleagues feel safe to go home?<br>• Thank colleagues for their support during today's shift | |

## 14 Details of other relevant or associated documents (including links)

- Royal College of Obstetricians and Gynaecologists. 2022. Each Baby Counts Learn and Support Improving Clinical Escalation toolkit. https://www.rcog.org.uk/about-us/groups-and-societies/the-rcog-centre-for-quality-improvement-and-clinical-audit/each-baby-counts-learn-support/

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## 15 Supporting references & national guidance


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- Institute for Healthcare Improvement. 2022. SBAR tool: Situation-Background-Assessment-Recommendation – IHI toolkit SBAR Tool: Situation-Background-Assessment-Recommendation | IHI - Institute for Healthcare Improvement


## 16 Definitions / glossary

- **Clinical escalation** - is defined as: *'safety critical communication to achieve a timely senior response for a complication or evolving* clinical situation' (EBC 2019)
- **De-escalation** - refers to the process of standing down following a clinical concern if there is an improvement and/or adequate response
- **Re-escalation** - refers to the process of a clinical concern increasing and therefore repeating an escalation via further ongoing support and/or a 2nd senior opinion
- **Conflict of clinical opinion** – this can occur if the proposed management of care causes concern, disagreement or conflict and cannot be resolved between team members.
- **Civility –** is the act of **showing regard for others by being polite. It is about how we treat each other at work with civility and respect**
- **Psychological safety –** is about building an environment where people feel accepted and respected. People feel *included*, safe to *learn*, encouraged to *contribute* and to *challenge* when they have concerns or question, without fear of repercussion.

## 17 Consultation with Stakeholders

This guideline was developed outside the NorthWest of England. Since redrafting it has been circulated to the Maternity and Neonatal Voices Partnership leads for their review.

The tools contained within the guideline were developed as part of the Each Baby Counts Learn and Support intitiative, led by the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives following Each Baby Counts reports from 2015-2020.