Clinical Escalation - Non-Clinical Guideline

Reference No: UHDB/02:24/O25

Contents

1. Introduction

Information should be given in a structured format when escalating clinical information. SBAR should be used.

2. Culture and Leadership

The leadership style and behaviours of doctors and midwives in shift leadership roles are fundamental to setting the culture within Maternity units. Doctors and midwives should learn to adapt their leadership style according to the situation.

At UHDB it is expected that doctors and midwives in shift leadership roles:

- Will build positive, cohesive relationships with the multidisciplinary team and with other specialties to ensure seamless, person-centred care.
- Should facilitate shallow authority gradients as these promote psychological safety.

Examples of this include;

- The use of first names for all members of the multidisciplinary team.
- Encouraging staff to escalate to a more senior doctor or midwife if they do not receive a timely response.

These positive working relationships are key to staff feeling able to raise concerns and learn from events. This, in turn, improves patient safety and reduces the risk of adverse events.

3. This list defines the clinical scenarios and situations when consultants should be informed and when they should attend in person.

In situations where the consultant is to be informed, this should include a full discussion regarding the patient's care and any concomitant clinical activity.

Situations in which the consultant must ATTEND unless the most senior doctor present has documented evidence as being signed off as competent. In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.
Obstetrics
Trial of instrumental birth
Vaginal twin delivery
Caesarean birth at full dilatation
Caesarean birth for woman with BMI>40
Caesarean birth for a transverse lie
Caesarean birth < 32/40
Vaginal breech delivery
3rd degree perineal tear
Gynaecology
Diagnostic laparoscopy
Laparoscopic management of ectopic pregnancy

- Inform the on-call consultant of any women requiring Enhanced care on Labour ward.

Situations in which the consultant MUST ATTEND
General
In the event of high levels of activity e.g a second theatre being opened. Unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for Obstetrics or gynaecology
Team debrief requested
If requested to do so
Obstetrics
EWS or sepsis screening tool that suggest critical deterioration where ITU care is likely to become necessary
Caesarean birth for major placenta praevia/ abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth for < 28/40
Premature twins <30/40
4 th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >1.5L where the haemorrhage is ongoing and MOH protocol has been instigated
Gynaecology
Any laparotomy

Documentation Control

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Version / Amendment	Version	Date	Author	Reason
	1	Feb 2024	Miss S Chaudhry - Consultant Obstetrician	New
Intended Recipients: All staff with responsibility for caring for women in the Postnatal period				
Training and Dissemination: Cascaded through lead midwives/doctors / Published on Intranet NHS mail circulation / Article in BU newsletter				
To be read in conjunction with:				
Consultation with:	Obstetricians			
Business Unit Sign off:	02/02/2024: Maternity Guidelines Group: Miss A Joshi – Chair 15/02/2024: Maternity Governance Group - Mr R Deveraj			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 20/02/2024				
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