Nurses in the trauma team have a duty to use their skills and knowledge to support the team leader in their decision-making (Lang and Lancman 2016). This collaborative practice improves team performance and contributes to enhanced patient care (Grint and Holt 2011) and requires nurses to be confident in raising concerns and to use clear and concise ways of communicating their concerns.

Nurses’ ability to speak up is crucial to avoid failure to rescue in acute and emergency care settings. Failure to rescue, defined as patient death following complications during a hospital admission, can be caused by suboptimal surveillance, failure to recognise deterioration and failure to act (Ede et al 2021).

Speaking up has complex sociocultural ramifications and there are many barriers to staff in emergency and acute care settings speaking up to senior colleagues (Beament and Mercer 2016, Lang and Lancman 2016, Raemer et al 2016, Amudha et al 2018, Ong et al 2021). This article uses a case study to discuss how nurses can respectfully but efficiently escalate their concerns to the trauma team leader. It describes barriers to nurses speaking up and tools that can support nurses to speak up, with a focus on graded assertiveness.

**Why you should read this article:**

- To recognise the importance of speaking up in emergency care settings to enhance patient safety
- To be aware of the barriers that can prevent nurses from speaking up
- To enhance your knowledge of structured assessment and communication frameworks that can support nurses to speak up

**Supporting nurses in acute and emergency care settings to speak up**

Binx Clarke-Romain

**Abstract**

Nurses’ competence and confidence in raising concerns with senior clinicians is integral to patient safety and the quality of patient care. If nurses do not speak up when needed it can contribute to incidences of failure to rescue. There are many barriers to nurses speaking up in busy emergency departments and complex major trauma patient cases. Assessment and communication tools such as the SBAR (situation, background, assessment, recommendation) approach and communication techniques such as graded assertiveness can help to overcome some of these barriers. This article uses a case study to discuss how nurses can respectfully but efficiently escalate their concerns to the trauma team leader. It describes barriers to nurses speaking up and tools that can support nurses to speak up, with a focus on graded assertiveness.

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**Keywords**

communication, emergency care, interpersonal skills, patient safety, patients, professional, professional issues, raising concerns

**Importance of speaking up**

Nurses have a central role in identifying deteriorating patients and escalating concerns, which contributes to maintaining patient safety and saving lives (World Health Organization 2010, Brindley and Reynolds 2011, Lang and Lancman 2016, Campbell et al 2018, Ong et al 2021). However, delays between the moment when the nurse identifies a potential issue and the moment they communicate the issue to the doctor are common (Brindley and Reynolds 2011, Campbell et al 2018). Such delays can contribute to a chain of errors that may lead to the death of the patient, as in...
the case of Elaine Bromiley (Bromiley 2005, Blackham et al 2022).

In 2005, Elaine Bromiley, a 37-year-old woman otherwise in good health, was admitted to hospital for a routine sinus operation. During anaesthesia she had experienced breathing difficulties. The team had faced a ‘can’t intubate, can’t oxygenate’ situation, but guidance on how to manage such situations was not followed. Too much time had been spent trying to intubate the patient instead of ensuring adequate oxygenation by other means, for example by gaining direct access to the trachea. The theatre nurses had prepared to secure a front-of-neck access, demonstrating that they knew this was the necessary next step, but it was not clear whether they had suggested this step to the intubating doctor – and if not, why not. The patient experienced a long period of hypoxia which resulted in brain damage. She died 13 days later, never having regained consciousness (Blackham et al 2022).

Elaine Bromiley’s case is often used in training and education on patient safety in emergency and acute care settings as an example of what not to do. Many errors that occurred in Elaine Bromiley’s case have been identified as human factor errors, which are known to negatively affect patient safety but are easily preventable (Blackham et al 2022). Human factors can be defined as behaviours not directly related to the use of medical expertise, medicines, equipment or technical skills. They encompass interpersonal skills, such as communication, teamwork and leadership, and cognitive skills such as situational awareness and decision-making.

Avoiding human factor errors is essential for safe clinical practice (Ede et al 2021, Blackham et al 2022).

In the case study in this article, the nurse raised concerns with the trauma team leader before the sudden blood output from the patient’s chest drain that prompted the decision to transfuse. This enabled the team to pre-empt the need for a blood transfusion and prepare cross-matched blood, speeding up the transfusion process and saving emergency blood, which the team would have had to use if the cross-matched blood had not been readily available.

**Barriers to nurses speaking up**

Nurses’ increasing workload significantly reduces their ability to identify patient deterioration and escalate their concerns (Ede et al 2021), but solutions to the issues of workload are beyond the scope of this article. However, there are many other barriers to nurses speaking up that are arguably less challenging to overcome. These barriers can be internal (individual to the nurse) or external (related to other healthcare professionals and the care environment). Box 1 lists internal and external barriers to nurses speaking up.

**Internal barriers**

Internal barriers to nurses speaking up include the perception of a hierarchy between staff, notably between nurses and doctors (Morrow et al 2016, Amudha et al 2018). Doctors do not always recognise and appreciate nurses’ skills and knowledge (Campbell et al 2018) and there is evidence that they generally feel less comfortable

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**Case study 1.**

On their first ever shift in the resuscitation room of a major trauma centre, a nurse took over the care of a 21-year-old man who had been assaulted with a knife four hours earlier. The primary survey had shown a single penetrating chest wound. A left side haemopneumothorax (the presence of air and blood in the pleural cavity) had been identified on X-ray and a chest drain had been inserted to drain the blood. By the time the nurse took over the patient’s care, the trauma team who had provided initial assessment and treatment had dispersed, except for a consultant who was assuming the role of trauma team leader.

**Deterioration**

On the nurse’s initial assessment, the patient was alert and oriented, all vital signs were within normal ranges and the patient’s pain was well controlled. The chest drain had drained 120mL of blood when it had been inserted two hours earlier, but nothing more since then. A urinary catheter was in place. Over the following 90 minutes the patient experienced increasing tachycardia and hypotension, he became agitated and his urine output decreased. The nurse interpreted these signs and symptoms as indications of shock and hypothesised that haemorrhagic shock was the most likely cause (Gallimore 2018).

**Escalation**

The nurse communicated the patient’s deterioration and the possibility of haemorrhagic shock to the consultant. The consultant said they were not concerned, and the nurse asked them to explain why. The consultant believed that the symptoms could be explained by the effects of analgesia wearing off and by the decrease in the patient’s intrinsic adrenaline (epinephrine) after his body’s initial response to the threat. The nurse, however, said they remained concerned that the symptoms might indicate suboptimal perfusion to the brain and kidneys. The nurse suggested preparing to transfuse a unit of blood. The consultant agreed that they could acquire cross-matched blood but said it should not yet be given.

**Outcome**

Half an hour later, 400mL of blood suddenly drained from the patient’s chest drain. The nurse alerted the consultant and the decision to transfuse was made rapidly. The cross-matched blood was transfused and the patient stabilised. The patient’s tachycardia and hypotension resolved, his urine output returned to normal and administration of analgesia helped to reduce his agitation.

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**Key points**

- Nurses’ ability to speak up is crucial to avoid failure to rescue in acute and emergency care settings
- Barriers to speaking up can be internal (individual to the nurse) or external (related to other healthcare professionals and the care environment)
- Evidence-based tools that nurses can use to speak up confidently and efficiently to the trauma team leader include the ABCDE approach, NEWS2 and the SBAR approach
- Graded assertiveness is a technique used to help people raise concerns in a respectful but effective manner
- Organisations need to deliver interprofessional communication training to entire teams
communicating with nursing staff than with other doctors (Curtis et al 2011). If nurses feel they are not acknowledged and trusted by doctors they may find it more difficult to raise their concerns to a doctor (Beament and Mercer 2016, Raemer et al 2016, Amudha et al 2018, Hanson et al 2020).

Nurses’ confidence in communicating with doctors is also affected by their previous experience, emotional state and personality (Curtis et al 2011, Beament and Mercer 2016, Amudha et al 2018). For example, those with less nursing experience, such as newly registered nurses, tend to lack confidence when speaking to senior clinicians while senior clinicians tend to respect them less than more experienced nurses (Raemer et al 2016, Amudha et al 2018). Furthermore, nurses who have been bullied or shunned by clinicians in the past are more likely to experience emotional barriers to speaking up, such as apprehension or fear about future interactions (Curtis et al 2011).

Other emotional barriers include unexpressed thoughts or feelings which can accumulate leading to hostile or passive-aggressive communication (Curtis et al 2011). Beament and Mercer (2016), meanwhile, identified factors relating to professionals’ personalities which can affect their ability to challenge one another, including their feelings of self-worth, friendliness and natural avoidance of conflict. Additionally, nurses may hesitate to communicate their concerns to doctors because they feel uncertain about their own knowledge and competence (Beament and Mercer 2016, Amudha et al 2018, Hanson et al 2020).

### Box I. Internal and external barriers to nurses speaking up

**Internal barriers**
- Perception of a hierarchy between staff
- Previous experience
- Emotional state
- Personality
- Lack of confidence
- Uncertainty about one’s knowledge and competence

**External barriers**
- Mental overload of others in the team
- Suboptimal conditions in the care environment
- Heavy workloads and staffing shortages
- Suboptimal interprofessional relationships
- Lack of open communication channels
- Fragmentation of the workforce
- Organisational culture and leadership that reinforce a hierarchical structure


External barriers to nurses speaking up include the mental load of others in the team as well as conditions in the care environment. Information overload can lead to stress, fatigue and impaired decision-making among emergency physicians (Staffi et al 2020). Suboptimal communication and communication overload correlate directly with adverse events, negative patient outcomes and stressors for healthcare professionals (Curtis et al 2011). In the case study in this article, the trauma team leader will likely have been working simultaneously with several teams caring for several patients in a busy resuscitation room.

Other external barriers to nurses speaking up include time constraints and conflicting priorities. Heavy workloads and staffing shortages may prevent staff from joining ward rounds, reduce their capacity to monitor each patient adequately and impair early detection of deterioration (Amudha et al 2018, Ede et al 2021). Nurses have also said that suboptimal interprofessional relationships leave them feeling intimidated and fearful of being reprimanded for voicing concerns (Amudha et al 2018). Communication between staff can be impeded by fragmentation of the workforce, with high numbers of temporary or rotational staff preventing the development of optimal working relationships (Campbell et al 2018, Ede et al 2021).

An organisational culture that reinforces a hierarchical structure is a widely recognised obstacle to speaking up (Beament and Mercer 2016, Amudha et al 2018, Ede et al 2021, Jones et al 2021), while ‘command and control’ leadership styles can result in disempowerment and disunity (de Zulueta 2016). Weller and Long (2019) and de Zulueta (2016) noted that a shift in organisational culture can ‘flatten’ the hierarchy and that this can be achieved by those in leadership positions acting with integrity and humility, admitting uncertainty and empowering others by inviting suggestions. Jones et al (2021) concurred with this in theory but concluded that changing workplace culture is an ‘immense challenge’.

**Tools that can support nurses to speak up**

There are several evidence-based tools that nurses can use to speak up confidently and
efficiently to the trauma team leader, including the ABCDE (airway, breathing, circulation, disability, exposure) approach (Resuscitation Council UK 2023), the National Early Warning Score (NEWS 2) (Royal College of Physicians 2017) and the SBAR (situation, background, assessment, recommendation) approach (Wacogne and Diwakar 2010). These are structured assessment and communication frameworks that have been shown to improve staff’s ability to recognise deterioration and increase their confidence in escalating concerns (Curtis et al 2011, Munroe et al 2016, Raemer et al 2016).

Escalating concerns is more efficient when information is packaged optimally and communication is credible. Using the ABCDE approach or the NEWS2 enables nurses to provide quantifiable evidence of deterioration in the form of vital sign measurements, providing a shared language and removing ambiguity (Ede et al 2021, Lo et al 2021). In the case study in this article, the nurse used the ABCDE approach, which helped them to recognise the signs of haemorrhagic shock (Gallimore 2015).

In a systematic review, Lo et al (2021) found that while the SBAR approach greatly improved communication in a classroom setting, improvements in practice were more modest. This implies that there are more complex challenges involved than simply the way in which nurses present information and may explain why widespread training on the SBAR approach (Riesenber 2009) and its promotion by the National Institute for Health and Care Excellence (2018) do not seem to have resolved the issues around the escalation of patient deterioration.

Curtis et al (2011) developed a practical guide on ‘how to talk to doctors’ based on their review of the literature on the factors contributing to ineffective communication between doctors and nurses. The guide is structured around four themes – personal considerations, preparation, structure and graded assertiveness – and is intended to create a premise conducive to optimal and mutually respectful communication between nurses and doctors. Curtis et al (2011) also listed points to consider when speaking to a doctor about a patient, which are shown in Box 2.

Box 2. Points to consider when speaking to a doctor about a patient

» Recognise your own emotional state
» Try to understand and acknowledge the doctor’s perspective
» Ensure the information you are communicating is based on fact
» Decide what you want to achieve from the discussion
» Determine how urgent the matter is
» Prepare your case
» Contact the right person the first time round
» Anticipate what information the doctor will need to make a decision
» Use a structured communication framework
» Advocate for your patient
» Use assertiveness appropriately
» Do not accept bullying
(Adapted from Curtis et al 2011)

Graded assertiveness
Graded assertiveness is a technique used to help people raise concerns in a respectful but effective manner (Brindley and Reynolds 2011, Lang and Lancman 2016, Trauma Victoria 2023). It was developed in the airline industry to mitigate factors that contribute to plane crashes. Graded assertiveness is a stepped process that must be used tactfully while prioritising patient’s safety over healthcare providers’ egos. It enables the junior member of staff to avoid conflict or triggering defensiveness while escalating their concerns and gives the senior member of staff a chance to correct any error or misunderstanding (Nickson 2020).

Box 3 shows the four levels of inquiry in graded assertiveness, illustrated by an example of a phrase for each level.

The four levels of inquiry in graded assertiveness can be further described using the acronym PACE (probe, alert, challenge, emergency) (Lang and Lancman 2016):

» Probe – When probing, the nurse assumes that the team leader has not noticed an abnormality and opens a dialogue about the issue, saying for example: ‘What are your blood pressure targets in trauma?’

Box 3. The four levels of inquiry in graded assertiveness

Level one: express initial concern with an ‘I’ statement
‘I am concerned about...’

Level two: make an enquiry or offer a solution
‘Would you like me to...?’

Level three: ask for an explanation
‘It would help me to understand...’

Level four: a definitive challenge demanding a response
‘For the safety of the patient you must listen to me!’
(Adapted from Curtis et al 2011)
Alert – When alerting, the nurse assumes that the team leader has either not noticed the abnormality or is managing other pressing issues. The nurse directly draws their attention to the abnormality and offers to help address it, saying for example: ‘Did you notice that the blood pressure is very low? Would you like me to give the patient some fluid?’

Challenge – When challenging, the nurse assumes that the team leader has a valid reason to ignore the abnormality and asks for an explanation, saying for example: ‘Is there a reason why you are happy with such a low blood pressure?’

Emergency – The nurse takes emergency action, saying for example: ‘The patient’s blood pressure is dangerously low and I am going to treat it now.’

In the case study, the nurse used the first three levels of graded assertiveness and the first three actions dictated by PACE: communicating and reiterating concerns; asking for an explanation; and offering a solution. The nurse did not need to challenge the trauma team leader (level four of graded assertiveness) or take emergency action (the ‘emergency’ aspect of PACE), since the team leader agreed for cross-matched blood to be prepared and later agreed for it to be administered.

In addition to PACE, other approaches that can be used to achieve graded assertiveness include the two-challenge rule, the CUSS (concern, unsure, safety, stop) acronym and 5-step advocacy (Nickson 2020). Box 4 summarises these four approaches that can be used to achieve graded assertiveness. Training in techniques such as PACE and the two-challenge rule have been found to increase nurses’ confidence in escalating concerns (Johnson and Kimsey 2012, Obenrader et al 2019, Weller and Long 2019).

Team-wide training in interprofessional communication

Healthcare organisations have a responsibility to support their staff to overcome barriers to speaking up (Curtis et al 2011, Weller and Long 2019). All nurses need to be trained in, and encouraged to use, the tools and techniques described above, especially junior nurses who are more likely to hesitate to speak up due to lack of confidence and uncertainty about their knowledge and competence (Hanson et al 2020).

Organisations need to deliver interprofessional communication training to entire teams. Training that encourages collaboration between doctors and nurses has been shown to lead not only to a reduction in clinical errors and waiting times but also to improvements in patient satisfaction, staff well-being and staff retention (Muntlin Athlin et al 2013, Obenrader et al 2019, Liu et al 2021, Lee et al 2022). To enhance communication, didactic training alone is insufficient. Role-playing and simulation can increase staff’s confidence to speak up, improve how staff apply communication tools and enhance interprofessional relationships (Lo et al 2021, Lee et al 2022). Competency and portfolio-based education needs to continue outside the classroom to consolidate good practice (Ong et al 2021).

Providing longitudinal training in the emergency department is difficult due to high staff turnover and ever-increasing workload (Curtis et al 2011). In their systematic review of training programmes designed to improve nurses’ ability to speak up, Lee et al (2022) found no studies examining programmes

Box 4. Four approaches that can be used to achieve graded assertiveness

Two-challenge rule

1. First challenge using advocacy-inquiry – ‘I see that you plan to administer a spinal anaesthetic to this patient. She has a platelet count of 80,000. I learned that we shouldn’t do a spinal unless the count was at least 100,000. Can you clarify your view?’

2. If no sensible response, provide second challenge with advocacy-inquiry – ‘I see that you plan to administer a spinal anaesthetic, but I worry her platelets are too low. I think it’s unsafe and we should do a general anaesthetic. What do you think?’

3. If no sensible response, get additional help to protect the patient and resolve the disagreement

CUSS

1. Concern – ‘I’m concerned that...’

2. Unsure – ‘I’m unsure that...’

3. Safety – ‘It is not safe...’

4. Stop – ‘Stop what you are doing...’

5-step advocacy

1. Get attention – ‘Excuse me, doctor...’

2. State your concern – ‘The patient is hypotensive’

3. State the problem as you see it – ‘I think we need to get help now’

4. State a solution – ‘I’ll phone the intensive care unit to arrange a transfer’

5. Obtain agreement – ‘Does that sound good to you?’

PACE

1. Probe – ‘Do you know that...?’, ‘I don’t understand why you want to...’

2. Alert – ‘I think that will cause...’

3. Challenge – ‘Your approach will harm...’

4. Emergency action – ‘Stop what you are doing! For the safety of the patient we need to...’

(Nickson 2020)
carried out in that setting. They did, however, identify that microlearning (that is, learning in small units around specific scenarios) is effective, reduces the cost of training and minimises the consequences of having several staff members ‘off the shop floor’. Simulation-style microlearning based on clinical scenarios typically encountered in acute and emergency care settings would be useful to train nurses working in such settings to speak up.

Conclusion
Uncertainty about one’s knowledge and competence, lack of confidence, perceived hierarchy and a stressful and hectic work environment are all barriers to nurses raising concerns to senior clinicians in acute and emergency care settings. Assessment and communication tools such as the SBAR approach and communication techniques such as graded assertiveness can help overcome some of these barriers. Training teams in interpersonal communication can enhance patient safety and patient outcomes as well as organisational culture, staff well-being and staff retention. Additionally, those in leadership roles should work to ‘flatten’ hierarchies within their departments and strive to create a culture of openness and mutual support to facilitate effective communication between team members.

References


