



THE FIVE SCRIPTS

L&D NURSES NEED WHEN SOMETHING FEELS WRONG

Clear language under pressure.

You know the feeling. Something in the room is off. Your gut tightens before you can form the sentence. The attending is already at the door. The resident is writing the order. The patient has not been asked what they understand.

This guide gives you five scripts you can practice before you need them. Not magic words. Language that slows the room down, names what you are actually seeing, centers the patient, and asks for a concrete next step.

01 — CLARIFY CONSENT

02 — CLARIFY REFUSAL

03 — NAME A CONCERN

04 — REQUEST A PAUSE

05 — ESCALATE STRATEGICALLY

EDUCATIONAL RESOURCE ONLY

General professional education—not individualized clinical, legal, employment, licensing, union, privacy, or mental-health advice. Adapt examples to the patient’s situation, your role, current assessment, applicable policy, emergency procedures, and available escalation path. This guide does not guarantee protection from retaliation, discipline, conflict, licensure consequences, legal claims, or any patient or professional outcome.



RETURN TO THE ROOM.

When the room gets loud and fast, it can get harder to organize what you are seeing and find the words you want. That is the moment to orient to what is happening and choose your next move.

THE NEXT JOB

Your job in that moment is not to perform courage. Your job is to get enough access back to your judgment to choose the safest effective next step.

01

ORIENT

Feel your feet on the floor. Look at what is happening in front of you. Use a grounding cue that is appropriate for you. The goal is not perfect calm; it is enough orientation to assess, choose your words, and act within your role.

02

WHAT IS HAPPENING RIGHT NOW?

Sort urgency. Is this an emergency that requires immediate action under your setting's procedures? Explain what is happening as appropriate and act. If the plan is moving forward but the patient has not been fully informed or heard, you may have seconds to use a script.

03

WHAT HAS THE PATIENT ACTUALLY SAID?

What did the patient tell you they understand, want, question, decline, or need more time to consider? A signature, silence, or nod alone may not show that an informed-consent conversation occurred.

EMERGENCY QUALIFIER

A script does not replace emergency procedures, clinical judgment, or current policy. In an urgent situation, use the appropriate emergency response for your setting.

CHOOSE AN ANCHOR. MAKE ONE CLEAR ASK.

04 / WHAT IS YOUR ANCHOR?

Your assessment data. Your scope of practice. The policy or protocol that governs the situation. The escalation path your organization has defined. You are not asking permission to exist in the room. You are using the tools the system already recognizes.

05 / PICK ONE CLEAR REQUEST.

An explanation. A pause. Another assessment. A different set of eyes. An escalation. One precise ask moves the concern forward.

CONSENT FRAMEWORK REFERENCED IN THIS GUIDE

ACOG identifies disclosure, understanding, voluntariness, and capacity as elements of informed consent. If one of those pieces appears to be missing, that may be a reason to slow the conversation down and help get the appropriate clinician back into it.

QUICK SCAN

Assessment data → patient's stated preference or question → one specific request.

A script is a bridge, not a substitute for judgment. Adapt it to the clinical situation, urgency, your role, and local policy.

CLARIFY CONSENT

USE WHEN

The conversation is moving fast and the patient has not had a real chance to ask questions, process, or state what matters to them.

TRY THIS / SAY IT OUT LOUD

“Before we move forward, I want to make sure we have heard the patient’s understanding and what matters to them here. Can we pause so they can ask questions and tell us what they want?”

SHORT VERSION

“I’d like to pause and confirm the patient’s understanding and preference before the next step.”

IF THE PATIENT LOOKS UNSURE

“I’m noticing a pause. Would you like more information, a moment to think, or a chance to ask a question before you decide?”

GROUND YOURSELF IN THE FRAMEWORK

Informed consent is more than a signature. It is a process that includes meaningful information about the proposed intervention, its risks and benefits, reasonable alternatives, and the opportunity to make a voluntary decision. The clinician responsible for the proposed treatment has responsibilities within that process. Nurses also have an ethical advocacy role, within their role and applicable policy: recognizing when a patient appears confused, unheard, pressured, or in need of additional information—and helping get the appropriate person back into the conversation.

RIOT REALITY

Sometimes the hardest part is not knowing something is wrong. It is saying it when everyone else in the room seems completely comfortable.

CLARIFY REFUSAL

USE WHEN

A patient is questioning, hesitating, declining, or asking for time, and others start treating the response as a behavior problem instead of a decision.

TRY THIS / SAY IT OUT LOUD

“I want to make space for the patient’s question and stated hesitation. Can we clarify what they understand, what they are declining or considering, and what information they still need?”

IF THE PATIENT HAS STATED A REFUSAL

“The patient has said they do not want this at this time. Can we make sure the patient’s preference is heard and discuss the available next steps with them?”

ETHICAL FRAMEWORK REFERENCED

ACOG’s ethical guidance recognizes that a pregnant patient with decision-making capacity may refuse recommended treatment. Consent, refusal, capacity, emergency exceptions, and applicable legal requirements can depend on the circumstances and jurisdiction. This guide does not provide a jurisdiction-specific legal rule.

RIOT REALITY

Pregnancy does not erase autonomy. A patient does not become “difficult” because their answer is inconvenient.

NAME A CONCERN

Use when you need to raise a clinical or safety concern and cannot let it slide. Say it out loud without turning it into a personality conflict.

BUILD THE SENTENCE

“I am concerned about _____. The patient has stated _____. I am requesting _____.”

THREE BEDSIDE-REALISTIC LEVELS

NORMAL VOICE

“Hey, I’m worried about what I’m seeing. Can you come reassess with me?”

CLEARER

“I’m concerned about this change in the patient’s condition. I need us to reassess before we keep going.”

IF DISMISSED

“I want to be very clear: this concern is unresolved. I’m asking for reassessment now.”

USE CUS—NARROWLY

CUS is one standardized way to name the stakes: “I’m concerned. I’m uncomfortable. This is a safety issue.” Use it when that framing fits the situation; it does not replace assessment, judgment, or an emergency response.

TRANSLATE THE FEELING INTO DATA.

BUILD YOUR SENTENCE FROM WHAT YOU KNOW

Name the current assessment, a change you directly observed, communication that occurred, or a patient preference that was stated. Describe what you actually know. That is observable. Whether and how it belongs in the record depends on the care actually provided and current documentation requirements.

THE PATTERN

Observable data → patient voice → specific request → closed loop. You are not required to win an argument. You are making the concern actionable.

IF YOU ARE INTERRUPTED OR DISMISSED

“I want to be clear: my concern is [observable concern], and my request is [specific next step]. Can we close the loop on that now?”

RIOT REALITY

Precision is not passive. It gives the room less space to turn a clinical concern into a personality conflict. Patient advocacy and professional accountability can coexist. Use factual language, current policy, and the available escalation path.

REQUEST A PAUSE

USE WHEN

The plan is moving fast and you need a moment for the team to reassess, the patient to ask questions, or the next step to become clear.

TRY THIS / SAY IT OUT LOUD

“I am requesting a brief pause before we move forward. I want to reassess [observable concern] and make sure the patient has had a chance to ask questions and state their preference.”

SHORT VERSION

“Can we pause for one minute to reassess and confirm the next step.”

IF THE ROOM KEEPS MOVING

“I want to be clear: I am still requesting a pause for reassessment before the next step.”

WHAT THIS SCRIPT DOES

When the situation allows, a brief pause can create space to reassess, hear the patient, and identify the next action. It is not a substitute for emergency action, current assessment, or clinical judgment.

RIOT REALITY

A pause is not the same thing as a delay. It is a decision to make the next move on purpose.



IF THERE'S TIME: CHALLENGE TWICE. THEN MOVE IT UP.

FIRST CHALLENGE

"I am concerned about [observable concern]. I am requesting [specific next step]."

SECOND CHALLENGE

"I need to restate that this concern is unresolved. I am requesting [specific next step] now."

THEN MOVE IT UP

Use the escalation path available in your organization. Escalate the concern, not the personality conflict. Ask for the next action and when you should follow up.

URGENCY CONTROLS

The tool is there to support communication—not to create a waiting period when immediate action is required. The Two-Challenge Rule does not mean you wait through deterioration. If the situation requires immediate escalation or emergency action, escalate. When there is time for iterative communication, TeamSTEPPS describes the Two-Challenge Rule as a structured communication tool: assert the concern and, if it is not addressed, state it again before taking a stronger course of action.



ESCALATE STRATEGICALLY

USE WHEN

You have named the concern, used communication tools when appropriate, and the concern, the patient's preference, or requested next step has still not been addressed.

"I am escalating through the available path because the concern is [observable concern]. The patient has stated [relevant preference or question]. I am requesting [specific support, assessment, or decision] now."

ADD A CLEAR FOLLOW-UP QUESTION

"Who is the appropriate next person to contact, and what is the expected next step?"

KNOW THE RESOURCES AVAILABLE IN YOUR SETTING

Your organization may define an escalation path for unresolved clinical or safety concerns. Titles, sequence, and available resources vary by setting. Learn the current path and the resources available in your workplace before you need them.

RIOT REALITY

Escalate the concern, not the personality conflict. Keep the message factual, specific, and time-aware.



USE SBAR. KEEP THE CONCERN VISIBLE.

S / SITUATION

"I am calling about [patient]. The concern is [specific finding]."

B / BACKGROUND

"The relevant history is [context: labor progress, medications, prior assessments]."

A / ASSESSMENT

"My assessment is [what you are seeing, what has changed]."

R / RECOMMENDATION

"I am requesting [specific action: evaluation, change in plan, presence at bedside]."

THE REALITY

SBAR (Situation, Background, Assessment, Recommendation) is a structured communication tool described in TeamSTEPPS. When appropriate, it can help organize an escalation. Documentation and escalation can help preserve care-related facts and clarify communication. They cannot guarantee protection from retaliation, discipline, conflict, licensure consequences, legal claims, or a particular outcome. Strategic escalation does not erase risk; it can help you use the process available in your setting.

Courage alone is not a system. Structured escalation can help make communication and follow-through easier to trace.

PUT FACTS IN THE RIGHT CHANNEL.

Different records and reporting processes may serve different purposes. Which channels exist, what belongs in them, and what documentation is required depend on your setting, EHR, policy, jurisdiction, and—where applicable—workplace or collective-bargaining processes.

MEDICAL RECORD MAY INCLUDE

As applicable to care actually provided and current documentation requirements: assessment, clinically relevant observations, patient questions or preferences, communication, interventions, response, and outcomes.

SAFETY / REPORTING — IF AVAILABLE

A designated process may address safety events, near misses, system concerns, communication breakdowns, workflow failures, or resource gaps. Use the process applicable to your setting.

STAFFING / ASSIGNMENT PROCESS — IF AVAILABLE

A designated process may address staffing, assignment, or resource concerns. Processes vary by workplace, jurisdiction, professional body, and collective-bargaining agreement.

KEEP THE CHART CLINICAL, FACTUAL, AND RELEVANT

The medical record generally focuses on clinically relevant facts and care. Avoid speculation about motives or personality judgments. Document the care actually provided and clinically relevant communication consistent with current documentation requirements, policy, and the circumstances. What belongs in the medical record versus another reporting process varies by setting and jurisdiction.

ILLUSTRATIVE EXAMPLE — NOT A DOCUMENTATION TEMPLATE

“[Time]: [Clinician/role] notified of [clinically relevant observed change]. Requested [assessment/action]. Response/plan: _____. [Additional resource/role] notified at [time], if applicable.”

Documentation requirements vary by clinical circumstances, organization, EHR, jurisdiction, and policy. Document the care actually provided and communications that actually occurred.

PRACTICE BEFORE THE ROOM GETS LOUD.

You do not need to memorize every word. Practice building one clear sentence from what you observed, what the patient said, and what you are asking for next.

WHAT I NOTICED

What did I directly observe? What did I hear? What changed? Be specific.

WHAT I SAID

What language did I use, if any? Did I name the concern, patient preference, and request?

WHAT I WISH I HAD SAID

"I am concerned about _____. The patient has stated _____. I am requesting _____."

WHAT I'LL PREPARE NEXT TIME

A policy to review. An escalation path to learn. One sentence to rehearse.

RIOT REALITY

You do not have to sound like a textbook. You need words you can access when the room gets loud.



USE THE SCRIPT. THEN BUILD THE PRACTICE.

These are examples, not magic words. Adapt them to the patient's situation, your role, your current assessment, applicable policy, urgency, and available escalation path.

RIOT BIRTH METHOD

Riot Birth shows nurses how obedience was built, where it lives in the body, what it costs patients, and how to replace isolated courage with evidence, strategy, and collective power. Use these scripts as rehearsal language: see the system, name what is happening, regulate before reacting, speak with evidence, document in the correct channel, and learn the escalation path available in your setting.

KEEP THIS GUIDE IN ITS LANE

This guide is general professional education—not individualized clinical, legal, employment, licensing, union, privacy, or mental-health advice. It is not a substitute for emergency procedures, current assessment, clinical judgment, scope of practice, applicable policy, supervision, or the escalation path available in your setting. Do not share patient-identifying or employer-confidential details in practice, debrief, or informal discussion. Documentation and escalation cannot guarantee protection from retaliation, discipline, conflict, licensure consequences, legal claims, or a particular patient or professional outcome.

RESPECT. PROTECT. DISRUPT.

KEEP THE FRAMEWORKS CLOSE.

These sources support frameworks named in the guide. They do not replace current policy, clinical judgment, emergency procedures, qualified review, or jurisdiction-specific guidance.

- 01 American College of Obstetricians and Gynecologists. Informed Consent and Shared Decision Making in Obstetrics and Gynecology. Committee Opinion No. 819. February 2021. Available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology>. Accessed September 6, 2026.
- 02 American College of Obstetricians and Gynecologists. Refusal of Medically Recommended Treatment During Pregnancy. Committee Opinion No. 664. June 2016. Available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy>. Accessed September 6, 2026.
- 03 American Nurses Association. Code of Ethics for Nurses with Interpretive Statements. 2025 edition. Available at: <https://www.nursingworld.org/coe-view-only>. Accessed September 6, 2026.
- 04 Agency for Healthcare Research and Quality. TeamSTEPPS 3.0 Pocket Guide. Available at: <https://www.ahrq.gov/teamstepps-program/curriculum/pocket-guide.html>. Accessed September 6, 2026.
- 05 Electronic Code of Federal Regulations. 42 CFR § 482.24, Condition of participation: Medical record services. Available at: <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24>. Accessed September 6, 2026.
- 06 U.S. Department of Health and Human Services, Office for Civil Rights. Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the HIPAA Privacy Rule. Available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html>. Accessed September 6, 2026.

FOUNDATION, NOT A SHIELD

Source currentness and applicability must be rechecked before release. References support professional learning; they do not create a universal clinical, legal, documentation, employment, or licensing rule.

WHEN SOMETHING FEELS WRONG

QUICK REFERENCE — SCREENSHOT THIS

01

SAY WHAT YOU SEE

"I'm concerned about ____."

02

CENTER THE PATIENT

"The patient has said/asked ____."

03

MAKE THE ASK

"I'm requesting ____."

04

IF DISMISSED

"I want to be clear. This is still my concern, and I need ____."

05

ESCALATE

"I'm escalating because this concern has not been resolved."

DOCUMENTATION CUE

As applicable to the care actually provided: assessment; patient's stated words or questions; clinically relevant communication and notification; response; intervention; and patient response or outcome—consistent with current documentation requirements.

EMERGENCY?

Emergency action follows setting procedures and clinical judgment.