Effective Followership: What It is and Why It's Important

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In any organization, including the cardiac cath lab, there is a life cycle of success, failure, and optimal/suboptimal performance that waxes and wanes over time. The causes of this cycle are multifactorial. The lab you work in today is not the same as the one you worked in 5 or 10 years ago (and may be better or worse). It is likely the same people are not working in the same place. The composition of the team is continuously evolving, always made up of different personalities. Moreover, changes beyond our control can impact operations, the institution as a whole, and the quality of the leadership.

We recently had a review within our own cath lab to address patient safety and quality care improvements. Team members as well as faculty leaders participated together (Figure 1). I learned some new approaches and thought it would be worthwhile to share them. Many of the concepts are old but presented in a new format or new terminology so we can better understand the actions that might be needed.

Patient Care is a Team Sport

Working in the cardiac cath lab (or any medical unit) is a team sport. Sometimes the goals, rules, roles, and expectations are forgotten or taken for granted. To improve our efficiency and safety in the lab, the Quality Assurance review for 2021 recommended we have all team members attend Cultural Team Training, which was conducted by facilitator Danna Harris and sponsored by the VA National Center for Patient Safety (https://www.PatientSafety.va.gov).

One of the main points of the program was to review the Safety Briefing Checklist before each case. As codified in the military and airline industry to ensure and optimize safe operations, a safety briefing checklist is performed before any major procedures or activities. The 6 checkpoints of the preprocedural safety briefing are shown on Table 1.

While the safety briefing checkpoints seem self-evident, their review is still vital. In most labs, some of the checkpoints are already in place but not in a formalized format. Many of the checkpoints are included and reinforced during our first timeout. Recall that the timeout is a mandatory team pause to ensure you have the right patient, right procedure, right site, and other critical information verified before starting. All team members participating in the procedure must be present for a timeout. Lately, we have instituted a second timeout when the procedure advances into new area such as a physiologic assessment, or into percutaneous coronary intervention (PCI) or other structural heart intervention.

Post Procedure Debriefing Checklist

After a new or challenging procedure, it is worthwhile to debrief. This conversation does not have to be lengthy. The team should review what went well, what did not go well, and what could we have done better. In addition, the team debriefing checklist (Table 2) includes asking "Did we have adequate team members and resources to get the job done?", "Did we have properly functioning equipment?", and "Who will follow up on the issue concerns noted from the questions above?"

Figure 1. The VA Long Beach Cath Lab Team. Drs. Kern, Seto, A. Baldwin RN, J. Kipp CVT, L. Sok.

Table 1. Safety Brief Checklist.

Checkpoint 1: Greet the team. Every morning, the team should gather and be greeted by the leader. It sets the correct tone for the day and the serious work ahead.
Checkpoint 2: State the goals. While everyone knows (or should know), restating the goals of ensuring patient safety and reducing risks needs reinforcement to all team members.
Checkpoint 3: Remind team members of our commitment to performance standards and policies. We take no shortcuts from safe practices. Like community and airport safety, in the lab, if you see something is wrong, say something. Speak up. Use closed-loop communications and courteous acknowledgment of directives.
Checkpoint 4: The roles of the team should be defined for each case/day.
Checkpoint 5: Discuss potential trouble for the procedures. Check the need for specialty equipment, anticipated complications, or any other issues that may reduce excellent clinical care for a patient.
Checkpoint 6: Express any concerns, comments, or questions, all of which should be answered before starting the procedure.

Behaviors of a High-Reliability Organization

The goal of our safety briefings, team building, and understanding the strengths and weaknesses of our operations should be to build a high-reliability organization. Several principles that are part of becoming a high-reliability organization were addressed in our recent training experience, namely:

1. *Sensitivity.* We should have awareness that lab operations depend on many people outside the lab. We should practice sensitivity to those who are working on the front line in support of the lab functions. We need to make sure that from the beginning to the end of the patient's experience that all individuals are familiar with processes and systems that impact how our patients feel and how they are cared for.

2. *Preoccupation with failure.* We should anticipate that bad things can happen even in the best of hands. We should work to minimize risk. Every staff member should be characterized as a problem solver. We should be focused on catching errors before they happen, eliminating risks before they harm our patient.

Table 2. Debriefing Checklist	
1.	What went well? What did not go well?
2.	What could we have done better?
3.	Did we have adequate team members and resources?
4.	Did we have properly functioning equipment?
5.	Who will follow up on the issues of concern?

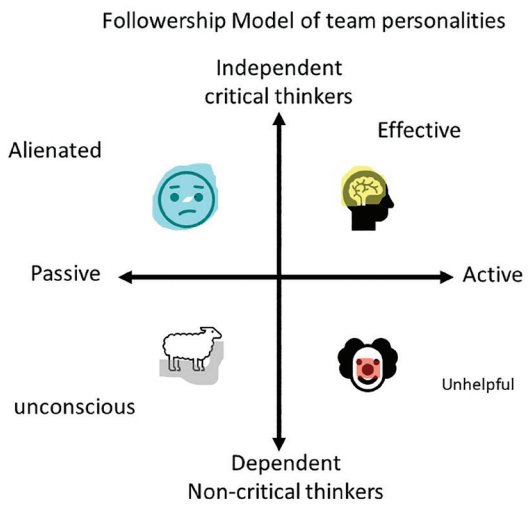

Figure 2. Followership profiles.

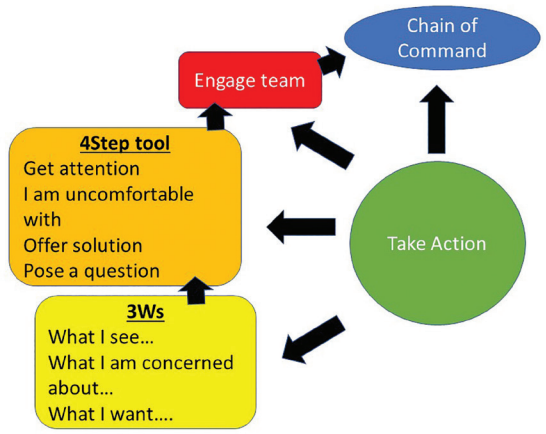

Figure 3. Effective followership algorithm.

From the VA National Center for patient safety (https://www.PatientSafety.va.gov).

3. *Avoiding simplification.* We should not simplify the presumptive causes of a problem for expediency but rather get to the root cause of a problem. We should work to understand the initial and proximate cause of an event, rather than cutting corners or settling for simple explanations. When an incident occurs, we should focus on the details and how to improve the weaknesses and processes that led to the incident. We should focus less on who was involved and more on how things deteriorated.

4. *Commitment to resilience.* We will all make mistakes. We should be mature enough to recognize it, admit it, learn from it, get back onto the previous course, and prevent these mistakes from happening again.

5. *Defer to expertise.* Knowledgeable teams perform better. We should empower everyone who has unique, specific knowledge to help us and provide perspectives and insights that can contribute to better patient care. Operators and team members will benefit from acknowledging and using subject-matter experts as needed, regardless of where they stand in the lab hierarchy.

Situational Awareness

Situational awareness means "being in the game" during a procedure, focused on the tasks with no distractions, and seeing that all aspects of your duties (and those of your colleagues) are functioning as they should. Successful teams pay attention to the ever-changing situation over the course of a procedure. To strengthen situational awareness, we learned about the "1-2-3 rule" and "Red Flags". The 1-2-3 rule means when there is a change in the situation for the worse, (1) step back from the problem, (2) analyze the issue, and (3) address and correct the problem with available resources (and personnel). The Red Flags concept encourages awareness and identification of certain red flags that herald imminent safety hazards. Here are several red flags:

1) Failure to cross-check conflicting input or results. When we have two pieces of information do not agree with each other, use the 1-2-3 rule to figure out what's happening. Is the patient hypotensive because of bleeding or is the zero off? Check the patient and the pressure connections. Do we need to rezero?

2) Another red flag is when someone says, "I'm confused. What I'm seeing does not make sense." For example, does the patient really have a blood pressure (BP) of 60 mmHg, but he's not acting like a patient with low BP?

3) A red flag is raised when someone is taking an action in violation of standard policy. We must have an extraordinary reason to do something outside of the established method or policy, which are set for safety purposes. Likewise, we should ensure that we are doing the right thing for the right reason for a specific patient event.

4) Did we meet the target expectations after an intervention? Did we miss a step or cut a corner leaving something undone? Check this red flag and review the procedure closely. Understanding what we can do better is key to growth and future success.

5) Lastly, the largest red flag is when people on the team are not talking to one another. There may be tension, and no one is seeing something or saying something. The most common cause of lab performance errors and poor work results is failure to communicate clearly with one another. Recognizing and addressing these red flags will result in better situational awareness and patient safety.

Effective Followership

At the meeting, we learned about effective followership, meaning the kind of team members you are working with and how we should approach each other when we see a safety issue. Some team members will not recognize a safety issue, some will not speak up about it, some will simply echo back what a coworker says, and some will recognize it as a problem and speak directly to those who can act to prevent injury. One model of followership places team members into a grid with four quadrants (Figure 2): independent critical thinkers, dependent noncritical thinkers, passive actors, and active effective followers.

Passive dependent followers (Figure 2, lower left) are present but not engaged — not thinking. They are just performing the minimum. Passive independent critical thinkers (Figure 2, top left) are often alienated, working passively but not contributing, sitting back, and may understand a problem exists but are not contributing to the solving the problem. They would rather just get through the day's work.

An active but dependent team member (Figure 2, bottom right) is characterized as a 'yes' person who is actively engaged but will not provide important information. His goal is to support leader's position to advance their own interests.

An active and engaged, independent critical thinker (Figure 2, top right) is the effective follower, helping to make decisions and giving positive feedback as well as cautionary notes when needed. He or she helps to make others into an effective team.

Effective Followership Algorithm

How does one communicate to be effective when a safety problem needs attention? There is an effective followership algorithm (Figure 3). It starts with feedback to the team leader. The feedback should be specific, direct, and concise. Do not use a method called "the hint and hope" technique where you see something, let's say ventricular tachycardia (VT), and hint that something should be done, like cardioversion. The hint might come by saying something like "The defibrillator is charged". Instead, it is important to speak directly (eg, "Looks like VT. You should consider a shock now."). Effective team members employ different tools to address the leader about an immediate problem.

The 3 Ws Tool

Communication of concern can be facilitated by using 3 W statements to convey the problem to the leader: "What I see is....", "What I am concerned about is...", "What I want to happen is...". For example, during a case, VT occurs. The cardiology fellow in the case ignores the monitor. You can say, "What I see is an arrhythmia. What I am concerned about is deterioration and hypotension. What I want is for you to address the arrhythmia."

Escalating Concerns: The 4-Step Tool, Team Engagement, or the Chain of Command

Let's say our fellow in the above scenario does not act after your communication of the 3 Ws. The next step is escalation. Get his attention (Hey, Dr. Bob), state your concern, (I am uncomfortable with VT that's not being treated), offer solutions (...Dr. Bob you can either remove the catheter, give a drug...), and if that fails, pose a question (Dr. Bob, would you like me to move the catheter or give amiodarone?).

After trying the 3 Ws approach and the 4-step tool, you can engage the team. "Is anyone else uncomfortable with VT that is untreated?" You could address the members of the team: "Betsy, I am concerned. I think this is a problem. Do you agree?" Finally, you can use the chain of command to get help. "Dr. Bob, I am calling the attending physician to help this patient."

Taking Action to Prevent Harm

When a safety problem exists, every team member is empowered to take action to prevent patient harm. For example, you could step in, put your hand on the operator's, and say, "This is not the right thing." You could refuse to give the operator further equipment. Be sure to have a supervisor in the lab as well, as this may need some administrative muscle.

The Bottom Line

I believe our whole team enjoyed learning more about teamwork and communication tools to improve safety. As you might suspect, our lab has already been using many of these techniques, particularly since Dr. Arnold Seto has long been a champion of cath lab safety (see his previous *CLD* articles[1-3]). Effective leaders and followers communicate with confidence, clarity, and brevity, factors that make for the best transfer of important information that has the biggest role in the safe performance of our procedures. ■

References

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