My response to your findings and subsequent conclusions regarding the Radiology Department at the CAVHS, Little Rock VA Medical Center left me less than disheartened.

The fact that your [agency] personally came to investigate the conditions led me to believe something might finally be accomplished with the Radiology Department. I thought there was some hope for our Veterans. Much of my evidence wasn't addressed or considered, but obviously wasn't deemed important enough.

By accepting the usual answers given by the very people that have created the problem, nothing will ever change. That is all that has ever happened *within* this facility. Apparently, these stock answers have been accepted as resolution.

I can assure you that other than perhaps the proposed "re-design" of the Radiology Department to address patient privacy; none of the other stated "solutions" have taken place.

I have witnessed, as have others, the conditions our Veterans are subjected to for ___ years. I have exhausted all Chain of Command options available within our Medical Center to bring this to the attention of those that I mistakenly thought could/would do something about it. When nothing changed, I felt no choice but to go further.

It is not my choice to wage this battle after ___ years of Federal Service with VHA. It is not my desire to see anyone's "head roll", but only to make those responsible accountable for their actions. Simply put: DO YOUR JOB! I love my job and our Veterans. That is why I continue to work here, but I have lost any faith I had in the alleged reporting process. I will never again report anything to your office no matter how egregious the offenses are to our Veterans.

There is no one left.

Cindra Stover BSRT(R)CV.CT.

Johanna L. Oliver
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

January 10, 2013

It saddens me that I was unable to remedy the situations in the Imaging Service before I was forced to retire. The option presented to me by the Acting Medical Center Director, Mr. Toby Mathew was to "voluntarily" retire or be terminated. Although retirement was by no means my choice, I was forced to sign a "Letter of Abeyance" for retirement or be terminated with "just cause", resulting in loss of benefits. The "just cause" was a lapse in my licensure as a Computerized Tomography Technician which was rectified by my accrediting agency prior to my dismissal.

At this point, it is not my personal crusade to see that our Veterans receive the best possible medical care they deserve. I know they will not. I am no longer employed and apparently one less thorn in the side for CAVHS and the Imaging Service.

I would never have pursued these issues through every avenue possible within the Chain of Command if I didn't know it was the right thing to do for our Veterans. After hitting one wall after another, my frustration led me to your Office.

I do thank your Office for your investigation and subsequent finding. I am, however, disappointed that you would accept the standard "pat" answers given by CAVHS regarding the deficiencies you found. Enclosed are my comments regarding the OMI findings.

CINDRA FLOWERS

The purpose of this correspondence is to address findings by the Office of the Medical Inspector (OMI) concerning the Imaging Service of the Central Arkansas Veterans Healthcare System (CAVHS) Medical Center in Little Rock, Arkansas.

IV. Findings, Conclusions, and Recommendations

C. Failure to Properly Reconcile Patient Medications

Findings

"On the day of scheduled radiographical imaging, RTs screen Veterans for possible allergic reactions, drug interactions, and contraindications prior to administering the contrast agent. RTs advise all Veterans taking oral metformin to discontinue the medication for 48 hours after receiving contrast agents. RTs counsel Veterans verbally, and then provide documentation of this counseling in the HER in the pre-contrast progress note in accordance with Medical Center policy, *Administration of Contrast Agents*. Additionally, RTs provide Veterans with written documentation of this counseling in the form of a handout. The OMI was told that some Veterans choose to discard these forms prior to leaving the imaging site.

The OMI reviewed a sample of ten Veterans who were prescribed metformin in FY 2011 and who had received radiologic imaging studies requiring the administration of intravenous iodinated contrast agents, in order to determine compliance with Medical Center policy. All EHRs reviewed contained documentation of counseling regarding the recommendations to discontinue metformin for 48 hours following the radiologic procedure."

Conclusions

- *"The OMI did not substantiate the allegation. The Medical Center is providing appropriate guidance to Veterans who are taking metformin and who receive an intravenous contrast agent for the purpose of CT scanning."*

Comments

The RT performing the actual scanning procedure does not enter the pre/post-procedural notes in the Veterans EHR. The Veterans paperwork is given to the "control" technician, an individual not involved in the procedure, who then enters the information into the Veterans EHR. The educational metformin paperwork is supposed to be handed to the Veteran by the technician performing the procedure. It is entirely possible that of the 10 Veterans EHRs reviewed, the documentation of counseling was entered. However, this is once again performed by the "control" technician. The fact that the Veteran received any educational handout from the scanning technician in paper form is not entered in the EHR. My primary concern is why are there so many of these educational handouts found in the recycle bin, a receptacle not readily available to Veterans?

D. Violation of Patient Privacy Rights

Findings

"The patient's informed consent is required before most medical procedures. The OMI was told that Medical Center staff obtain informed consent from ambulatory patients either in private rooms or in clinic rooms. However, patients on stretchers or in wheelchairs are consented in an alcove located in the hallway outside the IR and CT procedure rooms. The iMed consent computer is located within this alcove in between two stretchers that are separated by a curtain. The Acting Chief of Imaging Service told OMI that they have been concerned about this as an ongoing issue. The OMI believes that this situation represented a privacy violation, and told the Medical Center it had to be corrected immediately.

During the site visit, the Medical Center provided the OMI with the *Temporary Patient Privacy Action Plan*. This plan identifies room 1D-177, adjacent to CT and IR, as a closed area that will accommodate a stretcher or a wheelchair and will provide complete privacy for obtaining informed consent. The Medical Center began using this room to obtain informed consent during the OMI's visit. The Medical Center will consent patients from the ED in the ED prior to arriving in the Imaging Service. Physicians will consent inpatients in a private room on the ward prior to their arrival in imaging for their procedure. All iMed consents will be obtained using a laptop computer when access to a desktop computer is not feasible. The OMI reviewed the long-term privacy action plan, which involves changes to the physical plant."

Conclusions

- *"The OMI substantiated that there were information disclosure issues in the Imaging Service that possible violate the Privacy Act of 1974, 5 U.S.C 552a; and the Health Insurance Portability and Accountability Act (HIPPA).*
- *At the OMI's request, the Medical Center devised an immediate plan to provide patient privacy."*

Comments

The iMed consent computer is located within the alcove in between two stretchers that are separated by a curtain. The consent computer is a laptop that has been stolen from its location on three separate occasions and been replaced each time. If the Acting Chief of Imaging Service felt that consenting Veterans in an alcove in the presence of other Veterans could be an ongoing issue, then why was is not an issue when these computers were stolen? Upon replacement, why were they put back in the very same location? These computers contain hundreds of thousands of Veterans and employees private information. Have the Veterans and employees been notified that their private information has been compromised?

Dear Ms. Gorman,

September 22, 2013

I've given up any hope I once had that there could be changes within the Radiology Department at the Central Arkansas Veterans Healthcare System (CAVHS), Little Rock, Arkansas.

I am not surprised at CAVHS's response to the Peer Review dated August 13, 2013
Unprotected Management Review for the Office of Special Counsel (OIG);
"The Medical Center conducted training for appropriate personnel".
That is the standard answer for any complaint or Congressional inquiry.

Two comments:

- I was never asked by my Supervisor, nor had **any** input to the Peer Review of this case. I understand the concept that *"Health care professionals are authorized to deliver health care exercising autonomous clinical judgment*", and I wouldn't be a part of that review team. I do, however, have a problem with why I was never asked about the situation before it was so easily dismissed based on the patient's other health issues. He was alert, oriented and sitting up talking to his family. They told him "Bye, we'll see you in the morning." They left him in CAVHS's and my hands. He died before they saw him again.

- The Radiology Department did not, unless I was specifically excluded, do any "additional training" with staff. There was an email "reminder" to everyone but if anyone but I read it, it didn't change any practices within the Department. I believe my enclosed personal documentation will show that. Supplies were **not** stocked/available when needed on several occasions throughout the next year. Expired supplies, I can't speak to. That is the Lead Technologist's responsibility.

Once again, CAVHS is the judge, jury and executioner.

Cindra Flowers

CINDRA FLOWERS

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj:
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

What a DAY!!!!! Torrence gathered requests from the printer. There were 5 request and at 1400 they called for all to come down. The vent was set up so there was someone coming down from a unit. Almost all came at the same time. There were a couple in ER also. A patient was brought down on a strecher for an AP routine, oral and IV.
I gave him 2 cups of oral contrast to drink, which he did. I was ready to bring him into the CT Room, his family told him bye and they left. Of course, I am here by myself after 1630, so whatever Torrence called for was of no concern because HE DID NOT HAVE TO DO THEM. I tried to move him onto the CT table, and I needed assistance. I called ER to see if someone could help me and BRian came. We got him on the table and just as soon as we did, he his whole mental status gone. I started shaking his chest and calling his name, and there was NO RESPONCE. I told Brian that this was a complete 180 from him at the time we took him in the room. At this point, he started vomiting, unresponsive, aspirating on his vomit and I told Brian to help me roll him on his side to lessen the amount for him to aspirate and told Brian to get a physican from ER. I was holding him up on his side and reached for the phone and called ER to call a code because he still was unresponsive and still vomiting. Dr. Snodgrass, Jennifer, and Brian came running. Dr. Snodgrass called for suction and LOW AND BEHOLD THERE WAS NO SUCTION SET UP IN THE ROOM!!!!! We needed a moniter and there was not one in the room. There was a monitor in the control area and I pushed it in the room, and guess? there was NO blood pressure cuff on it! I had to go to angio to find one. Mind you the ER staff were here, the CODE TEAM was here, and "CT" was NOT STOCKED AS IT SHOULD HAVE BEEN!!!!!

S

on the monitor. I had to go to angio to find one. Dr. Snodgrass was almost ready to do a trach. Finally the code team showed up and they gave EPI, ran the code for several minutes, got him intubated and went up to the unit.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj:
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Well I get here and Torrence and Alesha worked in CTL. Almost at the time I got here, Torrence shut it down. Down to 1 room and that left Torrence, Dustin, and Rodney scanning in CT1. At some point, Alesha dissappeared around 1430. Who knows????? I called Bobbie to come see the mess THEY left. Vent, used syringes in injector, sheet still on the table. I wonder if they think that nothing will be done in that room to be able to walk out leaving everything in there to clean up tormorrow????? I am not a maid or their keeper, so someone needs to make it end or just stay complaicent and overlook their BAD WORK HABITS, BECAUSE ANYONE IN ANY POSITION TO ADDRESS THESE ISSUES, DOESN'T OR IF THEY DO, THEN FOR THE MOST PART THEY ARE INSIBORDINANT AND NOONE CARES TO MAKE THEM COMPLY TO ANY RULES, OR ANY, ANYTHING.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: Where do we go from here?????
From: FLOWERS,CINDRA G 1 of 1 response read. In 'flowers' basket. Page 1

When and how will "this" be addressed?

I sent the email info you gave me to the higher ups interested in the issues surrounding the CT dept. Did you send the email to Gayla, and the others higher up in your dept? If not, I suggest that they have receive the info to. That way they will have an opportunity to correct the issues before the pressure comes from a different direction. Thanks, Tiffany

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj:
From: FLOWERS,CINDRA G 1 of 1 response read. In 'gayla' basket. Page 1

Gayla, I am not their maid nor am I their mother. I called Bobbie to come to see how the room was left. She got Debbie to come look at what was left. I took pictures of the way it was left and I know we are supposed to leave a room, clean and ready for the next patient. ANY words of consolation or legitimate excuses for their actions

1) WHITT,GAYLA R 10 lines

No excuses. Every time I come out on call I clean while I am there.

I had to clean the CT room Friday night before I could do the first call case. I know how you feel. I believe you had had a code in that room earlier in the evening. I could tell as soon as I walked in by some of the trash I found around the room.

I think all of us become desensitized to our surroundings and we don't see what other outsiders see when they walk in. I will send out a reminder.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj: 8 lines
From: WHITT,GAYLA R In 'gayla' basket. Page 1

Cindy, Dr Major brought a case to me today that was done yesterday evening. from CCU had an AP. The request was protocoled with contrast. The resident on call read it without contrast. Dr Major noted that there was not contrast visualized in the abdomen but found images that included his elbow. His elbow appears to have a large amount of contrast infiltrate.
Do you have any additional information on the event-nothing was noted on the progress note? I need to enter a incident report.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: 18 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Alesha is not here today. CTL is down, so Torrence Dustin anad ROdney worked in CT1 together. One room down and the other taken for biopsies, so the scheduled CT patients had to wait until the biopsy was over. At 1400, patients that had been here since 1030 were still waiting to be scanned. Interventional has presidence over scheduled CT patients, and some have been scheduled for over a year. Noone will challenge this presidence, so therefore scheduled CT patients have to wait. GE came in to work on the room and, at 1550 the GE guy was ready to try a patient in there. Torrence got up and walked away at the very time the GE man needed to scan. I picked up the phone and called Gayla and told her that I needed some help and that Torrence and Dustin were gone. 3 patients waiting, 2 ER's to call and the first patient waiting to be scanned was a bilateral amputee. Of course Torrence never bothered to see if I needed any help, like normal he bailed. Gayla came to help, but nothing was mentioned about why Torrence wasn't here. She did make reference to the patient that coded on the table _ So she has been made aware ot the code, but never made any attempt to ask me for a statement, information, or anything about it.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj: Room Cleanliness and Preparation 19 lines
From: WHITT,GAYLA R In 'gayla' basket. Page 1

The techs are responsible for cleaning and preparation/stocking/setup of exam rooms. You are not finished with a case until you clean up your mess. This includes changing linens, disposing of trash, removing the injector syringe from the injector, picking up pillows and sponges OFF the floor and stowing them appropriately(no pt care items may be on the floor), and performing required RME cleaning.
Each day the table sides, cabinetry and gantry should be wiped of any contast, body fluids, blood splashes.

RME Policy states that if a sheet is used that the table should be wiped with a caviwipe daily. BUt if you see the splash, you should immediately clean it before bringing in another patient.

Also, the early morning tech is responsible for ensuring that all oxygen and suction is set up prior to the beginning of the day. However, if you use the suction and dispose of it, you should not start the next patient until this is set up again. You cannot predict when you are going to have an emergency situation in which you don't have time to chase down the supplies and get it set up.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj: Arteriogram trays 14 lines
From: WHITT,GAYLA R In 'gayla' basket. Page 1

I want to stress to all of you the importance of listing the arteriogram trays on the SPD sheet located with the Dirty Bins. SPD picks up the bins and takes them to the decon room where all the instruments are washed together. Then they use the sheets of paper to re-assemble the clean instruments into trays according to how many are listed on that sheet. IF only half the trays are listed, then they only make up half the trays and the other instruments are stored away.
Today there should have been 12 dirty trays listed on the sheet but only five were marked.
We ran out of trays today because of the backorder on EPI trays. We have only ever had 20 trays but we could only inventory 15 today so we have lost some along the way.
Your diligence in writing these dirty trays on the list will assist in maintaining our supply.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: 11 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Well, CTL is down and apparently CT1 is having some problems, because the GE guy is over there and 9 patients are waiting to be scanned. Of course I am assigned to CT1 and when GE left, no IV"S were started, noone loaded the injector, no one put a clean sheet on the table, mor did they bring my next patient in. All 4 were sitting in the control area, laughing and having a good time, unlike when one of them are scanning, it takes all 4 of them to do a patient. The room wasn't stocked with sheets, saline bags, or intercaths. Do we even have a 700 person anymore????? OH yeah I guess we do because Rodney left at 1530. Well all the rest got up and left at 1620. Got blood splashed in my face, had to go to personnel health and have blood drawn.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: 8 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Dustin is not here today, does Susan know? ER had a confrontation with Gayla and ALesha, with Gayla standing up for Alesha and physically pushing Lori the charge nurse from ER. There are too many things that happened today and I will not stay over past my shift to document it all. They held 5 patients for me to call down and do, 1 ER, and a drain for interventional. No archieving was done. The room wasn't stocked. No 20g heplock, no saline bags and no linen. Same shit different day and does anyone CARE?????

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: * No Subject * lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

I paged Gayla at 1620 when Aleha and Torrence walked out to discuss the amount of patients left for me to do with what was already left over, knowing a drain from IR was also waiting. I never got a call back. I continued to do what was waiting so I could do the IR patient. I was never told by anyone that the in patients were "emergencies".

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: 9 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Rodney is not here today. Dustin was in and out. After everything that happened yesterday, Gayla had the audacity to call me to the office and tell me that there were complaints about the in patients left to call down were no done. Nevermind the fact that all of that was left over from the day, no one stayed to help me and never was I told that any of the inpatients were Emergencies. She had me sign a letter for FACT FINDING. She is determined to make me responsible for the day peoples insubordination, because she makes excuese for them, and knows that I have a work ethic that she can make me feel guilty.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: 8 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Everybody here today. Dustin working on his Master's degree in the control area of course with Torrence and Alesha. The people are here to work on CTL and Torrence is sitting overthere asleep. Perfect representation of Radiology. Dustin left at 1515 and I haven't seen Torrence since. Gayla is in Gina's office cancelling patients off tomorrows schedule because CT1 is acting up, and where is Torrence????? Shouldn't he be the one cancelling them????? He is the lead and once again as daily GAYLA COVERS FOR HIM AND THEM.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj: Repeat 2 lines
From: FLOWERS,CINDRA G 2 of 2 responses read. In 'gayla' basket. Page 1

Gayla, I left the room just like I found it. I guess not everyone got your mailman.

1) WHITT,GAYLA R 3 lines

It looked like the Hanging bottle may have been leaking around the tubing. THat is the only way that pool of contrast could have been under the iv pole but not under the wheels. I will talk to the others.

2) FLOWERS,CINDRA G 2 lines

It was in refrence to the injector boxes on the counter and the used intercaths that were crisscrossed between them.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: Pre warned 5 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

I guess there was enough specific information disclosed from the phone call on Thursday, from the IG"S office, that today, I found expired supplies in the trash, and a more indepth hands-off sheet, which would help with their case about NO communication. I knew it was too good to believe that there could be an inspection without any forewarning.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj: Vascular patients for CT and x-rays 9 lines
From: WHITT,GAYLA R In 'gayla' basket. Page 1

Dr Moursi has a research protocol that his EVAR patients get both a CTA and a KUB the same day. He has had three in the last couple of weeks who reported to him that they all three told "the tech" that they were for CT and KUB. But none of those three went to check in at front desk and went home without x-rays.
If a patient questions you about being here for both CT and KUB or x-ray, either direct them to go to Orange Atrium to check in;
OR look them up to see if there is an x-ray ordered, and send them to X-ray if so.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: question 9 lines
From: FLOWERS,CINDRA G 1 of 1 response read. In 'flowers' basket. Page 1

Gayla, is there an acceptable excuse for 8 patients in the stack to not have IV"s started? Rodney is in CT1 and Torrence and Alesha are working in CTL, and Dustin is control. There is one extra person, but when I got here, I relieved Rodney and started IV's on the ones that were for me to scan. Also, IR was to do a biopsy in CTL at 1300 and Alesha and Torrence did not have another patient to scan after 1200. Is there any reason that a tray wasn't made up for the procedure? I was relieving Rodney and just as he got back, Sara already had the patient on the table, but I had to make a tray before I could do the scouts.

1) WHITT,GAYLA R 2 lines

I cannot justify the patients not being ready given the staff available if no one had gone to lunch. I will follow up.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj: Repeat 2 lines
From: FLOWERS,CINDRA G 3 of 3 responses read. In 'gayla' basket. Page 1

Gayla, if you get called in, I left the condition of the room exactly like it was left, when I got back from lunch.

1) WHITT,GAYLA R 1 line

the room did not look in disarray to me.

2) FLOWERS,CINDRA G 1 line

The stuff that can't make it to the trash

3) WHITT,GAYLA R 2 lines

Okay, I do remember some of the plastic injector syringe boxes on the counter.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: FACILITY AND SERVICE COMMUNICATIONS 7 lines
From: WHITT,GAYLA R In 'flowers' basket. Page 1

It is becoming more and more common to receive communications from the facility director and from Imaging Service administration via OUTLOOK and NOT VISTA MAILMAN.

You must view OUTLOOK at least daily to stay informed on current issues and changes. Failure to read the communications is not an excuse for not being informed.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: CT STaff updates and reminders
126 lines
From: WHITT,GAYLA R In 'flowers' basket. Page 1

We have a had few occurrences that have been reported over the last two months that I need to respond to or clarify.

1. Whether it is due to equipment downtime of IR procedures in progress, it is imperative that the patients who are having to wait an excessive amount of time be kept informed of why there are delays. The Health Techs are expected to answer questions from the patients. However, it is the Lead Tech's responsibility to do this and in his absence it is the Control Tech's responsibility.

Keep the pts informed
Give them the option to eat or go to other appts when appropriate
Offer to reschedule if they want but ensure we will do them if they decide to stay.

2. Do not call down more than one or two patients after 4:00. The night tech cannot be doing scans and supervise multiple waiting patients. We have had at least two occurrences in a month in which IR informed the night tech after 5:00pm that they were ready for a interventional CT and the day or night techs did not expect it; in each case 4 other patients were waiting in the hall called down by the day shift. The night shift tech will be responsible for calling down the left over patients.

3. Hand-off: Be sure to include all information concerning pending patients. If they were Emergencies added by the Radiologist, label it so. If they were add-ons the techs took to the radiologist for protocol but are not emergencies, label it so. The night tech has been instructed that if there are too many patients added than can be accomplished, either because of ER activity or IR patients, the call tech will have to be called in the finish them.

Make sure to include information about OPs who were added but never showed up. If there were IR patient the Control tech was told about that were never done, at 4:00 the Lead Tech or control tech should contact the APNs and get an update.

Hand-off is to include the opportunity to ask and answer questions. BOth the giver and the receiver are to acknowledge the handoff.

4. The "float" technologist is expected to be assisting with shuffling patients and starting IVs for both rooms whenever not filling in for absent staff.

However, IV's should not be started too far in advance of the scan as the patient may opt to leave if there are delays. TO have 4 patients at any given time with an IV in would keep both rooms busy for at least a half hour.

5. Habitual tardiness, habitual leaving early or long lunches is not acceptable. It is the Lead Techs responsibility to monitor this. Occasional occurrences due to unavoidable situations happen, but not daily. You are expected to report to duty on time. If you need to take a long lunch, or leave early, get approval from a supervisor and you will be charged leave.

6. Cell phones may be used for official or urgent personal business. Cell phones may not be used for games or personal business accept when on official breaks. You should not answer your phone in the presence of a patient.

7. Breaks: You are allowed two breaks daily. If you need to conduct personal business either on the phone or on the computer, or you need to leave the area for a few minutes,you need to notify the supervisor that you need a break. If you just need to step away for five minutes, just let the control tech know you will be right back. Breaks may be taken in th scan area so long as it is not disruptive to the work flow. Group game playing is prohibited in the control room.

8. No employee is required to be standing continuously except when specific tasks require it. If there is a room down, everyone is expected to contribute to expediting the work going on, but standing around is not required.

9. Technologists operating the scan room, whether independently or with assistance, are expected to perform exams proficiently and efficiently; moving from patient to patient, without carelessness due to being rushed, as well as without undue delay. This is not a competition but we are here to serve the veterans as expeditiously and accurately as possible.

10. Each shift is expected to stock and clean rooms. The day shift should stock first thing in the morning and clean as you go. The night shift is expected to clean as you go and to stock the rooms when there is no patient procedures going on. This is everyone's responsibility. IF you find something that we are out of, either stock it immediately, or make a note and stock it yourself before going home. Before you leave at the end of any shift, you should take 5 minutes to ensure that your room is in order, trash disposed of, and ready for a patient. Never leave after a IR procedure without tearing down and putting away the soiled biopsy tray. On two occasions in the last two months, trays were left behind and found later. It is unacceptable to leave a room un-stocked or messy if you find it that way. Clean/stock yourself and report it to me.

11. As stated many times, it is against Infection Control Policy to eat or drink in patient care areas, and the control room is considered a patient care area. Keep you drinks put away. Take a break if you are hungry.

12. CIVILITY and RESPECT: Article 17 of the union agreement states that employees will work in an atmosphere of mutual respect. It also states that employees will not be subjected to reprisal for reporting occurrences or deficiencies. Co-workers do not have to be friends. BUt everyone must exercise self-control, exhibit professional behavior and unoffensive language, not only in the presence of patients, but at all times in the facility. Anything else will not be tolerated. Outbursts,throwing things and publicly criticizing co-workers is unprofessional and unacceptable. This includes interactions with any supervisor.

13. Many changes are on the horizon. We should see a new room installed by April. It is unclear how long it will be before the CTL is replace. It appears they plan to renovate MRI prior to starting on renovating CTL.

14. A "Stroke Protocol" is being proposed that will require stroke CT

heads to be completed within 30 minutes; not called for but completed. It requires 24/7 in house coverage. This will require several new positions to be filled and trained if approved. I just want you to be aware that within the year, you could experience a partial or significant change in income. I will try to keep you informed as plans progress but I felt that it was imperitive that you be given a heads up.

15. Any day now I expect to receive confirmation that 30 minute call back is implemented. When that happens you will be given two weeks notice. I still am asking you to enter in the overtime book what time you were notified by the radiologist of ER call backs.

If you have questions or concerns about any information provided here, you may see me in the office to discuss.

11.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:25
Subj: Point of Clarification Late shift/call back
12 lines
From: WHITT,GAYLA R In 'flowers' basket. Page 1

It has come to my attention that on one of the points in the email sent out yesterday has been misunderstood. Let me clarify:

"The night tech has been instructed that if there are too many patients added than can be accomplished, either because of ER activity or IR patients, the call tech will have to be called in the finish them."

I intended to communicate that at 8:30pm the call tech may be required to come in to complete the emergency exams. This was communicated a few months ago and has always been the practice-it just never comes up. Most of the time the night tech stays and finishes the work. I did not mean to imply that you would be expected to come in during that shift.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: 6 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Well you can see that it's only 1616, I am in the computer and noone is here. Gayla is off, Bobbie is off, Vicki is off and Dr. Worley has already been down here yesterday wanting to know who was in charge, and there is noone. Dr. Gocio also called yesterday. New machine being installed, and noone from Radiology of any title is here, this week.
SSDD

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: Drain leftover 4 lines
From: FLOWERS,CINDRA G 1 of 1 response read. In 'flowers' basket. Page 1

Is there an LEGITIMATE EXCUSE why a drain tray isn't prepard for me to do the drain they left me with? I would think that out of 3 perfectly capable boys, one could seperate themselves from the others to make one. Amazing, when there is drain during the day, someone makes one.

1) WHITT,GAYLA R 6 lines

Just catching up on emails from my vacation.. It has been so long since you sent this that I am sure no one remembers any specifics.
I had discussed with Torrence recently that even though it is against the rules to set up trays ahead of time, that they should gather the supplies and bag them the way we used to do in ANgio so that there is a set readily available. Is that not happening?

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: Drain Tray 7 lines
From: FLOWERS,CINDRA G 1 of 1 response read. In 'flowers' basket. Page 1

MY, MY, I think I figured out why NONE OF THEM made a tray! There were NO XYLOCAINE NEEDLES, NO 3WAY STOPCOCKS, NO DRAIN BAGS, LET ALONE ANY 10F APD's. Guess the 3 of them were more productive running the only room we have. It is obvious that it REGUIRES 3 people to complete any given exam, so it appears that they could not be away from each other long enough to make a tray for the night tech who performs all these things ALONE!
FYI.

1) WHITT,GAYLA R 1 line

noted.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: Drain 10 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

No Gayla, they have never made a bag of supplies to leave for me. Just like today, with you sitting here, Torrence stood inside the doorway visiting with Dustin and Cody while they were scanning and watched me go in and out of this door gathering supplies out of the cabinet at least 5 times. He knew that the drain was the next thing to do in the new room, but you never saw him get anything for me, nor offer any assistance. Bottom line, you know this goes on. I have reported these same things to you, over and over again, which makes one think that they are not being addressed, unless they are insubordinate and have no respect for you or your position, because everything is condonned

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:44
Subj: CT Room Communications 8 lines
From: WHITT,GAYLA R In 'gayla' basket. Page 1

I want to remind you all that with the new room being across the hall from the control area, it is important to be diligent about privacy. Please refrain from yelling back and forth from the two rooms anything that concerns a patient. Also be aware that loud conversation in the new control room can be overheard by those outside in the hallway.
Make sure that all communications within ear shot of a patient are conducted respectfully and professionally. This pertains to patients in the exam room as well as in the hallway or waiting areas.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: Lack of supplies 14 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

I had to go to Dr. Major's office to see if she had a key that would unlock Debbie's office because there were NO Biopsy grids in the cabinet in CT3. Luckily Debbie ratholes at least 1 package in her office. Torrence didn't come in today, Alesha left around 1300, and Gayla left before then. No one here with any authority. Had a patient allergic to contrast and was given only a benedryl and had a CAP to be done. Dustin and I were the only ones there after 1600 and dustin was sitting in the control chair when I made the comment to Dr. Chung that I didn't particularly want to scan that patient with NO doctors in the department. Dustin gave NO second thought to leaving at 1617, knowing that there could possibly be a reaction to contrast. The lack of consideration and assistance of the other people that work in CT is bordering on the line of abuse and neglect. WHO IN THIS DEPARTMENT OF ANY AUTHORITY CARES?????????

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

I was at Central today getting ready for the drill tomorrow. It is crazy with patients left over. Dustin left at 1600. Never saw torrence. Alesha left at 1620, and rodney followed. A SICU patient post surgery came down for a chest looking for a leak. Everything that could be with a patient was with him. Needed suction because he was about to aspirate, and THERE ARE NO SUCTION CANISTERS. Had to run to the new room and find supplies for the old 64!!!!! So much for the 0700 person stocking!!!!! Don't think I'll send anymorMM to gayla, it is just a waste of SPELL CHECK!!!!! Got mail from OSC, IG. Will check later

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: Supplies 2 lines
From: FLOWERS,CINDRA G 1 of 1 response read. In 'flowers' basket. Page 1

Gayla, there were NO tegaderms, NO 30"extension tubeing, NO male-male connectors, or red blunt needles in the cabinet.

1) WHITT,GAYLA R 3 lines

Just know reading week old email. Did you stock the items when you found them missing?
I will pass on to early morning people.

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:26
Subj: Full schedule, 1 room 22 lines
From: FLOWERS,CINDRA G In 'flowers' basket. Page 1

Susan, I don't know if you or Dr. Majors is aware that the injector in CT1(64) is not useable. Tomorrow is Vascular Clinic day and we have 28 patients(without add-ons) that have to have contrast. This means they will all have to be done in CT3(new room). When we have machine problems that are not going to be rectified by the next day, patients are called at home, made aware of the situation, and asked if they care to be rescheduled as soon as possible. Some of these patients have 3 to 4 hour drives to Little Rock. Many times patients have to make arrangements for transportation to their appointments, and if they are not notified about the machine situation, and on arrival are asked if they would like to reschedule, some will have to wait as long as it takes to get their scan because they were not given the option the day before. This causes undue anger and frustration as well as wasted gas at $3 a gallon that could have been avoided. The employees here would not tolerate such a thing happening to them, so WHY are veterans expected to?

working

MailMan message for FLOWERS,CINDRA G RADIOLOGY TECHNOLOGIST
Printed at LITTLE-ROCK.MED.VA.GOV 09/05/12@12:21
Subj: Access to exam rooms 9 lines
From: 1 of 1 response read. In 'bobbie' basket. Page 1

Please refrain from entering Diagnostic Radiology examination rooms except to attend to a patient in that room. These rooms often have patients on the table when staff are walking in, doors to the exam rooms are being left open (which are supposed to be kept closed), technologists are having their work interfered with by foot traffic. Primarily interference is coming through rooms 1,2,and 3.
The inside hallway is accessible from the front desk, the hallway to the file room, and from the blue atrium. Please use these routes rather than exam rooms.

1) [redacted] 3 lines

So glad to see this memo. I have had it happen numerous times (with a patient on the table) by employees outside of diagnostic. Have even locked the door several times to keep this from happening.