January 2017! The new year brings a sense of renewed purpose for the Association for Radiologic and Imaging Nursing (ARIN). As we enter 2017, ARIN continues to work on accomplishing its goals of expanding and evolving the role of the radiology nurse through education, communication and building relationships with key health care organizations/groups that impact our practice. It is important that our specialty continues to advance to meet the ever-changing demands in health care and continue to advance the standard of care in the imaging environment through knowledge and resources.

A New Clinical Pathway: Interventional Oncology (IO)

ARIN has recognized that subspecialties within the radiology and imaging environment are numerous. Subspecialty knowledge and resources are necessary to deliver safe, quality patient care in the imaging environment. The planning portion of this essential clinical pathway has been completed and in the early part of 2017 begins the work of the IO task force in developing this clinical pathway. The American Cancer Society estimated that over 1.6 million new cases of cancer would be diagnosed this past year. In addition, more than 15.5 million children and adults with a history of cancer were alive on January 1, 2016 in the United States (American Cancer Society, 2016). These statistics are indicative of the need to address the existing knowledge gap. ARIN’s proactive approach to create the necessary education to meet this growing demand of this knowledge and skillset will foster the growth of nurses to advance the standard of subspecialty care in the imaging environment. The development of IO educational modules will outline the various aspects of the radiology nursing care of patients undergoing imaging studies and/or interventional procedures for the diagnosis or treatment of cancer.

Interprofessional Collaboration for Improved Patient Outcomes.

ARIN recognizes the significant role of APRNs in patient care across all healthcare settings. On December 14th, 2016, the U.S. Department of Veterans Affairs announced its decision to grant full practice authority to identified roles of APRNs. This is a significant move for APRNs, whose education, training and certification, prepare them to deliver high quality patient care in various specialty practices. Furthermore, the Institute of Medicine’s (IOM’s) Report titled The Future of Nursing: Leading Change, Advancing Health (2010) recognizes that APRNs are highly valued and an integral part the health care system. However, this ruling has been met with hesitation within the radiology community who feel APRNs will be jeopardizing quality patient care in respect to ordering and interpreting imaging. Clearly, as the premier radiology nursing organization, we have a responsibility to educate others on our various
roles in patient care. ARIN is committed to embrace and drive change that will have a positive impact on the professional work of APRNs and the continued contributions to elevate the standard of care.

The VA ruling is a significant stride in the evolution of the roles of advanced practice. This is particularly important for the role of the APRN in the radiology and imaging environment. The complexity of patient conditions undergoing radiological exams and/or interventions merits the role of the APRNs in such settings. Patient care within the radiology and imaging environment requires expert clinicians such as nurse practitioners (NPs) and/or clinical nurse specialists (CNS) with advanced training to provide high-quality, patient-centered care in assessment, management and decision-making for improved outcomes. The VA ruling is a paradigm shift that will continue to need a steadfast commitment among the professions for quality and cost effective patient care (Eisler & Potter, 2014). ARIN is committed to educating others on the role of the APRNs in the radiology & imaging environments and look forward to the evolution of the role. As the VA ruling continues to generate more comments and inquiries, ARIN will be at the forefront as representative of the radiology nursing community.

Annual ARIN Convention: Washington, D.C.

ARIN’s 36th annual convention is being held in our nation’s Capital, Washington, D.C. From March 5th through the 8th, attendees can gain knowledge, network, build new relationships and strengthen those already developed. The educational program this year is comprehensive and includes new presentation topics in transgender care, simulation sessions on airway management and interdisciplinary joint sessions with Society of Interventional Radiology (SIR) on topics of anticoagulants and sedation. ARIN is leading the way in radiology nursing education. I encourage everyone to visit the ARIN website and find out more about convention and its continuing education opportunities. As last year, for those that are not able to attend, virtual attendance is a convenient option to build upon your radiology nursing knowledge. I look forward to seeing you all at convention to connect and learn of ways ARIN can support its members continue to lead the way in expanding the body of knowledge for radiology nurses everywhere.

References:

Vison is a publication of the Association for Radiologic and Imaging Nurses Association. Comments and questions may be addressed to Senior Editor; Greg Laukhuf ND, RN-BC, CRN, NE-BC at Greg.laukhuf@arinursing.org.

WE NEED YOUR HELP!
ARIN is sending out a Survey Monkey to gather member feedback on Vision.
We want to hear what you like and what we can do better.
Please take time to complete the survey.
We can’t do it without you!
“The best way to find out if you can trust somebody is to trust them.”
- Ernest Hemingway

It is no secret that over one-third of our days are spent at work. As nurses we know that we spend more time and holidays with our co-workers than some family members. The work environment can either enrich or shrink morale and productivity. Learning how to build trust with coworkers can heighten efficiency, attitude, and confidence. It is a leadership building block. As we start 2017, the following points can help you build this important skillset.

Choose positive environment
Talented people are in demand and have workplace options especially in the era of the shrinking nursing pool left by Baby Boomer retirement. “A high-trust environment fosters what some call psychological safety, resulting in a more open and collaborative work culture,” explains Robert Bruce Shaw, author of Trust in the Balance and Extreme Teams (1997). “Research suggests that psychological safety is a key to success particularly at a team level.”

Exhibit concern
“Trust operates on multiple levels: at a company level in terms of culture, at a team level in regard to the relationships among the members, and at an interpersonal level between two people,” Shaw (1997) states. By showing you care about your colleagues, others will begin to trust and a “Trust” culture can be built.

Share yourself
Sharing about who you are can be extremely helpful within limits. Ruth Sherman (2015), author and speaker shares, “Especially for leaders or managers, sharing a story about a time you may have failed and what you learned from it can make you seem more human, not perfect, and certainly builds camaraderie and trust.”

Strive for competency
The Joint Commission requires proof of competencies. Ryan Outlaw, PhD, assistant professor of management at Indiana University (2015) states, “Employees should strive to be seen as competent in their role. This means having the requisite knowledge, skills, and abilities in his or her area.” Outlaw also feels employees should maintain a core set of values held by others in the organization. “For example, if other employees arrive early and leave late, does that employee do the same? These sorts of behaviors suggest shared values. Employees should focus on their competence, values, and benevolence in order to build trust.”

Lead by example
Leaders should model the behavior that they seek from others. (Lipman, 2014). Although this may seem common sense, this means listen and consider others’ ideas with an open mind; focus on the issues at hand regardless of personalities and be respectful. The reason for doing this is simple; it works and is effective. The news is littered with countless stories of leaders whose downfall was not following this simple tenet.

References

Appreciate the role of electronic media
A magazine article in Time (Luscombe, 2010) explores how electronic media can make workers feel disconnected. In the article, two groups are compared from a recent study. “So even if a colleague is working hard, his e-mail correspondent doesn’t know it and is thus less likely to work hard himself. In the study, the groups who met by videoconference did better than the e-mailers, who tended to shirk their responsibilities—suggesting that visual cues are key for trust.” The study author went on to state, “If you work virtually, show up in person for key meetings as much as possible.”

And remember…
We need each other (Mattson, 2016). The sage wisdom “No man is an island” is true today. In a recent article in Reflections on Nursing Leadership, Mattson discussed that all healthcare disciplines need each other as we care for our patients. This truth should resonate with each of us as we strive to—build trust with our colleagues.
ARIN NEWS

COMING SOON
ARIN 36TH ANNUAL CONVENTION,
WASHINGTON D.C. IMAGING REVIEW COURSE
MARCH 5-8, 2017 MARCH 3-4, 2017

Bruce Boulter
ARIN Executive Director

ARIN is now in the home stretch in preparation for the annual convention. All the committees have been working hard to present an outstanding program. As always, in addition to the convention, we will be presenting our outstanding Imaging Review Course. Now is a great time to work on your CRN and prepare for the exam in May.

As we head to one of the most amazing cities in the United States, we will celebrate the completion of ARIN’S 35th Anniversary. We will be in the midst of one of the cradles of US history. Not only will our participants be able to take advantage of great presenters, but also a hands-on simulation on “Airway Management for the Interventional Nurse”. As in previous years, the convention will be offered virtually for those unable to attend in person.

For those that are will be visiting Washington D.C., you will find a never-ending list of things to do. From the Capitol Building to the White House, and the multitude of buildings that make up the Smithsonian, you are guaranteed not to be bored.

Make your plans now to join ARIN in Washington D.C. for a 36 year anniversary convention you’ll never forget.

AN EVENING OF CELEBRATING YOU!

ARIN 35th Anniversary Reception

ARIN’s Annual Convention is less than two months away! Last year we began our yearlong 35th anniversary celebration in Vancouver recognizing the amazing work of its past and current leaders and how far the organization has come!! The dedication, knowledge and skillset of members throughout the years have contributed to ARIN’s continued growth in its body of knowledge and advancement of the specialty. This year, ARIN once again will be hosting a celebration on the evening of March 6th. This is a celebration of YOU – the members, whose every day commitment to the profession of radiologic and imaging nursing, has positively impacted the lives of patients, families and healthcare professionals. We look forward to sharing an evening of celebration with all of you. See you in D.C.!

CLICK HERE TO REGISTER

ARIN ATTENDS SYNERGY CONFERENCE
UNIVERSITY OF MIAMI 2016

Synergy is an annual symposium that offers attendees a review of an assortment of oncological diseases with the latest advances in medical, interventional and surgical treatment options in multiple practice areas. This is the second-year ARIN has participated in this conference.

The meeting this year was a blend of panel discussions and instructive case presentations focused on hepatocellular carcinoma, lung cancer, metastatic colorectal cancer, cholangiocarcinoma and liver metastases, renal and prostate cancer, pancreatic cancer, neuroendocrine and musculoskeletal tumors. Leading national and international experts presented the latest data and treatment innovations for oncological challenges in multiple organ systems with emphasis on implementation from diagnosis to treatment. At this year’s conference, Special emphasis was given to prostate ablations.

The conference was enjoyed by membership in attendance. It was agreed that many new practice ideas were shared. The group is looking forward to Synergy 2017 next fall.
Q: What is Interventional Oncology?

A: Utilizing interventional oncology techniques, radiologists can access tumors via small percutaneous punctures, advancing catheters via blood vessels with the assistance of image guidance. These minimally invasive advances benefit the patient who in the past would need to undergo traditional open surgical approaches.

Q: How does IO fit into IR and what significance does it hold in care options for our oncology patients?

A: Cancer patients at Sylvester Comprehensive Cancer Center, part of UHealth, have benefited from a subspecialty of IR, interventional oncology, in which physicians use catheters or transcutaneous needles to directly expose cancerous tissue to chemotherapy or energy-based treatments such as radiation. Dr. Narayanan remarks that cancer therapy at Sylvester has been enhanced significantly by the application of cutting-edge Interventional Oncology with state-of-the-art procedures, such as irreversible electroporation and radiopaque beads. Other techniques such as prostate artery embolization, has been utilized to block the blood supply to enlarged prostates (Interventional Oncology 360, 2016).

Q: What is your vision for the future?

A: With cancer being the second leading cause of death, Interventional oncology (IO) procedures are expected to continue to grow to treat this large population of patients in all age groups (CDC, 2016). IO offers options for less invasive targeted treatments with less pain and shorter hospital stays. This along with the shift to a clinical model will see more and more Interventional radiologists becoming a more integral part in the treatment decision making process rather than being a procedure service. This shift will also lead to more evidence from trials and move IO treatments into National Comprehensive Cancer Network (NCCN) guidelines.

Q: Can you describe the team’s training?

A: The nursing team consists of hired experienced nurses with a combination of floor nursing care and critical care experience. Additional nursing roles consist of nursing educators and advanced registered nurse practitioners. Certification in Radiology is encouraged and combines nursing skills of critical care, radiology, sedation, and peripherative.

The nursing team attends tumor board rounds. This is significant as a well-trained interdisciplinary team is necessary. In addition, for the past 5 years, we hold an annual symposium, called Synergy (University of Miami Miller School of Medicine, 2016), which offers a review of various oncological diseases and latest care options. Members of the Association for Radiologic and Imaging Nursing are offered discount registration and are encouraged to attend to learn of the latest evidence in cancer care. It doesn’t matter how good the Interventional Radiologist is if the radiology team isn’t just as good. We value the Core Team. Working in IR is a team sport. The team is given the room and space to grow, supported and encouraged to distinguish themselves.
When he answered, she had a very difficult time understanding him and suspected something serious was going on.

There were issues with the patient being able to talk and understand questions. We told the patient that we were going to call 911 on his behalf. The patient was admitted to the hospital with a dangerously low potassium level that could have been fatal. We reached out to the family to see how the patient was doing and he was doing well. If it had not been for the concern of Bree and her colleagues, this may have turned out very differently. Thank you, Bree!”

ARIN-Hopkins Simulation Training

ARIN’s Simulation Faculty traveled to Johns Hopkins for a team training session on December 1st, 2016 at the Simulation Lab at Hopkins. The opportunity to work at the simulation lab allowed Faculty to work together to prepare this program that will be presented at the 2017 ARIN Annual Conference in Washington, DC.

As a first step, the Faculty met to discuss and finalize this unique ARIN program: “Simulation Airway Management”. The goals were (1) to focus on airway assessment and management for patients undergoing procedural sedation; (2) determine the order and flow for the PowerPoint slides and practice stations; (3) conduct a dress rehearsal to ensure slides and practicum content were appropriate to complete the stated objectives in the allotted time frame.

At the end of our session, the Faculty believed our updates focused on the task and clearly met the objectives. ARIN is now excited to offer this Simulation Session in Washington, DC, and welcome ARIN attendees to our program. Attendees are encouraged to review the ARIN Capnography Position Statement and read the articles published in Journal of Radiology Nursing, September, 2016: Capnography: A Primer for Radiology Nursing and Capnography Monitoring During Procedural Sedation in Radiology and Imaging Settings: An Integrative Review.

ARIN-Hopkins Team Effort

Located in Baltimore, the Johns Hopkins School of Nursing is a globally-recognized leader in nursing education, research and practice and ranks #1 nationally among graduate schools of nursing and #2 for online programs, according to U.S. News & World Report. In addition, the school was named the “Most Innovative Nursing Graduate Program in the U.S.”
by Best Master of Science in Nursing Degrees, and ranks #1 among nursing programs (Johns Hopkins University School of Nursing, 2017).

ARIN thanks the Johns Hopkins Hospital for the use of the Simulation Classroom, the wonderful tour of the Radiology Departments, and the informative lunch with radiology nursing staff and leadership. We enjoyed learning of the many educational initiatives including the recent hosting of the ARIN Imaging Nurse Review Course taught by ARIN Master Faculty, Kristina Hoerl.

Johns Hopkin's dedication to growing radiology nursing leaders mirrors Charlotte Goodwin's vision. It was a full day and we recognize the entire team for taking time out of your busy day to spend time with us!!

BIG Thank You!!

Get a Sneak Peek: New Online EBP Course
Johns Hopkins Evidence-Based Practice Online Educational Series Available on the ARIN website: http://arinursing.org/index.cfm

References:

Barbara Gutmann RN, BSN is a new ARIN member working in a busy Radiology Department at University Hospitals of Cleveland Medical Center.

Why did you become a nurse?
I love helping others! Being able to help families and patients through difficult times is extremely satisfying for me. I wanted a career that was challenging, interesting, and made a difference in people's daily lives.

What about nursing makes you happy?
The moments you can celebrate with patients and their families are special. As a nurse, it is always the little things that make me happy, like when a patient can finally able to manage their pain, or even go to the bathroom!

What has been the most amazing experience you have had as a radiology nurse?
It is amazing to be a part of the life-saving medical care available to patients. It is also amazing to be a part of the patient's journey starting from detection to treatment.

What are the challenges you encounter and how do you overcome them?
As a nurse, you are the patients advocate. Sometimes there are challenges that arise between myself and other healthcare providers, but the key is to remember that you are an advocate for the patient. It is always what is best for the patient and the safety of the patient.

Have you experienced anything extraordinary in your career?
Every day I see and experience extraordinary events. Medicine has come so far! It is amazing to see patients with life threatening issues that even 5 years ago, had a low chance of survival recover and continue with their lives.

What has your nursing journey been like?
In the three years I have been a nurse, I have been able experience the flexibility of a nursing career. I have my license in three different states (Ohio, Indiana, and Michigan). Throughout my career, I have been in two different departments. I started in the NICU and then transitioned to the radiology department this past year. Through my journey, I have learned so much, and look forward to what is ahead of me!

At the end of a busy day, how do you find balance in your life?
The key is not to bring work home with you. Outside of work I do things that I love like walking my dogs, yoga, and cooking.

How has ARIN played a role in your career?
ARIN helps to keep my update on procedures and EBP for me to provide safe and quality care for my patients.
March 5-8, 2017 Washington, D.C.

With 4 days and over 30 credits available through lectures, workshops, and poster sessions; your education needs will be met.

Some of this year’s topics will include:

- Interventional Oncology
- Pediatric IR Cases and Challenges
- Safety in the Imaging Setting
- Leadership and Management
- New Technologies/Treatments in Imaging
- Patient Education in Radiology

Three ways to attend!

- Attend live in Washington, D.C.
- Watch virtual live broadcast
- Watch archive podcast
ARIN ON THE MOVE

ARIN EXTENDS A WARM WELCOME TO OUR NEW MEMBERS!

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MAKE ARIN YOUR NEW YEARS RESOLUTION!

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Cleveland Clinic physician tells team to ditch the word ‘just’
Becker's Hospital Review.com, November 8, 2016
In response to a woman calling herself “just a float,” a Cleveland Clinic physician sent an email to his team encouraging them to cease using the word “just” when referring to their job. Tom Abelson, MD, medical director of the Cleveland Clinic Beachwood Family Health & Surgery Center, shared his message in a daily briefing. In the memo, Dr. Abelson asked the woman to rephrase her introduction, stating with pride, “I am a float, and my name is …” “I have heard myself say, ‘I am just a general otolaryngologist,’” Dr. Abelson wrote in the email. “I have heard others say, ‘I am just a receptionist.’ So let’s lose the word ‘just’ at our center. We can describe ourselves without the word ‘just’ without losing the humility that we hopefully all feel as well.” He encouraged his team to “gently correct” colleagues who use “just” in this fashion and for individuals to “have pride” in their work.

Health risks of dumpster diving for make-up
Cleveland19.com, November 7, 2016
With the holidays, dumpster diving for free make-up products has become that the latest money saving trend in cities across the country. Many cosmetic store make-up products thrown out in the trash are treasures for some and cash by others. Dr. Baron, a dermatologist at University Hospitals Cleveland Medical Center, shares there are serious skin conditions that could develop and land you in the hospital. “Itchy skin, red skin, inflamed skin, even acne or eruptions that look like acne, it can take several forms,” said Baron. … Just because the product is sealed doesn’t make it safe. It depends on how long the product has been exposed to certain temperatures and how long it’s been sitting out. Baron warns that products were likely thrown out for a reason, and are probably beyond their “lifespan for stability” according to manufacturer standards.

University Hospitals Seidman Cancer Center performs new image-guided prostate biopsy
Public Now.com, November 9, 2016
University Hospitals Seidman Cancer Center physicians are among the first in the country to offer a promising new screening tool to detect prostate cancer - MRI (Magnetic Resonance Imaging) - guided prostate biopsy. Using MRI imaging, the new technology enables physicians to visualize and biopsy prostate cancer by distinguishing tumor from healthy tissue. “The in-gantry MRI guided biopsy has the potential to revolutionize prostate cancer detection,” says Vikas Gulani, MD, PhD, Director of Magnetic Resonance Imaging at UH Cleveland Medical Center.

NIH’s Collins Optimistic About 2017 If No Budget Delay
Medscape.com, November 18, 2016
The year ahead could be incredibly beneficial for biomedical progress and the National Institutes of Health (NIH), but a politically driven delay in 2017 funds would halt the forward motion, said NIH Director Francis Collins, MD. The election of Donald Trump as president may be sending shudders through Washington’s establishment but Dr. Collins, speaking at a forum sponsored by the Bipartisan Policy Center, said he does not anticipate issues for the NIH and biomedical research. In Washington, “people like to predict catastrophe,” said Dr. Collins, “That seems to be the thing that gets the attention and gets everybody’s blood boiling.” But, he said, “I’m here to actually predict success. “With the appropriate resources in hand, we are confident that this could be the most remarkable moment in medical research history,” Dr. Collins said, citing advances in single-cell biology, understanding of the brain, spinal cord injury, Alzheimer’s disease, stem cell research, infectious disease, diabetes, precision medicine, and the soon-to-be-started NIH project to enroll a million people in the “All of Us” database to jumpstart that effort.

Cleveland Clinic CEO Has a Warning for U.S. Hospitals
Fox Business.com, November 21, 2016
Dr. Toby Cosgrove, CEO of the Cleveland Clinic … [said] … that consolidation specifically would give hospitals more purchasing power and avoid duplication of services without substantially raising costs. “Hospital occupancy across the United States is about 65%…. In Ohio, we have 202 hospitals across the state. One of the concerns right now is with decreasing payments that hospitals are getting for their services they provide, we are seeing almost a quarter of the hospitals now running in the red. So ultimately, if we do not see consolidation and increase efficiency, we are going to see hospital closures across the country,” he said. “I think we are going to see consolidation across the insurance industry … across the pharmaceutical industry … and I think we are going to see it amongst the hospital providers.” He added: “This is what the response is to the demands to have more efficiency in our health care delivery system. There’s no question that if the insurance industry consolidates, we are going to have to consolidate as providers who negotiate with them,” he said. The Cleveland Clinic CEO also stressed the importance of keeping the current 20 million people with health insurance covered. “We have to continue to keep those people covered otherwise the premise for hospitals of more patients, even though we are being paid less, is going to cause more and more hospitals to have major economic problems. We need to continue to cover those individuals, the question is how we do it, and we do it most efficiently,” he said.
AACI Commends House Passage of Revised 21st Century Cures Act
The U.S. House of Representatives passed a revised version of the 21st Century Cures Act, which provides $1.8 billion for cancer research by a roll call vote of 392-26. The bipartisan bill is needs a vote in the Senate for final approval. "We welcome the increased federal investment in cancer research," said the Association of American Cancer Institute's (AACI) President Dr. Stanton Gerson. "Investing in the NIH and NCI not only plays a vital role in addressing cancer incidence, but it also contributes to curbing the overall costs associated with cancer." Dr. Gerson is … director of University Hospitals Seidman Cancer Center in Cleveland and a member of the NCI Board of Scientific Advisors.

eNNOVEA Medical’s CardioQuick Patch® Reduces Electrode Placement Errors During ECG Acquisitions in New Study
Researchers at Ulster University, University Hospitals Case Medical Center, and the Department of Cardiology in Altnagelvin Hospital reveal a new, promising solution to the common problem of electrode misplacement. … A recent study has found that an engineering solution called the CardioQuick Patch® significantly improves the … accuracy of placing … electrodes … Over the last 60 years, studies have shown that single electrode misplacement is the single largest contributing factor in 12-lead ECG analyses errors. A misplacement of as little as one-inch can result in ECG errors and contribute to misdiagnosis of 1 in 5 patients.

Physicians Missing Clues in Human Trafficking
“The US State Department estimates that, in this country, we’ve only managed to identify 1% of the people trafficked here. Human trafficking is a hidden crime and we are not the best detectives,” said Susie Baldwin, MD, MPH, from the Department of Public Health in Los Angeles County, who is president of the board of directors of HEAL Trafficking, an organization dedicated to ending human trafficking. Physicians are generally not trained to address issues of physical, sexual, or psychological abuse with their patients, she explained. “Many of us don’t ask our patients about exposure to violence or coercion because we don’t know how to or we don’t know where to refer them if someone admits to us they need help.” she said at TEDMED 2016 in Palm Springs, California

Artificial intelligence, machine learning find role in radiology
Leo Wolansky, neuroradiologist and professor of Radiology at University Hospitals, Cleveland … [says] … “The role of the radiologist has changed so much. It used to be that we were just asked to distinguish black from white. Now, we’re asked … what is the percentage of white and black and gray, or how much that percentage has changed over the years.” Because of the growing need for accuracy in assessments, applications that can assess images becomes important, Wolansky adds. “With software, we can see changes in diseases such as multiple sclerosis over time,” he says. “If a patient comes back with more lesions, that can impact how the patient is treated. That’s something software can do - it can compare images and find a new lesion, or indicate where a lesion might be. So if a follow-up scan shows an increase in lesions, that could have an important implication for treatment. “There’s an explosion of information confronting radiologists, and there’s a need for speed in processing it for patient care,” he adds. “With stroke, the window of opportunity to effectively treat the patient means an assessment has to be done in minutes, and radiologists need to look at images and be able to make a diagnosis instantly.”
Over recent years, stories about cyber attacks at large corporations have become as commonplace as the nightly news. What the media has failed to convey is that 30% of privacy data breaches occur at small to mid-sized businesses. Or that healthcare organizations account for 42% of all infiltrations, giving it the dubious distinction as the #1 most targeted industry in the U.S. The goal of this article is to provide the healthcare community with the information you need to:

• Understand your privacy data breach risks
• Implement some control over these exposures
• Receive a basic understanding of cyber liability insurance

Cyber Exposures in a Healthcare Practice
For most healthcare practices, the days when patient records were kept in manila folders came to an end years ago. Electronic health records can help improve the quality of care, efficiency, patient safety and access to information. Those practices that still maintain paper records will soon have to comply with federal regulations related to Electronic Health Records. The personally identifiable information you collect from your patients and store on computers can include:

• Full name
• Address
• Date of birth
• Credit card numbers
• Financial information
• Medical records
• Social security number
• Phone numbers and more

According to federal HIPAA and HI-TECH privacy laws, as well as state privacy laws enacted in 47 states, you have an obligation to protect this data.

Below are three, common activities used by most healthcare practices that involve a certain degree of risk to patient data. Use the included risk management techniques to reduce your exposures…

1. Storing Patient Records
When storing patient records, transmitting records or using processes like billing and appointments, you probably store the data using one of these methods:

Flash drive or computer hard drive: This is an acceptable way of storing patient’s personally identifiable information, but there is a potential for hacker infiltration or equipment theft.

eBackUp: These services provide additional security by encrypting and storing the data at a remote location, but if you look carefully at their contract ‘terms and conditions,’ they bare no responsibility for lost or stolen data.

Cloud computing: Cloud vendor agreements generally contain language that you own the data. Older agreements may not contain this language. While advertised as reliable, stories abound of cloud centers going down after incidents such as lightning strikes, as well as security breaches resulting in stolen data.

Risk Management Tips
• Control access to the information kept on patient records
• Ensure that online patient forms are kept on secure servers
• When transferring patient records use an encrypted connection
• Pay close attention to the terms and conditions within eBackUp contracts
• Manage the language in cloud computing agreements
• Store your system backup data offsite

2. Maintaining a Wireless Network or Website
While maintaining a website or wireless network is a great way to foster patient relations, they’re also a gateway cyber criminals use to access your servers and steal data. While it is wise to consult an IT expert or security specialist, below are some basic measures you can take to reduce your exposures.

Risk Management Tips
• Change the System ID: to something that makes it less likely for a hacker to identify your network
• Disable Identifier Broadcasting: set up your network so that its name is not broadcast when someone searches for a Wi-Fi spot
• Enable Encryption: don’t use Wired Equivalent Privacy (WEP) that has been deconstructed by hackers; use Wi-Fi Protected Access (WPA)
• Restrict Unnecessary Traffic: assess who has access to your network; do all employees need access?
• Routinely Change the Default Password: ‘P-A-S-S-W-O-R-D’ is not a good password. Create passwords with an above average security rating

3. Accepting Credit Cards
When you accept credit cards you transfer some of your risk to a payment processing service like TransFirst Health who provides some level of coverage for a data breach involving credit cards processed through their system. You still have the exposure for credit card data maintained in your computers.

The Payment Card Industry Security Standards Council publish the Payment Card Industry Data Security Standard (PCI DSS) for organizations that handle cardholder information for debit, credit, prepaid, e-purse, ATM and POS cards. PCI DSS contains six key components for protecting credit card data:

• Build and maintain a secure network
• Protect cardholder data
• Maintain a vulnerability management program
• Implement strong access control measures
• Regularly monitor and test networks
• Maintain an information security policy

There are over 220 sub-requirements, some of which can place an incredible burden on the business owner, but these requirements provide a baseline for credit card security. Non-compliance with PCI standards can result in fines from banks or credit card institutions from $5,000 to $500,000 per day.

Risk Management Tip
• To protect yourself practice control: control the data, control the access and control your network
In the aftermath, property and casualty insurance companies inserted a provision into their contracts to exclude cyber exposures and began to develop cyber liability insurance products.

**Cyber Liability Insurance Today**

Prior to 2010, cyber liability insurance was primarily designed for large retail, financial and medical organizations. It’s only in the past few years that the insurance industry has begun to realize that small businesses are being victimized as well. As this is a new risk for them, the industry is moving cautiously, so depending on where you practice you may find access to coverage limited.

Because the product is relatively new, it has not been standardized. It may be called ‘network security’ or ‘internet liability.’ It may be a standalone policy or attached to another policy. It may be optional or it may be a standard feature.

Though policy limits will vary, what they all have in common is coverage for litigation that results due to a privacy data breach. Typical coverage includes:

- **Cyber Liability**: if you are sued as a result of a privacy data breach it provides a legal defense and pays for settlements/judgments up to the limits of the policy
- **Legal and Forensic Services**: reimbursement for the verification of compliance with notification laws, including expenses involved in determining how and what data was accessed
- **Customer Breach Notice Expenses**: coverage for costs associated with patient notification and credit monitoring
- **Public Relations Expense**: costs to assist in organizing a media response
- **Administrative Action**: coverage for an investigation by a state or federal regulatory agency

While using the risk management tips suggested in this article may help reduce your exposures, knowing that criminals have gone high-tech and often times know more about our computer systems than we do, all healthcare practices should be exploring their cyber liability insurance options for their practice.

**References**


By Mark Buccko, CPCU, CIC, RPLU

This risk management information was provided by Nurses Service Organization (NSO), the nation’s largest provider of nurses’ professional liability insurance coverage for over 550,000 nurses since 1976. The professional liability insurance policy is administered through NSO and underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company. Reproduction without permission of the publisher is prohibited. For questions, send an e-mail to service@nso.com or call 1-800-247-1500. www.nso.com.
“Trust this knowing that when the team member does push you they are doing it because they care about the team”

–Patrick Lencioni

My tenure as Co-Chair of the departmental quality committee has seen many changes. In recent years, improving quality has gained considerable momentum in healthcare. The need is apparent but too often initiatives fail because quality is considered an impossible goal and an element that resists measurement. To improve radiology nursing, we will need a stronger and more objective definition of quality. My working definition of quality is defined as the probability that the service or product meets or exceeds expectations. It is derived from other fields. The next obvious question from my definition is, “Whose expectations are we trying to meet or exceed?” Despite its intricacies, the heart of healthcare is serving the needs of patients and their families. Granted, our system includes a multitude of teammembers, but if we understand and fulfill the expectations of patients, the needs and demands of referring physicians, insurers, and other stakeholders will occur.

The Perspective Shift

So, what created and now drives patient expectations? The media and internet have impacted this shift. Television programs like Marcus Welby, M.D., and ER, helped foster the expectation that a patient’s every need could be accurately diagnosed, solved, and treated in 60 minutes. The marketing campaigns of pharmaceutical companies and hospitals reinforced the idea that every need can be addressed by numerous drugs or use of the latest technology. Patient expectations are also shaped by guarantees that the planned imaging study or imaging guided for seizure is safe, quick and effective. These expectations can be reinforced by internet articles or blogs in which medical conditions are discussed by nonprofessionals without an understanding of involved co-morbidities. All too often, we as medical professionals find ourselves facing an uphill battle, weighted down with unrealistic expectations.

We tend to view imaging and image guided procedures from our perspective. It takes seconds to acquire hundreds of CT images and minutes to perform an image guided biopsy. But from the patient’s perspective, these procedures include traveling to our workplace, waiting for the procedure, and post procedure recovery. Other industries have long been aware of the value of viewing the client’s perspective. They give their customers control over the interaction and allow them to tailor it to their needs. For example, most on line retailers allow customers to choose which shipping option they want. Even when processes are outside the customers control, savvy firms create transparent processes for customers to update expectations. For example, companies that posts information so customers to track shipping of packages for arrival and departures.

With this external perspective in mind, one realizes the interpreting images and performing procedures is a small part of the patient experience. Difficulty with parking, confusing directions within the medical center, or an offhand remark at reception desk are all apparent to the patient. By contrast, the radiologist expertise is hidden from view. Imagine what patients think when they encounter reports that contained obvious errors or the radiology nurse did not care for the patient as described on the internet. Clearly it is critical that we understand patient’s expectations so we can begin aligning patient’s expectations with what Radiology can provide.

Taking a team approach

This shift in patient perspective places a greater emphasis on teamwork and the inclusion of the patient as part of that team. As the healthcare team grows and becomes more diverse, this becomes a monumental task. There is a clear need to create care models that provide reasonable expectations for both patients and providers. Everyone will need basic quality improvement training to acquire the knowledge, skills and abilities necessary to identify improvement opportunities. Creating a team approach that satisfies patients’ needs is a worthy quest and one worth pursuing. Some day you or a family member will likely step into the role of the patient. The question we should ask ourselves is, When you are the patient, who do you want on your team?

References

Duncan, James. (August 2016). Quality improvement is a team sport. RSNA NEWS 26 (8). P 4.
When safety is first, you last.
- Unknown

While radiologic procedures are improving patient care in the United States and worldwide, the complexity of the procedures with the use of high-alert medications and the possibility of communication failures during handoffs contribute to medical errors. Errors have been documented in high risk settings such as cardiac catheterization, endoscopy laboratories, radiology, and other imaging settings where health care professionals may administer contrast media, adjust rates of IV fluids, and flush vascular access.

Radiology errors are a challenge for hospitals and providers operating in the new health care environment. Payments have become increasingly linked to complex performance measurements in which underperformers face decreased payments and possible penalty fines. Tackling these payment issues may require a change in clinical operations with an emphasis on high reliability and the establishment of processes directed at improving patient care and safety. The process can begin with improvements in staff communication and patient identification.

First Challenge: Communication

The Joint Commission contains in its national patient safety goals a section on critical values reporting. This section emphasizes sharing “important test results to the right staff person on time.” The communication must be timely and requires documentation of “closed loop communication” between the originator of information and the healthcare provider so that he or she is aware of the finding.

In a radiologic setting, such conditions may include an unexpected lung cancer, a newly discovered pneumothorax on a routine chest X-ray or reaction to contrast. The Joint Commission states that there must be a process to address these situations and their inherent challenges. First, the radiologist must contact the physician when issues arise. What if the medical provider doesn’t respond to the communication or is signed off to another provider? How is the chain of communication documented? Critical information that is not passed to another is a cause of malpractice claims and an important patient safety issue.

Second Key Challenge: Patient Identification

Identifying the right patient, right side/site, and right procedure holds the same level of importance for procedures performed in IR as it does in operating rooms. An example is this case from the Annals of Internal Medicine (Chassin, 2002).

A 67-year-old woman was admitted to the hospital for cerebral aneurysm embolization. The first aneurysm was embolized while the second aneurysm was decided to be clipped at a separate hospitalization. The patient was recovered post procedure on a different floor then she was in pre-procedure. Discharge had been planned for the next day, but the patient was taken to invasive cardiology electrophysiology early the next morning. One hour into the procedure, it was determined that she was the wrong patient. The study was aborted; she was returned to her room and in stable condition.

The article stresses that there was a series of errors—16 in total—that lead to errors in this case and could have resulted in patient harm. To ensure patient safety, there must be an appropriate “time-out” performed by the procedure team with two-person identifiers and the correct site/side marked. Departments should optimize their daily operations and embrace high reliability organization elements such as transparency or sensitivity to operations to improve patient quality of care and safety (Gamble, 2013). This requires a commitment to safety in the area and measuring outcomes.

The Solution

How do we make patient care safer? Increasing communication and correctly identifying the patient to the intervention is a great start. Adapting tenets of high reliability organizations is an important continuation of the process to make radiology a safer place.

References
The new year brings “Top Ten Lists” from many sources, including the dreaded New Year’s resolution list. What should an ARIN nurse really pay attention too? Below is a list of the top 10 technology hazards compiled by ECRI Institute, whose public service mission is to inform healthcare facilities about safety issues involving medical devices and systems (Brooks, 2016).

Many of the listed items are relevant to our practices. The list is not based on the number of reported incidences but rather the judgement of the ECRI organization regarding which patient care hazards should receive the greatest priority in the upcoming year. The hazards cited are based on severity, preventability, frequency, breadth, insidiousness and profile. The top ten technology hazards for 2017 are:

Infusion errors, this year’s number 1 tech hazard, can be deadly if safety steps are overlooked. Although modern large-volume infusion pumps incorporate features that reduce the risk for infusion mistakes, these safety mechanisms can’t eliminate all potential errors, and the mechanisms themselves have been known to fail, ECRI points out. “The ECRI continues to receive reports and investigate incidents of uncontrolled flow of medication to the patient — a potentially fatal circumstance known as ‘IV free flow’ — and other infusion errors. Fortunately, as ECRI points out in its guidance document, a few simple steps can help catch use errors and component failures before patient care is affected.”

For example, in several incident reports, harm could have been avoided if staff had noticed physical damage to infusion pump components, made appropriate use of the roller clamp on the intravenous tubing, and checked the drip chamber beneath the medication reservoir for unexpected flow. Potentially deadly infusion errors that may occur with infusion pumps are the top health technology hazard that hospitals and clinicians should focus on in 2017.

Taking the number 2 spot on the list is inadequate cleaning of reusable instruments, including duodenoscopes. It’s high on the list, the group notes, in part because of the severity of the infection risks and the persistence of the problem. The ECRI Institute “regularly sees reports of contaminated medical instruments being presented for use on a patient.” “Often, we find that inattention to the cleaning steps within the reprocessing protocol is a contributing factor. Healthcare facilities should verify that comprehensive reprocessing instructions are available to staff and that all steps are consistently followed, including precleaning of the device at the point of use,” they advise. Contaminated duodenoscopes made headlines in 2015, as reported by Medscape Medical News and is a focus of the Joint Commission during regulatory visits.

The number 3 spot is missed ventilator alarms. “Ventilators deliver life-sustaining therapy, and a missed alarm could be deadly,” ECRI notes. Top concerns include alarm fatigue, in which staff become overwhelmed by, distracted by, or desensitized to the number of alarms that activate, and alarm notification failures, in which alarms are not effectively communicated to staff, they say.

The number 4 spot on the top hazards list is undetected opioid-induced respiratory depression. The ECRI group says “spot checks every few hours of a patient’s oxygenation and ventilation are inadequate.” They recommend that healthcare facilities implement measures to continuously monitor the adequacy of ventilation of these patients.

The Number 5 spot belongs to infection risks with heater-cooler devices used in cardiothoracic surgery. This hazard has been identified in previous years. Heater-cooler systems have been identified as a potential source of nontuberculous mycobacteria infections in heart surgery. In October 2015, as reported by Medscape Medical News, the US Food and Drug Administration issued recommendations for all heater-cooler devices to help prevent and manage device contamination risks and to minimize patient exposure to heater-cooler exhaust air.

Rounding out the top 10 technology hazards ECRI wants hospitals and clinicians to tackle in the coming year are:

6. Software management gaps put patients, and patient data, at risk;
7. Occupational radiation hazards in hybrid operating rooms;
8. Automated dispensing cabinet setup and use errors may cause medication mishaps;
9. Surgical stapler misuse and malfunctions; and
10. Device failures caused by cleaning products and practices.

More information can be found on their website.

References
MEMBERSHIP CORNER

35 YEARS IN THE MAKING: THE WASHINGTON CELEBRATION!
Greg laukhuf ND, RN-BC, CRN, NE-BC
Vision Editor

The story of the Association for Radiologic & Imaging Nursing (ARIN) began 35 years ago. In November 1981, 35 highly motivated radiology nurses from 15 states met in conjunction with the 67th Scientific Assembly and Annual Meeting of RSNA in Chicago to establish the foundation for the American Radiologic Nurses Association. From these humble beginnings, Arin has grown into a 2,000-member strong organization that includes a thriving review courses, academically strong magazine, publications, and contact hour offerings, – all working together to serve radiology nurses worldwide.

As ARIN took shape over the years, it distinguished itself within Radiology, the Nursing community and worldwide. Our international reputation for promoting high-quality care, our direct involvement in promoting Radiology nursing knowledge and a continued commitment to training the next generation of radiology providers demonstrate that from the beginning, we were living the ARIN Mission: To provide Radiology Nurses with the knowledge and resources to deliver safe quality patient care in the imaging environment.

Our history is richly woven into the growth of this organization, and having the support and trust of the members we serve has enabled us to flourish through the decades and become a respected leader. ARIN is prepared for the future of Radiology, inspired by our rich history and dedicated to our mission. We look forward to continuing to serve Radiology nurses with purpose, passion and promise for decades to come. Please join us for our 35th anniversary celebration in Washington, D.C to share our heritage and success.

CELEBRATE CERTIFIED NURSES DAY

Every March 19, employers, certification boards, education facilities, and healthcare providers celebrate and publicly acknowledge nurses who earn and maintain the highest credentials in their specialty. The day was inspired by Dr. Margretta ‘Gretta’ Madden Styles, RN, EdD, FAAN, a pioneer in nursing certification. The Association for Radiologic & Imaging Nursing wishes to celebrate all Certified Radiology Nurses (CRNs) on this day! The dedication to your profession through certification is an example of the comprehensive care you offer to patients. ARIN recognizes your expertise and diligent efforts not only on this day, but throughout the year as stalwarts in the area of radiology and imaging nursing. Visit the “Certification Toolbox” found on ARIN’s website today for ways you can celebrate your CRNs within your radiology and imaging department.

2017 RESOLUTION: JOIN A CHAPTER

ARIN has many new members and is growing! With growth, new members may not be aware of a chapter close to them. The above map with links can be found on the ARIN Website under the Chapters tab on the home page. Make 2017 the year you join your local chapter!
The RNCB conducted an item writing session October 15-16, 2016, in Atlanta, GA. Members of the Item Writing/Test Development workgroup were Jan Sprague, BSN, CRN, Boise ID; Patricia ChongTenn, RN, CRN, CNRN, CMSRN, Brooklyn, NY; Patricia Griffith, ADN, RN, CRN, Mohegan Lake, NY; Amanda Price, BSN, RN, CRN, Pittsburgh, NC; Michele De Vito, RN, CRN, Hewitt, NJ; Rick Orton, RN, CRN, RRT, RPFT, Evergreen, CO; and Mark Hammons, RN, CCRCM, CRN, Minford, OH. RNCB Board of Directors members President Mary Myrthil, MS, RN, CRN, NE-BC, Secretary-Treasurer, Elizabeth Anderson, BSN, RN, CT, CRN; Tinley Park, IL; Director Linda Alliprandini, BSN, RN, CRN, and Director Christine Hockenberry, RN, CRN, Ocean City, NJ also participated in the workgroup activities. The workgroup reviewed the current exam questions for ongoing validity and was charged to develop new questions for future exams. The item writing work is rigorous and rewarding. The RNCB gratefully acknowledges the work of the individuals and looks forward to inviting other CRN's to participate in future item writing activities.

Certification is one of the most important decisions a nurse can make. Certified nurses are recognized by their peers and employers for having achieved a standard of competency in their nursing specialty. The next Certified Radiology Nurses (CRN®) Exam will be administered March 8, 2017, at the Marriott Marquis, Washington, DC, at the conclusion of the ARIN annual convention. The CRN exam will be administered nationwide on May 20, 2017, and October 14, 2017. For more information and to download the CRN Exam application and the Guidelines for Certification and Recertification handbook please visit www.certifiedradiologynurse.org or call 855-871-6681.

Congratulations to the newly certificatified and recertificatified CRNs!

The Radiologic Nursing Certification Board, Inc. (RNCB®) would like to congratulate the following nurses who passed the Radiology Nurse Certification exam on October 15, 2016. These nurses have met the requirements to obtain the Certified Radiology Nurse (CRN) credential.

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<tr>
<td>Leslie Williams</td>
<td>Chapel Hill, NC</td>
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<tr>
<td>Kelly Zuck</td>
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A total of 86 nurses took the Certified Radiology Nurses (CRN®) Exam on October 15, 2016, in Baltimore, MD, with a total of 68 passing. This is a pass rate of 79%.
Recertification

The Radiologic Nursing Certification Board, Inc. (RNCB®) works hard to maintain the standard of excellence among nurses who have made the commitment to set themselves apart as Certified Radiology Nurses by maintaining certification. The RNCB would like to congratulate the following 71 nurses who met the stringent standards to maintain their certification in October 2016.

Evangeline Bondoc  San Diego, CA
Kelly Leonard  Wappingers Falls, NY
Tamara O’Connor  Orland Park, IL
Cristina Sokarda  Hickory Hills, IL
Colleen Cabralf  Peabody, MA
Nancy Kendall  Westford, MA
Medjy Fontin  St. Albans, NY
Sue Kehoe  Saugerties, NY
Patricia Young  Mattituck, NY
Stacy Skelding  Atwater, OH
Leah Cremen  College Station, TX
Sarah Whitehead (Atherton)  Little Rock Cabot, AR
Brenda Boone  San Diego, CA
Christine Nuttall  Monterey, CA
Leticia Sanchez  Torrance, CA
Laura Prior  Watertown, CT
Marianne Szarkowicz  Wilmington, DE
Barbara Wilson  Miami, FL
Cecile Manahan  Lombard IL
Diane Sullivan  Olathe, KS
Patricia Voda  Middletown, MA
Reene Leonforte  North Chelmsford, MA
Kathleen Morrison  Dennis, MA
Stephanie Parker  Peabody, MA
Danielle Patturelli  Duluth, MN
Diane Rosberg  Anchorage, AK
Renee Kennedy  Secaucus, NJ
Joel Garcesa  Bergenfield, NJ
Deidre Kochkian  Clifton, NJ
Mark Koryzma  Riverdale, NJ
Kathleen Lacey  West Creek, NJ
Anna Pona  Osinner, NY
Patricia Casarella  Smithtown, NY
Denise Daly

Ann McRory  San Diego, CA
Heidi Noce  Wappingers Falls, NY
Joni Ondra  Orland Park, IL
Anna Versace  Hickory Hills, IL
Ryan Ford  Peabody, MA
Peggy Howard  Westford, MA
Kathleen Kelly  Saugerties, NY
Arnold Manguerra  Mattituck, NY
Candace Meyer  Atwater, OH
Jessie Ramirez III  Watertown, CT
Gloria Walker  Wilmington, DE
Cynthia Ralston  Miami, FL
Kathleen Shannon  Plattsburg, CT
Tracy Thompson  San Diego, CA
Kristine Erickson Thompson  Torrance, CA
Paula Norton  San Diego, CA
Pamela Potter  Wantsage, NY
Mary R. Sichko  California, CA
Bonita F. Jones  Florida, FL
Miriam L. Whetton  Torrance, CA
LuAnn S. Ballais  Plattsburg, CT
Donna M. Keith  Watertown, CT
Jacqueline M. Kixmiller  Wilmington, DE
Donna G. Silva  Miami, FL
Jennifer K. Karp  Olathe, KS
Mary B. Hodson-Bihmher  Middletown, MA
Valinda L. Petri  North Chelmsford, MA
Heather A. Macaulay  Dennis, MA
Judith A. Peck  Peabody, MA
Joan S. Mimmack  Duluth, MN
Celma A. Capuz-Weaver  Anchorage, AK
Kim R. Moroz  Secaucus, NJ
Lisa Pella  Bergenfield, NJ
Kimberly McElhenny  Clifton, NJ
Anie A. Daniel  Riverdale, NJ
Christiane C. Van Wickler  West Creek, NJ
Pamela Zenger  Osinner, NY

A total of 114 nurses with the CRN® credential were due for recertification in October 2016. There were 71 nurses who renewed their certification and 43 that did not submit for recertification via continuing education credit. The recertification rate for this period was 62.2%.

LEADERSHIP UPDATE

Piera Robson MSN, CNS, NP, AOCNS, ANP-BC, OCN
ARIN Director of Leadership

The Leadership Development Committee has had an active fall. The committee of 4 members, Joann Graf, Heidi Jones, Leah Keller and Kathy Pittman, have completed their election, awards, and scholarship activities in preparation for our Annual Conference 2017. The committee is chaired by Piera Robson, Director of Leadership. Our ARIN membership elected officials who will be sworn in during the Annual Business Meeting on March 7th. At that time, the recipients of awards and scholarships will be announced.

If you have interest in becoming a leader within ARIN, every year there are opportunities to serve on the Board of Directors positions and Leadership Development Committee. We welcome your experience, enthusiasm and leadership skills! Please contact Piera Robson to discuss at piera.robson@arinursing.org.

ARIN offers many Awards and Scholarships to recognize the contribution our members make to the quality of radiologic and imaging nursing. Each year, some of these awards and scholarships are not awarded due to insufficient applicants. Most awards require one year or more of membership so be sure to maintain your membership with ARIN and consider submitting your application for an award or scholarship. Our goal is to recognize the best ARIN members and there is a good chance that member is you!
ARIN’s dedication to providing members cutting edge education continued in Fall 2016. It has been a productive time for the webinar committee. Many live webinars were recorded and archived. These are available for continuing education credit through the Alabama Nurses’ Association. Once earned, CE credits remain on your ARIN membership profile for 5 years for you to print off as needed. Members can access these offerings on the ARIN website by clicking on the Education tab and selecting ARIN Webinars.

Recent additions to the webinar library by month include:

**October:**
*An Overview of Pediatric Sedation in Radiology Part I and II* by Lori Reilly MSN, CRNP, CPNP-AC

**December:**
*Rheolytic Thrombolysis: Radiological Nursing Care* was presented by Terri Cronbaugh MSN, RN, CCRN

**January 2017:**
*Improving the Experience for Sexual and Gender Diverse (LGBTQ) People* by Marni Panas, BHAdmin.

Watch your email for the following upcoming webinar series to include:

**January 25, 2017:** Critical Appraisal and Evaluation of Evidence Based Nursing Research: A Practical Approach by Lois Marshall PhD, MSN, BSN, RN.

**February 22, 2017:** Human Trafficking by Denise Robinson BSN, RN SANE-A.

If you have an idea for a webinar, a suggestion for something you’d like to see covered or are interested in presenting a webinar, please reach out to Cathy Brown, webinar committee chair at [Cathy.Brown@ari.nursing.org](mailto:Cathy.Brown@ari.nursing.org).
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