ARIN VISION

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In this issue

THE RADIOLOGY & IMAGING NURSE: A LEADER IN PATIENT CARE

ARIN 2016 INAUGURATION SPEECH

Evelyn Wempe, ARNP, MBA, MSN, ACNP-BC, AOCNP, CRN
2016 ARIN President

Good afternoon, colleagues and distinguished board members, I would like to begin by welcoming all of you to the 2016 Association for Radiologic and Imaging Nursing (ARIN) Annual Spring Convention. I hope you have enjoyed the educational sessions, the networking opportunities, but most of all each other's company with our shared passion for Radiology and Imaging nursing.

Today, I have the privilege to begin my journey as ARIN's 2016 President. I am deeply honored to have been elected into this role and to continue the amazing work of my predecessors. For the past year, I have served on the board as President-Elect. I have had the wonderful opportunity to work alongside a talented group of individuals that served on the 2015 Board of Directors. At this time, I would like a moment to acknowledge the 2015 Board of Directors for their hard work and dedication to ARIN's core purpose of fostering the growth of nurses and advancing the care in the radiology & imaging environment. Please join me in applauding this amazing group.

Additionally, I want to recognize Mary Sousa, our 2015 ARIN President, who has worked diligently and successfully to ensure ARIN's Visibility within the healthcare environment through leading it to the forefront in radiology and imaging nursing; not only at the national level but also internationally. She advanced our Virtual capabilities through increased accessibility to online resources and educational courses and finally through voicing the Vital role of the radiology and imaging nurse. She has been a great mentor in preparing me for my Presidency. Mary, you mentioned last year that you had big shoes to fill; I think I will re-iterate it this year!

Over the next year, my goal is for ARIN to continue to expand and evolve the role of the radiology nurse. As nurses, we are an important part of the patient's experience in radiology and imaging. Look around this room and see all the talent, experience and skillset that we bring to our departments, colleagues and most importantly, our patients. Without realizing it, we are all leaders in patient care. It is important for ARIN to continue to foster the growth of nurses within the radiology and imaging environment for several reasons. First, it is important for us as nurses to advance our specialty. As members of our specialty organization, we are increasing our knowledge on what we do. We are learning of the latest education available on caring and managing our patients through webinars, journal articles and member forums. Second, we are

delivering high, quality care to patients in the imaging environment in an era where patient safety and individualized care is critical in health care. Lastly, the more we know as radiology and imaging nurses, the more we are able to educate others on what we do. Through participation in local chapters, member forums, and conference attendance, we are strengthening and advancing our specialty. As active participants, we are further developing our roles as leaders in patient care.

The role of the radiology and imaging nurse can be seen in many facets of our everyday work in the imaging environment. Look at the different leading roles we have. We have staff nurses comforting patients when undergoing interventional procedures or imaging studies. We have educators teaching patients and health care professionals about radiology nursing care. We have nurse managers overseeing the day-to-day operations. We have advanced practice nurses developing treatment plans for patients. We have nurse navigators and their collaborative efforts in coordinating patient care. It is amazing, all that we do as radiology and imaging nurses. As health care continues to transform, our roles will only continue to strengthen and transform along with it. For these reasons and many more, it is essential that ARIN continue to expand on educational opportunities and resources for nurses working in the specialty. ARIN online resources and practice guidelines are important examples that offer such educational opportunities.

This next year, I would like to expand on new areas of educational opportunities through clinical pathways. An example of this is within Interventional Oncology, a subspecialty within interventional radiology, that is rapidly gaining focus. There is an opportunity to expand the education of radiology and imaging nurses working and caring for oncology patients. In 2016, the American Cancer Society estimates that over 1.6 million new cases of cancer will be diagnosed in the United States. (American Cancer Society, 2016). From a global perspective, there were 14 million new cases in 2012. These numbers suggest to me that there is an opportunity to expand ARIN's educational platform within this area. A goal I envision is to develop an interventional oncology clinical pathway. Many of the patients we care for in the radiology and imaging environments are newly diagnosed or undergoing care for their cancer diagnoses. This educational platform can be a valuable tool for radiology and imaging nurses to continue to deliver high quality care, provide patient education and meet the clinical and psychosocial needs of the oncology patients. Other possible clinical pathways include nursing within imaging modalities, radiology nursing management, advanced practice and radiology education. These are areas that I believe need further development.

As ARIN President, I look forward to a year of working with you to continue to expand on the knowledge and clinical care of our patients through open communication and collaborative efforts. I will strive to continue to embrace and drive change while pursuing opportunities for growth and learning.

As leaders in patient care, the work that we do is important. As health care continues to evolve, so will our roles. In the words of Walt Disney, "we keep moving forward, opening new doors, and doing things because we're curious and curiosity keeps leading to new paths". As radiology and imaging nurses, we will keep moving forward. We will keep opening new doors to clinical care of patients, and we will keep doing what we do because we are advocates, and because of this, we will keep leading our specialty to new paths.

So look around this room and recognize the wonderful role you play. As radiology and imaging nurses YOU are ALL leaders in patient care! Thank you for your time and enjoy the rest of the convention!

2016 PRESIDENT'S AWARD
SHARON LEHMAN

The President's Award was conceived and presented to the ARIN Board by President Greg Laukhuf RN-BC, ND, CRN, NE-BC, in 2015. It was unanimously approved. Unofficially known as the "Heart Award", the purpose is to honor ARIN members who have went above and beyond providing service to the organization over many years. This award is not given every year but only at the discretion of the president with board approval.

Sharon Lehman has dedicated many years to advance ARIN's mission, and has been a quiet unsung heroine since her Presidency. She is very thoughtful and engages new member interest in ARIN. For years she has contributed handmade APRONs for our ARIN Silent Auction…. perhaps you may have worn one of Sharon's Aprons.

At the University of Minnesota Hospital, she is a respected clinician and nursing role model. Sharon has authored many articles and publications, mostly recently a CE article entitled Prostatic Embolization in JRN. Sharon has served as Vision Editor for the past 6 years, giving endless time and forgoing the usual compensation for this position, during times that ARIN's finances were strained. It is an honor for me to present Sharon Lehmann with the 2016 President's Award for Exemplary Service.

THE NEW ARIN: **VISIBLE, VIRTUAL AND VITAL. THE FUTURE IS NOW.**

Mary Sousa BSN, RN, Presidential Speech for ARIN Business Meeting Vancouver, British Columbia, Canada

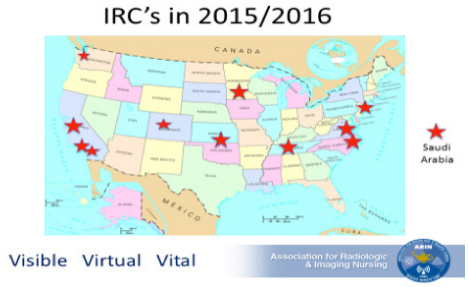
The following was the 2015-2016 President's speech as delivered at the annual business meeting in Vancouver.
– The Editor

In 2015, we embarked on a journey of change and optimistic advancement bringing the Association for Radiologic and Imaging nursing (ARIN) into a new realm of possibilities. ARIN boldly changed management companies, hiring Boulter Management Company (BMC), a company whose philosophy was more in line with ARIN's vision of moving away from the traditional and moving toward fresh, new ideas, utilizing advantages within the technology world to propel us forward.

This year, we connected with members in ways we had never done before through strategic investments in our infrastructure, which enabled us to reach more nurses, more members and provide more education and more member engagement than ever before.

A most prominent example of this is our Vancouver convention. Members can, not only participate in the traditional manner by attending the convention in-person, but they may also participate via our first ever live stream. We are proud to offer our members this NEW option. Additionally, the convention programs will be captured through virtual recordings, which will be archived and accessible through ARIN's website for members to listen to later at times that are convenient to their schedule. You choose the method you want to participate. Education has never been so easy or accessible. Another great example is the Virtual Imaging Nurse Review Course (IRC) course—we broadcasted our first two international programs this past year and we are excited for our next virtual course set to be broadcasted in the fall. This course will be open to all so anyone anywhere in the world can register and attend if you have internet access. The Virtual Fall course will open up possibilities to nurses all over the world!

This year ARIN increased our IRC offerings by 300%. We held two International events, two ARIN hosted events and nine facility hosted courses. Below are slides detailing our courses and the possible outreach.



In 2015-2016, the ARIN Imaging Nurse Review Course was offered at the following venues:

- Longmont United Hospital - Longmont, Colorado – April 3-4, 2015
- Northwest Chapter ARIN – Tacoma, Washington – May 9-10, 2015
- Southwest Healthcare – Murrieta, California – June 20-21, 2015
- Kaiser Sunset - Los Angeles, California – August 29-30, 2015
- Morristown Medical Center/Atlantic Health System – Morristown, New Jersey – September 12-13, 2015
- Abbott Northwestern Hospital – Minneapolis, Minnesota – September 19-20, 2015
- San Francisco General (Golden Gate Chapter) – San Francisco, California – September 19-20, 2015
- Vanderbilt – Nashville, Tennessee – October 17-18, 2015
- Carolinas Chapter ARIN – Durham, North Carolina – November 7-8, 2015
- University of Virginia – Charlottesville, Virginia – March 12-13, 2016

Virtual Town Hall Meeting and Chapter Meetings

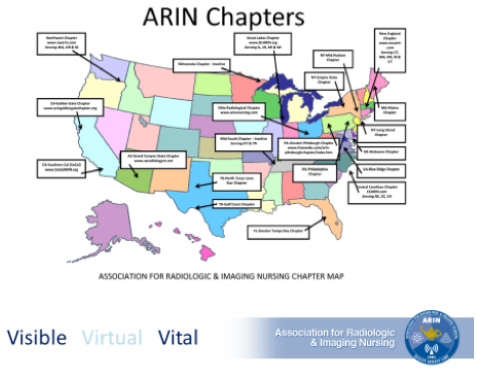
Virtual Town Hall Meeting and Chapter Meetings are another example of ARIN being *Visible*. This year we had another big first—the introduction of the virtual ARIN Town Hall Meeting. On December 2nd, we conducted the first of a three-part series geared toward the education and development of our local Chapters Leaders. In first meeting we discussed the legal and financial responsibilities of Board members, and how to form and run a successful chapter.

On March 3rd, we discussed the organizational roles in a non-profit. The third part of the series will be broadcast next month on May 4th with a presentation of ***How to run a meeting using Roberts Rules of Order,*** and the introduction of our **new** President, Evelyn Wempe.

What we have found is with each Town Hall Meeting we have seen an increase in the number of members calling in, with lively conversation and discussion. This gives us encouragement that we are on the right track to finding new ways of connecting with **YOU,** our members. These sessions are also being recorded so members who could not attend live, may listen to the recordings later at a time that is convenient to their schedule. The Leadership series can also be used as a tool to help orient new Chapter Board Members.

Interactive Chapters Map

Over the past year, ARIN has provided chapters with a unique opportunity for individual website development including a link to the ARIN website; currently, seven chapters have taken advantage of this benefit. Linking local Chapters to ARIN provides a means for communication between Chapters, sharing of educational events and connects us together. If you don't see your Chapter listed on the slide, I encourage you to ask your chapter leaders to contact us and get linked up to ARIN.



Steady Membership growth

Steady membership growth has occurred by offering more member benefits and increasing our visibility. These new changes have paid off. ARIN, a year ago had declining membership, but this year, ARIN's membership has increased by 17%. Reassuring us we are on the right track to what our members want and informing us to continue in our development of more educational materials offered in a multitude of methods (traditional and new). I thank my predecessors, and our management company whose influence and input has placed us in this position of growth for the future.

Finances in good shape

We invested significantly in our infrastructure, increased our educational offerings, hired two additional Master Faculty last year and currently recruiting a fifth one this year, cut waste and negotiated sound contracts. Treasurer Chris Keough will report on these details in her report. **ARIN IS in solid financial standing.**

Maintaining and Growing Collaborative and Collegial Partnerships

ARIN continues with our yearly Association of Vascular and Interventional Radiographers (AVIR) collaboration with a full day of combined education for technologists and nurses. New this Year, ARIN Poster Presentations were displayed together with Society for Interventional Radiology (SIR) Posters for mutual sharing of information. On Monday, we had our first joint session between ARIN and SIR on the topic of Capnography. We've recruited an ARIN/SIR physician liaison, Dr. Ana Echenique is a Radiologist and ARIN member and in her liaison role, she Champions ARIN's interests to SIR leadership. I believe that these are all signs of progress and continued recognition of our **VITAL** role and the **VISIBILTY** of Radiology Nurses and our worth--our knowledge--and the value we bring.

Visibility in Advocacy and Public Policy

Public Policy Committee members here with display and informative flyers

Arin continues to work on bringing visibility to advocacy and Public Policy. Attending convention are two members from our Public Policy Committee, Pauline Lentowski and Joanne Gaft RN. A testament to the resolve and commitment of this committee is the display table they have created for this convention with information on how nurses can influence policy and advocacy.

This year, working together with the members of the Nursing Community, we have worked on advocating for:

- Title V111 $244 million to Nursing Workforce Development Programs.
- National Institute of Nursing Research (NINR) requests of $157 million for nursing research,
- Supporting nurses practicing to the full scope of their license.

ARIN continues to send its President to Nurse in Washington Internship (NIWI) for training on Advocacy and a trip to Capitol Hill to advocate for nursing interests. Last year, I attended and this year President elect Evelyn Wempe attended the program.

ARIN is the expert in all things Radiology Nursing related

ARIN has a **Vital Role** in creating a strong body of knowledge. The ARIN Board of Directors has taken this initiative very seriously.

- **Clinical Practice/Research Committee:** This committee will focus on the development and promotion of a robust practice and research arm of ARIN.
- **As ARIN grows and becomes more Visible we realize we need to have sound Body of Knowledge.** As Brenda Boone completes her time as ARIN Director of Education, she will now begin the work of this group.

Examples of materials of ARIN as a Body of Knowledge are:

- **Capnography Position Statement—approved January 2016**
- **Staffing Survey Paper—total of three publications coming on staffing.**
- **Radiology Nursing Census Survey—which is providing baseline membership data. (on your work environment, age and experience of our nurses, and reporting mechanism with in our departments).**

New Task Forces

New Grad Nurse in Radiology Orientation Task Force

Formed in response to inquiries from members and nurse educators who were faced with newly licensed nurses being hired directly into Radiology Departments, combined with data indicating increasing age of the current workforce and expected mass exits of experienced nurses retiring in the next ten years, the importance of creating strategies to deal with the anticipated knowledge void is evident. The group is tasked with developing an orientation template for the Newly Licensed Nurse (NLN) and their preceptors, and research Nursing Residency Program/ Internships.

We understand the need to engage with National Student Nurses Association, as these new nurses will be our future caregivers. We've opened the door to developing mentorship relationships with this group.

Pediatric Task Force

The Pedi Task Force was formed in May 2015 to develop a Pediatric Radiology Review Course for nurses working in Radiology. These Continuing Education (CE) learning modules will be housed on the ARIN website for member education.

Podcasts

New this year, ARIN has created fifteen self-paced, online podcasts on a variety of radiology topics. These may be purchased and accessed through the ARIN website. They are an excellent way to earn CEs for maintaining certification and remaining current in our practice. We currently have under development; a MRI Safety Module and a Radiation Safety Module.

Look at the changes in our convention.

This year, we have added simulation, a lunch and learn, we have displays by industry vendors, display from employers recruiting radiology nurses, a Capnography focus group request by our industry partner seeking expert opinion from our radiology nurses, a new ARIN/SIR joint session on Capnography in the Radiology Environment. These changes are indicative of our **Visibility** and our **Vital Role**; that your opinion, as a Radiology Nurse is respected and valued and wanted. This is a new change and we are excited that this is only the beginning.

Conclusion

As your outgoing president, I want to thank you for the privilege of allowing me to represent you this past year. It has been both an honor and enormous responsibility to have served as ARIN President.

My special thanks to my esteemed colleagues on the ARIN Board, the talented Editors of Vision and Journal of Radiology Nursing (JRN) and my very capable team at BMC. I also want to recognize the tremendous work of the volunteers without whom our committees and projects would not happen. I would not have been able to serve this year without the love and support of my husband and my family who been extremely generous and understanding of my time away and have supported me every step of the way.

Lastly, the collective progress of each of these achievements and projects I highlighted, has fortified a strong and sustainable ARIN organization, ready to embrace the challenges of our ever changing healthcare world. It is with great pride and tremendous confidence that I hand over the new ARIN to Evelynn Wempe, our next ARIN President.

It's Never Been a Better time to be a Radiology Nurse;

It's Never Been a Better time to be an ARIN Member!

IMAGING REVIEW COURSE **NEWS**

By: Bruce Boulter
Executive Director

2016 has started with a bang. We have had great attendance at our courses held at the University of Virginia, the Johns Hopkins Hospital, and Lowell General Hospital hosted by the local ARIN New England Chapter. Mixed in there was ARIN's 35th annual Spring Convention with another review course as well. Needless to say, our master faculty have been busy yet again.

Fortunately, like school teachers, they get most of the summer off before jumping in again in August. The first weekend of August finds us back in the beautiful state of Virginia at Virginia Commonwealth University Hospital. The same weekend we pay a visit to Big D! Dallas, Texas. Look to the website for more details as they come along.

We move up the country a bit in the Midwest to Aurora Health Care in Milwaukee, WI, on September 10-11. We're very excited about having not one, but two courses in the Midwest, the other will be held at St. Cloud Hospital in Minnesota on September 26-27. We are thrilled to be building up the frequent flyer miles in 2016 with our master faculty. Keep your eyes on the ARIN website for more details for these and other possible courses coming to a facility near you.

ARIN ANNOUNCES
THE 2016 WINNERS OF AWARDS AND SCHOLARSHIPS:

LEAH KELLER, BSN, RN
PIERA M. COTE ROBSON, MSN, CNS, NP, AOCNS, ANP-BC, OCN, CRN
2016 Leadership Development Committee

The ARIN Board of Directors and Leadership Development Committee are pleased to announce the recipients of this year's awards and scholarships. The committee reviewed the applications from an impressive pool of candidates who represent the quality of radiologic and imaging nurses today. Their practice emphasizes ARIN's core values of professionalism, advocacy, leadership, and responsiveness to technological advances.

The 2016 Radiology Nurse of the Year is awarded to Valerie Aarne Grossman. Valerie is a dedicated radiology nurse having practiced in an imaging environment since 2006. Valerie is currently employed at the University of Rochester. In addition to her clinical practice, Valerie is a prolific writer serving as editor for the Journal of Radiology Nursing Hot Topic Column since 2011. In addition, she has published on multiple topics including inflammatory bowel disease, catheter associated blood stream infections, and teamwork. She has served on ARIN task forces and serves as a member of the New York State Board of Nursing as a resource for radiology nursing scope of practice. Valerie Aarne Grossman is a radiologic and imaging nursing leader, a mentor, and a gifted writer.

The winner of the Helen Malenock Award for 2016 is Kimberly DuBore, BSN, RN, from Hoquiam, Washington. This award provides Kimberly with a one-year membership to ARIN. Kimberly is a radiology nurse in Grays Harbor Community Hospital since 2010 and has the distinction of being the first radiology nurse at her facility. Kimberly's application for this award reflected her enthusiasm and passion for radiology nursing. She is an advocate for the radiology nursing role in her community hospital environment and policy development. To quote Kimberly, "The missing piece of the puzzle is HOW a nurse adds value to the care provided in the imaging environment. Knowledge is powerful, and many nurses in the smaller communities don't really know that nursing exists within my department. My goal is to change the perception and "image" of radiology nursing."

The Long Island chapter is awarded the 2016 Chapter's Award for their outstanding commitment to radiologic and imaging nursing and their motivation as a chapter. This award honors the chapter that best promotes the goals of ARIN though their member relationships, community activities, and promotion of community health issues. The Long Island chapter hosts bi-annual educational events and also was one of the first chapters to utilize the ARIN website template. They have increased their virtual presence with the use of social media as well as their overall membership over the past year.

This year, the Dorothy Budneck Memorial Scholarship, the Charlotte Godwin Award, and the CRN Scholarship were not awarded. The Budneck Award received no applications while the CRN and Godwin award did not have applicants that met the membership requirements. With this information in mind, the ARIN Board of Directors has voted to change selected awards and scholarship criteria to support members new to ARIN so they may apply for these important awards.

The Leadership Development Committee is looking forward to soliciting candidates for the 2017 Awards and Scholarships. Applications are distributed in early fall. Information is available here. We look forward to seeing your applications!

POSTER EXTRAVAGANZA

An important part of the yearly convention education are the poster presentations. This year we had posters presented by 15 ARIN members. In an effort to promote inter disciplinary education, the ARIN posters were presented in the exhibit hall. The winners were:

Nancy L. Dorinsky RN, MS

FIRST PLACE

Being Ready for Medical Emergencies in the Outpatient Radiology Setting

Nancy L. Dorinsky RN, MS
Jonathan Rosko RN, CNII

SECOND PLACE

A Solution to Geographically Challenged Communication: Virtual Huddles

Candice M. Zabko RN, MSN
Christopher Rowe BSN, RN, CRN

THIRD PLACE

Interventional Radiology Patient Throughput QI Project

Alison Owens MSN, RN

CREATE EFFECTIVE **ANTI-BULLYING POLICIES**

Nurses Service Organization

Workplace bullying, incivility, and disruptive behaviors are related actions threatening the safety culture in healthcare organizations.[1-3] These behaviors also contribute to decreased team cohesion, burnout, retention issues, and absenteeism.[4-7] In 2008, The Joint Commission issued Sentinel Event Alert 40, *Behaviors that Undermine a Culture of Safety*, a document that requires accredited healthcare organizations to establish policies that address disruptive behaviors, such as workplace bullying and incivility.

Despite this directive, many nurse managers and clinical nurses report that their organizations don't have the required policies, that they aren't widely disseminated and are virtually ignored, and that they're often unclear and difficult to use in practice.[8,9] The goal of this article is to provide managers and other nurses with the opportunity to influence policy development with suggestions, which come from research and practice, on how to craft usable and effective anti-bullying policies.

Differentiating the disruptive

Workplace bullying, harassment, and general incivility can manifest similarly. Although all of these behaviors are undesirable workplace behaviors, managers recognize that they need to be managed differently.[10] It's important to understand the differences between workplace bullying, incivility, and harassment, all of which fall under the category of disruptive behaviors, and how to manage each.

Workplace bullying consists of frequent (daily, weekly, or monthly) and persistent (lasting for several months or years) harassing and intimidating behaviors. Common bullying behaviors fall into the categories of physical bullying, social bullying, and work-related bullying. These behaviors may be subtle, and individually may seem relatively innocuous. However, due to the recurrent nature of workplace bullying, it can be classified as a chronic occupational stressor. As a result, victims of bullying are more likely to suffer negative health effects such as frequent headaches, gastro-intestinal (GI) upset, severe anxiety, depression, and symptoms of posttraumatic stress disorder than their nonbullied peers.[11]

One of the reasons that workplace bullying behaviors persist over a long period of time is that the bully has more power (either positional, having more institutional knowledge, or more social support in the workplace) than the victim. This power differential creates a situation wherein victims of bullying are generally unable to end bullying by merely confronting the perpetrator.[12] Likewise, the power differential means that the perpetrator of bullying has no motivation to end the behavior (other than possible fear of disciplinary action). Therefore, conflict resolution and mediation, which require compromise from both parties, have been found to be ineffective strategies for ending ongoing bullying.[13] It's important that workplace policies recognize this fact and don't include language that requires victims of bullying to confront perpetrators, or to engage in unfruitful mediation.

Incivility, which can be confused with bullying, is characterized by low-intensity rude and discourteous behaviors.[14] These behaviors occur occasionally, and don't cause long-term distress. Incivility, which is often unintentional, can generally be dealt with by bringing the behaviors to the attention of the perpetrator, by conflict resolution or by mediation. Organizations and individual departments can prevent incivility by establishing and reinforcing a code of conduct, a document which delineates norms of healthy behaviors.

Harassment may also look like workplace bullying. However, harassment is a legally defined term that covers unwelcome and offensive conduct that's based on the recipient's race, color, religion, gender, national origin, age (40 or older), disability, or genetic information. In contrast, there are no legal definitions or laws that address workplace bullying. All organizations should have anti-harassment policies, however, legally speaking, they don't cover bullying or incivility that's not based on an employee's legally protected class (for example, behaviors that occur between women).[15] Therefore, it's important that organizations also have a document specifically addressing workplace bullying.

Brainstorming effective policies

When drafting workplace bullying policies, it's important to include representatives from the various groups who will be affected by the policies. This includes human resources, unit-level managers, representatives from employee health, and employees. Make sure to get buy-in from unions or at least allow them an opportunity to comment on policies; managers often cite union grievances as one of the obstacles to successfully disciplining perpetrators of bullying behaviors[8] By including the stakeholders and end-users, organizations will ensure that they have policies that are clearly understood and easy to use. Additionally, members of the organization who helped draft policies can be instrumental in ensuring that these policies are widely disseminated and enforced.

Successful policies are clear and concise, and contain the following elements: an introduction, an outline of the roles and responsibilities of organizational members in workplace bullying management, and the actions that employees and managers can take in response to workplace bullying.

Drafting the strategy

Policies should begin with a brief introduction to the problem of workplace bullying, and why it needs to be addressed. Because bullying behaviors have historically been ignored in most workplaces, it's important to underscore that these behaviors aren't acceptable. The introduction should include statements that these behaviors can negatively impact the health of workers, the safety of patients, and the efficient operation of the organization.

The introduction should then define workplace bullying and give examples of bullying-type behaviors. In the introduction, organizations can also make it clear that not all rude or uncivil behaviors rise to the level of bullying. In addition, the policy might contain language differentiating legitimate and fair management of employees and workplace bullying.

Organizational roles and responsibilities

The next section should list the roles and responsibilities of staff, managers, human resources, and employee health as they relate to workplace bullying. Although employee health hasn't traditionally been included in workplace bullying policies, it's important to include this department because workplace bullying can have negative effects on employee's health and well-being.

When drafting staff roles and responsibilities, organizations need to be aware that one of the elements that differentiates workplace bullying from incivility or workplace conflict is that targets of bullying don't have the leverage needed to get the perpetrator to end the behaviors.[16] Therefore, language that requires targets of bullying to confront perpetrators is inadvisable. Instead, policies need to clearly delineate the actions that targets may take to enlist the help of others. On the other hand, employees who aren't targets of bullying, but are aware that it's occurring, may be able to confront the perpetrator; and this group of employees shouldn't be forgotten when drafting policies.

Formal and informal responses

The final section of the policy should contain suggestions for formal and informal actions that managers can take if workplace bullying does occur. Although stating that the organization has zero tolerance for bullying is tempting, such a statement isn't useful in practice because it doesn't clearly state the consequences for these behaviors. Even with zero tolerance policies, organizations that are unionized can't summarily dismiss perpetrators of bullying. Furthermore, merely dismissing perpetrators of bullying may result in the loss of valued employees who can learn to change their behaviors or employees who've been wrongfully accused.

If managers catch workplace bullying before it has occurred for a long period of time, they may be able to successfully resolve it through conflict resolution or mediation. These actions are only appropriate in early stages of the conflict, and, as previously stated, haven't been found helpful for bullying that's ongoing.[16] Because managers often lack the time or skill to engage in mediation or conflict resolution, organizations should consider using a neutral third party, such as an ombudsperson (a person who serves as a neutral facilitator for conflict resolution and problem solving) to assist in this capacity. If conflict resolution or mediation is undertaken, managers need to frequently touch base with the victims of bullying to make sure that the behaviors have stopped. If perpetrators continue to engage in bullying after informal processes have begun, formal disciplinary processes should be initiated.

Formal responses to bullying include disciplinary measures such as a performance plan and progressive guidance. To make sure they're following the proper procedures, and can successfully defend their actions if there's a grievance, managers should be encouraged to consult with human resources if they need to initiate formal action. Performance plans and progressive guidance should include clear expectations for immediate behavior change. If perpetrators of bullying behave well for a period of time, then revert to their previous behaviors, managers should be able to reinstate progressive guidance at the same, or higher, level and shouldn't be required to start the process all over again. This will prevent situations wherein perpetrators behave well for a while, then revert to their former behaviors as soon as they graduate from their performance plan.[8]

Codes of conduct

Some organizations, or individual units, may wish to issue a code of conduct in addition to a policy that addresses bullying. Codes of conduct can be used to address incivility, disruptive behaviors, or mere rudeness. A code of conduct might consist of a list of desirable or positive behaviors, or may be a single sentence that states employees have a right to be treated with dignity and respect. For instance: All employees of this organization have the right to be treated fairly, with dignity and respect.

If organizations don't want to draft more than one policy, elements of a code of conduct or dignity policy can be incorporated into the anti-bullying policy. Codes of conduct can help managers and staff discuss desirable behaviors, set norms for workplace interactions, and prevent bullying from occurring. Some units ask members to sign a statement indicating that they'll abide by the code of conduct, and post this code in a prominent place.

Dissemination

Policies are only effective if members of the organization are aware of them, actively discuss them, and utilize them. Support for policies needs to come from all levels of administration. Education regarding policies, particularly those that address behaviors, needs to recur frequently. Behavior change takes time, and requires constant reinforcement. Open acknowledgement of the existence of these policies isn't an announcement that the organization is dysfunctional. On the contrary, it indicates to current and prospective employees that the organization is serious about establishing and maintaining an open, professional, and collegial workplace where all employees are treated with dignity.

Dignity for all

Workplace bullying is a pervasive problem for the healthcare industry. It's important that healthcare organizations have well-written policies that can be used by managers and employees to respond to bullying. After being written, policies need to be periodically revised with input from the end users. Anti-bullying policies are important documents that will help organizations function at their highest capacity to provide excellent patient care and customer service.

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Adapted from "Create effective anti-bullying policies" by Susan L. Johnson, PhD, RN. This article originally appeared in the May 2015 issue of Nursing Management © 2015 Wolters Kluwer Health.

This risk management information was provided by Nurses Service Organization (NSO), www.nso.com, 1-800-247-1500.

AS A RADIOLOGY NURSE

Michelle Rabelo, RN, BSN, CRN

The following was read in Vancouver. It is published here as a tribute for Radiology Nurses Day.
– The Editor

As a Radiology Nurse, I am privileged to take care of a multitude of patients and their families. Many times, I see patients as they are newly diagnosed with their disease processes. Many times I see patients for their final visit due to their disease processes.

It is a specialty which many nurses and outsiders do not understand. You see, we are not the mainstream nurses who look to a distinct physiological aspect of the disease process to guide our practice. Many times, we are experiencing procedures for the first time and acting upon the physicians and technologist's quick decision to try a new approach.

We are a specialty unit like no other. Many times we are asked to accommodate our non-nursing cohorts on the fly to mitigate the best image quality and outcomes. Many times acting spontaneously with little background on the patient to provide comfort measures such as sedation, protocol medications, or a simple second set of hands. Many times our patients come through as a quick stop to their next level of care. They come to us with many acute and chronic conditions, which require the Radiology Nurse to have extensive knowledge of all disease processes.

As a Radiology Nurse, many times I work independently as the sole nurse in the unit where I must be able to make autonomous decisions in a tech-centric environment.

As a Radiology Nurse, I have to feel self-assured in my decision making skills and feel confident going forward with those decisions.

As a Radiology Nurse, I am looked upon by the technologists as their sustenance to provide safe care and achieve the most optimal scan to diagnose the patient's disease.

As a Radiology Nurse, I am prepared to cry with the patient(s) when their family is not with them and hold their hands when they are afraid.

As a Radiology Nurse, many times I know I am looking at the patient for the last time as their scan images reveal a terminal outcome.

As a Radiology Nurse, I continue to smile as I walk my terminal patients out the door, as I cry to my inner self.

As a Radiology Nurse, I am prepared to work with all age populations from birth to elderly and expect to hold not only the young crying but hold the older patients while they are crying too.

As a Radiology Nurse, I am prepared to look the patients in their eyes and answer their questions, while comforting their anxiety.

As a Radiology Nurse, I protect our most vulnerable population; pediatrics as I provide comfort, play, and safety while in my care.

As a Radiology Nurse, I hold the hands of family members who are scared and do not understand this complex place we call home away from home.

As a Radiology Nurse, I teach, orientate, mentor, and educate patients, families, physicians, nurses and technologists to the complex exams we perform.

As a Radiology Nurse, I educate others in the hospital providing both mentoring and learning opportunities to help others achieve a higher knowledge and respect of Radiology.

As a Radiology Nurse, I assist to mitigate the patient's journey in the community, providing information and acting as a liaison of care.

As a Radiology Nurse, I help many and all patients achieve a level of security, safety, and continual care across the spectrum of their journey.

As a Radiology Nurse, I help other disciplines and specialties achieve knowledge of Radiology imaging techniques, protocols, and outcomes.

As a Radiology Nurse, I am a professional who combines and exhibits the foundation of Nursing, Educator, and Physics to achieve stellar patient outcomes.

As a Radiology Nurse, I am asked over and over what job duties I perform and many times I ponder the answer and respond appropriately, "As a Radiology Nurse… I CARE." When asked how I affect a patient's care at Tampa General Hospital (TGH), it's not the care of one patient in particular that I speak about, it's the multitude of patients who are in my care every day who rely on my expertise, knowledge, and caring attitude that makes their visit safe and secure.

WE NEED YOUR HELP!

ARIN is working on a history book for the 35th Anniversary. We are reaching out to membership for any mementos, pictures or favorite memories from the past 35 years. If you have any items, please forward a high digital picture or a description of the memory to Greg, at greg.laukhuf@arinursing.org. We can't do it without you!

THE RESULTS ARE IN:
2015 ARIN DEMOGRAPHIC SURVEY

Greg Laukhuf RN-BC, CRN, NE-BC
2015 ARIN Past President

In the fall of 2015, the Association for Radiologic and Imaging Nursing Board of Directors (ARIN BOD) authorized a survey in Vision to determine a staffing benchmark from our membership. A big THANK YOU to all who participated. Over 200 ARIN members volunteered to share answers concerning their daily practice in an effort to formulate a benchmark to the questions proposed. As promised in the original survey request, the ARIN BOD is now sharing the results of this important Radiology Nurse benchmarking survey.

The survey was divided into several sections. The first section dealt with demographics from the area in which the respondent worked. The second section delved into nurse staffing and staffing ratios. The third section examined prepping and recovery of patients. The fourth section studied the use of ancillary personal in the department and the final section surveyed patient throughput benchmarks in the department.

With any survey, the greater the participation, the more accurate the results. The 201 respondents in the survey represented approximately 12.5 percent of ARIN membership at the time of the survey. Over 67 percent of the members who responded to the first demographic question **"What is the bed size of your hospital?"** work a medium to large size institutions.

What is the bed size of your hospital?

Answer Options	Response Percent	Response Count
0-100	6.5%	13
101-250	24.9%	50
251-500	37.3%	75
Greater than 500	31.3%	63
answered question		201
skipped question		0

The type of setting that the members work in was also identified. The second demographic question asked, **"What type of setting do you work in?"** Fifty-six percent of the members' work in a community setting with thirty-eight percent working in an academic setting. The remaining respondents work in an outpatient or other setting.

What type of setting do you work in?

Answer Options	Response Percent	Response Count
Community-Based Hospital	56.2%	113
Outpatient/Ambulatory Center	3.5%	7
Academic Hospital Setting	37.8%	76
Other (please specify)	2.5%	5
answered question		201
skipped question		0

The second section of the survey questions deal with Radiology Nurse staffing. A frequent question over the years on the List Serv is the question "Is there a nurse present for every type of image-guided procedure conducted within the Radiology Department?" The survey revealed that sixty-six percent of the time a nurse is not present.

Radiology nurse patient staffing ratios are a key element in the second section of survey questions. **"Select your usual nurse to patient ratio in the following Interventional situations,"** was the stem question used with the various modalities examined. A 1 nurse: 1 patient ratio was the predominant staffing ratio in the interventional MRI, Ultrasound, CT and the Interventional Radiology suites.

Is there a nurse present for every type of image-guided procedure conducted within the Radiology Department?

Answer Options	Response Percent	Response Count
Yes	33.8%	68
No	66.2%	133
If no, please write who documents pertinent information for each case		127
answered question		201
skipped question		0

Select your usual nurse to patient ratio in the following Interventional situations:

Answer Options	1 Nurse : 1 Patient	1 Nurse : 2 Patient	2 Nurse : 1 Patient	Other	Rating Average	Response Count
What is your usual Nurse to Patient Staffing ratio in the MRI suite?	117	2	3	68	1.00	190
Other (please specify)						88
What is your usual Nurse to Patient Staffing ratio in the Ultrasound suite?	135	2	2	46	1.00	185
Other (please specify)						75
What is your usual Nurse to Patient Staffing ratio in the C suite?	154	5	3	29	1.00	191
Other (please specify)						51
What is your usual Nurse to Patient Staffing ratio in the Interventional Radiology suite?	156	10	13	15	1.00	194
Other (please specify)						38
answered question						201
skipped question						0

The ratio in the diagnostic modalities varied from that in the interventional areas in the next question, **"State your usual nurse to patient ratio in the following diagnostic areas."** The greater use of a 1:1 ratio of nurse to patient in interventional areas as opposed to the diagnostic areas may be due to moderate sedation and frequent monitoring used in interventional suites.

Select your usual nurse to patient ratio in the following diagnostic modalities:

Answer Options	1 Nurse : 1 Patient	1 Nurse : 2 Patient	2 Nurse : 1 Patient	Other	Rating Average	Response Count
What is your usual Nurse to Patient Staffing ratio in the MRI suite?	73	8	0	107	1.00	188
Other (please specify)						107
What is your usual Nurse to Patient Staffing ratio in the Ultrasound suite?	76	4	1	103	1.00	184
Other (please specify)						103
What is your usual Nurse to Patient Staffing ratio in the C suite?	94	6	1	87	1.00	188
Other (please specify)						96
What is your usual Nurse to Patient Staffing ratio in the Interventional Radiology suite?	148	7	9	27	1.00	191
Other (please specify)						37
answered question						201
skipped question						0

The third section of questions concerns the prepping and recovery of radiology patients. Fifty-six percent of areas contained a dedicated radiology prepping area.

Where do you prepare patients (Give pre-procedure instructions, perform assessments, medication administration, IV starts, undressing of patients, and

Answer Options	Answer Options	Response Percent	Response Count
Dedicated Radiology prep area		56.2%	113
IR nurse preps patient in the procedure room		7.5%	15
Hospital PACU preps the patients		3.0%	6
Other (please specify)		33.3%	67
ed question	*answered question*	*201*	201
	skipped question		0

Recovery of patients is a question that frequently arises in ARIN emails. According to the survey, the recovery of general anesthesia patients in radiology is handled by a hospital PACU. This is probably related to the advanced training and additional personnel needed to recover a patient from general anesthesia.

How do you recover patient who have undergone general anesthesia?		
Answer Options	Response Percent	Response Count
Dedicated Radiology recovery area	16.4%	33
Send to hospital PACU	73.1%	147
Send to floor	0.0%	0
Other (please specify)	10.4%	21
answered question		201
skipped question		0

The recovery of patients from moderate sedation was accomplished in a different manner according to the survey. Fifty-six percent of the survey participants indicated that moderate sedation patients were recovered in a dedicated Radiology recovery area which is different form the area in which general sedation patients are recovered.

How do you recover patients who have received moderate sedation?		
Answer Options	Response Percent	Response Count
Dedicated Radiology recovery area	56.7%	114
Send to hospital PACU	7.5%	15
Send to floor	2.0%	4
Other (please specify)	33.8%	68
answered question		201
skipped question		0

Important in the recovery and prepping of the patients is the nurse: patient ratio. The preponderance of areas have a 1:1 to a 1:3 nurse to patient ratio for recovery and prepping.

Select your usual nurse to patient ratio in the following situations:								
Answer Options	1 Nurse : 1 Patient	1 Nurse : 2 Patient	1 Nurse : 3 Patient	1 Nurse : 4 Patient	1 Nurse : 5 Patient	Other	Rating Average	Response Count
If the Radiology department recovers the patients, what is the Nurse to Patient staffing ratio?	51	34	40	20	5	42	1.00	192
Other (please specify)								60
If radiology preps the patients, how are nurses in this area staffed?	56	35	38	16	4	36	1.00	185
Other (please specify)								58
answered question								201
skipped question								0

The fourth section of survey questions concerned the use ancillary personnel in the running of the area. Forty-nine percent of areas have a secretary or clerical person in the area to answer phones, schedule or order items. Twenty-four percent of the area surveyed have a medical assistance that helps in the department.

Do you have a secretary or clerical person in the area to answer phones, schedule, or order items?		
Answer Options	Response Percent	Response Count
Yes	49.3%	99
No	50.7%	102
Comments (please specify)		46
answered question		201
skipped question		0

Do you have a medical assistant who helps the nurse in this area?		
Answer Options	Response Percent	Response Count
Yes	24.4%	49
No	75.6%	152
Comments (please specify)		18
answered question		201
skipped question		0

The final section of the survey elicited information from members on benchmarking of prep time and room turnover times. Both elements are key when examining productivity and process flow in the IR areas. These answers can impact staffing decisions by radiology administrators.

The prep time revealed a wide variety in times. The variability may be tied into earlier questions which publicized the variety in how radiology patients are prepped.

What is your prep time benchmark in minutes?		
Answer Options	Response Percent	Response Count
10 minutes	3.0%	6
15 minutes	15.9%	32
20 minutes	16.4%	33
25 minutes	15.4%	31
Other (please specify)	49.3%	99
answered question		201
skipped question		0

Room turnover is an important issue in the productivity of the area. Respondents shared that the average room turnover time in minutes is 15 to 20 minutes for approximately fifty percent of the group.

What is your room turnover time benchmark in minutes		
Answer Options	Response Percent	Response Count
10 minutes	16.9%	34
15 minutes	30.3%	61
20 minutes	19.9%	40
25 minutes	7.0%	14
Other (please specify)	25.9%	52
answered question		201
skipped question		0

This article was a review of the responses from a 2015 survey of ARIN membership. As you can see from reading the survey, the results are compelling. This assessment was a step by the ARIN Board in the building of a Radiology Nursing body of knowledge on staffing characteristics. Up to now, most information was anecdotal in nature from emails or blogs. A complete review of the survey with comments from participants is available for **Members Only** by contacting your ARIN Board member or the ARIN national office.

ARIN RECOGNIZES AND CELEBRATES ITS **INTERNATIONAL MEMBERS**

Fiona Law MSN, RN, Master of Clinical Nursing (UTAS)

On Tuesday, April 5th, ARIN President Mary Sousa hosted a reception for our International members and Past ARIN Presidents. The venue was warm, inviting and allowed for easy conversations, introductions and networking. As in years past, the annual convention was attended by many International members. Among the attendees was Fiona Law, an ARIN member and convention presenter.

Fiona is passionate about her work as an Imaging Clinical Nurse Consultant. She is an active member of the Medical Imaging Nurses' Association (MINA) in the New South Wales (NSW) and Australian Capital Territory (ACT). Fiona has been a part of the organizing committee for over a decade, serving as President Elect from 2011-2014 and Vice President in 2014-15. In addition, Fiona is an active member of the MINA National Committee. In this role, she holds the position of 'Special Projects Officer' whom is responsible for seeking opportunities to raise the profile of MINA Australia both at home and internationally.

The goal of MINA is to promote the interests and education of Medical Imaging Nurses across Australia. Each of the five States, New South Wales, Victoria, South Australia, Western Australia and Queensland operate independently, in a similar manner to ARIN's Chapters, to provide regular educational workshops, seminars and conferences for their members. MINA holds a biannual National Conference, in which members from all over Australia come together to share learning opportunities and exchange ideas. In addition, MINA provides Clinical Practice Guidelines for members and offers opportunities to gain Continuing Education Points (CPD's). In Australia, 20 hours are required annually to maintain National Registration.

The next National meeting will be held in Melbourne in 2017, and MINa welcomes any ARIN members who would like to attend, or maybe even present a paper.

SHARE YOUR **KNOWLEDGE!**

ARIN values your expertise! We are putting together a practice book of test questions for the CRN exam. If you have a few questions to submit, we would like to use them. The questions must be multiple choice with the correct answer and rationale from the core curriculum 2nd Edition. Please send any questions to greg.laukhuf@arinursing.org.

ORNA SPRING FLING EDUCATION 2016

By; Greg Laukhuf RN-BC, ND, CRN, NE-BC

April 23, 2016, was a cool Ohio Spring Day and the date of the Ohio Radiological Nursing Association(ORNA) Annual Spring Fling Education day. The ORNA event was hosted at Summa Akron City Hospital. The is the first of two annual education events sponsored by the association and the date for the annual business meeting.

This year, the annual event was well attended by a mix of nurses and technologists. The meeting started with a continental breakfast accompanied by a mingling time with old friends and colleagues. The meeting continued with the first speaker, Paul Lee Chesis MD, Ph.D presenting Acute Stroke: Emergent Diagnosis and Interventional Treatment. This was followed by Janice Diane McDaniel, MD sharing Interventional Radiology: A growing sub-specialty. Jon C. Davidson, M.D. presented Vascular Access: Basic Techniques, Pitfalls, and Complications which included a hot topics discussion among the physicians on vascular access. The program concluded with Patricia Bunce, RN, BSN, MSHA, discussing CEN Pediatric Trauma Concerns and Education.

Door prizes were awarded which included a one-year membership to ARIN. Vision Editor Greg Laukhuf was also present and invited ORNA members to submit to Vision. He emphasized first time authors are welcomed.

ORNA would like to thank our vendor support from Covidean and EMT. Without their help, this event would not have been possible. Finally, ORNA would like to invite everyone to attend our free annual education event in conjunction with University Hospitals Case Medical Center held the first Saturday in November.

NEWS FOR RADIOLOGY: **WHAT YOU REALLY NEED TO KNOW!**

Greg Laukhuf ND, RN, CRN, RN-BC, NE-BC

Healthcare Providers Should Use Vein Visualization Technology

PR Newswire (02/03/16)

In its newly revised Infusion Therapy Standards of Practice, the Infusion Nurses Society (INS) states that vein visualization technology should be utilized for patient safety when placing a peripheral IV. The INS Standards target patients with difficult venous access or multiple failed needle sticks. The Standards of Practice recommend that clinicians "consider the use of near-infrared (nIR) light technology to aid in locating viable superficial peripheral venous sites and decreasing procedure time for short peripheral catheter insertion." The standards further state nIR light technology should be considered "to identify peripheral venous sites and facilitate more informed decisions about vein selection."

FDA Lists Difficult-to-Use Devices Subject to Human Factors Validation Testing

Fierce Medical Devices (02/04/2016) Saxena, Varun

The U.S. Food and Drug Administration (FDA) recently released a list of medical devices which should include human factors data in the application to ensure usability. These devices include anesthesia machines, auto injectors, infusion pumps (including implanted ones), insulin pumps, and robotic catheter manipulation systems. Usability has become key due to the increasing use of home healthcare. Usability criteria include considering device users, environments, and interfaces; performing cognitive walk-throughs with end users regarding difficulties or concerns about the devices; and conducting human factors validation testing of devices in use.

One in Three Americans Had Their Health Records Breached in 2015 as Hackers Follow Medical Data

International Business Times (01/27/16) Stone, Jeff

Approximately 100 million out of 318.9 million Americans were victims of healthcare data breach in 2015. The International Data Corp predicts that one in three Americans' health information will be comprised in 2016. Healthcare data have become more valuable than stolen credit and retail information. The situation could worsen as Internet-connected medical devices are projected to rise from 13.4 billion currently to 38.5 billion in 2020. "There are devices like an insulin pump, or the hospital systems that control IV flows, that control lots of information at the patient level," said V. Miller Newton, CEO of enterprise encryption and compression company PKWare. "The pharmaceutical companies get it, the manufacturers get it, or you can look at it in the cloud from home, but none of it is encrypted. If you hack into one of those IV machines you've actually now accessed the hospital's software through a backdoor, and you've got access to patient information on the entire hospital."

Fewer Surgical Deaths Linked in Facilities with High-Quality Nursing

Outpatient Surgery (01/21/16) Gapinski, Kendal

A recent JAMA Surgery study revealed patients undergoing surgery at hospitals recognized for their nursing environments and above-average staffing levels have better outcomes. "A surprising finding was that better nurse staffing throughout the hospital does not have to be costlier. Indeed, we found that Magnet hospitals achieved lower mortality at the same or lower costs by admitting 40 percent fewer patients to intensive care units and shortening length of hospital stay," said study author Linda Aiken, PhD, RN, Director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania. The study found the costs for treating patients at both the Magnet and standard hospitals were similar but the 30-day post-op mortality rate was lower than hospitals with below-average staffing. This is suggestive that facilities with high-quality nursing represent a better patient value.

PISTE: Endovascular Therapy on Top of tPA Better Than IVT Alone

Medpage Today (02/19/2016) Lou, Nicole

The addition of intra-arterial thrombolysis (IAT) to intravenous thrombolysis (IVT) may improve outcomes after stroke, according to investigators of the PISTE trial, which was presented at the International Stroke Conference. All the efficacy endpoints are "consistent with IAT benefit," concluded Keith W. Muir, MD, of Queen Elizabeth University Hospital, and colleagues.

The PISTE trial included 65 stroke patients who underwent thrombolysis with or without IAT in the U.K., and is the first trial to initiate endovascular intervention directly after simple imaging without waiting hours for a patient's response to tPA.

Australian scientists develop bionic spine for paralyzed patients

The Telegraph (2/9/2016) Pearlman, Jonathan

According to the researchers, stroke and spinal cord injuries affect one out of every 50 men

and women, and are the leading causes of disability. The US Military's scientific research and development organization DARPA have unveiled a potential "neural interface" which, if inserted into the brain, could allow humans to control computers using nothing but thought. Their goal is to help completely paralyzed patients regain mobility by recording their brain activity and converting those signals into electrical commands that control exoskeletons and prosthetic limbs.

The device consists of a stent-based electrode (stentrode), which is implanted within a blood vessel next to the brain, and records the type of neural activity that has been shown to move limbs through an exoskeleton or to control bionic limbs. Scientists believe the device could be used to help people with epilepsy, Parkinson's and other neurological disorders. Researchers hope to implant the stentrode device in humans sometime in 2017.

Temple and Drexel Combine Resources for Seizure Study

The Triangle March 03, 2016, Azwad Rahman

A new collaboration between researchers at the Drexel University College of Medicine and Temple University will be focusing on status epilepticus. Currently, there are several options for treatment but it is not clear which treatments are the most effective and the reason why.

The study will involve the administration of one of three randomized FDA-approved antiepileptic drugs: Valproic acid, Levetiracetam or Fosphenytoin. According to researchers, studies such as this have had success in the past. Previous studies found that 10 mg of Midazolam administered through intramuscular injections was more effective than 2 mg of Lorazepam given intravenously.

VANCOUVER 2016

JOANNA PO LECTURE ANNOUNCEMENT

The following announcement was delivered by President Mary Sousa RN, BSN at the 35th annual ARIN Convention in Vancouver, British Columbia April 5th. 2016.

Robin Shauma said…

"Leadership is not about a title or designation. It's about impact, influence and inspiration. Impact involves getting results, influence is about spreading the passion you have for your work, and how you inspire your colleagues"

Joanna Po, one of ARIN's founding member and a distinguished Radiology Nurse, was instrumental in revolutionizing the specialty. As an inspirational leader, mentor, and philanthropic luminary within the profession of nursing, her vision and leadership throughout the early years resulted in the ARIN we have today.

As the premier organization for radiology and imaging nursing, it is important that we continue to foster the growth of our nurses and acknowledge those individuals through the Joanna Po Lecture Series each year.

Yesterday JoAnn presented Greg with a Dragonfly pin at the conclusion of his talk. And she explained The Symbolism of the Dragonfly: flexibility and change. As nurses we are flexible to the changes that surround us every day.

The past three years, presenters honored during the Joanna Po Lecture Series have exhibited flexibility and change that has evolved and transformed their roles as radiology nurses.

Today, on behalf of ARIN, I would like to announce that Joanna Po has committed to honoring each upcoming year's presenter of the Joanna Po Lecture series with a $350 Award. This award is in recognition of the 35 charter members that founded ARIN and is established in this our historical 35-year celebration. Please STAND to thank and recognize this amazing woman who has a unique ability to uplift and inspire everyone she comes in contact with.

Mary Sousa RN, BSN
2016 ARIN Past President

ARIN SECRETARY REPORT - CONFERENCE EDITION

By: Kristy Reese, BSN, RN
ARIN Secretary 2016

It has been a privilege to serve as ARIN Secretary this past year. I appreciate the many opportunities to interact with radiology and imaging nurses from North America and around the world! I enjoyed the chance to attend the NALA Conference, in August, 2015, and the ARIN Annual Conference in Vancouver, British Columbia. Last year, ARIN made great strides in adding value for its members. This year, ARIN will continue this endeavor with a focus on the clinical aspects of this unique area of practice. I am very excited to help our new President, Evelyn Wempe, achieve her vision for ARIN!

My work takes place behind the scenes, as I format and present board meeting minutes, assist with policy updates, inform the board of ListServ/FORUM discussion topics, update the New Board Orientation Manual, and compile the Historical Report! In addition, I work to maintain a relevant website for our members.

During the coming year, ARIN will be looking for ways to improve upon the ListServ/FORUMs. We appreciate the feedback from our membership related to this transition, and we are pressing forward to improve the format for this interactive feature on our website.

At the close of this year's conference, I had the pleasure of exploring the Capilano Suspension Bridge Park, trekking over the Capilano Suspension Bridge, navigating the Cliffwalk, and meandering through numerous treetop paths! It was amazing to leave the beautiful harbor of Vancouver, and within a short distance, arrive at this scenic area with river and woodland views! To cross the suspension bridge, you had to stay focused on the goal while enjoying the journey. This is my hope for each of us this year, in all of our endeavors!

Thank you for your past support, and I look forward to a productive 2016-2017 year as your Secretary

SPRING 2016 **ARIN TREASURER'S REPORT**

Chris Keough BSN, RN, CRN
ARIN Treasurer 2016

ARIN has had a great year in 2015! There have been many exciting changes and opportunities that continue to provide increased value to membership. I would like to report on some financial highlights from this past year. The Board of Directors have worked closely with Boulter Management Company (BMC) and made strategic decisions to invest in ARIN's infrastructure.

What does that mean? Monies have been spent to ensure a new robust website with a professional organized layout and format. An improved education platform that provides member profiles, houses educational transcripts and tracks member's CEUs was obtained. This educational platform has the capability to store a speaker database with topics and evaluations. There are now over 30 CEU'S currently available in the education database for members. These webinars cover a variety of topics that interest and educate imaging nurses. There are currently twenty-two webinars available in ARIN's educational database. The Journal of Radiology Nursing (JRN) has directed journal readings with CEU credits. All of these offer members several options for obtaining required CEU's in preparing for the Certified Radiology Nursing Certification exam or continuing education needed for the renewal process.

A continual focus this past year was on increasing membership and focusing on member value. Membership provides at least 30% of our operating income. In 2015, membership provided 32% of our operating income. There has been a steady increase in membership. Membership total as of February 29, 2015 equals 1,731 members. Imaging nurses see the value in joining their professional organization.

ARIN's continues to provide the Imaging Review Course (IRC) in many locations. ARIN Master Faculty have taught at the annual convention, one ARIN hosted site, nine facility hosted sites and the first virtual IRC in Saudi Arabia! There were a total of 12 IRCs in 2015. In 2016, there already has been two IRCs with eight more to be scheduled. The IRCs provide a steady income revenue source. ARIN educational resources; Core Curriculum, Scopes and Standards, and Orientation Manual continue to offer imaging nurses knowledge and support in their practice. These items can be purchased through the ARIN website and are shipped to the members with a one day turn around.

The Board of Directors continues to evaluate, streamline and reduce expenses. The board conducted their second virtual meeting in January, which significantly reduced expenses. Another financial strategy approved by the Board of Directors, was to place reserve funds into an investment portfolio. The reserve funds were moved into a low risk portfolio that provides three to five percent return instead of leaving the money in a low interest CD. This step will provide ARIN with an opportunity to grow revenue with minimal risk.

ARIN's financial outlook is positive. The ARIN Board continues to make sound and fiscally responsible decisions in planning the organization's future. If you have any questions on the finances, please contact Chris Keough at Chris.Keough@arinursinf.org.

PASSING **THE REINS**

Sharon Lehmann, MS, APRN, CNS

I want to take this opportunity to thank the ARIN membership for the privilege of allowing me to serve as the Vision Newsletter Editor for the past 5++ years. I have found this job to be highly rewarding and it has given me the opportunity to interact with many amazing radiology and imaging nurses that I have such high regard for.

Now I will be passing the torch on. Greg Laukhuf, ND, CRN, NE-BC, RN-BC has graciously accepted the position as the Vision Newsletter Editor. Greg as you know has just completed his term as past president and is eager to remain engaged with ARIN and can take the newsletter to the next level.

ARIN BOARD OF DIRECTORS
2016-2017

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ARIN EXTENDS A WARM WELCOME TO OUR **NEW MEMBERS!**

First Name	Last Name	City	State
Michael	Hill	High Springs	FL
Justin	Chaize	Rochester	NY
Jeannie	Bolger	New London	NH
Marie	Chery	Brooklyn	NY
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Dorothy	Rudolph	Mineola	NY
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Kathleen	Bullard	Unionville	CT
Jane	Menendez	Chicago	IL
Jennifer	Windpassinger	Oak Creek	WI
Jasmin	Kaye	San Diego	CA
Donna	Mcarthur	Mentor	OH
Deborah	Narramore	Willoughby Hills	OH
Lisa	Julio	Brunswick	OH
Eric	Chatal	Medina	OH
Jessica	Prince	Cleveland	OH
Glynda	Grays	Richmond Heights	OH
Tamara	Reising	Lakewood	OH
Maureen	Linder	University Heights	OH
Lee	Spann	North Royalton	OH
Armando	Gonzales	Friant	CA
Andrea	Hammond	Rockford	MI
Katherine	McCoobery	North Easton	MA
Cassie	Tillery	Stevensville	MI
Priscilla	Thomas	Portland	OR
Ina	Mitchell	Clementon	NJ
Melinda	Bon	Pueblo West	CO
Darshana	Patel	San Jose	CA
Tracy	Hiles	Alloway	NJ
Deborah	Stubing	Havre De Grace	MD
Kelly	Caporaso	Corning	NY
Aurora	Howard	Flagstaff	AZ
Erica	Bolt	Louisville	KY
Cathy	Biles	Cannon Hill	QLD
Brenda	Mcglynn	Franklin	MA
Katie	Pfau	Abingdon	MD
Even	Parduba	Nottingham	AL
Faith	Canaveral	Reisterstown	MD
Charlene	Trino	Bergenfield	NJ

First Name	Last Name	City	State
Chandra	Mccarthy	Weymouth	MA
Kevin	Cornell	Cincinnati	OH
Annemarie	Miller	Windsor	CO
Marianne	Foley	Georgetown	AL
Lisa	Lang	Derry	NH
Sandra	Donohoe	Rio Rancho	NM
Amber	Jirschele	Mount Pleasant	WI
Jac	Crenshaw	Fort Collins	CO
Carolyn	Anderson	Fort Collins	CO
Dawn	Grossano	Allentown	NJ
Lisa	Shurtleff	Groton	NY
Roberta	Snyder	Queen Creek	AZ
Cherry	Myers	Nottingham	MD
Rachel	Reas	Suamico	WI
Pam	Eckert	Rochester	NY
Charlotte	Mendez	Berwyn	IL
Elizabeth	Korzybski	Baltimore	MD
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Maegan	Hartman	Norfolk	VA
Linda	Scarpato-Place	Fort Collins	CO
Kim	Jordan	Fort Collins	CO
Danette	Anderson	Cottonwood	AZ
Jacki	Lindblom	American Canyon	CA
Patty	Broderick	Derry	NH
Meghan	Jones	Pasco	WA
Rick	Orton	Evergreen	CO
Patricia	Suggs	Belmont	NC
Sara	Sheets	Richmond	VA
Roberta	Arbuckle	Vancouver	WA
Jennifer	Merhar	Wethersfield	CT
Michelle	Moseley-Ladell	Desoto	TX
Kim	Mcdowell	Albuquerque	NM
Carey	Deluca	Columbia	MD
Sherry	Orsargos	Homer City	PA
Robin	Shelton	Goodlettsville	TN
Latoya	Howell	Fresno	TX
Mark	Haydell	Colorado Springs	CO
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Maryann	Oestman	Cooperstown	NY
Dakota	Stone	Cookeville	TN

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First Name	Last Name	City	State
Erin	Boyd	Chilliwack	BC
Corazon	Dominguez	Queens Village	NY
Renjini	Vaiccath	Irving, Dallas	TX
Eileen	Henning	New Lenox	IL
Heidi	Sommers	Evans	GA
Gogi	Badhesa	Abbotsford	BC
Iris	Saberola	Glendale	CA
Gale	Daughtry	Durham	NC
Tenley	Johnson	Saint Paul	MN
Natoya Frederick	Satcherwhite	Houston	TX
Ashley	Coffelt	Stephens City	VA
Ann	Jones-Brown	Keller	TX
Cheryl	Viggers	Setauket	NY
Sharice	Davis	Chicago	IL
Chunyu	Li	College Point	NY
Julie	Werner	West Sand Lake	NY
Nancy	Chandler	Burlington Flats	NY
Kaitlyn	Orbin	Fleming Island	FL
Julie	Lawrence	Manchester Center	VT
Karin	Hanson	Fort Wort	TX
Phillippa	Huggins	Conyers	GA
Angela	Wharam	Earlysville	VA
Latanya	Hayes	Springfield	IL
William	Honeycutt	Bloomfield	NJ
Lynne	Ochoa	Centennial	CO
Brenda	Schroeder	Brunswick	ME
Vickie	Craver	Westminster	CO
Henedina	Escalona	Fair Lawn	NJ
Judy	Lacy	Snohomish	WA
Annette	Silver	Palmyra	VA
Whitney	Smith	Winchester	VA
Mark	Merritt	Springfield	OH
Elaine	Mara	Grove City	OH
Tina	Watts	Martinsburg	WV
Suzanne	Sheppe	Charlottesville	VA
Teresa	Maddox	Esmont	VA
Charleen	Cheng	Los Altos	CA
Carla	Carrillo	Lawndale	CA
Kerri	Hesselrode	Hurst	TX
Elizabeth	Woodyard	Huron	OH
Kristin	Prentice	Timonium	MD

First Name	Last Name	City	State
Donna	Collins	Coram	NY
Stephanie	Rose	Boise	ID
Maurice	Clores	Hollis	NY
Joan	David	Rockville Centre	NY
Francisco	Ponce	Santa Fe	TX
Samantha	Green	Dallas	TX
Kristina	Canizares	Vancouver	BC
Cindy	Simpson	Mount Airy	MD
Anish	Lukose	Missouricity	TX
Kim	Wrensch	Waukesha	WI
C. Claudia	Vanwickler	Earlysville	VA
Kimberly	Whigham-Barr	Syracuse	NY
Carol	Wright	Columbia	MD
Marian	Galang	Tampa	FL
Sharon	Schwartz	Turnersville	NJ
Anne	Buck	Durham	NC
Kimberley	Smith	Hudson Falls	NY
Emma	Mealer	Richland	WA
Susan	Tuttle	Houston	TX
Sheldon	Snyder	Harwood	ND
Elaine	Paguio	Alexandria	VA
Trenel	Jackson	Arlington	TX
Xinyue	Yang	Plano	TX
Sharon	Caravetta	Glendale	AZ
Karen	Magri	Charlottesville	VA
Carol	Clifford	Anderson	CA
Teresa	Trank	Dundee	NY
Helen	Vandenessen	Stony Brook	NY
Bridget	Bowen	Pickerington	OH
M	Durkincramer	Anderson	CA
Shona	Seiler	Omaha	NE