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DEVELOP A PASSION FOR LEARNING. IF YOU DO, YOU WILL NEVER CEASE TO GROW. – ANTHONY J. D'ANGELO

Katherine Duncan BA, RN, CRN
2017-2018 ARIN President



your Board of Directors.

Hard to believe it is time to start planning Thanksgiving and Christmas! Time flies and the year will be closing sooner than expected. Still, the Fall still holds many activities for members and



Insight. Inspiration. Ingenuity.

Our President-Elect, Cheryl Jagkowski-Ho will be attending the National Student Nurses' Association (NSNA) November 2-5. This will be the NSNA's 35th Annual Midyear Career Planning Conference. Cheryl will be part of a career panel to orient these soon to be nurses to a future in Radiology Nursing. NSNA represents over 60,000 nursing students nationwide so this opportunity assists all of us with recruiting the graduating nurse.

McNamara, our Director of Education. The agenda for this event is impressive with projects in Liberia, Nigeria, Guyana, Haiti, Tanzania, Kenya, Vietnam, Nepal, Guatemala, Nicaragua, Malawi, and in rural United States. For more information, their website describes this agenda in detail and we will look forward to a report from De'Ann (<https://www.rad-aid.org/programs/rad-aid-conference/2017-rad-aid-conference/>).



November 9-12, Synergy 2017 is being held in Miami. Synergy is a multidisciplinary approach to interventional oncology. ARIN members are offered a reduced tuition for this event. Again, we look forward to a report from those attending. Feel free to review this conference agenda and consider marking your calendar for next year's conference (<http://synergymiami.org/agenda>).

Thank you to our corporate sponsors



RAD-AID serves the world, especially developing countries, in promoting, teaching and implementing radiology technologies. This year, the conference is November 4th and will be attended by De'Ann



Finally, for this busy November, members of the Executive Committee will be attending The Nursing Organizations' Alliance Fall Summit in Birmingham, AL November 16-18. The Alliance represents

nursing organizations offering guidance, education and invaluable networking opportunities (<http://www.nursing-alliance.org/Events/Fall-Summit>). Previous summits have introduced us to organizations who we are now partnering with for unique educational modules. Watch for a report in future *Vision* editions.

Your Board of Directors and Executive Director strive to represent ARIN membership at these events and bring home to you new information and more opportunities. I would encourage you to reach out to your Board with events you participate in locally or nationally. We improve our own practice with partnerships with other organizations and our radiology peers. Thank you for your time.



WHAT LEADERSHIP MEANS TO ME AS AN ARIN MEMBER

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

Leadership is not about a title or a designation. It's about impact, influence and inspiration. Impact involves getting results, influence is about spreading the passion you have for your work, and you have to inspire team-mates and customers.

— Robin S. Sharma

It is the time of year for ARIN to solicit nominations for leadership positions. In another article in this issue is the actual nomination link. I thought it would be a great time to talk about leadership. I am sure that there are many members who can help fill this need after considering the following elements of leadership.

For me, leadership is an active process. It means having the belief and respect for human dignity. It means listening, inspiring and encouraging, being attentive, and maintaining a rewarding culture. It requires an all-inclusive management that constantly focuses on quality. Effective nurse leaders impart a shared vision in which high-quality patient care is paramount within their staffs. Nursing leadership should be customer-oriented. Sincere customer orientation means viewing patients holistically rather than merely in terms of their illnesses.

Nurse leaders—including Radiology nurses at the bedside—should be admired as role models. It's a matter of believing in and respecting human dignity. Courage is another important leadership skill. Nurse leaders must earn their status as role models; it doesn't simply come with the job title. There is no place in modern nursing for leadership styles based on fear.

Perfect candidates not required.

While the list of leadership characteristics in the literature is long, it does not include perfection. Effective leaders recognize they are imperfect and need to develop and grow in their profession. Also, it's important to remember that the human-dignity values and attitudes previously listed are bidirectional—from staff nurses toward those who oversee them and from nurse managers toward those they supervise. Leadership belongs to all of us.



My career in leadership was nontraditional. My personal journey started in 1972, when I was in Junior High School. In fact, it didn't begin in healthcare at all, but rather on an agricultural farm.

Growing up in rural America, the only jobs were summertime work in fields.

This involved a group of local youth

with a leader to direct work and line up future jobs. In some fields, the leader was the farmer or his representative while at other jobsites it was the leader of the workgroup. In my case, the obvious reward was the summer money. The other rewards I received included recognition and appreciation for a job well done with a sense of being needed and on equal footing with the others. This was my first experience with successful teamwork and a servant leadership culture in which rewards were used.

In my role as leader of the workgroup, I was faced with many issue that needed a solution. My challenge was to come up with solutions that allowed the team to perform at its maximum while creating a win-win for the group. Sometimes I was successful and sometimes it was a learning experience. This is the essence of leadership. In part because of this experience, I have come to believe that leadership should involve teamwork and cooperation with management. Early solutions to problems in the fields showed how a single outstanding example can shape someone's perception of good leadership and guide that person's actions over many years. My experience in the fields gave me a perspective on leadership and customer-oriented service that I have applied in my professional career.

You can learn a lot from example

During my nursing career, I have observed changing work environments that included increasing importance of the internet and social media, advances in medicine, multi-professional teamwork, and greater emphasis on customer orientation. However, the importance of good leadership has remained constant. Both in healthcare and business, I have interacted and worked with many managers and directors. A significant number are role models I admire who have excellent leadership skills. But not all have lived up to the ideals I cited at the beginning of this article. Fortunately, even from those who have not provided good examples of leadership, I have learned much.

My experience suggests that we should not think in terms of different generations but rather emphasize individuality. In my opinion, leadership is more about coaching people than ordering them around, and micromanagement often leads to poor results. Effective leaders learn new things throughout their careers, share their knowledge, and have the courage to speak up when they encounter what they don't fully understand.

Open your eyes and listen!

Should all nurse leaders and nurse managers have strong backgrounds in nursing care? I think it is necessary for them to understand healthcare, but I don't think they need to be experts in every aspect of nursing care. I suggest that nurse leaders who supervise others organize regular "open eyes and attentive ears" days and take more time to listen to employees.

I also see a need for visible leadership. We need to frequently ask those we supervise—face to face—how things are going. Recent surveys show

that subordinates consider supervision they receive as inadequate, especially in terms of listening, opportunities to participate, fairness, and equity. This is consistent with my experience and confirms my personal stance that listening to members and acknowledging the work they do is vital to good leadership.

Finally, I think there should be a caring approach to leadership. In health-care nursing and our organizations, we often talk about "lean process" and transformational management, which involve a motivational, coaching, and inspirational style of leadership. In my opinion, whatever management or leadership style one prefers, it is vital to take care of all issues related to the work environment, including provision of high quality, evidence-based practice; safe patient care; adequate human resources; justice; equality; and a clear vision of the future.

I visualize leadership as a powerful engine. The customers, patients, and staff members are the passengers on the train. Without the passengers the journey is extraneous and without the train engine nothing moves. To ensure that the journey is swift and smooth, we must maintain the locomotive and upgrade it when possible. I believe, therefore, that self-management is a necessary attribute for effective nurse administrators, nurse managers, and staff nurses. Through self-management, leaders can better deal with the growing importance of teamwork and remote work.

How does all this relate to ARIN? The leadership positions currently posted are part of the locomotive. We as ARIN members are the passengers on the train. To keep moving forward we need a solid engine. Many ARIN members have been prepared for leadership positions. It is my hope by sharing some of my experiences, it will take the mystery out of leadership and encourage the next generation of ARIN leaders. I encourage all to apply.

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Vision 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.

JOINT ORNA/UNIVERSITY HOSPITALS OF CLEVELAND RADIOLOGY DEPARTMENT FALL CONFERENCE

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

It was a cool, crisp, rainy day in Cleveland on the first Saturday in November and 102 radiology professionals committed to meet in a small auditorium. That can only mean one thing, The University Hospitals of Cleveland Department of Radiology/Ohio Radiological Nurses Association Joint Educational Day. This is an annual free conference sponsored by Vendors and the organizations to enhance the radiology knowledge of their members.

The day started with a powerful presentation by Dr. Holly Marshall on **Breast Imaging**. This lecture allowed participants to discuss all the current screening options for breast cancer including 2D mammography, tomosynthesis, ultrasound and MRI. Participants reviewed the current screening recommendations as well as all the breast imaging procedures and indicators for procedures. The session concluded with a question and answer session driven by the audience.

The second session was George Gordon, BTG Territory Manager, on **Why Y90? Why Therasphere?** This talk discussed the basic chemistry and properties of Y90 Theraspheres. It included dosing and mechanisms of action (MOA). The riveting presentation included the goals associated with care and provided clinical evidence supporting the therapy. The session was concluded with a review of set up and administration of the dose.

Michael Russell opened the third session of the day with **Cryo-Ablation Techniques and Patient Selection**. Participants learned the basic principles of cryo-therapy with an emphasis on proper patient selection in renal, thoracic, pain, and other appropriate patients for cryo-ablation. The session ended with a Q&A prior to the vendor sponsored lunch.

The afternoon sessions opened with Greg Laukhuf ND, RN, CRN, RN-BC, NE and **Smashing Infection**. This presentation explained the rules of asepsis and described the techniques used to maintain asepsis in the Interventional Radiography (IR) procedure room. In addition, standard precautions used during IR procedures were addressed as well as the practice of proper aseptic techniques reviewed.

Following Smashing Infection was Kelly Montgomery RN, from the Neurovascular Institute, **Stroke and FAST Imaging**. In this presentation, attendees gained an understanding of the importance of early stroke recognition, acute stroke alert activation and rapid CT imaging for potential stroke patients. Differences between ischemic and hemorrhagic stroke were described in addition to the identification of current treatment options. The imaging involved in decision making for stroke patients was discussed.

The day ended with the distribution of 6.25 Category "A" ASRT approved credits. Attendees shared the day was a success and they are looking forward to next years event. Stay tuned, the next event will be the Annual ORNA Education day in the Spring.



ARIN AND SPS COLLABORATIVE NEWS

The Association for Radiologic and Imaging Nursing (ARIN) and The Society for Pediatric Sedation (SPS) are announcing a collaborative effort to benefit the members of both organizations. ARIN and SPS are dedicated to providing safe quality patient care and nurses of both organizations are involved in the care of children who require sedation in the radiology environment, further supporting this joint venture.

One of benefits to both groups is the sharing of membership benefits. SPS nurses can become members of ARIN for the cost of \$60 for the first twelve months. Once they create an ARIN membership profile, they would have access to all educational modules on the ARIN educational platform apart from those in the Imaging Review Course. For the cost of \$25, ARIN members can join SPS and take advantages of member benefits which include online education modules.

We look forward to this collaboration and encourage our members to consider this new benefit!

THE FUTURE OF NURSING AND RADIOLOGY

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

The future depends on what we do in the present.

– Mahatma Gandhi

Healthcare organizations and Radiology are facing unmatched changes in the delivery and management of their services. Years ago, the initiation of the affordable care act required resources to implement and monitor several new regulations. These regulations and changes prompted changes in care delivery which impacted Radiology nursing practice (Blumenthal, Abrams, & Nuzum, 2015).

Concurrently, the nursing profession is in the middle of several other challenges. The most talked about issue is the current shortage of nursing professionals. It is anticipated that by the year 2025 there will be 260,000 make a nursing positions of United States (NSI Nursing Solutions, 2017). While some senior-level nurses have postponed retirement because of the current economic recession, a large group of baby boomer nurses will be retiring from the profession. Currently, the number of RN vacancies is steadily increasing in hospitals. In 2016, hospital nurse vacancies were reported to be 10% or more (Twibell, St. Pierre, 2012).

Experts express alarm that there could be more nurses leaving the workforce from a strong economy and baby boomer retirements, creating many vacancies within a short time (NSI Nursing Solutions, 2017). Another challenge are nurses who have entered or want to enter the profession. Studies have revealed a graduate nurses lack of adequate preparation before entering the workforce. A 2012 survey revealed, 10% of nurse executives indicate graduate nurses were prepared to work in a hospital setting. Nurse graduates were identified as lacking in knowledge and skills required to begin. In addition to the needed changes, there is also a shortage of academic nurse educators and nursing programs. During the 2014- 2015 academic enrollment, the American Association of Colleges of Nursing (AACN) reported 68,938 nursing applicants did not have a program space available. In 2014, AACN reported 13,444 Master's program candidates were turned away, as well (American Association of Colleges of Nursing, 2017).

As a nursing is faced with so many challenges, we also need to look at what is being done to support these challenges in the profession. In 2009, experts begin to evaluate the needs of nursing practice and improving patient outcomes. In 2010, the Institute of Medicine published The Future of Nursing leading changes, advancing health, making recommendations for the improvement. Also in 2010, the Robert Wood Johnson foundation, along with AARP, The Future of Nursing: Campaign for Action (Institute of Medicine, 2010).

Action coalitions were formed in every state and are working with healthcare professionals, educators, and business leaders to support safe, high-quality health care. Most of the individual healthcare organizations have been developed doing long and short-term strategies based on the industry recommendations. There have been several successful programs, such his nurse residency programs. Residency programs were put into place to improve recruitment and retention efforts. These programs have proven to be instrumental in improving nurse commitment, work satisfaction, clinical competence, and patient safety, which in turn has reduced nurse turnover in hospital say (Goeddeke, 2017).

Through all of the resources, support, and successes nursing is achieving, there is one additional concern that is being raised by educators. The concern raised is simple as nurses retire what knowledge will be take with them? Many organizations recognize and support the lifelong work of Patricia Benner author of **Novice to Expert**, theory for nursing professional growth and development. The Novice to Expert Theory, a construct theory first proposed by Hubert and Stuart Dreyfus (2004) as the Dreyfus Model of Skill Acquisition, and later applied and modified to nursing by Patricia Benner, supports linking incident variance to mastering. Know how is usually considered non-technical



in nature and, typically information that is not written down. This knowledge incorporates the complexity of the health care system and the ability to make sound clinical judgments during patient care. It is the ability to think critically to make safe decisions while improving patient outcomes. Many education experts believe this “know how” information will be walking out the door with retiring nurses. This lost knowledge could pose a significant problem in nursing and ultimately impact patient outcomes (Benner, 1984). With evidence linking quality outcomes to nursing care, there is a strong implication for the need to include the transfer of know-how into the professional growth process for nurses. Some experts believe this know how is essential for patient outcomes and a key ingredient to ensure patient outcomes will continue to improve.

While efforts to retain nurses with enticing new hire packages, creating a welcoming environment, and offering residency programs are important, they should also be accompanied by a plan to ensure that knowledge transfer from the baby boomers to current staff occurs. Strategic plans should be assessed and evaluated for each organization to determine what information should be shared. There is no one solution that will fit everyone, but there are some key aspects that should be considered (Pena, 2013).

Supporting expert knowledge transfer within an organization requires a well-designed secession plans for all levels of nursing. This can occur in several ways. One option is to incorporate a mentorship program. This type of program would pair senior-level nurse with a beginner and provide an ongoing one on one relationship to provide coaching, moral support, individual job-related skills, and the knowledge that can only be shared when relationships are built. The final idea is for the senior level nurse to seek out their colleagues to share their knowledge. You don't have to wait for a formal program to be established within your organization. This is a nurse initiative that could be started simply by making an effort to build a relationship. Why would you want to keep knowledge to yourself if a younger nurse happens to reach out? Each of us has something to share and something we can learn no matter where we are in our prayers. It is time to set aside all the lateral violence and bullying and the appearance of eating our young. More than ever before, the challenges facing nursing profession and health care are enormous. Sharing our knowledge is an essential part of moving our profession and our professional organizations forward. What legacy would you like to leave?

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SUPPORT

PFOC* PATHWAY FOR FOSTERING ORGANIZATIONAL CIVILITY

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

We must update our country's workplace policies to remain competitive against other developed countries.

—Suzan DelBene

Imagine a vibrant work environment where you flourish in your career and profession—a productive, energetic environment in which you feel valued, affirmed, and appreciated. Imagine being a member of this group that encourages creativity and expression of diverse ideas. A group in which high-performers flourish and where the commitment to patient safety and civility forms a supporting framework for a healthy work environment.

The American Nurses Association (ANA, 2015) describes a healthy work environment as safe, empowering, and satisfying. A place where all members of the organization perform with a sense of professionalism, accountability, transparency, involvement, efficiency, and effectiveness while being mindful of the health and safety of all. Additionally, the American Association of Critical-Care Nurses (AACN, 2015) has reaffirmed six standards for establishing and sustaining healthy work environments: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership.

In *Creating and Sustaining Civility in Nursing Education* (2013) by C. Clark, the idea was suggested that healthy work environments require co-creating and adhering to a shared vision, core values, and team norms. To ensure commitment to a positive, productive work atmosphere, policies and procedures need to be active, and effective communication must be utilized at all levels of the organization.

The ability to recruit and retain employees by providing satisfying jobs is the mark of a healthy organization (Fontaine, 2012). This element is essential in healthcare where patient safety is the goal. Converting an organization's culture requires commitment to a shared vision, a well-articulated strategic plan, devotion to meeting long-term objectives, and supportive, decisive leadership. There is no "one-size-fits-all" approach to fostering positive organizational change, but the following PFOC action items outlined below can be used to help anyone get started on this rewarding process (Clark, 2017a).

Raise leadership awareness and support

To grow a vibrant work setting, it is essential to first increase awareness of the types and frequency of uncivil behaviors occurring; educate employees about the harmful effect of these actions on individuals, teams, the organization and patient care; and finally enlist broad, leadership support for executing an action plan to reduce and eliminate these harmful behaviors. Leaders understand the work environment needed and will support the positive change. Transformational and permanent change requires broad teamwork, individuals seeking to lead change need the support of key stakeholders and leadership in the organization who share the vision and have the resources to support it (Clark, 2017a).

Raising awareness is key. Calling attention to incivility, its effects and expressing desire for change can be powerful persuaders when soliciting support from leadership. Such support is essential as leaders and administrators have access to needed resources and have a vested interest in organizational success. Their

understanding of incivility can help identify problems and provide potential solutions (Cavanaugh, 2014).

Starting a Civility Team

To enact the PFOC Action Plan, a Civility Team (also known as an Organizational Design Team) must be assembled and empowered with authority to make changes. Without it, they will be unable to bring about needed changes. The team will also require support and resources from the organization. Members of the team should be a diverse workplace cross section, be committed to the organizational vision, and dedicate themselves to teamwork and collaboration (Clark, 2017a).

Assessment

Every organization possesses a unique history, culture, and workforce. Careful assessment of these elements can yield meaningful information for customizing the action plan. To make a meaningful assessment, tools specifically designed to evaluate the culture, before and after implementing the action plan should be considered along with information gleaned from reports, notes, evaluations, satisfaction surveys, interviews, focus groups, and open forums. This process will provide the most accurate assessment of the culture and help in devising a productive action plan.

Develop strategies and policies

In this crucial step, the team fuses data from the step above into a strategic PFOC Action Plan to be implemented. This information and subsequent plan generates a vision for organizational change. During this phase, a SWOT analysis of the findings is performed to identify areas of strength, weakness, opportunities and threats. In preparing the strategy, clear objectives, expected timelines, and required resources (financial, human, and organizational) are detailed.

Policy development is a critical item in the PFOC Action Plan. Policies need to be specific, extending beyond simply defining disruptive behavior to include a clear consistent plan for addressing incivility. Policy statements should also include rewards for the demonstration of desired behavior (Clark, 2017a).

A PFOC Action Plan must include a written team charter. The charter includes the team's direction, purpose, goals, and processes for decision-making. In addition, the charter includes a clear commitment to coworkers and defined norms for behavior. When these structures are in place, the work group has a clearer vision of the future and are better positioned for success.

Implementation

To secure commitment to the action plan, a two-pronged goal of helping all members recognize the undesirable consequences of incivility and the desired outcomes of achieving a positive, productive, and civil workplace should be implemented. Staff-development topics to address in this phase include improving communication skills, developing a conflict-capable workforce,

enhancing teamwork and collaboration, and building leadership skills and capacity. These goals can be accomplished through reflection, civility assessments, role-playing, simulation exercises and debriefing, and implementation of evidence-based communication and conflict negotiation tools.

Evaluation and reassessment

The PFOC is a circular and not a straight path. It's a process that includes assessing, planning, educating, strategizing, evaluating, and reassessing. Evaluation and reassessment are necessary steps to review the effectiveness of the change process in bringing about organizational health and civility.

Recognition

Recognizing and celebrating individual and collective achievements fuel momentum for change while rewarding individual and organizational efforts. Evidence of success includes fulfillment of shared vision, values, and norms; achievement of long- and short-term goals; improved morale and job satisfaction, and gains in recruitment and retention rates. Indicators of success include more effective communication and decision-making skills; resonant and reliable leadership; meaningful recognition of members; growth of new programs, initiatives, endowments, and revenue; career advancement; and increased community trust and integrity. Celebrations can be formal or informal—the goal is to honor and reward successes, achievements, and accomplishments.

While each organization's experience is unique, when members of an organization come together and share experiences, the possibilities for organizational health and civility are endless. Creating and sustaining organizational civility requires an evidence-based structure and initiatives. With the process outlined above you too can experience a vibrant work environment where you flourish in your career and profession.

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ARIN MOVING FORWARD

Bruce Boulter
Executive Director, ARIN

Fall is a great time of year. You get the World Series, football, the leaves changing color and of course the best one, registration opens for the ARIN Annual Convention. The 2018 annual convention finds ARIN in beautiful Los Angeles, California. One of the great changes coming in LA is that for the first time in recent history, all three associations will be hosting their meetings in the convention center. We anticipate that with this proximity, our attendees will take better advantage of visiting the exhibit hall to experience all the convention offers.

As always, the convention kicks off on March 16/17 with the newly revised Imaging Review Course. Be sure to take advantage of the opportunity by coming in early to prepare for the CRN or just to enhance your knowledge of Radiology.

As in previous years, Sunday is our joint AVIR day. Over the last few years, this has been one of the highlights of convention. Additional highlights include the Joanna Po lecture, the annual business meeting and 30+ CE's being offered via general and concurrent sessions. We anticipate offering something for everyone. Not only do you hear outstanding presentations, but you can have the opportunity to continue networking and team building with your associates.

Make plans to attend now. The 2018 sessions promise to be one of the best conventions ever. Building on the successful Capnography Simulation from last year, ARIN will increase the number of sessions

to four. In addition, we will also be offering a Pediatric Sedation simulation session. Both the Capnography and the Pediatric Sedation sessions will be offered for a nominal fee. Sign up soon as slots are sure to fill up fast! Not only has ARIN launched registration, but the brand-new ARIN APP as well. Keep up with all things ARIN via this great tool. You will now be able to access the Online CE Center, view the calendar, pull up the newest Vision, login to the ARIN Forum and so much more. Within this app will be the Annual Convention APP to stay up to the minute on the speakers, location, potential changes, maps, etc. Download the new APP now and view ARIN from a new viewpoint.

Upcoming events for ARIN include gearing up for more Imaging Review Courses around the country. ARIN has already scheduled IRC's at two of the most prestigious hospitals in the country, Mayo Clinic in Phoenix, and Johns Hopkins Hospital in Baltimore. Look for details on the ARIN app or on the ARIN website. Details on the event and others will be coming soon.

It's a great time to be a member of ARIN. Never has the opportunity been greater to interact with your fellow radiology nurses than now. Take advantage of all your ARIN membership has to offer and tell your fellow nurses about it.

Presented by
NSO and CNA

Nurses Medical Malpractice Case Study with Risk Management Strategies

Case Study: Failure to perform an appropriate assessment on a patient that had undergone extensive surgery, Failure to properly evaluate and monitor a patient that had undergone extensive surgery, Failure to recognize a known risk of liposuction with abdominoplasty procedures, Failure to take the appropriate measures to assure that a patient received timely medical intervention.

Indemnity Settlement Payment: Greater than \$325,000

Legal Expenses: Greater than \$230,000

Medical malpractice claims may be asserted against any healthcare practitioner, including nurses. This case study involves a nurse working for a cosmetic surgeon in a private office practice.



Summary

Our insured was a registered nurse employed by a cosmetic surgery practice, who performed on a healthy 60 year-old female patient. The patient was discharged the day of surgery and transported home by the insured and the surgeon that performed the procedure. Both the surgeon and nurse assisted the patient in settling into bed and then instructed the patient's friend regarding post-operative care including diet, positional requirements and medication regimen.

On post-operative day one, the physician and nurse returned to the patient's home. Both were concerned that the patient was not following the post-operative care instructions. The patient confessed to using alcohol, not following the post-operative diet and sleeping flat in her bed despite being instructed to sleep reclined.

Regardless of the patient's noncompliance, the physician concluded that the patient was progressing "reasonably well and on schedule." The nursing notes indicated that on post-operative day one, the patient appeared stable, having normal vital signs with incision sites and drainage tubes clean and dry. The nurse arranged for a nurse to stay the night with the patient to ensure that she received proper nursing care.

On post-operative day two, our insured nurse returned to the patient home to assess the surgical incisions and receive a patient report from the nurse that stayed the night at the patient's home. Initially, the nursing notes by our insured

nurse and a second nurse indicated that patient was progressing normally. However, as the insured was cleaning the abdominal dressing the patient suddenly and without warning, began vomiting black emesis and lost consciousness. Chest compressions were initiated and 911 was called. No mouth to mouth resuscitation was performed because our nurse indicated that she did not want to come into contact with the vomit.

The patient was taken to the hospital via ambulance and was eventually resuscitated. Her condition declined and later she was taken off of life support. Unfortunately, the patient expired a few days later. The autopsy report indicated the cause of death was cardiac arrest following complications from an infection secondary to a perforated colon.

The patient's adult son filed a lawsuit against the cosmetic surgeon, our insured and the second nurse that was involved with his mother's care.

continued...

Resolution

The insured nurse was aware of the risks of going to a trial voiced wishes to have the claim mediated.

Risk Management Comments

During discovery, our nurse testified that she and the cosmetic surgeon were involved in an affair. The insured produced multiple text messages between her and the physician in the days prior to and following the patient's surgery which detailed the nature of their relationship.

These messages made it clear that the two were aware of the patient's deteriorating condition. The messages also contained insensitive and callous statements as well as unflattering pictures of the patient.

Our nursing expert opined that without the text messages, she could support the care provided by our insured. However, considering the existence of the text messages, she could not support the care provided. The verdict value was estimated at greater than \$2 million.

Risk Management Recommendations for Nurses

- **Maintain competencies (including experience, training, and skills)** consistent with the needs of assigned patients and/or patient care units.
- **Maintain thorough, accurate and timely patient assessment and monitoring**, which are core nursing functions.
- **Communicate in a timely and accurate manner** both initial and ongoing findings regarding the patient's status and response to treatment.

- **Provide and document the practitioner notification of a change** in condition/symptoms/patient concerns and document the practitioner's response and/or orders.
- **Report any patient incident, injury or adverse outcome** and subsequent treatment/response to risk management or the legal department.

Risk Management Recommendations for Nurse Leaders/Managers

- **Establish a social media and electronic communication policy.** The policy should include written guidelines that protect patient privacy, prohibit misleading and harassing statements and designate individuals who can speak on behalf of the organization.
- **Provide staff training to all new employees and annually thereafter.** Sessions should cover such key concerns as social networking rules and etiquette, parameters for use during working and non-working hours, potential legal perils, patient confidentiality issues and disciplinary consequences for misuse. Training session content and attendance should be documented.
- **Institute an environment that makes it easy for employees to identify misconduct or breaches** related to social media and report them in accordance to policies.

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional's standard business practice. Risk Management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks – a good Risk Management Plan will help you perform these steps quickly and easily!

Visit www.nso.com/riskplan to access the Risk Management Plan created by NSO and CNA. We encourage you to use this as a guide to develop your own Risk Management Plan to meet the specific needs of your healthcare practice.



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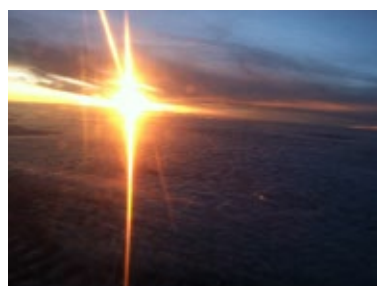


A TALE OF PATIENT CARE

In the busy workplace, with the additional time demands from electronic medical record and focus on volume driven productivity, it is easy to lose site of the patient. The following vignettes are stories from ARIN members about their experiences in Radiology from the other side of the bed. The intent of the selections is to refocus each of us on what our patient may be experiencing. It is one thing to work in Radiology and know what the exam entails. It is quite another to experience the exam first hand as a patient.

THE OTHER SIDE OF THE BED

Chris Campbell, RN Port St. Lucie, FL
Reprinted ARNA VISION VOL 9, NO. 3 FALL 2004



On February 17, 2003, my life changed. I'd had a short, but profound, episode of dizziness that concerned me enough to make an appointment with my doctor. I'm a registered nurse with 30+ years of critical care experience. I knew which tests I wanted done, and, fortunately, my doctor complied. In the back of my

mind, I was concerned about a brain tumor, as my mother had died of a glioblastoma multiforme several years before.

I had my CAT scan with contrast on February 17. Thankfully, I knew the technician. From years of working with critical patients and attending to them while they were having CTs done, I was familiar with what to expect. The contrast was injected, and I realized that he was taking very small cuts. I knew he had found something. While taking out my IV, we were both oddly nervous. I didn't want to take advantage of our friendship, but I asked him outright if he had found something. He held my hand and said, "I'll be right back." Within moments the radiologist came in to see me, sat down beside me, and told me I had a brain aneurysm. He was so kind, but I felt as though I was being catapulted into a deep ocean without a life preserver. The radiologist was kind enough to call not only my primary physician but also the neurosurgeon.

Shortly thereafter I was scheduled for an MRI/MRA. I'm not a big fan of that test! With frequent calls to me over the intercom to check how I was doing, the tech was wonderful and kept me smiling with comical little comments. To lay so perfectly still with my head encased in a quasi-football helmet for over 2 hours certainly tested the limits of my patience. Engaging in short, frequent conversations helped the time appear to pass more quickly.

My MRI/MRA was reviewed by the neurosurgeon and interventional neuroradiologic at the University of Miami where I had been referred, and it was determined that I would have a routine cerebral angiogram. May 13, I was prepped and ready at 8:00 a.m. for my procedure, but it was delayed by six hours because a 17-year-old boy having an AVM repaired was having complications. A mix of emotions flooded me—I was relieved to be delayed, my heart went out to this young man with such a life-threatening problem, and I was anxious to get my test over with. Finally, at 3:00 p.m., I joined the nurses in the radiology suite and the test was underway. The most comforting aspect was the nurse who stayed at my side and gently talked to me while getting things ready. Her attitude was so calm and friendly, and she never hesitated to touch my arm, squeeze my hand, or give me words of encouragement and comfort, all the while doing her assigned tasks. The staff found out I was a nurse from one of the radiologists, but

the care did not change. I was never in pain but was unnerved by the flashes of light in my eyes and the uncomfortable heat that radiated all the way down my spine during the injection of the contrast. I wish they had told me what was going to happen, as I initially thought something happened to the aneurysm! The final diagnosis: large aneurysm of the Paraclinoid region of the left internal carotid artery.

My pre-surgical consultation was June 2. After much discussion with my most incredible and kind neurosurgeon, I opted to have clipping done and scheduled it for June 13. Unfortunately, my near 7-hour surgery failed because the aneurysm was very close to the ophthalmic artery, and to proceed with the clipping would have resulted in stroke and/or loss of vision in my left eye. My family was devastated that I would have to endure yet another surgery. They had to wait nearly 2 days before I could understand what they were telling me. Oddly enough, I knew that my neurosurgeon had tried his very best and had kept the promise he made to me that

if he saw anything that would cause me harm, he would stop the surgery. He promised to keep me safe, and he did.

Before I was discharged from the hospital, I was scheduled to have endovascular coiling done July 3. I was blessed yet again to have a kind and gentle physician directing the coiling surgery, done under general anesthesia. I was back in the hands of the caring nurses in the neuroradiology suite. They remembered me and assured me they would be taking wonderful care of me during the surgery, which lasted nearly 6 hours. The nurse was exceptional with my family, who were all emotionally and physically drained from going through yet another surgery with me. The coiling was successful, and I was discharged home in 24 hours.

My follow-up angiogram was done February 7, 2004. The same nurses were present, very happy to see me in good health and doing so well. The most unpleasant aspect of this angiogram for me was the lying flat for 4 hours after the test. They had used the arterial plug after the first angiogram, but I'd had an allergic reaction to the Clindamycin, so they couldn't use the plug again.

Considering I had undergone two major surgeries in 2 weeks, I was grateful for the 4 months I had taken off from work, so I could regain my strength and mental clarity without being rushed to do so. October 6, 2003, I returned to the emergency department full time. I certainly have a new appreciation for patients who are in my care.

One never knows when a simple test will reveal something horrible. I found unlimited caring and kindness during my ordeal, and I will be forever grateful to have had those particular people in my life when I needed them most.

A DATE IN MRI

Elisa Baker Maryland

Reprinted ARNA VISION VOL 9, NO. 3 FALL 2004

Last night, I offered up my body ... in the name of science. I have a friend who works at NIH, and he alerted me to the fact that they needed healthy people to come in and get their brains scanned twice- once on the current MRI machine and once on the new MRI machine-so they can calibrate it or something. My incentives: \$80 and a picture of my brain! Shoot, I'd do it for either one. Possibly for free.

So, I leave work around 6:30 p.m. and head to NIH. The woman suggested I try and get there around 7:00 p.m. for my 7:30 p.m. appointment. Okay I think to myself, I come here once a week, no problem, right? She mentioned something about valet parking, but I don't know what's up with that. So I arrive on campus with 5 minutes to spare and start trying to figure out where to park. Okay! Wow. The clinic is the building the size of, well, a huge hospital in the middle of everything, but in the dark and shadows, and maze-like road network, it's all very confusing. Plus there's construction. So I'm trying to follow the signage. I can't decide if I'm an outpatient or a visitor/guest, so I settle on the latter for safety's sake and keep going in circles. I encounter not one but two loading dock dead ends, and I've still got no idea. Finally, in irritation I just pick a small parking lot, the hours of which are 9:00 a.m.-7:00 p.m. It's like 7:05 p.m. There's a booth, a gate, and a ticket machine. I sort of pause ... does 9:00 a.m.-7:00 p.m. mean I can't park there

now? Or that it's free now? Hmmm. I look at the ticket machine. I look at the gate and look at the booth. No one is in there. The gate is up, so I take this as my cue to mean "free parking" and pull in; there are maybe three other cars in there. Okay, fine!

So now I must find my way back to the clinic. However, it's one of those buildings that has a lot of wings, and there are also dozens of other buildings all around it, so from ground level in the dark, it's slightly impossible to figure out which one you want. I head off in the direction I believe to be right and eventually find a sign with an arrow which leads me to a locked door. In bewilderment I accost a man in a lab coat, and he points me to the main entrance. Whew!

In the lobby, there is a sign-in and security check. The woman asks me what floor I'll be going to. I have no idea! I don't have my contact's phone number either and don't remember her last name. Hmm. She sighs and signs me in. The man at the security table asks where I'm going. I'm like "I don't know! I need an MRI." so he gives me directions for how to get to the other corner of the building some 1/4 mile away.

When I arrive in radiology, I finally find someone who appears to work there. I announce, I'm here for an MRI. She looks puzzled and checks the schedule and my name, repeatedly. Nope. Not on the schedule. I plaintively offer up the name of the woman I talked to; there is no one in this department by that name. The woman suggests that I want to go down to level B1. I'm like "so, there's another different MRI place?" Yes. Yes, there is.

Right then, I try to find the elevator, but I'm abysmally lost by this point. I've taken so many turns. A kindly man takes pity on me and gets me to the elevator. Down to B 1, I wander past laundry rooms, with the pervasive smell of hospital cafeteria (they always smell like fake mashed potatoes to me) lingering in the air. Finally, I find my woman. She announces that first I need to check in at admissions, so we troop back upstairs. They make a file for me, and I get a packet of information. Then back down.

Finally, we are getting somewhere! We do a height-weight check (I'm taller than usual and, as suspected, weigh less. Interesting.) And then I must take out my jewelry. That was a process! It felt very, very weird not having the nose ring and tongue rings. I found it difficult to talk properly; having full range of motion just seems like too much to me now.

At last I'm free of metal and credit cards, and we enter the room with the glorious huge machine with "GE" proudly emblazoned on it. They take three vitamin E capsules and tape them inside my ears and to the left side of my face. I'm told these provide reference markers. Then, I lie back and get comfy, and she pads my head inside this basket, so it can't loll about very much. When I'm all positioned, with a smooth whirr of precision machinery, I slide backwards into the depths of the tube. I feel a strange tugging at my pants, and realize that the snap or zipper is being pulled up toward me by the magnetic field. Heh.

Now, they had not told me what to expect at all, in terms of length of time. The technician did say that the machine makes a noise "like a jackhammer" and that when it's making this jackhammer noise I should lie as still as possible. Jackhammer?! That had me a little bit alarmed. The room itself, I should mention, had a very cool soundtrack going on. When I walked in I honestly thought they were playing music. There was a

sound almost like wheezing bellows offset by a low beat. WheeeezDunkWheeeezDunkWheeeezDunk. I found it pleasing.

Anyway, so I'm inside the tube, and she clicks on over a microphone that the first one will be about 1 1/2 minutes. First there are some clicks and noises and EEEH! EEEEH! EHHHH! three times, like a fire-alarm "May I please have your attention" kind of sound-very annoying. However, then it just started going dundundundundundundundundundundundundundundundun, and I thought "jackhammer? Why, I've been at clubs that were playing music more invasive than this is."

At first, I have my eyes open, but they keep wanting to twitch about. I find it easier to close them and just let myself be lulled by the repetitive droning. We go through several iterations like this in 1 min - 2 min segments, and then she tells me the next one will be 10 minutes. I'm gratified to hear this because I was really enjoying the whole thing; the monotonous sounds coupled with doing nothing at all only work in long blocks of time. I have this ability, and love for just completely shutting down all movement and sensation while just letting the mind wander. It's why I love 20-hour plane rides. Often, I'll barely get up to use the bathroom because I'm so happy to just be sitting, staring out the window. I'm entirely positive that one of those sensory-deprivation tanks is just the ticket.

But this is the next best thing. The 10-minute one made different, even better sounds. It was a dual-tone alternating song where one tone would start a sort of rise in either frequency or intensity, I'm not sure which, and then the other tone, which was like a low, resonating chord struck on a synthesizer set to "Organ." WhooooooooooooooooDON gggggg Whh hooooooooooooDoonggggggg

And with nothing else to do except listen, I started to hear all manner of subtleties in the tones-varying pitches, background tones-all unfolding, with no distinction drawn between what I was hearing and what my head was filling in, no way to tell, and no difference anyhow. I was reminded, strangely, of the time I spent posing for a figure-drawing class where you must remain as still as possible for expanses of time: 5, 10, 15 or even 20 minutes. I was quite good at that; it's like once my body is set in a position I can feel if it breaks out of the boundary layer, and once the body is immobilized you're free to just think or listen. Inventing songs in my head to go with the monotonous heat, just like when I'm stroking an 8-boat and must keep seven other people on the same rhythm together, the beat of the oars fill in with meaningless songs in my head to hold it together.

All of this I am thinking while I lie in there, and the 10 minutes was up too soon. She slides me out, so I can sit up and crack my back, then back for one more (yay!) 10-minute session. I can feel my heart rate slowing as I drift almost asleep on the rocking waves of sound. When the 10 minutes are over, the sound stops far too abruptly, and I'm left with a ringing, echoing vacuum that seems to pull at my body where before the sounds and vibrations were a soothing pressure.

When I'm all done, they let me take out the vitamin E capsules, and I sleepily reorient myself. They already have a picture of my brain on the lightboard when I emerge, and the man jokingly says that it looks fine; now I have no excuses. Hah. He asks how many times I've done this? I sort of raise an eyebrow and say it was the first. "Oh," he says. "Wow, you hold very still."

I smile smugly; "Yes, I know."

WHAT DID YOU SAY?

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

Having worked in Radiology over a decade, I was well acquainted with all the exams it had to offer. It was quite a different story when I found I needed an MRI due to a decrease in hearing in my left ear. In departmental safety meetings I co-chaired, the previous MRI manager would always say that she wished all nurses would get into the MRI machine to experience it. They would then better understand the safety issues and the fears of the patient. How right she was!

I arrived early to the MRI suites at one of the community hospitals in the system. (I was able to get an earlier appointment and was not known by staff at this facility) the desk was courteous, and the MRI technologist was able to start my metal screening questionnaire, TSA wand with the Garrett Super Scanner, and place the IV after I changed into my gown. Now the fun could begin!

I was instructed to get comfortable for the 40-minute scan. Having a background in Neuroscience Intensive Care with Stroke and Post op patients, I began to understand their dilemma I observed from years ago. It is impossible to get comfortable. The table is narrow and due to the size of the bore, it is impossible to get an adequate blanket to keep the chill from creeping under the blanket.

I kept my eyes closed for most of the prep. As I was rolled into the gantry, I looked up and thought, "How nice they put a cloth over my eyes?" When I was pulled out for the Gad injection, I put my hand up to remove the cloth and realized that it did not exist! That was when I realized how small the space is inside the machine. It now made sense why patients may have trouble with claustrophobia in MRI. Although not normally claustrophobic it was certainly a gut check to finish the test.

Perhaps the most enlightening part of the exam was the noise and the shaking from the perfusion phase of the scan. No matter how well placed the headphones and the volume of "Soft Jazz" piped into them, the sound permeated with the shaking of the table. Truthfully, it made me wonder how my patients with impaired cognition made it through the tests. It is no wonder they reacted the way they did.

I finished the test without incident. Little did I know at the time that this was not to be my only MRI. What I took away from the experience was a greater understanding of what my patients experience. This has helped me to prepare them better for their exam and make their experience the best it can be.



TOP TEN EXCUSES FOR NOT TAKING THE CRN EXAM

Joann Stevens, RN, CRN
Reprinted from RN News, 6(3). Page 7



Excuse Number 10:

"I don't take tests well." The exam is prepared for a nurse with two years of Radiology experience.

Excuse Number 9:

"I forgot to sign up." Well, sign up now for the next one!

Excuse Number 8:

"My friend's cousin's aunt's sister said it was hard." Sec excuse Number 10.

Excuse Number 7:

"I have a headache." Treatment Rx: acetaminophen 625 mg PO 45 minutes before exam with 240 cc of herbal tea.

Excuse Number 6:

"You try it." "I'm not going to try it. Let's get Mikey. He hates * everything." Mikey did just fine. So did MaryAnn, Dinah, and Kathleen.

Excuse Number 5:

"I have to work." With six months' notice, even I can have a day off.

Excuse Number 4:

"It's expensive." Small price to pay for increased self-esteem, pride, prestige, power and glory. Besides, many hospitals are paying for it and using it as criteria for clinical promotion. Check it out.

Excuse Number 3:

"I left my application in my other jacket."

Excuse Number 2:

"The dog ate my copy of the Core Curriculum." Really now

And the Number 1 excuse for not taking the CRN Exam:

I just haven't gotten around to it.

FAQ on the exam [can be found here](#). The exam is offered two times a year in addition to special exam sites that may be set up. Applications [may be obtained here](#). Good Luck and do not succumb to the top ten excuses!

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

First Name	Last Name	City	State
Margaret	Gustavson	Minneapolis	MN
Debra	Cox	oroville	CA
Uyen	Huynh	Oakland	CA
Lara	McDonnell	Columbia Falls,	MT
Vicki	Bernard	Blacksburg	VA
Jane	Underwood	Dublin	VA
Arianna	Slate	Shawsville	VA
Virginia	Williams	Marina	CA
Lindsay	Marshall	Scottsdale	AZ
Andrew	Dignan	Oak Park	IL
Eldora	Fraser	Lithonia	GA
Kimberly	Stephenson	Fayetteville	NC
Shawnee	Thomas	Tampa	FL
Thomas	Hansen	Great Falls	MT
Cyndie	Sherer	Stanford	MT
Leslie	Ambuehl-Frasz	Great Falls	MT
Blair	Boetticher	Fairfield	MT
Wendy	Hill	Southport	NC
Adolfo	Estandarte	Orland Park	IL
Charlene	Sanchez	Sacramento	CA
Mellony	Cude	Fairfax	VA
Maria Lourdes	Imperial	Jamaica Estates	NY
Rochelle	Gardner	Puyallup	WA
Alicia	Galgano	Merrick	NY
Morgan	Harrison	Douglasville	GA
Amy	Hulst	Fremont	MI
Victoria	Cruz	San Mateo	CA
Nelson	Mercado	South San Francisco	CA
Ann	Gill	Billings	MT
Darlene	Doran	Ipswich	MA
Elmer	Bienz	Chicago	IL
Ashley	Jimenez	Collierville	TN
Rosalind	Farrell	Dublin 6	DN
Deidre	Devaux	Norwood	MA
Michelle	Graham	Forked River	NJ
Maureen	Nclnerney	MILFORD	PA

First Name	Last Name	City	State
Christa	Nichols	Hixson	TN
sherri	staggs	Carrollton	GA
Joshua	Dylka	Cortland	IL
Cynthia	Orona	Broken Arrow	OK
Tuananh	Vu	Etiwanda	CA
Lisa	Moore	Palmer Lake	CO
KATHY	ALLINGER	Chambersburg	PA
Ashlee	Shoard	Wollongong	NSW
Sandy	Lovati	Irvine	CA
Susan	Finley	Myrtle Beach	SC
Peggy	Noonan	Holtsville	NY
Nikki	Augustin	Vacaville	CA
Eileen	Harrington	Garden City	NY
Christina	Bardsley	Howell	NJ
Nakisha	Jones	Baltimore	MD
Reynaldo	Ines	Stamford	CT
Paula	Dixon	Mount Pleasant	SC
Donna	Bartenfelter	Perry Hall	MD
Patricia	Rabbett	Wellesley	MA
Lesley	Brooks-Tardiff	Scarborough	ME
Krista	Owens	Fayetteville	NC
Sydney	Simpson	SAN FRANCISCO	CA
Cindy	Chellin	Puyallup	WA
Marina	Gonzales	Scottsbluff	NE
Amanda	Robinson	Kansas City	MO
Toni	Stobie	Calgary	
Tammy	Rabboni	san diego	CA
Barbara	Miller	ruther glen	VA
Leslie	Wulfekuhle	Puyallup	WA
Kim	Mahoney	Newtown	PA
Michelle	Zundel	Kenmore	WA
Abigail	Smith-Owens	New York	NY
Znovia	Hill-Meeks	houston	TX
Nancy	Merriken	Warrenton	VA
Sarah	Raml	Sheboygan	WI



THIS IS AN EXCITING TIME TO JOIN ARIN!

Sarah K. Whitehead, BSN, RN, CRN

Come blaze a trail with us.... we are looking for other energetic nurses who share the same passion about Imaging nursing as much as we do to join our board of directors!

2018 Annual Call for Nominations

Service on the board of directors for ARIN is a rare chance to help drive the decisions of our national association and help shape the future of Imaging Nursing. The opportunity to work with our team of other leaders in Imaging Nursing offers you the ability to:

- Be on the cutting edge of decision making on a national level.
- Expand your professional network
- Gain recognition from your employer, community, and peers
- Develop and expand your leadership skills
- Gain experience in program planning, non-profit governance, and strategic planning

Elected positions will begin their term at annual convention in March 2018.

[President Elect Position](#)

[Treasurer Position](#)

[Director of Education Position](#)

[Leadership Development Committee](#)

[Click here to apply.](#)

I hope you sincerely consider the chance to join our team and help lead your association and profession into the future by nominating yourself or someone else.

SCHOLARSHIP OPPORTUNITIES

The Association for Radiologic & Imaging Nursing is pleased to announce the distribution of scholarships to ARIN members this year at the annual convention in Washington, DC. As usual the scholarship program is very competitive, and we thank the generosity of those who provide items for the silent auction each year that raises money to raise the level of professionalism of radiology nurses.

Meet Kristina Hoerl, Radiology Nurse of the Year 2017 Award. Do you know someone who demonstrates excellence in leadership in advancing Imaging Nurse? Next year's winner will be announced at our annual convention in Los Angeles March 18th – 21st, 2018.

[CLICK HERE TO NOMINATE](#)

You must be an active member in ARIN, to apply



Piera Robson, 2017 Director of Leadership; Kristina Hoerl, 2017 Nurse of the Year; Evelyn P. Wempe, 2017 ARIN President

A RADIOLOGY NURSE VISIT TO SOUTH AFRICA

Kristina Hoerl MSN, RN, CRN



Nelson Mandela was a champion of freedom and peace who wanted to change the way "society treats its children and youth" (Nelson Mandela Children's Fund, 2017). Imagine being asked to use your talents and passions to travel half way around the world to help fulfill the dreams of this well-loved and admired world leader. Would you jump at the opportunity? Would you hesitate for fear of the unknown? Would you question why someone would think you were the right person for the job? As a recognized subject matter expert in Radiology Nursing with pediatric experience, I was approached by Johns Hopkins Medicine International (JHI) to do

just that – bring Mandela's dream to reality by supporting pediatric nursing specialty services at the newly built Nelson Mandela Children's Hospital (NMCH) in Johannesburg, South Africa. When I was asked about participating in this project, I was awed that I was considered and then humbled to have such a fantastic opportunity.

The project involving JHI is funded through the United States Agency for International Development's global flagship Maternal and Child Survival Program, which is led by Jhpiego, a global health non-profit and Johns Hopkins affiliate serving women and families in more than 40 countries. As a former Girl Scout, I know the importance of using my resources wisely, so I reached out to Bruce Boulter, Executive Director for the Association for Radiology and Imaging Nurses (ARIN) to see if I could use some of the material we used as part of the Imaging Review Course as a jumping off point for the Radiology Nurses at NMCH. After consultation with the rest of the Board of Directors, I was informed that ARIN thought the outreach was a great idea and they willingly allowed me, as a member of the Imaging Review Course (IRC) Master Faculty, to use the 2015 version of the IRC as a starting point in creating the education requested by NMCH.



Using the IRC as my framework, I developed a program that focused on ionizing radiation use and safety, MRI use and safety, contrast administration and adverse event management, sedation, ultrasound, and the concepts of interventional procedures. Adjusting the program was challenging as I needed to change terms to be consistent with terms used in South Africa. Some examples included radiographers instead of technologists, emergency trolley instead of crash cart, micturating cystourethrogram instead of voiding cystourethrogram and the use of millisieverts and grays as measurements of radiation instead of millirems and rads that are part of the radiology vernacular in the United States. I was also disheartened to find it difficult to find pictures that targeted my audience that I could add to my presentation. It was a stark reminder to me of the lack of complete and full diversity in our world. In addition to the didactic sessions, I was also asked to observe operations in the Radiology Department - MRI and CT, were the only areas of the hospital that were currently seeing patients – and provide scenarios for growth and development of the staff.

On arrival in Johannesburg, we got our first small taste of a different country. Our driver was on the right-hand side of the car. It was strange to have headlights coming at you from the right side. The next morning, we woke to a beautiful late winter day – yes, we went in August but since we crossed the equator South Africa was coming to the end of its winter season. I found Johannesburg to be a typical modern city in many ways. There was a great deal of traffic and lots of new buildings and some familiar sites such as McDonald's and Pizza Hut. One thing that was different was all the houses were surrounded by walls. Many of these walls had barbed wire or electric fences across the top to help prevent crime. Even our hotel was protected. We could not walk onto the grounds of the hotel without being buzzed into the compound. We were told these security measures were because there is a large amount of petty crime in the country. Even knowing that, I felt safe and welcomed by all with whom I came in contact.

At the hospital, I found a state of the art facility with a modern, fully equipped imaging department. I also found a staff of compassionate, dedicated, and caring individuals who wanted to do things the best way possible, not just the way it had always been done. They currently had two nurses hired for radiology with no previous radiology experience and a Nurse Manager for Radiology who was experienced in the cardiovascular lab. Additionally, there were two CT and two MRI technologists, a diagnostic technologist, two anesthesiologists, two radiologists – one, who happened to be a woman, was the head of the department, and a nurse specially trained in anesthesia but did not seem like she was the exact equivalent to a CRNA as we have in the States. The hospital had also hired many of the nursing leaders for the various areas of the institution, registration staff, dietary staff, and pharmacy staff. Many of the nursing leaders were empowered and looking forward to setting the foundation of what was to come at NMCH. I also found a country in need of additional resources. The NMCH is one of just a small handful of hospitals in the country of South Africa that focuses on the needs of the pediatric population. The hospital has opened its Radiology Department first to try to meet the backlog



of cases. One MRI that I observed was of a child with severe developmental issues who had been waiting over 14 months to get an MRI of her brain. Think how you would feel if you needed to wait that long for a scan for your child.

During the didactic sessions and one of my day in the life scenario sessions, we were joined not just with the radiology staff. The other leaders in the institution wanted to attend and learn what radiology is all about. I got many comments on how helpful it was for non-radiology staff to learn the unique aspects of the Radiology Nursing specialty. While I was there to teach, I also learned a

great deal. I learned that, just as in the US, radiology nursing is not taught in nursing schools and the technologists have traditionally provided care that is more traditionally thought of as nursing care. They also have levels of nursing similar to our Associates Degree and Bachelor Degree. Nurses with the equivalent of a Bachelor's are referred to as 'Sister' if they are female and 'Mister' if they are male. I learned there are many challenges in healthcare that cross boundaries. For example, there are 12 official languages in South



Africa so there was issues with communication barriers. There are still regulatory bodies that influence practice. In South Africa, they use the European Union Standards for Radiation safety. In these standards (Official Journal of the European Union, 2014), it states that an employer shall create employment conditions that prevents fetal exposure from exceeding 1 millisievert which equals 100 millirems. In the US, a pregnant radiation worker's fetal dose must not exceed 500 millirems (5 millisieverts). Most importantly, I learned that nurses everywhere have a desire for their patients to get the best care possible. I learned that nurses everywhere want to make a difference. I learned that the nurses at Nelson Mandela Children's Hospital are poised to help South Africa achieve Nelson Mandela's dream for the way "society treats its children and youth."

Reference:

Nelson Mandela Children's Fund (2017). <http://www.nelsonmandelachildrensfund.com/>

Official Journal of the European Union (2014). European Union Radiation Standards. <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02013L0059-20140117>



9TH ANNUAL ULTRASOUND SYMPOSIUM 2017

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

ARIN members are on the move. Fresh off the combined ORNA/ University Hospitals Radiological Education; member Greg Laukhuf was an invited co-speaker at the 9th Annual University Hospitals Department of Radiology Ultrasound Symposium 2017. Smashing Infection was the topic co-presented by Greg Laukhuf, RN & Jacqueline Zanolli, RDMS. This is a course designed for physicians and technologists involved in the practice of diagnostic ultrasound.



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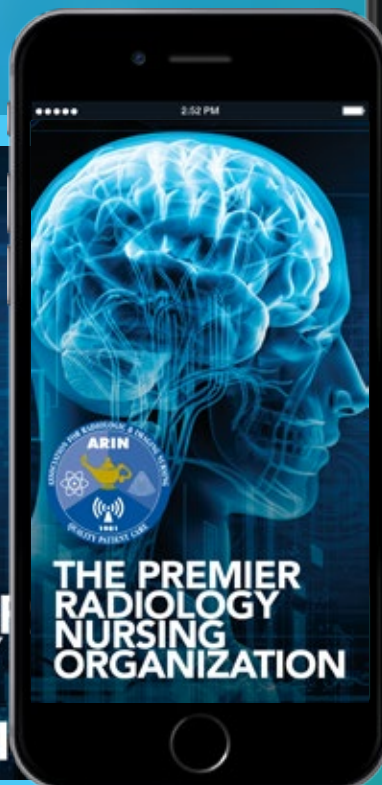
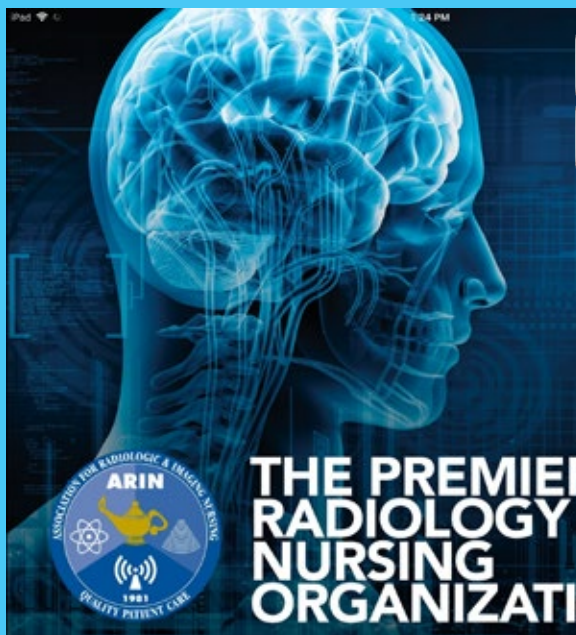
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