



In this issue

ARIN IS SYNONYMOUS
WITH EXCELLENCE

NURSING ALLIANCE LEADERSHIP
ACADEMY- NALA

ARIN MEMBERS IN PRINT

INTERVENTIONAL RADIOLOGY
AWARDED BEST NURSING TEAM

NEW MEMBERS

COMFORTABLY NUMB

NEWS FOR RADIOLOGY

TAKING PRACTICE FROM
VEIN TO MAINTAIN

WHAT IS EVERYONE SMOKING?

PUBLISH OR PERISH

PANPUS RETENTION SYSTEM (PRS) AND
NEPTUNE TOPICAL HEMOSTASIS PAD

2015 ARIN CENSUS RESULTS

2017 NOMINATIONS ARE OPEN!

I AM A RADIOLOGY NURSE!

ARIN BOARD OF DIRECTORS
2016-2017

ARIN'S ROAD TO RELEVANCE

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



"Great things are not done by
impulse, but by a series of small
things brought together."

– Vincent van Gogh

ARIN continues to work diligently in many areas to pave the way for the advancement of radiology nurses everywhere. ARIN committees and task forces continue to expand on the education of the various clinical pathways. In addition to the work within the organization, we need to be aware that ARIN's road to relevance is impacted by what's occurring within the nursing profession. As leaders within radiology nursing, we need to consistently seek knowledge and understanding of the issues, trends, and challenges affecting the nursing profession. Such knowledge allows us to be catalysts for change and growth while paving the road for great achievements! For ARIN, this is achieved through participation and attendance at conferences that connect us to other national nursing groups for the common goal of patient care. Our presence and participation at national nursing meetings

mean visibility to our specialty and a seat at the table engaging with principal national organizational nursing leaders. The following projects detail some of the impactful venues ARIN is involved in to advance radiology nursing.

ANA 2016 Member Assembly

The ANA 2016 Member Assembly meeting was held June 23rd through the 25th in Washington, D.C., providing the opportunity to learn about the latest topics affecting nursing practice. This year, Bruce Boulter, ARIN's Executive Director and I were in attendance. ARIN presented at the Organizational Affiliates Meeting updates on ARIN-related activities as well as presenting ARIN's Capnography Position Statement to the Alliance members in attendance. This was a great opportunity for ARIN's visibility and voice on how we are setting the nursing care standard in radiology.

One of the key take away messages from the Member Assembly meeting was about the *value of nursing*. As nurses, the roles that we play in patient care are impactful! As an organization, ARIN certainly is at the forefront of educating others on the value of radiology nursing which

Thank you to our corporate sponsors



COVIDIEN

positive results for life™





is evident through our committee work, imaging review courses, webinars, town hall meetings, journal publications and annual convention. As leaders in radiology nursing, we need to continue to contribute to our specialty through networking, volunteer work, and active participation. It is through patient care and outcomes that we see the value of what we do as radiology nurses.

Virtual Town Hall Meeting

As President, it is important for me to know what are the issues in radiology and imaging nursing that affects our practice every day. However, as members, it is important for you to learn of the ways ARIN is continuously working towards bringing visibility of our specialty to others while creating the standards in radiology nursing care. Join ARIN leaders on Tuesday, October 4th, for its Fall Virtual Town Hall meeting. I am looking forward to spending an hour discussing how as leaders in patient care, radiology nurses are continuously making a difference in the lives of others.

Fall Into a Season of Education

As mentioned earlier, ARIN continues to expand on the education of various clinical pathways. This fall, ARIN has several educational opportunities for members to learn and interact with each other!

• Pediatric Radiology

Providing safe, quality care is of the upmost important to radiology nurses everywhere. On **October 12th and October 26th** ARIN will be hosting a webinar on Pediatric sedation and capnography by Lori Reilly, MSN, CRNP. This webinar is designed to provide an overview of *pediatric sedation and capnography in radiology*. This is a great educational opportunity for radiology nurses everywhere taking care of our little ones!

• Imaging Review Courses

This Fall between the months of September and October, ARIN will be presenting imaging review courses(IRC) in various locations. Members are encouraged to visit the education page on ARIN website to learn if one of these locations is near you. However, the month of October has a treat in store for those unable to travel, but interested in virtual learning! ARIN will be offering two virtual IRC opportunities. The first virtual IRC will be held **October 8th-9th** with second offering being held **October 22nd-23rd**. The IRCs are a great way to expand on your radiology knowledge for safe, quality patient care delivery in the various imaging, interventional and therapeutic environments. I encourage all of you who have not taken the course or are looking for a "refresher" to register today!

• Synergy – November 3rd-6th, 2016

ARIN has partnered with the University of Miami and the Synergy Conference in Miami, Florida for a second year in a row. This is of great value to radiology nurses, as Interventional Oncology is an important sub-specialty within Radiology that continues to grow. ARIN members can take advantage of discounted registration to come and learn about the latest clinical information on treatments and care of the oncology patient.

Pave the Road

ARIN's road to relevance is through its education and its members. It is through contribution of personal and professional growth that we become experts in our profession and help others obtain knowledge to advance the standard of care in radiology and imaging environments. I encourage all of you to be catalysts for change and growth to help pave the road for great achievements and relevance for our nursing specialty.



ARIN IS **SYNONYMOUS** WITH **EXCELLENCE**

Greg Laukhuf RN, ND, CRN, RN-BC, NE-BC
VISION Editor.

"Excellence is never an accident. It is always the result of high intention, sincere effort, and intelligent execution; it represents the wise choice of many alternatives - choice, not chance, determines your destiny."

— Aristotle

The current world is full of healthcare uncertainty but 2016 brings optimism as ARIN marks its 35-year anniversary this year. Our organization, known as the voice of radiology nursing, the authority in radiology nursing care and for setting the standard for radiology nursing, has grown exponentially in the last 35 years. It is exciting to know that the specialty of radiology nursing is one that touches the lives of patients and healthcare professionals in the United States and internationally. Our specialty is unique in that the experts in radiology are involved collaboratively with the patient and other healthcare professionals to deliver positive patient outcomes.

The Future of Nursing Leading Change, Advancing Health, and Initiative report underwritten by the Robert Wood Johnson Foundation and the Institute of Medicine, emphasized an important message in 2010. The US healthcare system encompasses a high level of fragmentation, which raises obstacles to providing assessable, quality care and a portable price (IOM, 2010). As patient care advocates, we are challenged to be knowledgeable, develop solutions, and deliver safe, effective care. Radiology nurses are responsible for assimilating the holistic principles of nursing, management, marketing, education, and performance improvement into the patient's plan of care to avert any potential harm. Radiology Nurses make safety a priority, share accountability and responsibility, focus on research priorities, and communicate efficiently with each other to provide care ranging from the newborn to geriatric and acute to chronic. Our specialty knowledge can be a solution for reducing healthcare

costs as procedures and tests previously done in the operating room continue to move to outpatient settings. To advance patient outcomes and reduce healthcare costs, there is considerable interest by healthcare providers, insurers, regulators, the patient and the cuts in continuing this trend. The radiology nursing family consists of thousands of nursing professionals who work in a variety of radiological and imaging settings, such as hospitals, clinics, physician practices. As a profession, we share the philosophy that radiology nursing is an art and the science and work together to perfect our field of practice. As noted previously, we offer patient safe and effective care as we accept the challenge and complexity of disease state management. We overcome such encounters through our leadership, education, accountability, and professional development. In order to keep up in today's Radiology department with technological advances, it is extremely important to continue to add our knowledge base. Thanks to ARIN, we are provided with many opportunities to advance our learning through the continuous education programs that are available; educational sessions and conventions, through webinars, or the ARIN archive center. I encourage all of you to take it advantage of these awesome opportunities. Though our healthcare systems have challenges, as an organization we can make a difference. 35 years of excellence is a statement: ARIN is synonymous with excellence. I would like to thank all of you for belonging to our wonderful organization and to contributing to a great 35 years.

References

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*.

Retrieved from http://books.nap.edu/openbook.php?record_id=12956&page=R1 Institute of medicine.

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.

NURSING ALLIANCE LEADERSHIP ACADEMY– NALA

Katherine Duncan, BA, RN, CRN
President-Elect

On August 26-28, 2016, the ARIN President and President-Elect attended the Nursing Alliance Leadership Conference (NALA) in Louisville, Kentucky. The Nursing Organization Alliance (NOA), the sponsor of this event, is a coalition of nursing organizations created to develop leaders, provide support and collectively provide a voice for nurses represented by these organizations such as ARIN. ARIN has been privileged to participate in this event for several years.

Held annually, this leadership conference provides a unique opportunity to network and develop relationships to collaborate on benefits to members. This year's attendees represented 25 different nursing associations across the spectrum of nursing disciplines. Education and discussion included the following topics:

1. Effective Board Governance
2. The Partnership Between the Board and Chief Staff Officer
3. Mental Diversity and Team Dynamics
4. Where Nursing, Associations, and Social Media Meet
5. Framework for Legal and Financial Stewardship
6. Becoming the Most Effective Spokesperson for Your Association

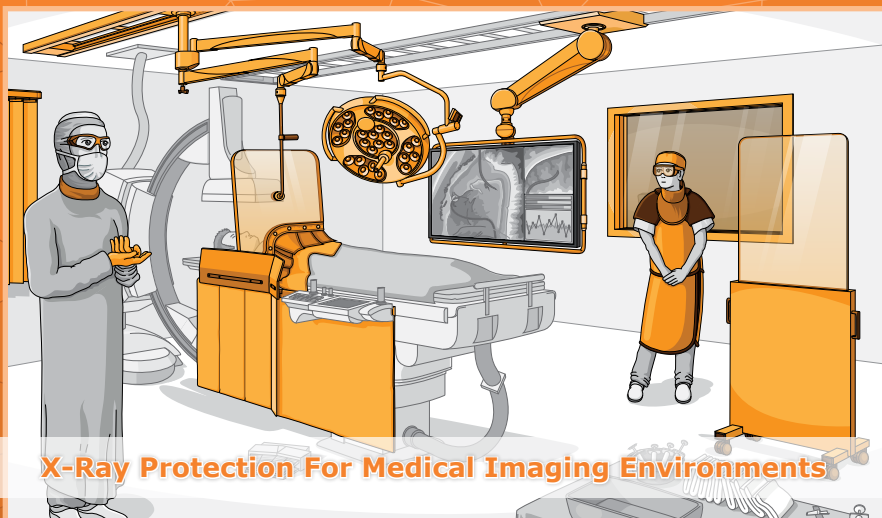
Future conferences will offer future leaders and current leaders continued education on how to be leaders that govern and provide strategic direction for the association. ARIN continues to participate in this productive educational opportunity.

ARIN MEMBERS IN PRINT

Are you in need of reference articles for your practice? Check out these recent articles in Journal of Vascular Interventional Radiology by JRN author Kathleen Gross RN.

Abi-Jaoudeh, N. , Walser, E. M., Bartal, G., Cohen, A. M., Collins, J., Gross, K.A., Stecker, M.S., Nikolic, B. (2016). Ebola and other highly contagious diseases: Strategies in interventional radiology. Journal of Vascular and Interventional Radiology, 27 (2), 200-202.

Rafiei, P, Walser, E.M., Rana, H., Ross, J. R., Kerlan, JR., R.K, Gross, K.A., Balter, S, Bartal, G., Abi-Jaoudeh, N., Stecker, M.S., Cohen, A. M., Dixon, R.G., Thornton, R.H., Duncan, J.R., Nikolic, B., for the SIR Health and Safety Committee. (2016). Society of Interventional Radiology Interventional Radiology Pre-Procedure Patient Safety Checklist. Journal of Vascular and Interventional Radiology. 27(5). 695-699.



X-Ray Protection For Medical Imaging Environments

MAVIG

- Ceiling Suspended X-Ray Protective Shields, with Panel Curtain For an Increased Radiation Protection
- A Wide Range of Personnel X-Ray Protection: Various Apron Designs, Thyroid/Sternum Shield, Protective Eyewear, Head Coverings, Gloves ...
- Table Mounted Lower Body X-Ray Protection
- Mobile X-Ray Protective Shields
- Patient Protective Coverings, etc.

For more information, please feel free to contact us, or discover the different ways in X-ray protection at:

www.mavig.com ✉ mavigusteam@mavig.com

INTERVENTIONAL RADIOLOGY AWARDED BEST NURSING TEAM FOR 2016 AT LOWELL GENERAL HOSPITAL

Mary F. Sousa BSN, RN
ARIN Immediate Past President

ARIN continues to bring you news about our members focusing on accomplishments and highlighting outstanding radiology teams and their achievements. This past May, the radiology nurses at Lowell General Hospital, Lowell, Massachusetts, were honored as the "Best Nursing Team" in their hospital system. The members of the Lowell General Hospital (LGH) Radiology team are pictured below. A special celebration was hosted by the hospital to honor these nurses and their accomplishments. Cecelia (CeCe) Lynch, MS, RN, NEA-BC, FACHE, Vice President of Patient Care Services and Chief Nurse Executive (CNE), shared with ARIN that this highly coveted award is presented each year during Nurse's Week to one outstanding team who consistently demonstrates exceptional teamwork and patient care. The selection process is competitive and rigorous with many wonderful and deserving teams putting forth tremendous effort in driving the organization's mission ("every patient is our patient") to deliver the best care. The following are excerpts from interviews with the CNE, charge nurse and an interventionalist.

What is your department's greatest achievement?

Martha Manning, BSN, RN, CRN, clinical radiology charge nurse, has been at Lowell General for 30 years and has worked in the radiology department for 18 years. One of the original three nurses who floated from the Surgical Day Care Department to "Special Procedures", she noted that the department's greatest achievement has been the recruitment and development of the current radiology nursing team. Often invisible in many organizations, these radiology nurses at Lowell General Hospital have managed to work together to increase their visibility within the organization, bringing awareness of their skills and expertise to groups within the organization and outside (e.g. VNA, referring clinics, and college nursing programs). They have communicated the significant contributions radiology nurses give to patient care "We have become a professional resource for the inpatient nursing units caring for our interventional patients, as well as, for VNA nurses caring for patients at home", says Manning. Manning recognizes the growing population of cancer patients seen in today's radiology departments and the need to partner with referring groups. "Our relationships with our oncology colleagues helps to improve the quality of care we provide both pre and post procedure. If I had to choose one achievement it would be the consistent and safe conscious sedation and monitoring of thousands of IR patients across two campus sites. Our radiologists and our patients trust us with this crucial aspect of care and we continue to demonstrate excellence in practice," says Manning.

How was this team built?

Building a successful functioning radiology nursing teams takes time, the right resources, and commitment from the interdisciplinary team members. Ms. Manning said, "We built this team with patience. Small steps eventually making great strides but you can't build a radiology nursing presence overnight. Demonstrating the difference radiology nurses make in procedures and in the department itself took time. We utilized the resources that are available. Administrative support came with evidence based planning. ARIN's Scope and Standards of Practice will help to support and implement practices that build your team. In addition, the American College of Radiology (ACR) and Society of Interventional Radiology (SIR) support our presence and efforts."



Would you share some demographics of your department and nursing staff?

Ms. Manning remarks, "Our nurses have varied degrees and backgrounds. We have diploma nurses, nurses with associate degrees, as well as, bachelor's degrees. All of our nurses have critical care experience and each of us has brought our unique nursing experience to incorporate in the Radiology Nursing Team. We have diversity in age, gender and years of experience. We do not employ any new graduates. Our most experienced nurses have practiced for 40 years while our youngest less than ten. Four of us are Certified Radiology Nurses (CRNs), three others are certified in critical care fields. Some are awaiting the results of the last radiology nursing certification exam."

How was the Radiology Nursing Department Selected for this prestigious award?

Ms. Lynch shared that the award requires completion of a detailed application, outlining the pillars of practice (people, service, quality, financial, growth) with examples of supporting behavior and a nomination. Dr. Gregg Franco, Vascular and Interventional Radiologist at Lowell General since 2013, was instrumental in the nomination process. Dr. Franco shared in an interview, "When I heard about this nursing award I felt the radiology nursing group was deserving of this award. They do an excellent job every day. Prior to joining Lowell General, I had seen many other IR departments and this is special here. Each person plays an important part in the kind of the atmosphere that exists in a department. Here at Lowell General the nurses are a large part of the great atmosphere in the department, teamwork and collegiality. Attitude affects working environment. It's a pleasure to come to work here. Nursing plays a key role and under Martha's leadership by example that she sets every day. She is an incredible nurse who leads by example. It's her actions that help guide younger nurses. Additionally, upper management seems different here than in other hospitals. The nursing care is excellent everywhere in the hospital, "a can do attitude" is the overall culture of the hospital. This positive work environment boosts our

production, quality and satisfaction. Patient safety is affected and improved because of a team that pulls together for excellent outcomes. Nursing has a big role in working up cases, teaching patients, reviewing instructions. They're the best I've seen."

What do you attribute your team's success to?

Ms. Manning commented, "Commitment... commitment to our patients, to each other and our radiology peers. Our team is respectful of each other, as well as, our patients and their families. We understand that we make a difference and remain committed to working together to consistently find ways to improve the quality of care provided. Our commitment is evident in our certification ratio and our attendance at continuing education programs. We at Lowell General are also fortunate to work with physicians and technologists that are just as dedicated and committed to exceptional patient care." Dr. Franco added, "The key to the team successes lies in each person. The individual person, each nurse is self-motivated, comes in with the right attitude, the right leader brings these qualities, and bringing out the best in everyone. Setting the bar high and the team responding."

Ms. Lynch also noted the way this nursing team has owned their practice, developing an IR/Radiology Clinic in which the radiology nurse call patients prior to procedures as well as after care follow up. They also provide follow up within the facilitate keeping the promise to our community that "you are our patient no matter where you are in the Lowell General system."

What is your vision of the future of radiology nursing?

Ms. Manning articulated, "My vision is to have a radiology nursing team that not only supports IR but also has a deep presence and the staff to support inpatient transport into the radiology department. I would like to develop enough depth that we can routinely cover transport and monitoring of critical patients during imaging exams. Radiology nurses have a deeper understanding of the exams, radiation safety and unique collaborative relationships with radiologist and our RT peers. My vision for the future would be for consistent practices that allow the radiology nurses to travel with patients and allow the nurses to remain on their units with their patient assignments. This practice is standard for all IR patients but my vision would be to implement it for all patients that require monitoring during imaging exams."

How do you foster professionalism in your nursing group?

Ms. Manning responded, "We are active in the New England Chapter of ARIN (NEC-ARIN) and find support in the collegial relationships we have

developed. Currently, one of our staff members, Beth Arsenault, BSN, RN, PCCN, is a member of the Board of Directors and I am past president of this active chapter. I can't emphasize enough the importance of professional organizations and the support and education they provide to the group. Holding membership in a professional organization is a start but integrating yourself into a local chapter brings professional rewards for both the team and your organization. Nurses working at Lowell General understand the responsibility to maintain certifications and the need for continued learning. They also understand the financial and budgetary strains faced by today's healthcare facilities face. Our hours are staggered to provide maximum coverage with minimal redundancy. We as IR nurses are attending both the ARIN 2-day Imaging Review course, as well as, the Moderate Sedation Symposium at our own personal cost. I believe this is evidence of our commitment to our patients and LGH IR Working as a lean team that work well together. We are cognizant of the importance of fiscal responsibility and manage our time and staffing appropriately.

What are the key elements for radiology nursing leadership success at Lowell?

Per Ms. Manning, "Magnet organizations promote nursing education and the development of evidence based practices. Lowell General has created a culture of growth and the support for radiology nursing has come from that foundation. Recently Ms. Lynch has restructured our managerial team to better suit the needs of the department. Our success is also due in part to the respect we have generated from our physicians and colleagues in radiology services." Ms. Lynch continued, "As a Magnet Hospital, we support strong nursing staff lead councils." When Ms. Manning wanted to bring ARIN into our facility leadership supported it. We asked, "What can I do to help you bring ARIN in?" Our nurses know they are supported to network outside the walls of the hospital, in fact, our staff nurses are encouraged to do so. Lowell General Hospital has a partnership with the University of Massachusetts Lowell Campus regarding research projects and sharing resources. We empower our nurses to seek these opportunities."

On behalf of the Arin BOD, we extend a very warm congratulation to this outstanding team and thank them for allowing us to highlight their success and share in their celebrations.

If you would like your team interviewed or share your team's achievement, please contact LizBoulter@arinursing.org.

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

First Name	Last Name	City	State
Patricia	Dooley	Penfield	NY
Cristina	Cosim	Sunnyvale	CA
Candace	Meyer	San Antonio	TX
Pauline	Gaughan	Los Angeles	CA
Christine	Mccarty	Fremont	CA
Laura	Rennie	Manchester	NH
Shannon	Maier	Philadelphia	PA
Sheila	Adam	Honeoye Falls	NY
Marcia	Garcia	Rochester	NY
Timothy	Hust	Rochester	NY
Ann	Morningstar	Churchville	NY
Velesia	Marston	Rochester	NY
Hilde	Bonhotal	Lima	NY
Alona	Anisimova	West Henrietta	NY
Eileen	Van Allum	Rochester	NY
Kelly	Merandi	Eastvale	CA
Amybeth	Milosek	Scottsdale	AZ
Barbara	Kofalt	Industry	PA
Rebecca	Klein	Birdsboro	PA
Kim	Perdue	Delmar	DE
Hainy	Lawson	Cheyenne	WY
Mandi	Knox	Cheyenne	WY
Joe Anton Louis	Belmonte	Doha	Qatar
Chalon	Hoffert	Tampa	FL
Mary	Latham	Hot Springs	AR
Julie	Jeter	Rockwall	TX
Luann	Ballais	Chula Vista	CA
Ruby	Bailey	Merrillville	IN
Chlin	Yemm	Chattanooga	TN
Martha	Taylor	Charlottesville	VA
Christopher	York	Midlothian	VA
Ladonna	Pacheco	Colorado Springs	CO
Joy	Simonson	Mechanicsville	VA
Beth	Blaney	Harrisburg	NC
Diane	Sullivan	Elmhurst	IL
Phuong	Hoang	San Mateo	CA
Mindy	Miller	Whitsett	NC
Anthony	Hanks	Morrisville	NC
Jennifer	Hanks	Morrisville	NC
Todd	Merrill	Chapel Hill	NC
Donna	Silva	El Sobrante	CA
Corita	Darby	Houston	TX
Rachelle	Legrow	Pleasant Hill	CA
Maria	Santos	Orlando	FL
Candice	Stonemetz	Macedon	NY

First Name	Last Name	City	State
Deirdre	Kochakian	Bergenfield	NJ
Carissa	West	Southgate	MI
Millie	Parducci	Mahopac	NY
Jeannie	Bradley	Ft. Worth	TX
Mindy	Cole	Sheboygan	WI
Donna	Kring	Columbus	OH
Ryan	Dunn	Friendswood	TX
Jacqueline	Schoen	Orlando	FL
Michelle	Shepherd	New Braunfels	TX
Vincy	Mathew	New York	NY
Robin	Mcbrearty	Egg Harbor Twp	NJ
Kathleen	Smith	Fullerton	CA
Tammy	Myers	Lincoln	CA
Miriam	Whetton	Mesa	AZ
Shari	Mcarthur	Belleville	MI
Sueellen	Heide	Fairmont	MN
Patricia	Dhers	Randleman	NC
Santiago	Rodriguez	Caldwell	NJ
Jacquelyn	Hughes	Metairie	LA
Narda	Leeming	Pasco	WA
Megan	Gibbons	Saint Louis	MO
Tracy	Sauve	Green Bay	WI
Marjorie	Brodersen	Longwood	FL
Angela	Chapuran	Indianapolis	IN
Hannat	Adenrele	Fresh Meadows	NY
Angela	Clark	Clearwater Beach	FL
Nancy	Alyk	Boise	ID
Jane	Andrews	Punta Gorda	FL
Kristen	Clifford	Ridge	NY
Raina	Ghai-Mehta	Forest Hills	NY
Geriann	Ellison	Elmira	MI
Celma	Capuz-Weaver	Edison	NJ
Rachelle	Fitzgerald	Oakley	CA
Sharon	Judd	Keswick	VA
Gina	Schultz	Rochester	MN
Ellen	Beeghly	Tunnelton	WV
Jennifer	Mccafferty	Morrisville	PA
Kristi	Perry	Bellingham	WA
Emily	Jungbluth	West Allis	WI
Eva	Feldman	Woodstock	MD
Sharon	Tubbs	Lancaster	TX
Debra	St Clair	Yardley	PA
Jacqueline	Murphy	Pittsfield	MA
Sally	Derosia	Glendale	AZ

COMFORTABLY NUMB

Greg Iaukhuf ND, RN-BC, CRN, NE-BC
Vision Editor



In the practice arena of Interventional Radiology, I am frequently asked by staff and physicians how to “numb the patient” in the case of a lidocaine allergy. As I have learned over the years after repeated conversations with my departmental pharmacist, this is not an easy question to answer

but depends on the patient allergy and the level of numbing required to safely complete the procedure.


In patients with an allergic reaction to local anesthetics, it is important to first determine what component is causing the reaction. Typically, when patients share they had an allergic reaction to lidocaine; it is an allergy to the ester or the amide component of the drug. Anesthetics that contain an amide component include bupivacaine, lidocaine, mepivacaine, articaine, prilocaine, and ropivacaine. Anesthetics that contain an ester component include benzocaine, chloroprocaine, procaine, and tetracaine. Additionally, some patients have allergic reactions to the para-amino-benzoic-acid; a metabolite of a preservative used in multi-dose vials. The final component of local anesthetics that can cause an allergic response in patients is the sulfite component that is used as an antioxidant in preparations that contain vasoconstrictors in addition to the local anesthetic.

In situations when it is known in advance that a patient will need a local anesthetic, patients can undergo intradermal allergy testing with their physician to determine which of the above components is causing the reaction. Skin pricks and intradermal allergy testing can be performed for immediate hypersensitivity reactions. Although true allergies to lidocaine are rare, possible alternatives could include local anesthetics containing an ester, preparations free of para-amino-benzoic-acid, or preparations free of sulfite depending on the cause of the reaction. If a patient truly cannot tolerate any of the local anesthetics, alternatives used range from diphenhydramine to opioids to general anesthesia, depending on the indication for the local anesthetic.

Each case is specific to the patient and their needs. What do you do if you still need to numb the patient and you have exhausted other ideas? From personal experience, I have used topical freeze and the Buzzy™ on very superficial biopsies without issue. In all cases with concerns over a lidocaine allergy, it is prudent and essential to consult your procedure team; physician, pharmacist, and patient, to come up with a pain control plan that is “comfortable” for all.

References

- Eggleston ST, Lush LW. Understanding allergic reactions to local anesthetics. *Ann Pharmacother*. 1996 July-Aug; 30:851-57.
- Gannes G, Kossintseva I, To D. Lidocaine contact allergy is becoming more prevalent. *Dermatol Surg*. 2014 Dec;40(12):1367-72.
- Jenerowicz D, Polańska A, Glińska O, Czarnecka-Operacz M, Schwartz RA. Allergy to lidocaine injections: comparison of patient history with skin testing in five patients. *Advances in Dermatology and Allergology*. 2014;31(3):134-138.





VIRTUAL IMAGING REVIEW COURSE

OCTOBER 8-9 AND OCTOBER 22-23
10AM-2PM EST

This 2-day course designed to provide an overview of the skills required for the nurses working in the imaging, interventional, and therapeutic environments.

Register now and Earn 15 CE credits for the two day course or 17.5 CE credits for technologists



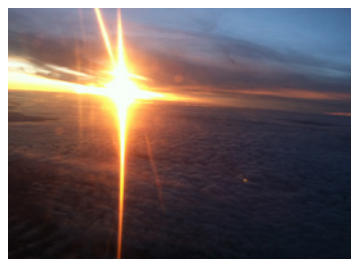


RADIOLOGY NURSES
LEADERS IN PATIENT CARE

[CLICK HERE TO REGISTER](#)

NEWS FOR RADIOLOGY: WHAT YOU REALLY NEED TO KNOW!

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



[New targeted drug effectively dissolves blood clots, has fewer side effects](#)

ITMO. (June 26, 2016).

Critical conditions associated with the blockage of blood vessels are a primary health concern worldwide. The main objective in such conditions is to effectively

implement thrombolysis, i. e. to quickly dissolve the clot. Scientists from ITMO University in cooperation with Mariinsky Hospital in Saint Petersburg have developed a magnetically controlled drug that can be condensed on a blood clot with a magnetic field. The new drug is safe for intravenous injection and can dissolve clots up to 4000 times more efficiently than ordinary enzyme-based drugs. The results of the research were published in a recent edition of Scientific Reports.

[Recognized as 2016 NJBIZ Healthcare Hero](#)

St Joseph's Healthcare System.

St. Joseph's Healthcare System is the Winner of the 2016 NJBIZ Healthcare Hero Award, Innovation/Organization Category, for its innovative Vascular Access Program. The first-of-its-kind sterile ultrasound-guided program in the United States, the Vascular Access Program, increases the accuracy and ease of "needle sticks." This drastically enhances the patient and provider experience in procedures from blood draws and peripheral IVs, to arterial lines and PICC lines.

"Anyone who ever sat through nurses making multiple IV needle sticks understands the value of ultrasound-guided vascular access, but this goes much deeper than an annoying hour trying to draw a few vials of blood or an arm that is bruised for a day or two," said Vascular Access Coordinator Matthew Ostroff. "In fact, we recently helped a 2-year-old pediatric oncology patient who was transferred to us from another local hospital because they were unable to successfully grant IV access after 8 attempts. It was after 10 p.m. when I got the call and we were able to place a line in just one stick."

Time-savings is a second value of the Vascular Access Program. Time is measured on many levels, from the minutes and hours it may take to gain vascular access in a difficult patient, to the days that access may require. "In the past, procedures and tests on patients who have vascular access difficulties were dependent on the availability of access," Ostroff explained. "Our bedside capability eliminates delays and allows more time for immediate care of the patient."

[Hampton Firm Develops Intravenous Leak Detector](#)

Gilmore, F. (06/16/2016). Retrieved

One fourth of all intravenous (IV) medications leak into body tissue, according to Gary Warren, CEO of a ivWatch. Many IV drugs can cause pain and tissue damage for patients if extravasation occurs, problems which Warren has experienced first-hand.

Based on work that had been done by the company, funding has been provided through the National Institutes of Health and the private sector to do further work on a sensor to alert doctors and nurses of leaking IVs. After years of research, Warren's company, ivWatch, received clearance from the Food and Drug Administration (FDA) in February 2015 for the ivWatch Model 400, a sensor the size of a pencil eraser that uses infrared light to detect leaks and sound alerts. On May 3 of this year the company announced it had received a U.S. patent and trademark for the device's ability to reduce the number of "false alarms" that often happen when a patient moves.

[Natural molecule could improve Parkinson's](#)

Thomas Jefferson University. (June 16, 2016).

Scientists report, a natural molecule shows benefit in a clinical trial for Parkinson's Disease. Current treatments for Parkinson's disease are restricted to temporarily replacing dopamine in the brain as well as some medications designed to slow the progression of the disease process.

According to a study published in the journal PLOS ONE, the natural molecule, n-acetylcysteine (NAC), with strong antioxidant effects, shows potential benefit as part of the management for patients with Parkinson's disease. Combining clinical evaluations of a patient's mental and physical abilities with brain imaging studies tracking the levels of dopamine, the lack of which is thought to cause Parkinson's. Doctors from the Departments of Integrative Medicine, Neurology, and Radiology, at Thomas Jefferson University showed that patients receiving NAC improved on both measures.

Current treatments for Parkinson's disease are generally limited to replacing dopamine in the brain as well as some medications designed to slow the progression of the disease process. "We have not previously seen an intervention for Parkinson's disease have this kind of effect on the brain," said first author and neuro-imaging expert Andrew Newberg, M.D., Professor at the Sidney Kimmel Medical College at Jefferson and Director of Research at the Myrna Brind Center of Integrative Medicine. The investigators hope that this research will open up new avenues of treatment for Parkinson's disease patients.

[MRSA detection technology developed by TGen-NAU is granted first patent](#)

Northern Arizona University. (June 15, 2016).

MRSA, Methicillin-resistant Staphylococcus aureus, is an antibiotic-resistant form of the Staph bacteria that annually kills more Americans than HIV. While MRSA technically refers to one particular strain of Staph, the genomics-based test developed by TGen, NAU and DxNA can precisely detect multiple types of drug-resistant Staph bacterial infections, including drug resistant Coagulase Negative Staphylococcus (CNS), a much more common infection than MRSA.

"This rapid, 1-hour test will precisely identify a family of antibiotic-resistant Staph infections we broadly refer to as MRSA," said Dr. Paul Keim, Director of TGen's Pathogen Genomics Division, or TGen North, based in Flagstaff. "The test also is effective in identifying infected

specimens where there are multiple types of Staph. The test will rapidly provide broader clinically-actionable results, improving antibiotic prophylaxis, early targeted intervention resulting in more effective treatment at lower costs," Taus said

"We hope this technology will be used worldwide by hospitals and clinics, and help identify and isolate these dangerous and difficult-to-eliminate infections that are plaguing our medical institutions," said Dr. Keim, Cowden Endowed Chair of Microbiology at NAU. "The result should be more rapid diagnosis, improved treatment of patients, and reduced medical costs."

[Jury Returns \\$5.6 Million for Failure of Emergency Room Doctor to Order Spinal MRI](#)

Yahoo Finance.(July 5, 2016).

A Cuyahoga County, Ohio jury ... on behalf of Aaron Riedel's family, sent a message about protocol an emergency room doctors must follow for patient safety by returning a verdict of \$5.6 million for Mr. Riedel and his two minor daughters. Mr. Riedel was rendered a paraplegic when an emergency room doctor failed to order an MRI that would have found the growing infection in his thoracic spinal canal

(spinal epidural abscess) in time to have the abscess surgically drained before it caused permanent neurological injury. ... At trial, lawyers ... proved that the E.R. doctor failed to look at all of the information available to him, and failed to ask the patient basic questions that would have alerted him to the recent MRSA infection diagnosis. On the witness stand, the doctor conceded that if he had been aware of this information that a spinal epidural abscess would have been high on his differential diagnosis necessitating an MRI of the spine.

[Variation of Reading Times for Radiologists Over Different Examination Types:](#)

Mitchell, J. (July 5, 2016). HealthCare Business.

A recent study conducted at the University Hospitals in Cleveland with Sectra research scientists found that each radiologist has strengths and weaknesses in reading time and other efficiencies. By tracking these variations, a preferred list of radiologists by exam type can be developed to deliver better turnaround times and efficiencies. The degree of variation for time to read and the relative rankings of radiologists has significant implication in workload distribution to improve productivity.

TAKING PRACTICE FROM VEIN TO MAINTAIN

Andrea Miller RN, BSN, VA-BC

President Northeast Ohio Association for Vascular Access

So many lines have been placed in your Interventional Radiology suite, but have you thought about what happens to your lines once they leave the IR realm? Your part is but a fraction of the life of the line. The risk of central line infections is greatest after insertion even if you are using the best practices of maximal sterile barrier in your area (Soufir, Timsit, Mahe, Carlet, Regnier, & Chevret, 1992). While the focus of our initiatives has been on insertion for so long, we must shift our focus to the importance of how we care and maintain our dressings.

The risk is real; the cost is exorbitant.

According to the CDC website, 50 patients die each day from a bloodstream infection (Center for Disease Control and Prevention, 2016). The website also estimated that in 2011 there were approximately 71,900 BSIs in the U.S that potentially caused up to 17,975 deaths. The numbers are staggering considering all the hard work the inserters have done to decrease infections.

The cost to hospitals financially is making hospital administration take another look at care and maintenance as well. In 2008, CMS (Centers for Medicaid and Medicaid Services) stopped reimbursing for Hospital Acquired Conditions (HAC) that included CRBSI (Catheter related blood-stream infections). This means that if a patient acquires this type of infection (or any of the 10 infections named in 2008), the ENTIRE stay will not be paid for by CMS. To add insult to injury, the Affordable Care Act of 2010 took another stab at facilities and added Value-Based Purchasing (VBP) to the list. This program pulls 2% of your participating facility's inpatient CMS payments to fund this program. Hospitals can then receive a penalty, get their money back, or receive a bonus under this program. CRBSI rates have a direct effect on the overall VBP payouts. Your facility's scores are based on comparison to other hospitals of similar size and make up, or against your previous performance (Centers for Medicare & Medicaid Services, 2015).



Why did this happen to already financially strapped facilities?

With the staggering number of infections and the possibility of reaching zero infections shown in the research, the government felt the need to compel hospitals to make necessary changes from the top to get them to achieve better outcomes.

What can the inserter do?

It's time to get involved. Interventional Radiology is often a forgotten area of expertise!

Ways you can make a difference:

1. Learn more about the lines you manage in your area. Join your local chapters of AVA (Association for Vascular Access) or INS (Infusion Nurses' Society) and become familiar with best practice for line care and maintenance.
2. Become a member of shared governance or offer to help with policies in your facility (write, proof, etc.) to make sure that best practice guidelines are being used to write them. Draft a table format for policies to make it easy for patient care areas to refer to for care and maintenance of various lines.
3. And here is a really scary idea, work a vascular access table at your facilities' skills day and make sure your lines are being cared for by staff per your facility policies.

Dressing care and maintenance

As mentioned above, there are a few societies that help with best practice content and give us guidelines to guide our practice. A few favorites related to care and maintenance of central venous catheters can be found in the 2016 Infusion Therapy Standards of Practice (Infusion Nurses Society. (2016). They include:

1. Assess VAD function by flushing and aspirating for a blood return prior to each intermittent VAD use and as clinically indicated for with continuous infusions.
2. Perform skin antisepsis as part of site care procedure:
 - a. The preferred skin antiseptic solution is >.05% chlorhexidine in alcohol solution.
 - b. If there is a contraindication to alcoholic CHG solution, tincture of iodine, an iodophor, or 70% alcohol may be used.
 - c. Allow any skin antiseptic agent to fully dry prior to dressing placement.
3. Select a gauze dressing if there is drainage from catheter exit site. These must be changed at least every 2 days.
4. Secure dressings to reduce the risk of loosening/dislodgement, as more frequent dressing changes are associated with increased risk for infection.
5. Change needless connectors no more frequently than 96-hour intervals. Changing on a more frequent interval has shown no benefit and has been shown to increase risk of CLABSI. Additionally, the connector should be changed if removed for any reason, if there is residual blood or debris within the connector, and prior to drawing a sample for blood culture.
6. Ensure that disinfecting supplies are readily available at the bedside to facilitate staff compliance with needless connector disinfection.
7. Use a chlorhexidine-impregnated dressing over CVADs to reduce infection risk when the extra-luminal route is the primary source of infection. Even with low baseline CLABSI rates, further reduction in CLABSI rate has been shown with use of chlorhexidine-impregnated dressings.

The Future

The power to make change beyond the radiology suite is in your hands. Deadly infections can be prevented when we get involved and educated. Practice change takes time and can be difficult, but there are benefits beyond the saving of patient lives. The cost savings to healthcare and your facility can be substantial and you will often be able to use the project for clinician "ladder-" type programs and magnet applications. While these reasons are not without merit, the most rewarding aspect for all of us in this endeavor are the 50 lives that can be saved each day with best practice care and maintenance of the lines we so carefully place each day.

References

- Center for Disease Control and Prevention (CDC). (March 2, 2016). HAI Data and Statistics. Retrieved <http://www.cdc.gov/hai/surveillance/>
- Centers for Medicare & Medicaid Services. (8-19-2015). Hospital-Acquired Conditions. Retrieved https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/hospital-acquired_conditions.html
- Infusion Nurses Society. (2016). Infusion Therapy Standards of Practice. Journal of Infusion Nursing. January/February. 39 (1S).
- Soufir, L., Timsit, J.F., Mahe, C., Carlet, J., Regnier, B., & Chevret, S. (1992). Attributable morbidity and mortality of catheter related septicemia in critically ill patients: a matched, risk-adjusted, cohort study. Infect Control Hosp Epidemiol. 20:396-401.



Pediatric Sedation & Capnography Course



Introducing our newest Pediatric course!
Learn about the latest industry breakthroughs
in **Pediatric Sedation and Capnography**

Join the first two modules
live on October 12th and 26th
at 7pm EST hosted by:



Lorie Reilly
MSN, CRNP,
CPNP-AC of
the Children's
Hospital of
Philadelphia

Modules 3-8 will be available
for viewing in November on
the ARIN website, hosted by:



Sylvia Miller
MSN, RN of
Stanford
Children's
Hospital

Register now and earn 8.5 CE credits for the full course

The first two courses are free to ARIN members!

Part 1
October 12
[Click to Register](#)

Part 2
October 26
[Click to Register](#)



WHAT IS EVERYONE SMOKING?

Sharon Lehmann, MS, APRN, CNS

The advent of computerized charting has ushered in a more comprehensive medical records. I was reviewing the chart of a patient recently and to my surprise, I discovered there are choices than cigarettes when I clicked on the smoking history radial button. Many of these products, I was not familiar with and so I am sharing my curiosity with you.

First on the list is an item that is familiar to many nurses. A cigarette is a small cylinder of finely cut tobacco leaves rolled in thin paper for smoking. Most modern manufactured cigarettes are filtered, and include reconstituted tobacco with other additive additives.

The term cigarette, commonly refers to a tobacco cigarette, but can apply to similar devices of other substances, such as cannabis. A cigarette is distinguished from a cigar by its smaller size, use of processed leaf, and paper wrapping, which is normally white. It is also available in other colors and flavors. This is in contrast to Cigars, which are typically composed entirely of rolled whole-leaf tobacco.

Cigarettes carry serious health risks, which are more prevalent than with other tobacco products. Nicotine, the primary psychoactive chemical in tobacco and therefore cigarettes, is very addictive. Cigarettes produce an aerosol containing over 4,000 chemical compounds, including nicotine, carbon monoxide, acrolein, and other harmful substances. Over 50 of these substances are identified as carcinogenic.

Perhaps one of the oldest products is the Cigar. Discovered by Columbus on the island of Hispaniola, modern **Cigars** are composed of three types of tobacco leaves. These variations determine smoking and flavor characteristics of the product.

A cigarillo is a short, narrow cigar. Unlike cigarettes, cigarillos are wrapped in tobacco leaves or brown tobacco-based paper. Cigarillos are smaller than regular cigars but usually larger than cigarettes, thus similar in size and composition to small panatela sized cigars, cheroots and traditional blunts. **Cigarillos** are usually made without filters. They are meant to be puffed like a cigar and not inhaled.

A cigarillo contains about 3 grams of tobacco, the length varies from 3 to 4 in. (7 – 10 cm) and the diameter is about 6 to 9 mm, usually 8 mm. Comparatively, a cigarette contains less than 1 gram of tobacco and is about 3¼ in. (8 cm) in length and 8 mm in diameter. Modern cigarillos are machine-made, which is cheaper than hand-rolling.

Bidis (a chocolate cigarette) is often called “the poor man’s cigarette.”

The bidi is made from the flakes and dust of dark tobacco leaves. Strong flavoring, such as vanilla, licorice, strawberry, cinnamon, or clove, is added to mask the poor quality of the tobacco. This concoction is then hand-rolled in green or brown tobacco leaf by impoverished laborers in oppressive “factories.” The unfiltered final product is a small, slim cigarette, tied at both ends with a colorful thread.

The sweet-smelling smoke of bidis is more dangerous than cigarettes. Each bidi cigarette is loaded with cancer-causing, chromosome-damaging, genetic poisons, far more than are found in a regular cigarette. “The safe alternative” also contains two to three times the tar and nicotine of regular cigarettes. Bidi cigarettes contain more tar and carbon monoxide than regular cigarettes.

On February 21, 2014, the Food and Drug Administration (FDA) used its powers to stop a manufacturer from selling and distributing this specific tobacco product (CDC, 2016). The U.S. Food and Drug Administration ordered four brands of bidi cigarettes to be removed from the market because the manufacturers were not able (or were unwilling) to provide documentation that proves the products do not raise new or different health concerns for the general public.

Since they don’t have chemicals added in concentrations to help with combustion, smokers must draw on a bidi cigarette more often and with more force to keep it from going out. This results in higher levels of toxins breathed in than with traditional cigarettes. Smokers puff on a single bidi cigarette approximately 28 times as opposed to 9 puffs on a regular cigarette. People who smoke bidis increase their risk of oral cancer, lung cancer, stomach cancer, and esophageal cancer. The risk of heart disease and heart attack is three times higher for bidi smokers than nonsmokers. Bidi smoking is associated with emphysema and increases the risk of chronic bronchitis by four times. Young smokers are attracted to bidis because they are easier to obtain than traditional cigarettes, provide a “rush” of nicotine, are small and flavored and look like marijuana joints.

Clove cigarettes typically contain between 60 to 70 percent tobacco and 30 to 40 percent shredded cloves (a spice). Considering their tobacco content, clove cigarettes are probably as harmful and addictive as a regular cigarette. The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) of 2009 prohibits the sale of flavored cigarettes in the United States;

therefore, data on the use of kreteks and clove cigarettes are no longer collected (U.S. Food and Drug Administration, 2016).

Kreteks—sometimes referred to as clove cigarettes—are imported from Indonesia and typically contain a mixture of tobacco, cloves, and other additives. Bidis and Kreteks have higher concentrations of nicotine, tar, and carbon monoxide than conventional cigarettes sold in the United States. Kretek smoking is associated with an increased risk for acute lung injury (i.e., lung damage that can include a range of characteristics, such as decreased oxygen, fluid in the lungs, leakage from capillaries, and inflammation), especially among susceptible individuals with asthma or respiratory infections. Regular Kretek smokers have 13 to 20 times the risk for abnormal lung function (e.g., airflow obstruction).

Dipping tobacco is a type of finely ground or shredded, moistened smokeless tobacco product. It is commonly and idiomatically known by various terms—most often as dip and sometimes as rub. It is used by placing a lump, pinch, or “dip” of tobacco between the lip and the gum. The act of using it is called dipping. Typically, before dipping, the act of “packing” is performed, where the user places the “can” in between their thumb and middle finger, then flicks their index finger onto the lid of the can. Dip is colloquially called “chew”, “snuff”, “chaw”, “chow”, “daps”, “baccer”, “spit tobacco”, or “mouth tobacco”, among other terms; because of this, it is sometimes confused with other tobacco products—namely chewing tobacco or nasal/dry snuff.

Dipping tobacco evolved from the use of dry snuff in early American history. Up until the late 1700s, dry snuff was taken nasally, but then early Americans would take snuff orally by chewing the end of a twig until it resembled a brush, and then “dipping” the twig in the snuff and placing it in their mouths until the snuff dissolved. Using dry snuff orally eventually evolved into modern day moist snuff.

Chewing tobacco is a type of smokeless tobacco product consumed by placing a portion of the tobacco between the cheek and gum or upper lip teeth and chewing. Unlike dipping tobacco, it is not ground and must be manually crushed with the teeth to release flavor and nicotine. Unwanted juices are then expectorated (spat).

Chewing tobacco is typically manufactured as several varieties of product – most often as loose leaf (or scrap), pellets (tobacco “bites” or “bits”), and “plug” (a form of loose leaf tobacco condensed with a binding sweetener). Nearly all modern chewing tobaccos are produced via a process of leaf curing, cutting, fermentation and processing or sweetening. Historically, many American chewing tobacco brands (which were popular during the American Civil War era) were made with cigar clippings.

Snuff or Dip, this you put in your lip and you leave it there, this gives you your biggest buzz. Snus. This is the “indoor” smokeless. This comes in pouches and you put in your lip and you can swallow your spit hence its flavorful array.

Hookahs are water pipes that are used to smoke specially made tobacco that comes in different flavors, such as apple, mint, cherry, chocolate, coconut, licorice, cappuccino, and watermelon. Although many users think it is less harmful, hookah smoking has many of the same health risks as cigarette smoking. Hookah smoking is typically done in groups, with the same mouthpiece passed from person to person.

Paan is a preparation combining betel leaf with areca nut and sometimes also with tobacco. It is chewed for its stimulant and psychoactive effects. After chewing it is either spat out or swallowed. Paan has many variations. Slaked lime (chunnam) paste is commonly added to bind the leaves. Some South Asian preparations include katha paste or mukhwas to freshen the breath.

Gutka or Gutkha is a preparation of crushed areca nut, tobacco, catechu, paraffin wax, slaked lime and sweet or savory flavorings. It is manufactured in India and exported to a few other countries. A mild

stimulant, it is sold across India in small, individual-sized packets that cost between 2 and 10 rupees (around 3 to 15 cents) per packet. Gutka is consumed by placing a pinch of it between the gum and cheek and gently sucking and chewing. It is considered responsible for oral cancer and other severe negative health effects.

Zarda or Chewing Tobacco Perfume. This fragrance is formulated with the use of fresh quality of compounds by processing these under stringent methods. This Zarda or Chewing Tobacco Perfume fragrance is available in various varieties such as Musk 287 and Geranium. A form of tobacco abuse in rural north India, in which the tobacco is mixed with lime and kept between the lip and gum. It is more damaging than chewing tobacco, and causes serious gingival ulceration.

Pipe smoking is the practice of tasting (or, more uncommonly, inhaling) the smoke produced by burning a substance, most commonly tobacco, in a pipe. It is the oldest traditional form of smoking.

Electronic cigarettes (also called e-cigarettes or electronic nicotine delivery systems) are battery-operated devices designed to deliver nicotine with flavorings and other chemicals to users in vapor instead of smoke. They can be manufactured to resemble traditional tobacco cigarettes, cigars or pipes, or even everyday items like pens or USB memory sticks. Newer devices, such as those with fillable tanks, may appear different. While e-cigarettes are often promoted as safer alternatives to traditional cigarettes, which deliver nicotine by burning tobacco, little is actually known yet about the health risks of using these devices. This is because there is insufficient information that is available on these products.

In an effort to help protect the public from the dangers of tobacco use, the U.S. Food and Drug Administration (FDA) has established a new rule for e-cigarettes and their liquid solutions. Because e-cigarettes contain nicotine derived from tobacco, they are now subject to government regulation as tobacco products, including the requirement that both in-store and online purchasers be at least 18 years of age (U.S. Food and Drug Administration, 2016).

E-cigarettes are designed to simulate the act of tobacco smoking by producing an appealingly flavored aerosol that looks and feels like tobacco smoke and delivers nicotine but with less of the toxic chemicals produced by burning tobacco leaves. Because they deliver nicotine without burning tobacco, e-cigarettes appear as if they may be a safer, less toxic alternative to conventional cigarettes. Although they do not produce tobacco smoke, e-cigarettes still contain nicotine and other potentially harmful chemicals. Also, testing of some e-cigarette products found the vapor to contain known carcinogens and toxic chemicals (such as formaldehyde and acetaldehyde), as well as potentially toxic metal nanoparticles from the vaporizing mechanism. The health consequences of repeated exposure to these chemicals are not yet clear.

Another worry is the refillable cartridges used by some e-cigarettes. Users may expose themselves to potentially toxic levels of nicotine when refilling them. Cartridges could also be filled with substances other than nicotine, thus possibly serving as a new and potentially dangerous way to deliver other drugs.

I realize that some of the products are no longer sold in the United States. However, we have many international patients that come to our clinics and this is what they may be smoking. It never hurts to ask and have an accurate history.

References

- Centers for Disease Control and Prevention (CDC). (February 22, 2016). CDC Factsheet on Bidis and Kreteks. U.S. Department of Health and Human Services. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/bidis_kreteks/index.htm.
- U. S Food and Drug Administration (FDA). (August 7, 2016). Tobacco Control Act. Retrieved <http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm246129.htm>.
- U. S Food and Drug Administration (FDA). (May 5, 2016). FDA takes significant steps to protect Americans from dangers of tobacco through new regulation. Retrieved www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm499234.htm.

PUBLISH OR PERISH

Greg Laukhuf
VISION Editor

Writing is an extreme privilege, but it's also a gift. It's a gift to yourself and it's a gift of giving a story to someone.

– Amy Tan

My early training was in academia before I answered my calling to Nursing. As such, I came of age in an academic environment in which publishing was the expectation and the norm. The unwritten rule was "Publish or Perish". If you did not publish you would soon be without a job.

Thankfully, this is not the case in nursing today for most of us, but the need to publish or write about our experiences is needed to build the body of knowledge. This is especially true of Radiology nursing. ARIN provides several opportunities to publish. Vision is the easiest opportunity to gain experience in publishing. Below are guidelines for submission.

Vision Author Guidelines

Assists ARIN in communicating Radiology nursing contributions and relevance to the health of patients worldwide.

Benefits to you

- Communicate nurses' contributions to members of ARIN and others who access the organization's website
- Gain prestige of being published in a newsletter
- Add published article to curriculum vitae
- Receive recognition as an ARIN member

What you will do

- Submit manuscript to an editor by deadline
- Focus manuscript as directed by an editor
- Ensure accuracy of content

Your commitment

- Articles should be 700 or more words on topics related to Radiology Nursing
- Dependent on subject matter, length and author's writing experience
- Must be available to communicate with editor on a timely basis

Acceptance criteria

- Manuscript drafts are preferred
- Editor may ask that a recommended source write an article or may review unsolicited manuscripts for publishing consideration

How do I apply?

- Submit article to Greg.laukhuf@arinursing.org

Questions?

- Contact Greg Laukhuf RN, VISION Editor at Greg.laukhuf@arinursing.org or Liz Boulter at Liz.boulter@arinursing.org.

PANNUS RETENTION SYSTEM (PRS) AND NEPTUNE TOPICAL HEMOSTASIS PAD

Alyssa Luttner
TZM Medical Sales Specialist

When it comes to femoral access procedures, obtaining a clear access site in high BMI patients can be a difficult task. With the Pannus Retention System (PRS), you no longer have the uncertainty of having access site obstruction caused by excess skin tissue or body mass. Traditional tapes and adhesives can take multiple nurses up to 10 minutes to properly secure a patient in an optimal position for access. It has been well documented that the use of taping for surgical dressings and intraoperative positioning can cause blistering and incidences of skin breakdown. As these are hospital related complications, this risk is exaggerated in elderly, obese, malnourished, and diabetic patient populations, and can therefore lead to future costs for the hospital for treating these complications.

The PRS can be safely and securely applied to the patient in only 1 minute! This system maintains skin tissue integrity with its latex-free, hypoallergenic, adhesive backing that was designed specifically for skin contact to retain large masses of tissue. When retaining large amounts of tissue, the velcro straps can be adjusted after initial application to be sure optimal positioning is achieved. At the conclusion of the procedure when the straps are removed, the patient's skin will be left intact and residue free. In the initial 1,500 applications in orthopedic, neurosurgical, obstetrical and gynecological surgical cases, the PRS

had no reported adverse events or blistering, and is now being utilized in hospitals and surgery centers across the US.

Radiology skin integrity is of major importance in today's procedure rooms. The Neptune Topical Hemostasis Pad is another invention that can reduce complication risk in radiology patients, while accelerating clotting at the same time. The Neptune is a calcium alginate (Seaweed) based topical pad approved for hemostasis following sheath removal from arterial/vascular sites. The calcium ions are activated by contact of blood on the pad, and help to naturally speed up clot formation at the puncture site. Once hemostasis has been achieved, a clear Ad-Skin patch is used to cover the site for 24 hours. This device has been in use for over 20+ years, with no known allergic reactions or adverse events reported in the literature.

As the Centers for Medicare and Medicaid Services (CMS) is reducing payments for in-house hospital complications, it has become ever more critical to identify and prevent those complications before they occur. More information on these devices can be [found here](#).

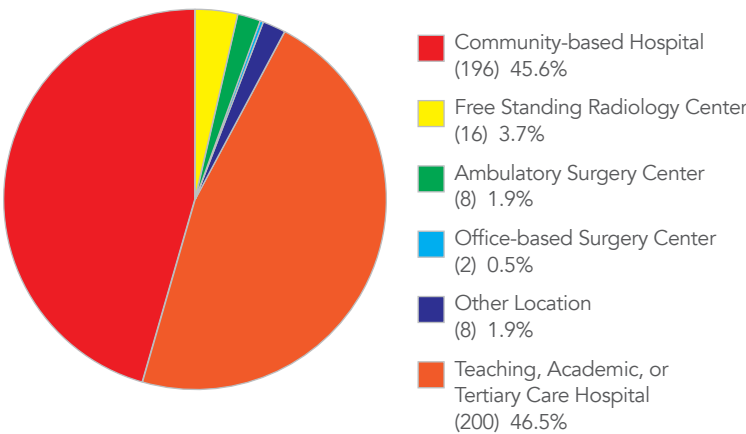
2015 ARIN CENSUS RESULTS
ARIN MEMBER RESPONSES

Total 598 responses from radiologic and imaging nurses.

73% Members (439)
27% Non-Members (159)

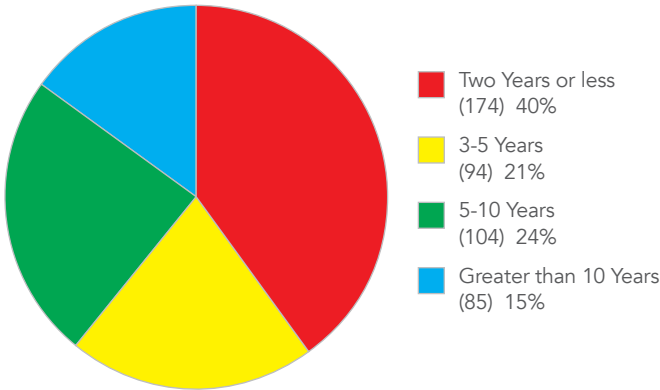
Other organizations that ARIN respondents belong	Percentage
American Nurses Association	16%
Sigma Theta Tau	13%
American Association for Critical Care Nurses	9%
Oncology Nurses Association	4%
Association for Vascular and Interventional Radiographers	3%

57% (248/437) members belong to other professional nursing organizations.



47% use social media daily.
17% said they never use social media.

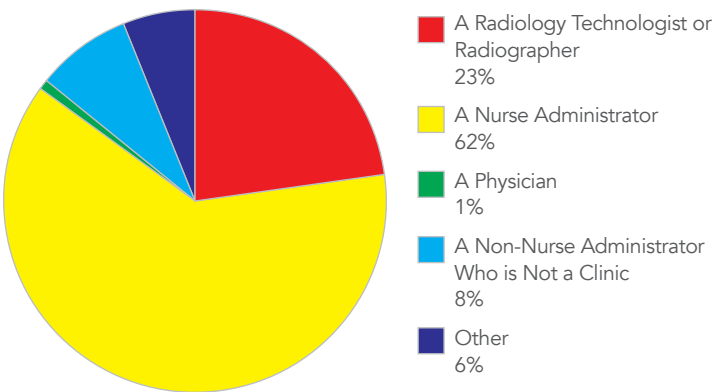
Most popular:
Facebook (71%), Pinterest (30%), LinkedIn (26%),
YouTube (21%) and Instagram (17%)



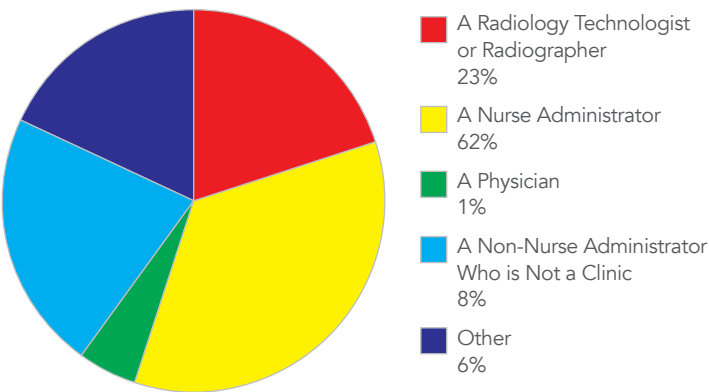
Area of practice	Percentage of respondents
Interventional Radiology	75%
CT	50%
Radiology Leadership	45%
MRI	37%
X-ray, Ultrasound, Mammography	30%
Nuclear Medicine	28%
Interventional Neuroradiology	18%
Pediatric Radiology	8%
Interventional Cardiology	6%
Neuroradiology	4%
Other	3%
Radiation Oncology	1%

The majority of the ARIN respondents were staff nurses (68%) followed by nurse administrators (16%), and advanced practice nurses (6%). Nurse educators, nurse navigators/patient care coordinators and other roles equally represented the remaining 10%.

Reporting Structure for those respondents who did not declare leadership position



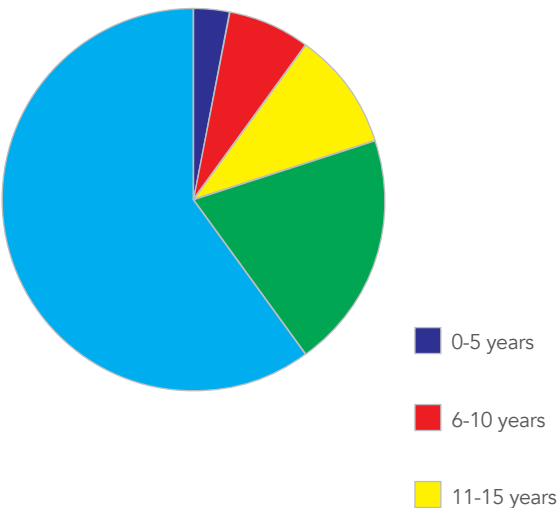
Nursing leadership reporting structure



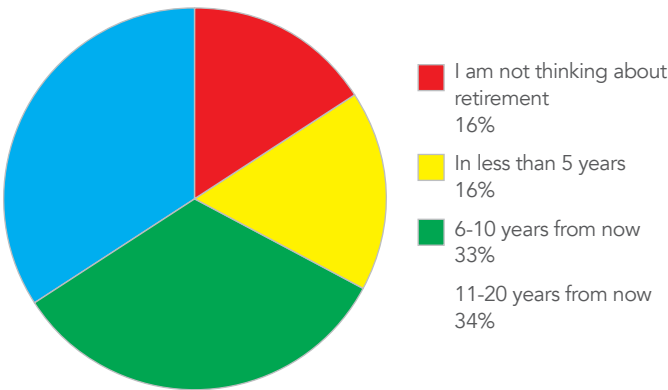
79% ARIN respondents said their annual nursing competencies were completed a nurse. Specifically, 52% were completed by a nurse leader, 11% by a radiology CNS or radiology nurse educator, and 16% by a nurse educator from another department.

Prior to your current job, what was your experience?	Percentage
Prior to your current job, what was your experience?	67%
I was a inpatient med-surg nurse	10%
I was a inpatient med-surg nurse	3%
I was a new graduate	1%
I was an advanced practice nurse in another setting	2%
I was an outpatient or office practice nurse	4%
I was an manager/administrator in another setting	4%
Other	9%

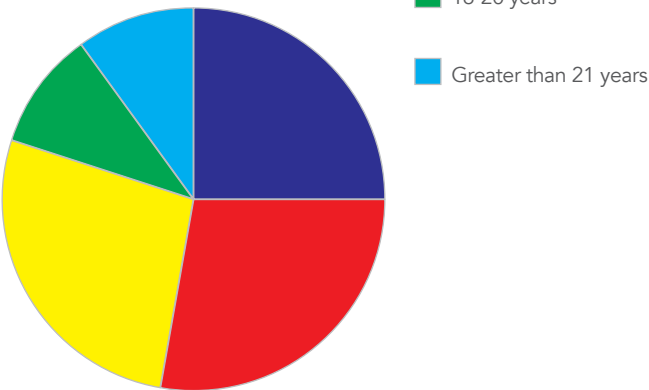
Years Nursing Experience



Plan For Retirement



Years Radiologic and Imaging Nursing Experience



2017 NOMINATIONS ARE OPEN!

Piera M. Cote Robson, MSN, CNS, NP,
AOCNS, ANP-BC, OCN, CRN
2016 Leadership Development Committee

The application for the 2017 nomination cycle have been posted. Please apply to become a member of the ARIN Board of Directors in 2017. ARIN becomes a stronger organization when qualified candidates join our dedicated team of leaders. Leadership offers an excellent opportunity to grow professionally as well as to develop a deeper understanding of national nursing opportunities.

Open positions for nominations include:

- President-Elect
- Secretary
- Director of Membership
- Two (2) Leadership Development Committee Member

Nominations are solicited, reviewed, and approved by the Leadership Development Committee. The final nomination slate is reviewed by the ARIN Board of Directors. Following the election, Officers and Leadership Development Committee members will begin their term at the Annual ARIN Convention in April 2017. Please [refer here](#) for application criteria.

Any questions or concerns may be directed to:

Piera M. Cote Robson, MSN, CNS, NP,
AOCNS, ANP-BC, OCN, CRN
Director of Leadership
Piera.robson@arinursing.org

Application deadline:
September 1, 2016

CORRECTION

In the last edition of Vision, Patricia McCarthy was incorrectly identified as Patricia McCarthy BSN, RN, CRN. Her correct title is Patricia McCarthy BSN, RN.



I AM A RADIOLOGY NURSE!

John Shrewsbury RN, is a busy Radiology Nurse in University Hospitals Case Medical Center System, full time Paramedic, and Board member of the Ohio Radiological Nurses Association. He is a new ARIN member.

Why did you become a nurse?

My first career was a paramedic and firefighter. I had always wanted to get my bachelor's degree so I chose nursing because I thought it would complement the paramedic skills that I already acquired. I have always enjoyed patient care outside the hospital setting and decided to continue that care inside the hospital. I looked at Physician Assistant (PA) programs however they were very limited at that time and only the Veteran's Administration Hospitals were using PAs at that time. With nursing, I could go anywhere and have many choices of hospital systems and disciplines. In this period of my life, I was also considering applying to a nurse anesthetist program.

What about nursing makes you happy?

Helping people through some of the most difficult times of their lives.

What has been the most amazing experience you have had as a radiology nurse?

When one of our IR fellows, used a new device called the Solitaire and pulled a large clot out of a vessel in the brain during an emergency stroke intervention and the patient regained full use of his right arm and leg.

What are the challenges you encounter and how do you overcome them?

I've experienced many challenges especially being involved in the opening of a pre and post area in radiology. If it wasn't for teamwork and collaboration with my colleagues, the opening would not worked out so smoothly.

Have you experienced anything extraordinary in your career?

Yes, on two occasions. The first was a gentleman from Turkey who ended up on ECMO for a week with every presser known after a complicated cardiac surgery. A year later, he walked into the unit and thanked everyone for their hard work. The other extraordinary event I experienced, was that I took care of the brother-in-law to the king of Saudi Arabia and then became his private nurse for two months. In that time, I learned their culture as they treated me as a relative and included me in all meals and any event that they had. Their Ethiopian cooks taught me a few of their special recipes. His grandchildren flew in from all over the United States to visit and shared with me their family stories. One granddaughter even attempted to teach me the Arabic language. The day before he was going to return, his family asked if I would accompany them back to Switzerland for a few months, until the cool season in Saudi Arabia. I stayed with them for two to four months more. I had to decline the Switzerland offer as I did not have a passport at that time.

What has your nursing journey been like?

Diversity is one of the greatest things about nursing, there are so many different areas to learn and work in. Nursing has so many areas that are interlinked. I started off in adult cardiothoracic intensive care unit then moved to pediatric cardiothoracic intensive care unit and I have worked in two different emergency departments. I utilized the information I learned to become a pharmaceutical sales representative and eventually moved into radiology sales. Currently, I am an interventional radiology nurse. The journey couldn't have been better! The best part it's not over yet.

At the end of a busy day, how do you find balance in your life?

The best way I found to decompress after a busy day at work is to take a little time for myself. A leisurely walk in the evening sun or stop by my favorite cafe to listening to relaxing music and then talking with family and friends help me to refocus. Occasionally, I'll head over to the football field and watch the college team practice.

How has ARIN played a role in your career?

I'm actually a new member of ARIN. I haven't been able to take advantage of some of the benefits that it has to offer. I do receive the Journal of Radiology Nursing and Vision newsletter online which I'm look forward to reading. I am also looking forward to attending annual conferences and attending the online webinars that are offered. I believe this will expand my knowledge base and forge relationships throughout United States.

"I Am a Radiology Nurse" features unique Radiology Nurses in everyday practice. To be featured in this column, contact Liz.boulter@arinursing.org

ARIN BOARD OF DIRECTORS 2016-2017



President

Evelyn P. Wempe, ARNP, MBA, MSN, ACNP-BC, AOCNP, CRN



President-Elect

Katherine Duncan, BA, RN, CRN
Staff/Clinical Nurse III



Immediate Past President

Mary Sousa, BSN, RN



Treasurer

Christine Keough, BSN, RN, CRN



Secretary

Kristy L. Reese, BSN, RN



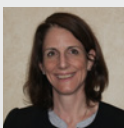
Director of Membership

Jim LaForge, MSN, BSN, RN, CRN



Director of Education

DeAnn McNamara, MS, ACNP-BC, CRN



Director of Leadership

Piera Robson, MSN, CNS, NP, AOCNS, ANP-BC, OCN