RTs can share management decisions

Follow one hospital’s example of sharing authority as an effective retention and quality improvement tool

As a department manager, you’ve likely spent your whole career climbing up the ladder to get where you are today. An effective way to manage from this level is to cede some of your authority to your staff.

That’s how the respiratory staff at Texas Children’s Hospital in Houston work. The department created what it calls a “feedback loop” to accomplish goals that managers sometimes find difficult, including the following:

- Improving work processes
- Improving safety
- Reducing the use of expensive therapists from outside agencies to cover shifts

“We have good people, and our goal was [to determine] what we can do to make it easier to do their jobs better,” says Susan Iniguez, RRT-NPS, staff therapist at Texas Children’s Hospital. “It goes beyond sending out a survey and asking [staff] what they need.”

How it began

Several years ago, Texas Children’s found communication in

In this era of ever-tightening hospital equipment budgets, the stethoscope remains an enigma. This simple device can cost a few dollars for the disposable models used in isolation rooms or up to several hundred dollars for the “Cadillac” models.

Multiply that by a staff of more than 100 RTs, and it can get to be an expensive tool of the trade, begging the question: How much stethoscope does an RT need, and how much should departments budget for them?

That’s one of the many things that Jonathan Waugh, RRT, PhD, a professor at the University of Alabama-Birmingham, and colleagues including Dale Callahan, PhD, audio expert and fellow professor, attempted to find out in a 2005 study that evaluated 38 different stethoscope models.

Ironically, with all of today’s high-tech analysis equipment, this low-tech instrument doesn’t come with a set of standard benchmarks; each company does it differently.
the respiratory department to be a little disconnected after the staff expanded to 127 full-time equivalent RTs because of the hospital’s growth, Iniguez says.

A change of department head, combined with new construction that scattered RTs throughout several floors of several buildings, contributed to the problem.

“In order to get back toward an integrated group where everyone is going in the same direction, we started with a focus group,” says Iniguez, who chaired the initiative. The group would represent RTs to management, offering a conduit for them to express their concerns about problems happening on their shifts as well as offer suggestions to improve patient outcomes and make work safer and more efficient.

In seeking volunteers for the focus group, Iniguez says she got lucky: A few from each unit (e.g., the pediatric and neonatal intensive care unit, emergency room, and the step-down unit) came forward, leaving no group of RTs unrepresented—a tall order in a hospital that has such a large scope of practice, including specialties such as asthma education.

Immediate improvements
The focus group at Texas Children’s Hospital first met to determine its scope of work. From those ideas, the group members created a survey for the entire RT staff to identify areas of concern that they wanted addressed. After the survey responses were collected and results were tabulated, the group devised an action plan to address their questions.

First, staff brought concerns to the focus group that they wanted the department director to address. The following list highlights some of the improvements that resulted from the discussions:

- Managers expanded their visibility among staff therapists by making rounds in the department and hearing their concerns one-on-one.
- The department reallocated its equipment stored in Omnicells on each floor so RTs didn’t have to grab gear from several different locations to do their jobs. This reorganization was done with direct feedback from the RTs performing the work.
- Agency fill-ins were reduced after adjustments were made to the schedule to maximize staff availability and utilization.

Part of the program’s success in drawing out such effective ideas is due to how promptly the hospital responded to the initial suggestions offered by the RTs, Iniguez says.

“Don’t just take information and never get back to [the RTs],” she says. “Listen, and follow up.”

Shift incentives
Another idea that came out of the focus groups included soliciting an extra shift per month or two-week pay period from interested therapists, with the goal of eliminating the extra pay and orientation/training hassle of bringing in agency therapists to fill in.

The leadership committee agreed to the plan, and the RT group leaders drew up a contract between administration and the RTs who volunteered for the program. It was a two-way deal: The RTs agreed to take the
same penalties for calling in sick for the extra shifts as they would for regular shifts, and administrators agreed to honor the extra shifts and not cancel them.

A total of 34 RTs signed up for the plan, the majority agreeing to one extra 12-hour shift per two-week pay period. Although the patient population fluctuated during the program’s pilot period of November 2004–February 2005, the plan enabled managers to maintain coverage.

The cooperative effort—and ensuing goodwill built up between administration and staff—paid dividends.

When the patient population remained elevated toward the plan’s expiration, all 34 volunteers agreed to add an extra month to their commitments.

Measurable results
As of late 2005, the program’s measurable results included the following:

- Greater employee satisfaction (per survey results)
- Halving the need for agency therapists with the extra-shift plan
- Lower expenditures on agency therapists by more than $150,000 in fiscal year 2005

Now that the feedback loop picked the low-hanging fruit and made some obvious improvements, the staff will tackle deeper quality improvement issues and measure that progress.

Many of the changes made have been small in scope but have reaped large rewards in terms of staff satisfaction, Iniguez says. As the respiratory department continues to grow, Iniguez says she believes that the department will be better equipped to handle it and keep up with changes in the field.

“Our focus group has sort of segued into a practice council,” she says. “Once we got the housework taken care of, [we were] able to improve patient care.”

Tips for trying management sharing

Perhaps you’re not ready to share management tasks with your staff by implementing a formal project and installing measurement tools as Texas Children’s Hospital in Houston did. However, Susan Iniguez, RRT-NPS, staff therapist at Texas Children’s, says managers can still stick their toes in the pool, so to speak, by trying the following:

- **Set up a feedback loop of some kind.** Give your RTs a channel with which to communicate to management and administration. At Texas Children’s, a manager would take questions that he or she couldn’t answer to someone higher up who could.

- **Make suggestion forms anonymous.** You’ll get better, more candid responses that way. Texas Children’s posted forms on its Web site, enabling RTs to print and fill them out at home.

- **Check out the book** *Hardwiring Excellence: Purpose, Worthwhile Work, Making a Difference* by Quint Studer, a past hospital president, for suggestions about developing manager’s rounds with an eye toward improving your department’s care as well as learning how to better lead staff and address their needs.

- **Seek input from a good cross-section of RTs;** younger RTs’ energy and lack of cynicism can spur more experienced but jaded RTs to voice important opinions.

Lastly, this can’t be a program that runs itself—you, the manager, need to participate directly and follow up even when a suggestion can’t be used. Participation on your part will stimulate participation on the part of staff RTs.

“The thing that made it successful [at Texas Children’s] is that our director sat in on the [focus group] meetings,” Iniguez says. “So when we brought issues to the table, he could at that point say, ‘Yes, we can correct that’ or ‘No, we can’t,’ so we had immediate feedback going back to the staff. If it was something he could change then, he did.”
**Stethoscopes**

“There is no objective standard for testing stethoscopes,” Waugh says. “Every stethoscope manufacturer has its own proprietary method of measurement, and [it] won’t reveal that. It’s basically a black box—[the manufacturer] will demonstrate it for you but won’t let you keep it and duplicate it.”

Although that might be advantageous for the manufacturers whose testing systems highlight the strengths of their products, it makes it difficult to compare the various models. As a result, respiratory managers often find it difficult to figure out whether spending more money on a particular stethoscope would net significantly better performance.

**Setting it up**

To compare stethoscopes objectively, the researchers set up an echo chamber free of outside noise and simulated a broad band of pink noise, which is a variation of the white noise that one might hear when a television station isn’t tuned in.

The pink noise sounds cover the same frequencies healthcare workers cover when listening to heartbeats (low noises) and lungs (higher sounds). Measurements of what came through the earpieces were then taken.

After setting up the lab, Waugh and colleagues requested four of each of the 38 stethoscopes that manufacturers submitted for the study and tested each one four times so each model would be represented by 16 tests to correct for inconsistencies. The better a stethoscope recreated the pink noise in its earpieces, the better score it earned.

Although the soundproof room and bench testing didn’t exactly mimic the sometimes chaotic, noisy backdrop of a clinical setting, it had to be set up that way to make it as objective as possible, Callahan says.

“We wanted the only variable to be the actual performance of the stethoscope,” he says.

For purposes of grouping the stethoscopes in roughly the same way they’re sold, they divided the models into five categories: high cardiology, cardiology, physical assessment, basic assessment, and disposable.

**What they learned**

As with a lot of hospital gear, it turns out that the most expensive stethoscopes didn’t necessarily show three times the performance as the less-expensive models that cost one-third as much.

Further, scopes with two-sided chest pieces—one side bell, one side diaphragm—sometimes performed well on one side but didn’t necessarily on the other.

In fact, the only consistent finding was that disposable scopes were inferior to nondisposable models because they just don’t pick up as much sound as the others. After that, buyers can’t rely on marketing classifications or price to guide them in buying scopes, Waugh says.

“What we expected was that the better, higher-end scopes would have a better response than the cheap scopes,” Callahan says. “There was no statistical difference between the five different categories except for the disposables, which was significantly worse than the other categories.”

For RTs, this means that if you’re not buying the most expensive stethoscopes, you’re probably not missing out on any additional performance that the Cadillac models supposedly provide because RTs don’t listen to the lowest frequencies as closely as cardiologists do.

Wheezes and breathing noises cover the mid to high range, so paying more for a scope that covers the low range well isn’t necessary for RTs, Callahan says.
However, Waugh is quick to note that it’s also important to introduce a human element to the testing. He concluded that his study’s results need to be compared against that of experienced auscultators (i.e., professional stethoscope listeners) in a clinical setting.

**Tips for buying yours**

Waugh and Callahan’s work offers plenty of information to help managers evaluate stethoscopes, including the following purchasing tips:

- **You get what you pay for at the low end.** The disposables are tough to use and don’t offer much performance. Waugh recommends that RTs spend a little more and use stethoscopes with replaceable earpieces and other parts, which the manufacturers typically replace at no cost.

- **Spend at least $50–$100 on a stethoscope.** Although they can be purchased for less and some of the cheaper ones can keep pace performance-wise with their more expensive competitors, when a piece breaks off or an RT accidentally wedges the chest piece in a tight place (e.g., a bed frame), they often can’t be salvaged. More expensive ones last longer because they can take rougher handling.

- **Check the fit of the earpieces.** If a $300 stethoscope fits badly, its statistical performance means little because the user won’t hear everything coming through the earpieces. Make sure that the earpieces fit comfortably, otherwise the RT will constantly move it around, probably out of optimal position, eventually causing irritation in the ears, Waugh says. It’s a good fit when you put on a stethoscope’s earpieces and almost all of the other noise in the room disappears, as if you just plugged your ears.

- **Don’t feel compelled to buy the Cadillacs.** “It’s the Mercedes syndrome,” Waugh says. “If you spend the money on a Mercedes, you come to believe it’s worth the money you spent because you’ll feel sick if it isn’t. . . . and say, ‘Oh, my gosh, I just wasted $300 on a stethoscope.’ ”

In the end, cardiologists and pulmonologists probably need the best-performing stethoscopes because they listen to all of the sounds of a patient’s chest, from the lowest to the highest frequencies.

“You can’t just look at labeling and trust it to mean a stethoscope will perform at the expected level,” Waugh says. “Looking at statistical difference in the scores, there’s quite a number that were no different from the scopes with the best performance. You have quite a number to pick from, and there’s quite a variation in price.”

**Help your RTs listen**

Stethoscope study authors Jonathan Waugh, RRT, PhD, professor at the University of Alabama-Birmingham, and Dale Callahan, PhD, audio expert and fellow professor, offer the tips below to help RTs listen better.

To ensure good auscultations, minimize the ambient noise in a patient’s room. In addition, follow these simple strategies to upgrade the work your stethoscopes do:

- Turn off the television or radio a patient might have on
- Eliminate the noise of any extra machines that might be running
- Tell coworkers to be quiet for a moment
- Put the stethoscope directly on the skin; don’t listen through a patient’s clothing

“People are ignoring a lot of the more important, basic stuff that may keep them from appreciating the benefits of their scope,” Waugh says.

Questions? Comments? Ideas?

Contact Managing Editor Janet Spiegel

Telephone: 781/639-1872, Ext. 3801  E-mail: jspiegel@hcpro.com

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.
Editor’s note: Kurt A. Patton, MS, RPh, served as executive director of accreditation services at the JCAHO for more than seven years until his retirement in December 2005. In that role, he worked with all types of accredited organizations seeking to be resurveyed and new organizations seeking to become accredited. He is now principal of Patton Healthcare Consulting, LLC, in Glendale, AZ, is the author of an upcoming book, and will speak during an upcoming HCPro audioconference about handoff communication.

RCM: What are the three most important things on which managers should focus right now to enhance JCAHO compliance?

KP: First, we need to remember that the accreditation process has changed. We can no longer rely on our skill to write good policies and procedures and think that we will be successful during survey. The JCAHO now focuses entirely on execution and goes to the paperwork only when inconsistencies are identified. Writing good policies and procedures that are not implemented can actually do more harm than good in the new process.

Second, we need to use the self-assessment process—or the periodic performance review (PPR)—more effectively. We can’t sit in an office and view the task of conducting the PPR as one person’s job or a paperwork exercise.

We need to identify techniques for getting out to the units, conducting tracers, and learning exactly how our staff serve patients and whether their techniques are compliant with the standards. The more thorough we can become at assessing our compliance, the more successful we will be on surveys. More important, the care we provide will be safer.

Third, we must read about midstream changes that are announced by the JCAHO. The accreditation standards are not static. They and the survey process change all the time. Given the advent of unannounced surveys, you cannot plan to gear up or implement change every third year. You must be ready at any point in time for the survey.

RCM: On which top three things should JCAHO coordinators expect to focus next year and why?

KP: Two issues of which we are currently aware—the Life Safety Code® (LSC) and National Patient Safety Goals—will continue to be areas of focus. These are important areas of emphasis because they both involve building, fire, and clinical safety.
By 2007, I believe that we may also see increased emphasis on the roles of leadership, medical staff, and governance. The JCAHO has been developing new leadership standards for more than a year now. The Leadership Accountabilities Task Force raised many important issues that are reflected in proposed new standards. I would advise JCAHO coordinators to keep track of these standards as they go through the last stages of the development process.

**RCM**: Do you have any tips for preparing for an unannounced survey?

**KP**: The best advice I can give is not to prepare for a survey at all. Prepare to implement consensus standards and safety goals developed by your peers because they can improve quality and safety. Then, after implementing these standards, rigorously assess and reassess your level of compliance and focus training where it is needed and you will be ready if the JCAHO shows up.

In addition, there are two important things survey coordinators must do to keep their organizations ready. They must keep up with changes announced by the JCAHO and have a leadership backup plan should the unannounced survey begin while a key leader is on vacation. All leaders should have backups who know that they must speak for their colleague and know their colleague’s area so they can address any potential survey questions.

**RCM**: What is the JCAHO’s internal report card on the life safety surveyors?

**KP**: The addition of the LSC specialists a year ago, along with the enhanced training developed by the American Society for Healthcare Engineers for the JCAHO, has been a major success.

The JCAHO and Centers for Medicare & Medicaid Services had been seeing a drop in consistency between JCAHO survey findings and state validation survey findings. The sole area of that drop was LSC. When the JCAHO hired the first class of LSC specialists, they were already experts in this area.

The results are that the large hospital surveys that included LSC specialists did have more requirements for improvement (RFI) at EC.5.20 in 2005. In addition, there was also a slight increase in the number of RFIs for EC.5.20 in smaller organizations because of the enhanced training of all of the surveyors. I have not seen aggregate data for 2006, but I believe that this trend is continuing as the regular surveyor cadre becomes more expert due to their direct participation with the LSC specialists on team surveys.

The careful review of hospitals’ plans for improvement has also identified some communication gaps in our hospitals as repairs and renovation deadlines have lapsed, seemingly without awareness by hospital leadership. These incomplete plans demonstrate a lack of follow-up on required safety issues.

**RCM**: Are surveyors writing more RFIs in general because of external pressure that JCAHO accreditation is “easy” or “rubber-stamped”?

**KP**: The government never said the accreditation process was too easy. It had been identified that the JCAHO’s process did not consistently identify LSC deficiencies, but that was corrected by the enhanced training and addition of the LSC specialists. There was a high degree of consistency between the federal validation surveys and JCAHO surveys in clinical performance areas. We are seeing more RFIs because the surveyors are becoming better at using the tracer technique. Tracers explore exactly what was done for a specific patient. A modern hospital has hundreds of policies, forms, and performance expectations for its staff, and the tracer technique helps uncover flaws in its processes. When the new survey process was being developed, JCAHO staff envisioned two distinct possibilities for the future: either the PPR was going to create an environment in which hospitals were more compliant and the number of RFIs would dwindle down to almost nothing over time, or the tracer technique would be so effective that the number of RFIs would continue to rise over time.

Currently, it appears that the latter view is more accurate. However, if hospitals take the PPR seriously, we might see the number of RFIs begin to drop.
As discussions continue among healthcare professionals and regulators about whether influenza vaccinations should be mandatory, the Centers for Disease Control and Prevention (CDC) has reinvigorated efforts to encourage hospitals to immunize all workers (see “JCAHO mulls flu-shot standard for infection control” on p. 12 for more information).

The accreditor has highlighted earlier recommendations meant to assist healthcare facilities in developing successful immunization programs that reach more staff to help thwart the spread of flu viruses to patients and colleagues.

As the industry and government put their heads together on what’s reasonable to require of hospital workers, respiratory care managers wrestle with how to keep influenza rates among staff low while staff therapists work the hospital’s infection-control front lines.

One of the hotspots for the mandatory flu vaccination debate is the Virginia Mason Medical Center in Seattle. With the intent of preventing deaths among patients from influenza, the hospital instituted a policy in 2004 that requires all staff to be immunized as a condition of employment.

Although the facility employs about 5,000 people, the Washington State Nurses Association (WSNA), which represents about 600 nurses employed at Virginia Mason, opposed the policy and took the hospital to court over the issue.

Months of legal arguments came to a head in January, when an arbitrator ruled in favor of the WSNA and exempted nurses from the flu-shot requirement. However, the hospital has filed an appeal seeking to vacate that decision.

**Good while it lasted**

Virginia Mason’s policy resulted in nearly 100% immunization among employees who were unassociated with the union, and most nurses who belong to the WSNA have also received flu shots.

“We have always encouraged and will continue to encourage nurses to get the vaccination,” says Anne Tan Piazza, spokesperson for the WSNA. “We do not believe it should be a condition of employment. Education and encouragement are the most effective methods when it comes to registered nurses getting vaccinated.”

The CDC has long been concerned about low flu vaccination rates among hospital staff. “Despite the fact that annual flu vaccinations have been recommended for many years, only about 40% of healthcare workers get annual flu shots—[fewer than one in two],” says Michele Pearson, chief of the prevention and evaluation branch of the CDC’s Division of Healthcare Quality Promotion.

“The [purpose of the] recommendation coming out now is really to give a more focused attention to the issue,” Pearson says. “The healthcare worker can be an important vector in the chain of transmission of flu in the healthcare setting by transmitting to coworkers or to patients.”

**Inspire staffers to volunteer**

Healthcare facilities need to improve vaccination acceptance among their workers, Pearson says. The CDC
recommends educating hospital staff about the benefits of vaccinations, particularly when workers are afraid of needles or believe that flu vaccinations aren’t effective.

It was education that helped Virginia Mason reach its goals, says Joyce Lammert, deputy chief of medicine at the hospital. “The literature was very clear to us that if healthcare professionals are immunized, they can save lives,” Lammert says. The campaign involved several education forums, including one session during which a national expert on vaccines from the Mayo Clinic in Rochester, MN, spoke to hospital staff.

Before the policy took effect, about 58% of Virginia Mason’s staff had been immunized for influenza, which is above the national trends reported by the CDC.

**Don’t charge employees for shots**

Research shows that cost has been a barrier for some staff to receive flu shots, and for that reason, the CDC supports free vaccinations for healthcare workers.

Virginia Mason offered free shots to all staff, says spokesperson Kim Davis. “Our organizational leadership was behind this effort 100%. The organization planned ahead for this cost allocation because it was directly linked to our organizational priorities, [namely] patient safety.”

Virginia Mason also ensured that all employees had access to the vaccinations regardless of their location, Lammert says.

**Other enticements**

Virginia Mason undertook the following efforts to introduce and promote its flu vaccination campaign:

- **Focus groups**—The hospital held these meetings with staff to determine what type of education was necessary to promote the vaccine policy. Virginia Mason compiled a list of needs and designed its campaign on what managers heard from workers.

- **Staff queries**—The facility ran question-and-answer sessions for staff to discuss the vaccine.

- **Tailgate party**—The hospital recruited football players from the Seattle Seahawks to attend a party with staff in support of 100% immunization. The Seahawks require their players to be immunized.

- **Slogan contest**—Virginia Mason held a contest for staff to create a slogan to remind staff about flu shots. “Virginia Mason saves lives, immunize” was the winning slogan.

- **Blue bracelets**—Immunized staff received blue bracelets that had the winning slogan on them.

- **Screen savers**—Hospital computer screen savers helped relate the importance of flu vaccination to patient safety.

- **Flu cart**—Nurses went to various hospital units with a cart filled with vaccines to immunize staff.

The CDC supports the idea of flu carts to reach workers who can’t find time to go to a central location for the vaccine. In addition, hospitals should designate peer vaccinators (i.e., staff within each unit who are trained to vaccinate colleagues), Pearson says.

**Get patients on the bandwagon**

Virginia Mason didn’t stop at employee vaccinations. To reach out to visitors and patients, the hospital placed signs at every entrance requesting that visitors who weren’t immunized wear masks, which it provided in nearby kiosks. The hospital also encouraged patient awareness by providing drive-through vaccination sites—not surprising in a city known for drive-through coffee shops.

Hospitals should monitor the success of their vaccination programs, the CDC recommends. “[Focus on] not only vaccination coverage, but how many you’ve reached and offered the vaccine to, how many decline and why, and understanding why people refuse the vaccine,” Pearson says.

Monitoring systems allow hospitals to determine whether certain areas of the hospital or specific employee groups point to low vaccination rates.

**Shots may improve the bottom line**

Beyond patient and staff health, flu shots are also good business, Pearson says. “Giving vaccine to the work force is good for the institution as well,” she says. “There is a decrease in secondary healthcare costs and lost workdays that go along with workers who develop influenza. So it’s a win-win for patients and the healthcare work force” if most or all staff receive flu shots. ■
Sleep apnea patients more likely to have irregular heartbeats

According to a study in the April 15 American Journal of Respiratory and Critical Care Medicine, people with sleep-related breathing disorders carry a high risk of complex, abnormal heart rhythms while in slumber. Researcher Reena Mehra, MD, MS, of University Hospitals of Cleveland at Case Western Reserve University and seven associates compared the prevalence of arrhythmias in 228 patients with sleep-disordered breathing and a control group of 338 patients with no sleep disorder. Because sleep disorders such as apnea involve slowing down the oxygen supply to the heart, they can cause atrial fibrillation and tachycardia, researchers said.

“Consistent with the study design, no sex or race differences were observed between groups,” said Mehra in the Journal. “However, the sleep-disorder breathing group was modestly older and had a higher body mass index than the control patients.”

Researchers hope trial will lead to asthma vaccine

A multicontinent study including 200 nonasthmatic children in New York and Perth and Melbourne, Australia, aims to design a possible asthma vaccine. Researchers from the Telethon Institute for Child Health Research in Perth told Australian newspaper Age that the study involves administering drops of allergens orally to children, similar to allergy desensitization therapy currently in use.

Children targeted for the asthma study show a genetic predisposition for the disease, but have not yet shown symptoms. Eventually, researchers will recruit children in Germany and Sweden to join the study, which will include five-year follow-ups, Telethon spokespeople said in the April 3 Age.

New Hampshire tops in asthma prevalence

Although urban centers might have their pockets of asthma prevalence, New Hampshire—a largely rural state of mountains and woods—tops the nation in overall asthma occurrence, reported an April 9 Portsmouth Herald story. According to figures from the New England Asthma Regional Council (ARC) public-private coalition of asthma groups, 10.9% of the state’s adult inhabitants indicated on a survey that they currently have asthma or have suffered from the condition at one point in their lives.

“We’re the tail pipe of New England,” said Jeffrey Salloway, an epidemiologist at the University of New Hampshire in the Herald story about the ARC report, citing acid rain, power plant emissions, and greenhouse gases from traffic as the culprits causing so many asthma cases in the state. “We have probably the worst air in the country.”

Harvard report outlines bird flu defenses

What should you tell your patients who are worried about the H5N1 bird flu virus? The Harvard Medical School’s report Bird Flu: How to understand your risk and protect your health gives consumers information about how the virus spreads and strategies for personal protection, including what to do if a pandemic hits their community, how to prepare poultry in the kitchen to avoid getting sick, and other direction from U.S. government health authorities. Specific tips include the following:

- Don’t touch injured or dead wild birds, and be careful not to step in bird droppings, pick up feathers, or handle them in any way
- Wash your hands thoroughly after handling bird-baths and bird feeders, and in general, wash your hands frequently
- On public transportation, loop your arm around a pole or strap rather than holding it with your hand to increase your odds of avoiding human-to-human spread of the virus.

Download the report for $16 at www.health.harvard.edu/special_health_reports/Bird_Flu.htm.

DMF 10 antibody may hold key to lung cancer

An antibody dubbed “DMF 10” could lead to a lung-cancer killing therapy, said researchers at the University of Massachusetts Medical School in Worcester in a press release. So far, the antibody has been tested and
shown promise in animals, and the researchers plan to take the next step and prepare a therapy for human testing. Research so far shows that the antibody works by binding to the surface of tumor cells and initiating apoptosis, an internal cellular mechanism that causes the cancer cells to self-destruct without affecting healthy tissue. Although DMF 10 might also work against other cancers, it has shown to be most effective against lung cancer thus far.

“There are several important steps ahead of us to evaluate the antibody’s efficacy in people,” said Kenneth L. Rock, MD, professor at the school, in the press release. “However, at this time, given what we understand about antibody therapies, this candidate looks very hopeful.”

**Pneumococcal disease down among infants—even those not vaccinated**

Invasive pneumococcal disease (IPD) is down among infants—even those too young for vaccination, reported the April 12 *Journal of the American Medical Association*. A study led by Katherine A. Poehling, MD, MPH, of Vanderbilt University School of Medicine in Nashville, TN, showed that in the nine years since the IPD vaccine was introduced for children two to 23 months old, the disease is also down in the overall population.

Specifically, among all study infants aged zero to 90 days, the average rate of IPD decreased significantly from 11.8 per 100,000 live births in the prevaccine years to 7.2 per 100,000 live births in the postvaccine years. The vaccination seems to have helped black infants especially, said the *Journal*.

Among them, average IPD rates decreased from 17.1 per 100,000 live births during the prevaccine years to 5.3 per 100,000 live births during the postvaccine years. Among white infants, average IPD rates decreased, but not significantly.

**Antibiotic might hold promise for asthma**

Telithromycin, a Sanofi-Aventis antibiotic marketed under the name Ketek, may turn out to be a treatment for viral-induced acute asthma, according to a study published in the April 12 *New England Journal of Medicine*.

The study, conducted jointly by the Imperial College London, the University of Milan, the University of Auckland, the National Jewish Medical and Research Center, G.R. Micro, Ltd., and Sanofi-Aventis, showed that when administered within 24 hours of viral asthma flare-ups, the medication helped eradicate bacteria that sometimes worsen asthma symptoms in these cases. It worked twice as well as a placebo in reducing recovery time and improving lung function for study patients, according to the *Journal of Medicine*.

**Lungs have their own immune defense**

Researchers documented the first organ-specific immune defense system, and it’s in the lungs. The lungs’ innate immune response is probably evolved in humans to minimize collateral damage to lung tissue caused by unchecked inflammation, theorizes University of California, San Diego (UCSD) School of Medicine Professor and study coauthor Eyal Raz, MD. The discovery could lead to new treatments for asthma, flu strains that affect the respiratory tract, or even inhaled bioterror agents, the authors said in the April 18 *Immunity*, the UCSD School of Medicine study.

The defense system works through the lungs’ alveola, which are the air sacs in the lung where exchanges of gases between the respiratory and circulatory systems take place. They are protected from invading microbes by the alveolar macrophage, white blood cells associated with immune responses throughout the body. The lungs appear to be able to activate or “put to sleep” the immune response, according to *Immunity*.

**Snoring could be passed down through parents**

Children with a parent who frequently snores have a three-fold risk of habitual snoring, supporting the theory that hereditary factors contribute to the development of snoring, according to a study of 681 children in the April *Chest*.

Although snoring itself doesn’t mean that a child has a sleep disorder, it could point to such problems in some. About 100 of the children in the study and 20% of their mothers habitually snored, whereas 465 of the fathers in the study reported that they snore habitually. Infants who habitually snored were nearly three times as likely to have a parent who habitually snored. ■
JCAHO mulls flu-shot standard for infection control

The JCAHO is reviewing a proposed standard for influenza immunization of healthcare workers, students, and volunteers in healthcare settings. The draft of the infection-control standard calls for hospitals to reduce the risk of flu infection and transmission.

The JCAHO’s preliminary recommendations include the following:
- Identifying patients, clients, or residents who are at high risk for flu-related complications
- Identifying workers, students, volunteers, and licensed independent practitioners (LIP) who work with or near high-risk patients
- Establishing an flu vaccine program for these identified workers, students, volunteers, and LIPs
- Providing access to free flu shots on the job to these workers, students, volunteers, and LIPs
- Educating these workers, students, volunteers, and LIPs about influenza vaccination and the epidemiology, transmission, and diagnosis of the flu
- Maintaining vaccination records for workers, students, volunteers, and LIPs
- Monitoring vaccination rates among workers, students, volunteers, and LIPs who work with high-risk patients
- Improving vaccination rates

In a preamble to the draft, the JCAHO raised the issue of mandatory flu vaccines for healthcare workers and, if it passed, whether there were legitimate reasons for staff to decline the immunizations.

Free e-zine offer

Respiratory Care Weekly (RCW), the free e-mail newsletter covering respiratory care news, is brought to you by RCM, the premium monthly newsletter on the pulse of the respiratory and cardiopulmonary care professions.

Please add RCW to your e-mail address book to ensure that you receive future issues. Our e-mail address is respiratory_care_weekly@list.hcpro.com.