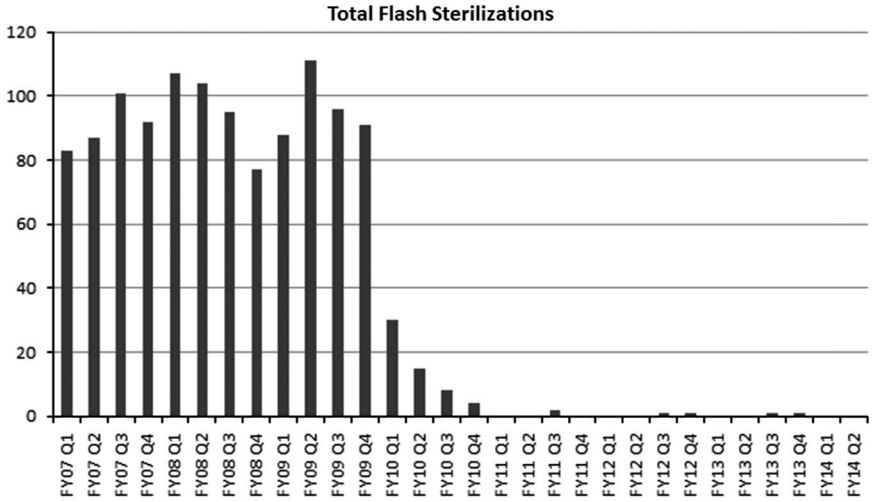

FIGURE 1. Reduction in the number of immediate use steam sterilizations (IUSS) performed per quarter (Q) from fiscal year (FY) 2007–2014 at Central Arkansas Veterans Healthcare System.

other variables to decrease the real need for flash: efficient quality assurance compliance, employee awareness/education, and collaborative OR/SPS teamwork.

The leadership of our facility supported a system redesign team to control one risk factor of SSI. The elimination of IUSS from our OR culture correlated with elimination of SSIs associated with IUSS for the past 3 years. The redesign team process promoted limitless thinking, and the intraprofessional collaboration increased respect for the role of each individual and/or department in ensuring the highest quality of care for our Veterans.

Sandee Foster, MNSc, RN;[1]
Sheila Cox Sullivan, PhD, RN;[2]
Julie Brandt, MSN, RN, NE-BC;[3]
Tom Brockway, CRCST;[4]
Renita Jackson;[4]
Diana Griffin, BSN, RN, CRCST;[4]
Tim Mullins;[4]
Bonnie K. Walker;[5]
Melissa Ball, BSN, RN;[5]
Margie Scott, MD;[5]
Michael R. Winn, MA[5]

Affiliations: 1. Nursing Service, Central Arkansas Veterans Healthcare System, Little Rock, AR; 2. Research, Central Arkansas Veterans Healthcare System, Little Rock, AR; 3. Patient Care Services, Central Arkansas Veterans Healthcare System, Little Rock, AR; 4. Sterile Processing Services, Central Arkansas Veterans Healthcare System, Little Rock, AR; 5. Central Arkansas Veterans Healthcare System, Little Rock, AR Central Arkansas Veterans Healthcare System, Little Rock, AR.

Address correspondence to Sheila Cox Sullivan, PhD RN, 4300 W. 7th Street, 003/LR, Little Rock, AR 72205 (Sheila.sullivan2@va.gov).

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Parental Perceptions about Required Influenza Immunization

To the Editor—We would like to discuss the article "Parental Perceptions about Required Influenza Immunization."[1] Linam et al. noted that "independent of their feelings regarding vaccine safety and efficacy, 76% of parents felt that annual influenza vaccination should be required for HCP [healthcare professionals]."[1] In fact, parents of pediatric patients usually require the best thing, best safety service, for their children. A vaccinated HCP is perceived to be a safe person to provide health care to the children with low risk for influenza transmission. In addition, the relationship between the status of "vaccinated or intending to be vaccinated against seasonal influenza" of an HCP is also directly related to the status

of "recommending universal pediatric seasonal influenza vaccine."[2] This means if the HCP is vaccinated, it is likely that he or she will educate the parent and patient and recommend that they get the vaccine. Nevertheless, there is a previous report indicating highly educated parents have a trend of negative attitude towards vaccination.[3] An interesting question is whether the education of the parents affects the perception on this specific issue or not.

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Sim Sai Tin, MD;[1]
Viroj Wiwanitkit, MD[2]

Affiliations: 1. Medical Center, Shantou, China; 2. Visiting professor, Hainan Medical University, China

Address correspondence to Sim Sai Tin, MD, Medical Center, Shantou, China (simsaitin@gmail.com).
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SHEA's White Paper on Electronic Surveillance Data Requirements

To the Editor—It is extremely disappointing that SHEA's White Paper in discussing validation makes no mention of Washington State's work.[1] Last year in SHEA's own journal, Washington State was recognized by leaders from several divisions of the American Society for Quality as the only one doing reporting validation of healthcare-associated infections by a protocol consistent with American (Department of Defense MIL-STD-105 and American National Standards Institute Z1.4) and international (International Organization for Standardization 2859) standards for acceptance sampling.[2] Throughout 5 years of continual operation, the Washington State Department of Health's Healthcare Associated Infections Program annual validation protocol has proven practical for infection control programs in hospitals of all sizes, credible to certified quality professionals by virtue of respecting their profession's long-established generic standards, sustainable, and scalable.[3,4] A technical reference manual, fully detailing all aspects of theory and practice, has been freely available since 2010.[5] Conversely, the other approaches cited by Woeltje et al[1] variously fail to document underlying statistical theory such that their sample size appears arbitrary (thus lack statistical power details); oversample large hospitals while exempting smaller ones (thus may not build overall public confidence nor ensure all facilities subject to public comparisons are on a level playing field); fail to set and enforce a prespecified level of sensitivity and specificity performance (thus do not accomplish the quality assurance that validation is understood to provide in all other industries); and appear to require larger workloads than the method used by Washington State (thus may not be the most cost-effective). In my own experience, it is essential to review each entire clinical and laboratory record for "external" validation of sampled cases, best done on a site visit, and then discuss results with local program leadership, rather than to rely solely on laboratory information systems or remote access for "external" validation. Furthermore, it is not logical or reasonable for electronic surveillance oversight to exempt itself from the generic validation methodologic standards respected in all other industries. Fortuna et al[2] suggest that a naïve and narrow understanding of validation among epidemiologists is due to quality assurance being an unfamiliar statistical specialty. Like Washington State's program, in matters of validation SHEA should be collaborating with the expertise of certified quality engineers, certified quality managers, and certified quality auditors of pertinent American Society for Quality divisions (eg, its healthcare, biomedical, statistics, and government divisions).

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David Birnbaum, PhD, MPH[1]

Affiliations: 1. Applied Epidemiology, British Columbia, Canada

Address correspondence to David Birnbaum, PhD, MPH, Applied Epidemiology, 609 Cromar Road, Sidney, British Columbia, V8L 5M5, Canada (david.birnbaum@ubc.ca).
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