UMC Clinical Quality and Professional Affairs Committee

June, 1, 2026 2:00 p.m.

Delta Point Building - Emerald Conference Room - 1st Floor

Las Vegas, NV

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
June 1, 2026 2:00 p.m.
901 Rancho Lane, Las Vegas, Nevada
Delta Point Building, Emerald Conference Room (1st Floor)

Notice is hereby given that a meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee has been called and will be held at the time and location indicated above, to consider the following matters:

This meeting has been properly noticed and posted online at University Medical Center of Southern Nevada's website http://www.umcsn.com and at Nevada Public Notice at https://notice.nv.gov/, and at 901 Rancho Lane, Las Vegas, NV.

- The main agenda is available on University Medical Center of Southern Nevada's website http://www.umcsn.com, For copies of agenda items and supporting back-up materials, please contact Stephanie Ceccarelli, Board Secretary, at (702) 765-7949. The Clinical Quality and Professional Affairs Committee may combine two or more agenda items for consideration.
- Items on the agenda may be taken out of order.
- The Clinical Quality and Professional Affairs Committee may remove an item from the agenda or delay discussion relating to an item at any time.
- Consent Agenda - All matters in this sub-category are considered by the Clinical Quality and Professional Affairs Committee to be routine and may be acted upon in one motion. Most agenda items are phrased for a positive action. However, the Clinical Quality and Professional Affairs Committee may take other actions such as hold, table, amend, etc.
- Consent Agenda items are routine and can be taken in one motion unless a Committee member requests that an item be taken separately. For all items left on the Consent Agenda, the action taken will be staff's recommendation as indicated on the item.
- Items taken separately from the Consent Agenda by Committee members at the meeting will be heard in order.

SECTION 1. OPENING CEREMONIES

CALL TO ORDER

1. Public Comment

2. Approval of minutes of the regular meeting of the UMC Clinical Quality and Professional Affairs Committee meeting on April 20, 2026. *(For possible action)*

3. Approval of Agenda. *(For possible action)*

SECTION 2. BUSINESS ITEMS

4. Receive an update on the Comprehensive Stroke Certification Program from Alma Angeles, Clinical Manager, Disease Specific Services; Carley Redmond, Stroke Program Coordinator; and direct staff accordingly. *(For possible action)*

5. Receive an update on the Quality, Safety, and Regulatory Program from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action).*

6. Receive an update on the FY26 Organizational Performance Goals from Patty Scott, Quality/Safety/Regulatory Officer; and take any action deemed appropriate. *(For possible action)*

7. Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of April 1, 2026 and May 6, 2026 including the recommended creation, revision, and/or retirement of UMC policies and procedures; and take any action deemed appropriate. (For possible action)

SECTION 3. EMERGING ISSUES

8. Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly.

COMMENTS BY THE GENERAL PUBLIC

All comments by speakers should be relevant to the Committee's action and jurisdiction.

UMC ADMINISTRATION KEEPS THE OFFICIAL RECORD OF ALL PROCEEDINGS OF UMC GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE. IN ORDER TO MAINTAIN A COMPLETE AND ACCURATE RECORD OF ALL PROCEEDINGS, ANY PHOTOGRAPH, MAP, CHART, OR ANY OTHER DOCUMENT USED IN ANY PRESENTATION TO THE BOARD SHOULD BE SUBMITTED TO UMC ADMINISTRATION. IF MATERIALS ARE TO BE DISTRIBUTED TO THE COMMITTEE, PLEASE PROVIDE SUFFICIENT COPIES FOR DISTRIBUTION TO UMC ADMINISTRATION.

THE COMMITTEE MEETING ROOM IS ACCESSIBLE TO INDIVIDUALS WITH DISABILITIES. WITH TWENTY-FOUR (24) HOUR ADVANCE REQUEST, A SIGN LANGUAGE INTERPRETER MAY BE MADE AVAILABLE (PHONE: 765-7949).

University Medical Center of Southern Nevada
UMC Governing Board Clinical Quality and Professional Affairs
April 20, 2026

Emerald Conference Room
Delta Point Building, 1st Floor
901 S. Rancho Lane
Las Vegas, Clark County, Nevada
April 20, 2026 2:00 p.m.

The University Medical Center Governing Board Clinical Quality and Professional Affairs Committee met at the time and location listed above. The meeting was called to order at the hour of 2:00 p.m. by Chair Rene Franklin and the following members were present, which constituted a quorum of the members thereof:

CALL TO ORDER

Board Members:

Present:
Renee Franklin, Chair
Laura Lopez-Hobbs
Dr. Don Mackay
Dr. John Fildes

Absent:
Bobbette Bond (Ex-Officio)

Also Present:
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Kathy Johnson, Director of Infection Prevention
Danita Cohen, Chief Experience Officer
Jeff Castillo, Director of Patient Experience
James Conway, Assistant General Counsel
Stephanie Ceccarelli, Board Secretary

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

Chair Franklin asked if there were any persons present in the audience wishing to be heard on any item on this agenda.

Speaker(s): None

ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee meeting on February 2, 2026. *(For possible action)*

FINAL ACTION: A motion was made by Member Fildes that the minutes be approved as presented. Motion carried by unanimous vote.

ITEM NO. 3 Approval of Agenda *(For possible action)*

FINAL ACTION: A motion was made by Member Mackay that the agenda be approved as recommended. Motion carried by unanimous vote.

SECTION 2. BUSINESS ITEMS

ITEM NO. 4: Receive an update on the Annual Infection Prevention Program Evaluation and Plan from Kathy Johnson, Director of Infection Prevention; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED:
- PowerPoint Presentation

DISCUSSION:

Ms. Johnson presented the review of FY2025 Infection Prevention evaluation and the plan for FY2026. The purpose of the plan is to provide framework necessary to reduce the possibility of acquiring or transmitting infection that is specific to the organization's services and population.

Successes for 2025 included sustained performance in device-related infections, with CAUTIs and CLABSIs; a reduction in ventilator-associated events, with 13 fewer events than the prior year; and sustained device utilization SIR below 1.0 across all monitored devices. There was improvement or sustainment in LABID events with SIR at or below 1.000, C diff SIR 0.534, and MRSA SIR 1.026

For environmental cleanliness surveillance, blacklight audits increased from 109 to 207, and cleanliness improved to 81%. There was improvement in hand hygiene compliance to 70% and PPE utilization to 87%.

Multiple Infection Prevention performance improvement projects were discussed, including the development and refinement of a Candida auris screening tool, evaluation of hand hygiene monitoring with SwipeSense, and the implementation of in-house UV disinfection. Reduction strategies for CLABSIs, CAUTIs, IVAC, SSI, MRSA/C. diff., hand hygiene, and influenza were reviewed.

Ms. Johnson noted that hand hygiene has improved by 2%, and the SwipeSense monitoring system will be installed by June. A discussion followed on the implementation of SwipeSense and how the system will work.

Chair Franklin asked how to determine the cause of ventilator complications. Ms. Johnson responded that the team reviews each event to determine the root cause analysis of complications. The Committee would like to see a detailed breakdown of the root-cause statistical analysis, and a comparison with similar hospitals.

The 2026 Risks, Priorities, and Interventions were reviewed. Key priorities for the community, patient, environmental, and healthcare worker categories include public health pandemics and highly infectious diseases; emerging threats such as Candida auris; emergency preparedness; Ebola retraining; device-related and surgical site infections; multidrug-resistant organisms, with enhanced surveillance, rapid isolation, and Just-In-Time education; and multidisciplinary performance improvement charters.

There will be continued collaboration with SNHD, CDC, and regional healthcare partners

FINAL ACTION TAKEN:

None

ITEM NO. 5 Receive an update on the Hand Hygiene Campaign from Danita Cohen, Chief Experience Officer; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- PowerPoint Presentation

DISCUSSION:

Danita Cohen reviewed the Hand Hygiene Campaign at UMC. The goal of the campaign is to improve hospital-wide hand hygiene compliance and achieve the hand hygiene performance target established by the Governing Board.

A hospital-wide, public-facing campaign was launched, featuring real UMC team members to promote visibility, accountability, and ownership of hand hygiene practices. Campaign materials are customized by unit and department, reinforcing that hand hygiene is a shared responsibility across all clinical and support areas.

The campaign is designed to empower patients and visitors to engage in safety by encouraging them to ask staff about hand hygiene.

Nearly 100 individual posters have been completed to date, reflecting broad participation and engagement across the organization.

The campaign supports broader Infection Prevention strategies and complements ongoing initiatives such as electronic hand hygiene monitoring and increased audit transparency.

Posters are being placed in public-facing areas across inpatient and outpatient units to maximize visibility.

Unit and department leaders identified Hand Hygiene Champions to represent their areas; selected staff participated in celebratory photo sessions for the campaign.

Chair Franklin suggested an opportunity to encourage hospital visitors, which will serve as a reminder to staff about hand hygiene.

FINAL ACTION TAKEN:

None

ITEM NO. 6 Receive an update on HCAHPS/CCAHPS/Communication Boards from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- PowerPoint

DISCUSSION:

Jeff Castillo provided an overview of HCAHPS, CCAHPS scores, and new UMC patient communication boards.

Overall Patient Experience Performance

UMC continues to demonstrate positive momentum in patient experience, with 8 of 10 adult HCAHPS measures are trending positively for 2025. The strongest improvements are seen in cleanliness and communication, both key drivers of overall patient satisfaction and safety perception. Adult inpatient performance shows steady quarter-over-quarter improvement across most domains, reinforcing the effectiveness of recent patient experience initiatives.

Responsiveness and quiet at night show opportunities for improvement.

Member Mackay asked whether environmental noise or shared patient rooms create issues with quietness. Mr. Castillo commented on the root causes of patient complaints and the mitigation measures that have been implemented.

Pediatric (Child HCAHPS) Performance

Pediatric HCAHPS results for 2025 show consistent improvement and stability. The majority of measures met or exceeded their prior-year 4th-quarter performance. Several domains are approaching or exceeding national peer group averages.

Strong pediatric communication scores were noted in nurse and physician communication with both children and families, discharge preparation and explanation, and staff efforts to help children feel comfortable and involved in care.

Key Pediatric Experience Interventions

Dedicated Patient Experience Coordinator assigned to pediatric areas
Experience rounding seven days a week
Expanded character visits, special events, and child-focused engagement
Increased availability of toys, activities, and resources
Introduction of gaming systems for pediatric patients
Unit of the Week rounding and enhanced Resident ICARE and customer service training
These targeted interventions are directly contributing to improved pediatric HCAHPS results.

EZ Communication Boards – Patient Safety & Experience Initiative

EZ Communication Boards were implemented to address barriers for:

- Non-verbal patients
- Stroke patients (short- and long-term)
- Trauma patients
- Intubated and speech-impaired patients

Prior communication methods were inconsistent, non-standardized, and often unavailable, increasing risk to patient safety and quality of care.

Impact and Benefits of EZ Boards Communications

Supports patient safety, quality of care, and emotional well-being
Reduces communication-related errors and patient anxiety
Improves patient participation in care decisions
Decreases over-reliance on caregivers for basic needs

Program Features

Single-patient use boards that remain with the patient throughout their stay
Available in English and Spanish
Combination of picture-based and word-based communication tools
Appropriate for all ages
Distributed to all ICUs and IMCs

The Committee commended staff on the implementation of the communication boards for non-verbal patients.

FINAL ACTION TAKEN:

ITEM NO. 7 Receive an update on the Survey and Regulatory Program from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. (For possible action).

DOCUMENT(S) SUBMITTED**:**
- None

DISCUSSION:

Patty Scott provided a review of the Survey and Regulatory Program. Fifteen of the seventeen measures are meeting goal.

In January, the State on behalf of CMS surveyed the Adult, Trauma and Pediatric ED on EMTALA with a strong focuson behavioral health patients. Findings were addressed with a plan of correction. The team is expecting a re-survey within six weeks.

In February, DNV returned for the annual survey. There were 7 surveyors for a total of 21 survey days. There were 10 findings. A resurvey was done, and associated finding cleared.

In March, the State and CMS returned for EMTALA survey for 15 days. There were no findings. The State surveyors reviewed 32 complaints. There were two minimal non-clinical findings. The annual Comprehensive Stroke Certification survey is scheduled for May 14th and 15th.

There was continued discussion about the types of behavioral health patient cases that were surveyed. Ms. Scott responded that they come from varied backgrounds.

ITEM NO. 8 Receive an update on the FY26 Organizational Performance Goals from Patty Scott, Quality/Safety/Regulatory Officer; and take any action deemed appropriate. *(For possible action)*

DOCUMENT(S) SUBMITTED**:**
- PowerPoint Presentation

DISCUSSION:

Ms. Scott provided an update on the performance objectives for FY2026.

1. **Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:**

   - Hand hygiene compliance has demonstrated continued improvement over the last three years, increasing from 66% to 70% (1Q25–4Q25)

2. **Improve or sustain improvement over the last three (3) year trending period or remain under the national index of 1.0 for the following inpatient quality/safety measures:**

   - This goal is not being met in total. The metric related to ventilators has increased over the three-year period with an index of 2.434. The Committee acknowledged this as an area requiring focused improvement, with continued monitoring and prevention strategies in place.

3. **Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:**

   - The overall Orthopedic SSI rate improved in the most recent period, decreasing from 1.14 to 0.973. Ms. Scott stated that this data only includes spinal fusion, laminectomy, hip & knee replacement.

4. **Improve or sustain improvement over the last three (3) year trending period or remain under the national index of 1.0 for the following inpatient quality/safety measures:**

   - This goal is being met. The PSI-90 composite score remains below the national benchmark at 0.831.

5. **Improve or sustain improvement over the last three (3) year trending period for the following quality/safety measures:**

   - This goal is being met. The ED median arrival-to-disposition time has decreased from 210 to 193, compared with the prior year. Improvement was noted in all ED's.

6. **Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (IP):**

   - Six of the seven HCAHPS measures are being met. Communication with doctors and nurses have sustained or shown improvement. The measure related to responsiveness of staff remains a challenge, as it declined to 54.15%. This is being monitored and initiatives for improving are in place.

7. **Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (OP):**

- This goal is being met and has shown improvement over the past quarter.

8. Develop, implement, and execute plans/campaigns to support and improve the following performance goals/programs during FY26:

- Communication with physicians remains in progress, and the Unit of the Week Rounding is at 94%.

The Committee would like staff to focus on and identify ways to improve and correct communication between physicians and patients.

FINAL ACTION TAKEN:

None

ITEM NO. 9 Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of February 2, 2026 and March 4, 2026, including the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. ***(For possible action)***

DOCUMENT(S) SUBMITTED**:**
- Policies and Procedures

DISCUSSION:

Policy and Procedures activities for February 2, and March 4, 2026 were reviewed.

There were a total of 203 approved 11 were retired. All were approved through the hospital Policy and Procedures Committee, Hospital Quality and Safety Committee and the Medical Executive Committee.

A discussion ensued regarding the review process by the Policy and Procedures Committee.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to approve that the UMC Policies and Procedures Committee's activities of February 2, 2026 and March 4, 2026 and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

SECTION 3. EMERGING ISSUES

ITEM NO. 10 Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly

Member Hobbs shared a positive experience from a recent encounter with UMC staff and suggested a review of policy to award and thank staff members for above-and-beyond service. There was a brief discussion regarding the Employee of the Month

COMMENTS BY THE GENERAL PUBLIC:

At this time, Chair Franklin asked if there were any persons present in the audience wishing to be heard on any items not listed on the posted agenda.

SPEAKERS(S): None

There being no further business to come before the Committee at this time, at the hour of 3:37 p.m. Chair Franklin adjourned the meeting.

MINTUES PREPARED BY: Stephanie Ceccarelli, Governing Board Secretary
APPROVED:

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue:	**Comprehensive Stroke Certification Program Update**	**Back-up:**
Petitioner:	Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on the Comprehensive Stroke Certification Program from Alma Angeles, Clinical Manager, Disease Specific Services; Carley Redmond, Stroke Program Coordinator; and direct staff accordingly. *(For possible action)*

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 1, 2026

Agenda Item #

4

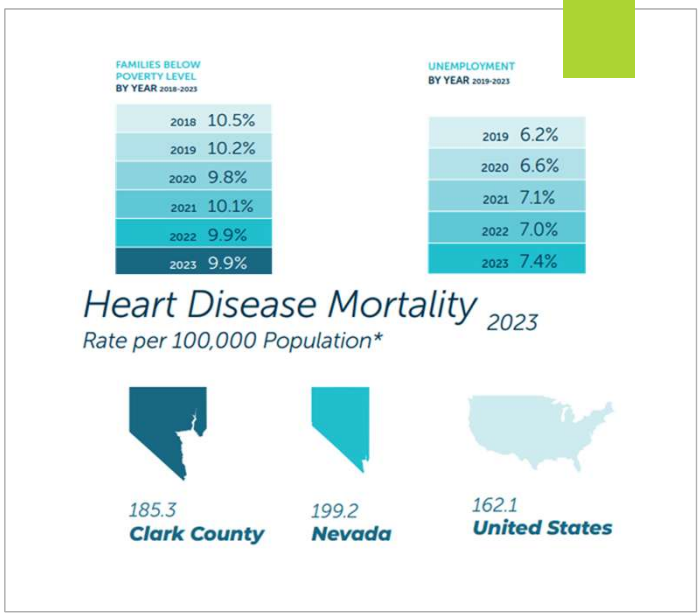
UMCSN COMPREHENSIVE STROKE CENTER

JUNE 1, 2026

1

Community Health Assessment

- 28.9% have Obesity ↑
- 12.9% have Diabetes ↑
- 34.6% have Hypertension ↑
- 14.9% are smokers ↓
  - Leading Cause of Death:
  - Heart Disease
  - 185.3/100,000 ↓
    - Rates highest in AA
- Rates higher than the country



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3

Magnet Designation

- Magnet Designation Achieved January 2026
- How:
  - shared governance and decision making
  - From participation to ownership
  - Data-driven decisions
  - Interdisciplinary teams
- Noted Highlights:
  - Strong shared governance culture
  - Leadership visibility and support
  - Patient outcomes and quality metrics
  - EBP and innovation

4

5

EMS Collaboration and Education

- 34+ educational events in total across multiple agencies/schools
  - New hire orientations
  - 700+ EMS personnel engaged
- 7 educational events by UMC physicians
- Engaging, diverse EMS symposium
- EMS week celebrations
- Recognition for first responders
- New community partnerships (e.g. MercyAir)

6

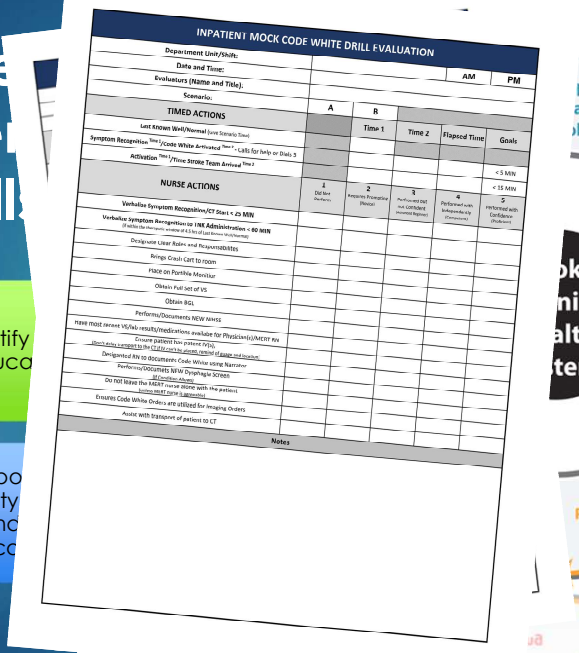
Code LVO

- Aims at improving treatment times for patients with an LVO
- Standardizes pathways
- LVO Team available 24/7
- Applies to all patients

7

Learning Ne
Assessme
And Drill

- Improve staff readiness and response to inpatient CODE WHITE events
- Identify
- Enhance interdisciplinary communication and performance
- Suppo



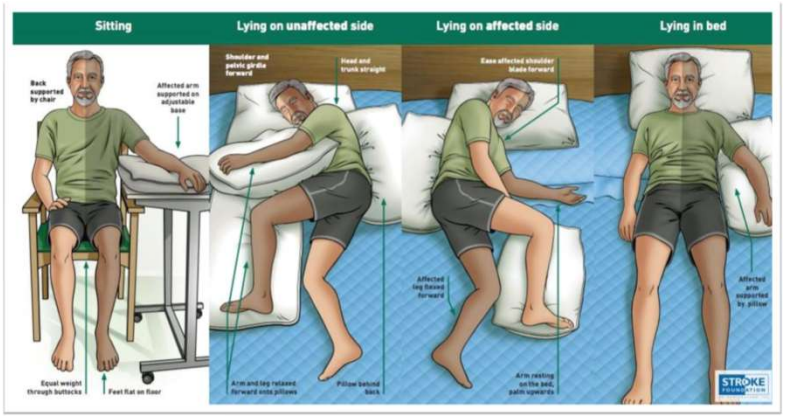
8

Drills in Action

Practice Makes Perfect

9

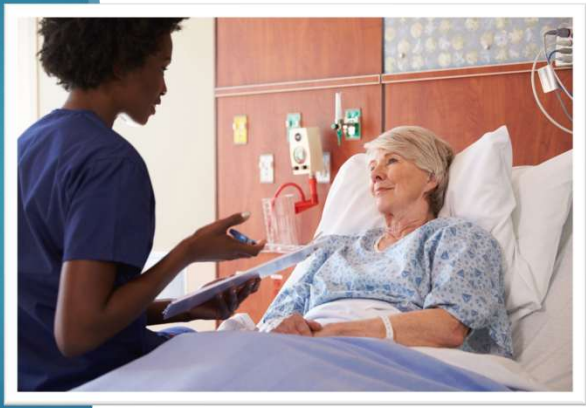
Turning Versus Repositioning Project



10

NSICU Stroke Champions Patient Education Project

- Improving Stroke Discharge Education
- Nurse-Led Teach-Back Initiatives
- Bilingual plain-language handout
- Content included:
  - What is a stroke?
  - B.E. F.A.S.T. , warning signs
  - medications,
  - risk-factor control,
  - aspiration prevention,
  - urinary infection prevention,
  - falls prevention,
  - emotional changes, and follow-up care
- Checklist and questionnaire used for evaluation
- Pilot in NSCU, and if successful, will potentially roll out to other units



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Quality

12

13

UMC Awards and Recognition

2025 AHA GWTG Award

Stroke Gold Plus with
Target: Type 2 Diabetes Honor Roll

2026 Projected AHA GWTG Award

Stroke Gold Plus with Target: Type 2 Diabetes Honor Roll AND Target: Stroke Honor Roll Award.

American Heart Association.


American Heart Association.
American Heart Association. Get With The Guidelines. Stroke
The American Heart Association and American Stroke Association proudly recognizes
University Medical Center of Southern Nevada
Las Vegas, NV
Get With The Guidelines® - Stroke GOLD PLUS with Target: Type 2 Diabetes Honor Roll
Achievement Award Hospital
The American Heart Association recognizes this hospital for its continued success in using the Get With The Guidelines® program.
Thank you for applying the most up-to-date evidence-based treatment guidelines to improve patient care and outcomes in the community you serve.*
Nancy Brown
Chief Executive Officer
American Heart Association
Keith Churchwell, M.D., FAHA
President
American Heart Association
*For more information, please visit Heart.org/GWTGQualityAwards.
American Heart Association.
STROKE
2025
GOLD PLUS
TARGET: TYPE 2 DIABETES HONOR ROLL
GET WITH THE GUIDELINES.

14

Our Future

Visualize our Growth

15

UMC's C.N.A. School

- Helping community members become a part of health care
- Available to non-clinical staff to explore career paths
- A 6-week weekends only program
- Nevada State BON accreditation in progress
- The 1st cohort of 25 students to start in the next 60 to 90 days

CERTIFIED NURSING ASSISTANT

CNA

16

Diagnostic Radiology Residency Program

- National shortage of radiologists
- January 2025, sponsoring Institution accreditation by ACGME
- September 2025 Diagnostic Radiology was our first ACGME-accredited program
- UMC's Diagnostic Radiology program is 4-years in length, with 4 residents in each class
- 1 of only 2 Diagnostic Radiology Residencies in the state of Nevada
- More than 450 applications for our 8 residency spots
- Successfully matched with 4 residents for class of 2030
  - 4 additional residents for our class of 2031
- 5 of the 8 residents have strong ties to Nevada, with one having been born and raised here
- Over 25 articles published and over 30 poster presentations created

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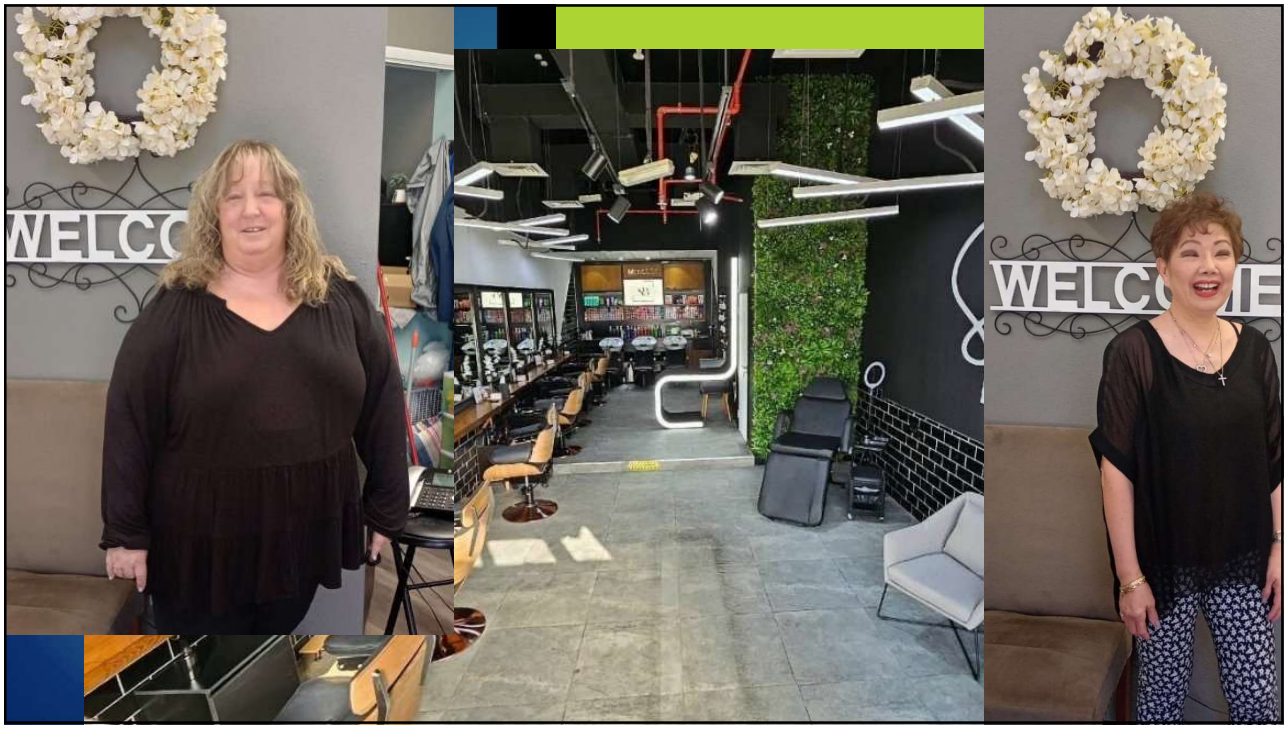

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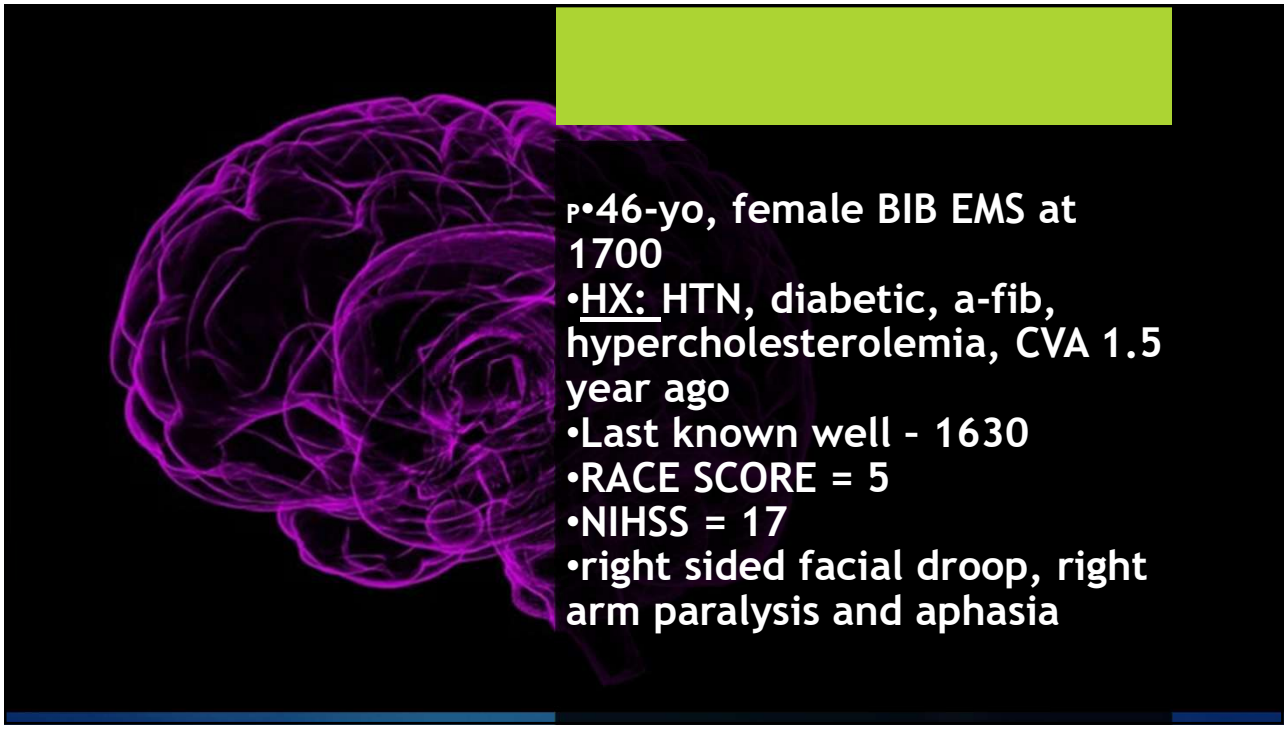
P•46-yo, female BIB EMS at 1700
•HX: HTN, diabetic, a-fib, hypercholesterolemia, CVA 1.5 year ago
•Last known well - 1630
•RACE SCORE = 5
•NIHSS = 17
•right sided facial droop, right arm paralysis and aphasia

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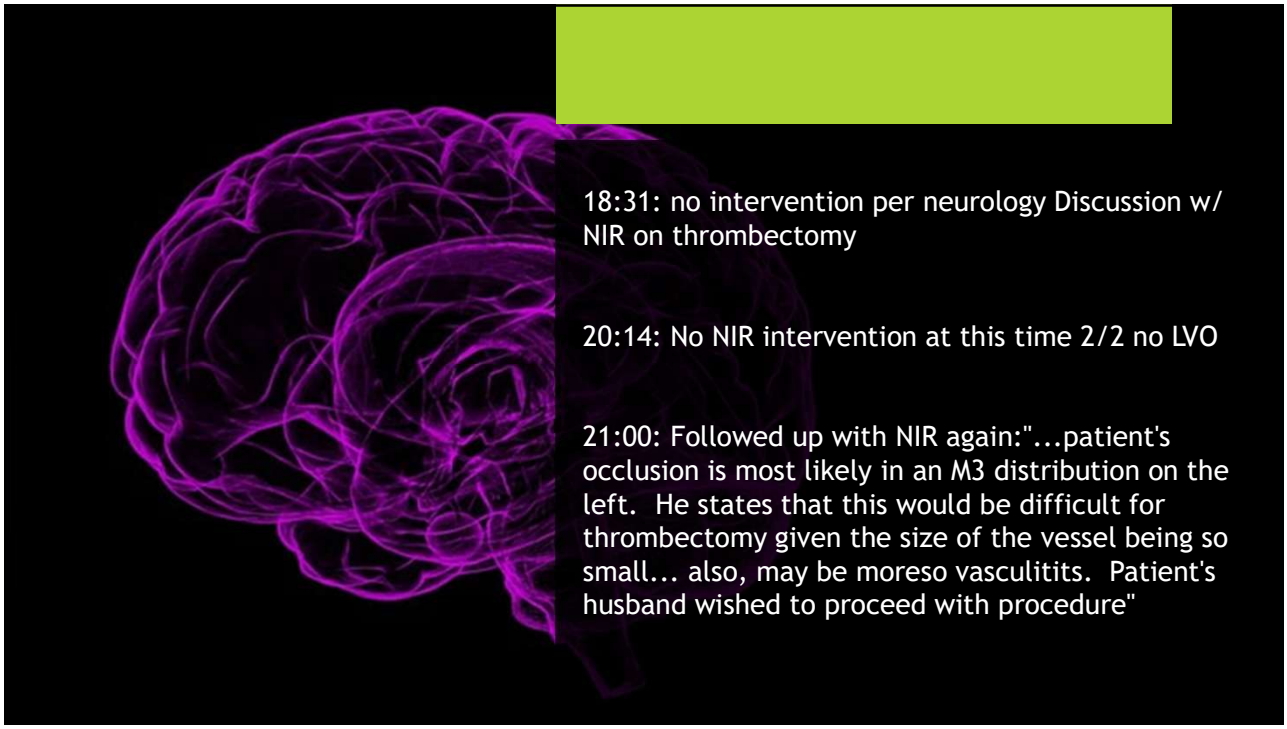
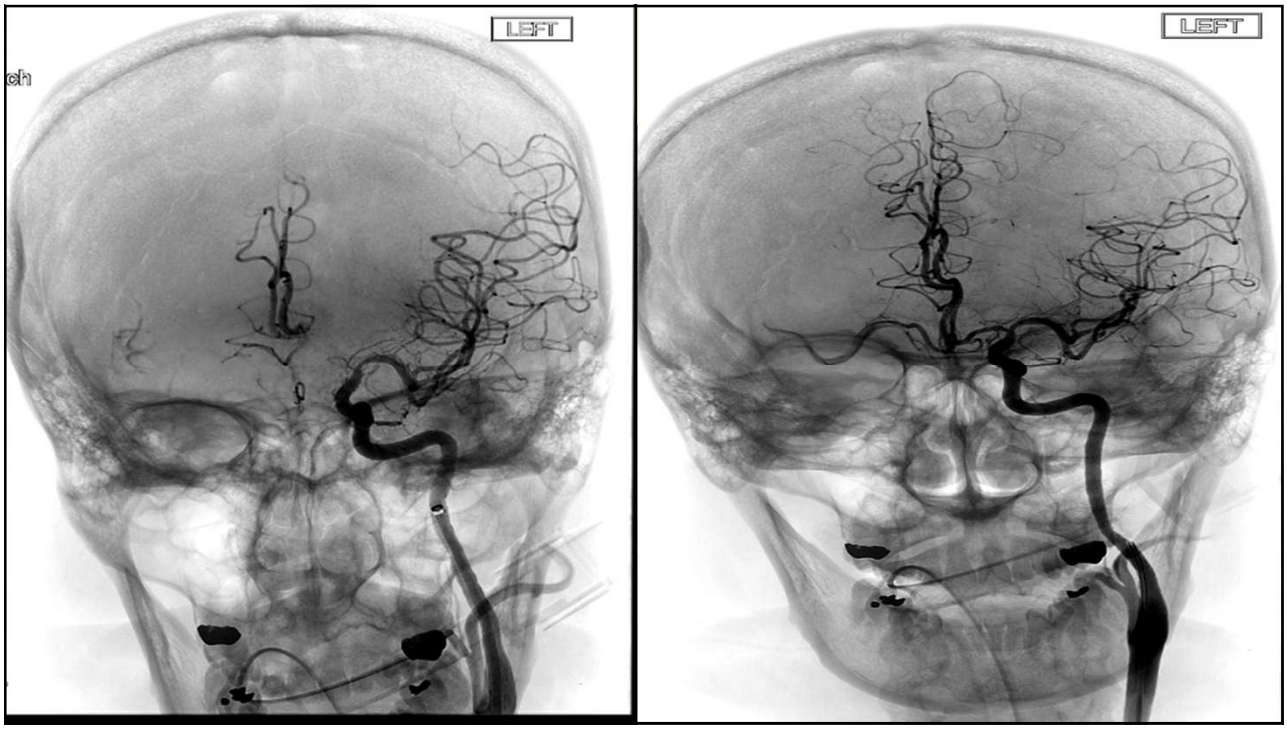

18:31: no intervention per neurology Discussion w/ NIR on thrombectomy
20:14: No NIR intervention at this time 2/2 no LVO
21:00: Followed up with NIR again:"...patient's occlusion is most likely in an M3 distribution on the left. He states that this would be difficult for thrombectomy given the size of the vessel being so small... also, may be moreso vasculitits. Patient's husband wished to proceed with procedure"

22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LEFT

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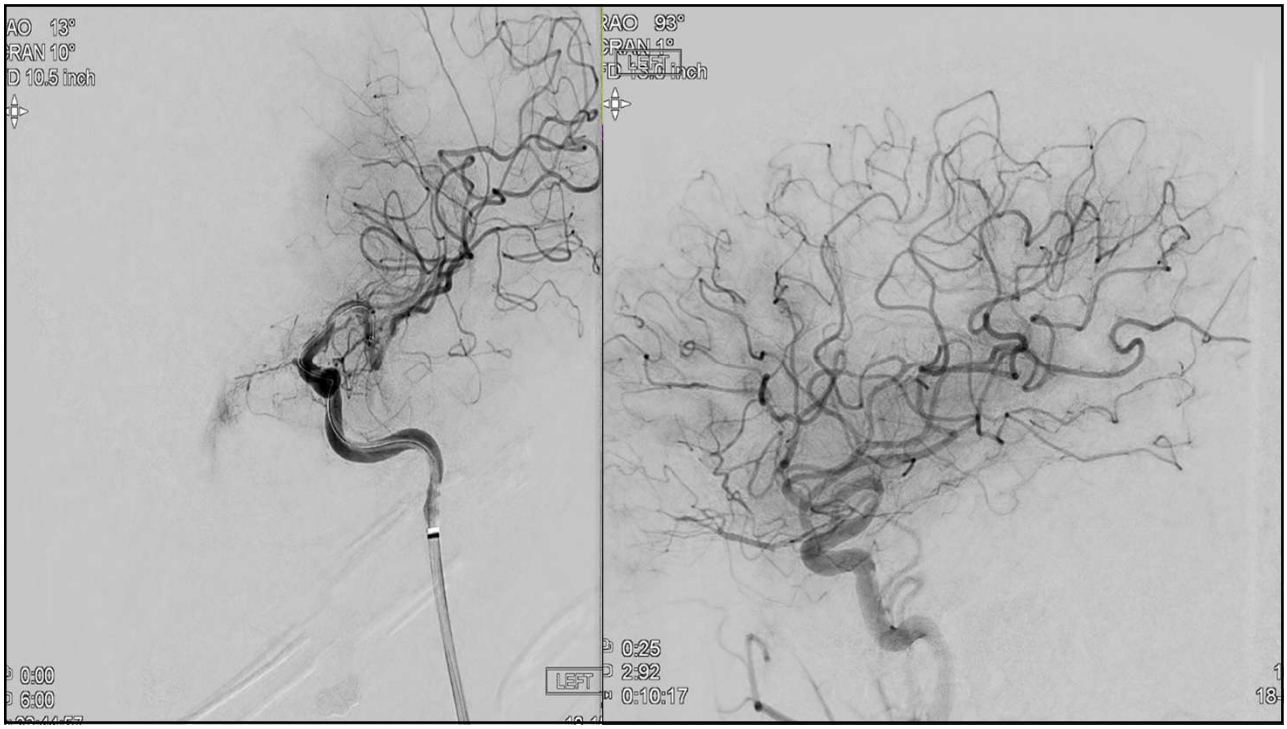
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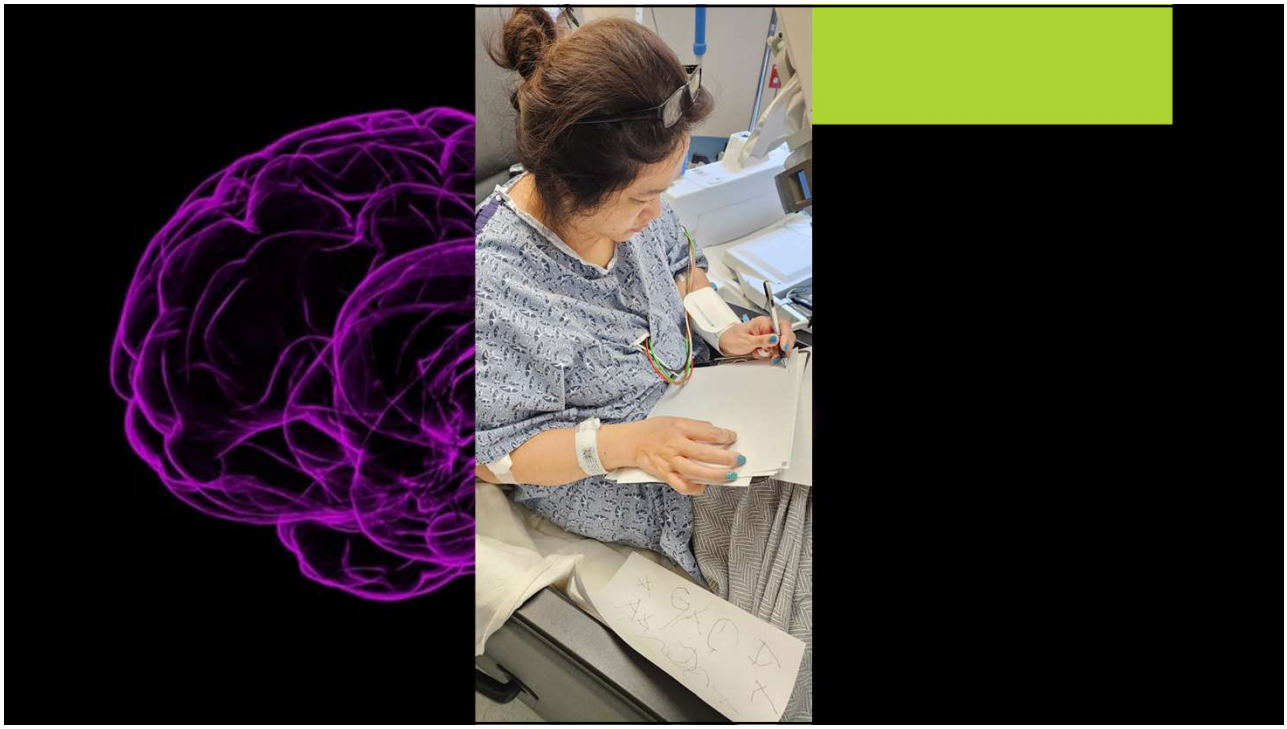

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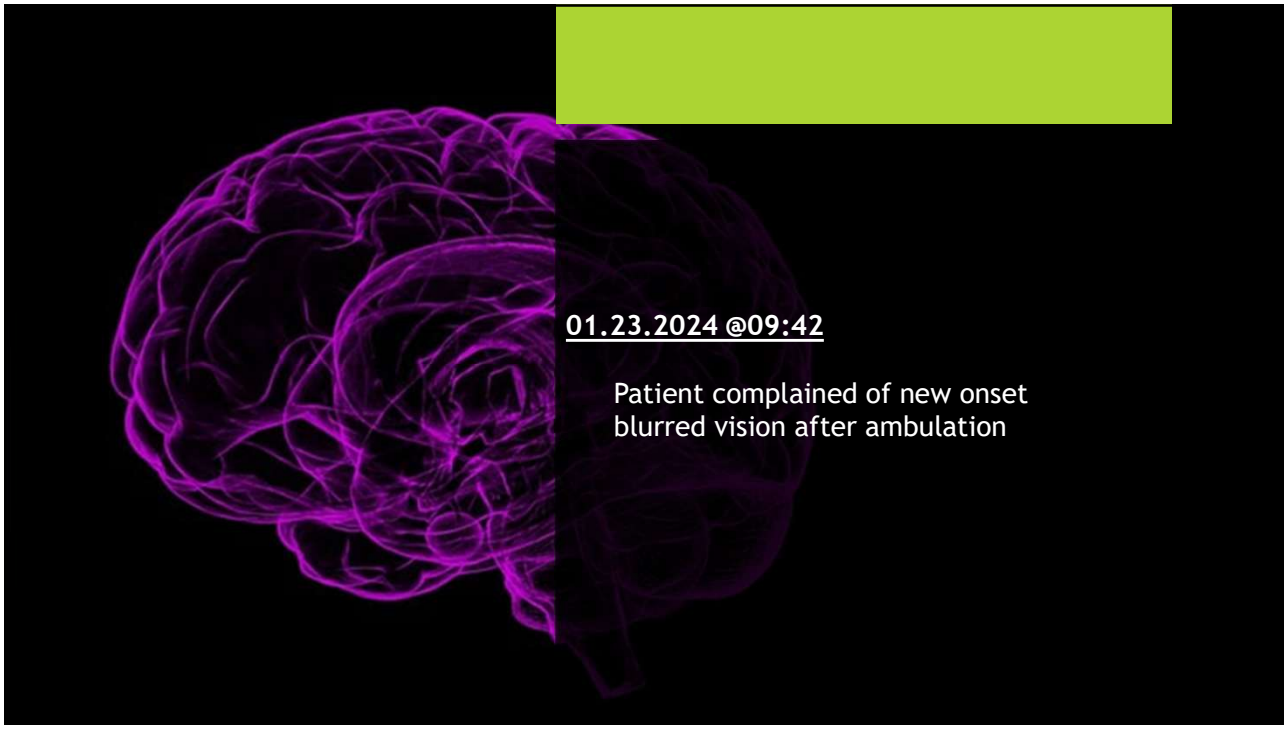
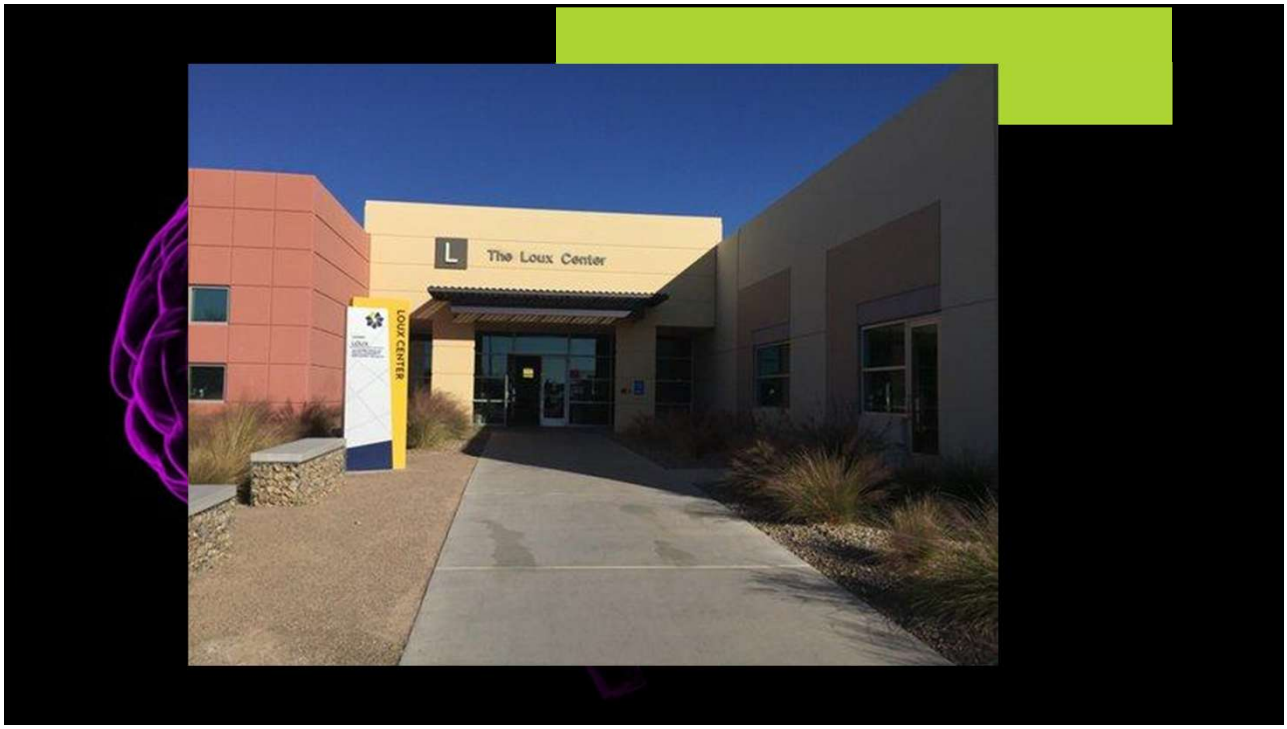

01.23.2024 @09:42
Patient complained of new onset blurred vision after ambulation

26



27

Why didn't I take better care of myself?

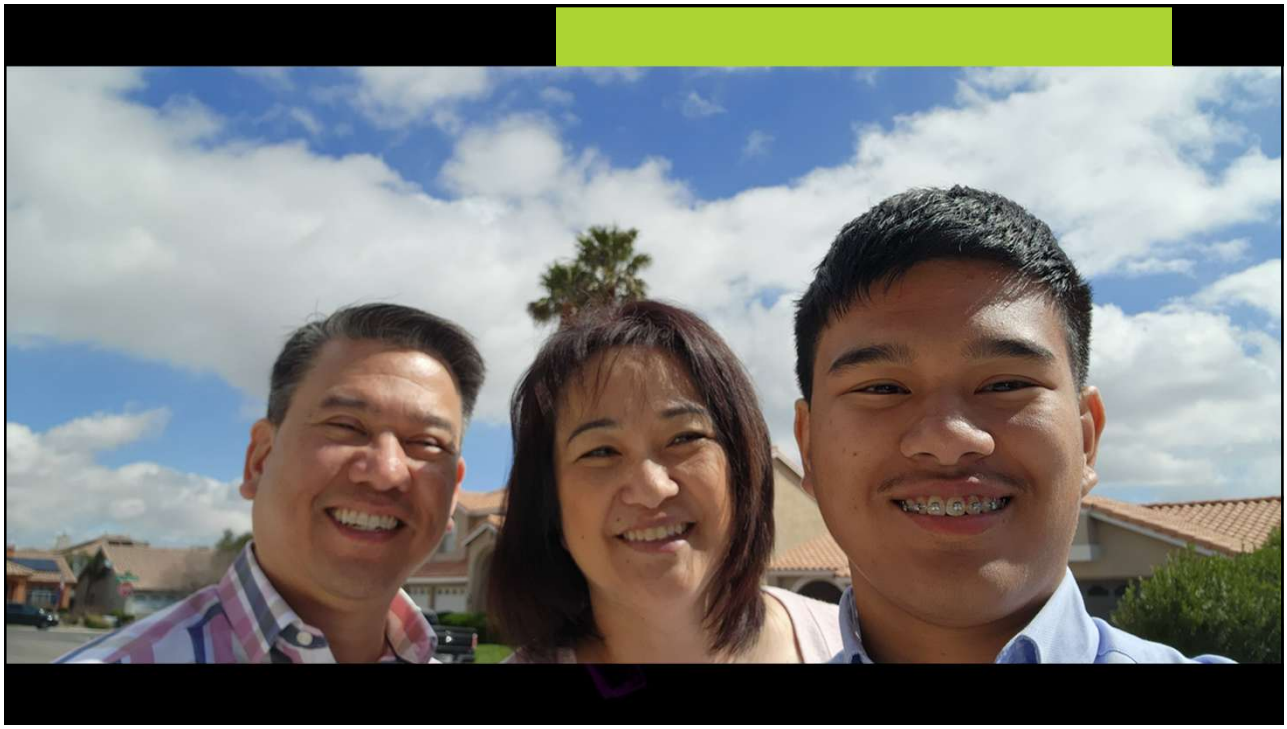
Why did my doctor's find my genetic defect?

Why didn't I do more to control my risk factors?

Why did my doctor's find my genetic defect?

Why did my doctor's find my genetic defect?

28



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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue:	**Quality, Safety and Infection Prevention Program Update**	**Back-up:**
Petitioner:	Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on the Quality, Safety, and Regulatory Program, from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

Patricia Scott, Patient Safety and Regulatory Officer, will provide an update on the Quality, and Regulatory Program measures.

Cleared for Agenda
June 1, 2026

Agenda Item #
5

Quality/Safety/Infection/Regulatory Update

UMC Governing Board Committee

Clinical Quality & Professional Affairs

June 1, 2026

Patient Safety

Grievances

Leapfrog Patient Safety Grade – Spring 2026

Safety Grade Release Date	Score	Letter Grade
Spring 2026	2.8746	C
Fall 2025	2.9354	C
Spring 2025	2.8759	C
Fall 2024	2.8105	C
Spring 2024	2.8708	C
Fall 2023	3.0796	B
Spring 2023	3.0978	B

THE LEAPFROG GROUP
Giant Leaps for Patient Safety

LEAPFROG
HOSPITAL
SAFETY GRADE

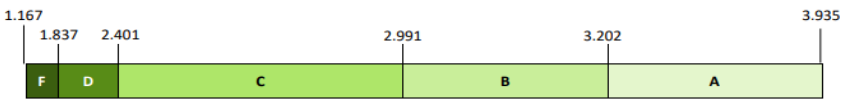
Leapfrog – Hospital Comparison – Spring 2026

Measures Contributing to LF Score	Standard Weight	UMC	Sunrise	Southern Hills	MT View	Valley	Spring Valley	Summerlin	Centennial Hills	Henderson	St. Rose San Martin	St. Rose Siena	North Vista	Source & Timeframe
Computerized Physician Order Entry (CPOE)	6.1%	100	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
Bar Code Medication Administration (BCMA)	5.9%	100	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
ICU Physician Staffing (IPS)	6.8%	100	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
Safe Practice 1: Culture of Leadership Structures and Systems	3.1%	120	120	120	120	120	120	120	120	120	120	120	120	2025 LF Survey
Safe Practice 2: Culture Measurement, Feedback, & Intervention	3.2%	120	120	120	120	120	120	120	120	120	120	120	120	2025 LF Survey
Total Nursing Care Hours per Patient Day	4.7%	70	15	15	15	100	70	70	70	70	100	70	100	2025 LF Survey 01/01/2024 - 12/31/2024 or 07/01/2024 - 06/30/2025
Hand Hygiene	4.9%	70	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
H-COMP-1: Nurse Communication	3.0%	87	84	89	89	87	88	90	85	86	93	89	87	CMS 01/01/2024 - 12/31/2024
H-COMP-2: Doctor Communication	3.0%	86	81	88	86	87	86	87	83	83	91	86	88	CMS 01/01/2024 - 12/31/2024
H-COMP-3: Staff Responsiveness	3.1%	78	74	79	82	80	80	80	75	75	85	80	76	CMS 01/01/2024 - 12/31/2024
H-COMP-5: Communication about Medicines	3.1%	69	65	69	70	74	71	73	68	69	76	73	72	CMS 01/01/2024 - 12/31/2024
H-COMP-6: Discharge Information	3.1%	82	78	81	84	83	82	84	81	79	85	84	81	CMS 01/01/2024 - 12/31/2024
Foreign Object Retained	4.2%	0.000	0.086	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2022 - 06/30/2024
Air Embolism	2.4%	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2022 - 06/30/2024
Falls and Trauma	4.9%	0.172	0.171	0.000	0.082	0.578	0.171	0.150	0.638	0.297	0.305	0.301	0.000	CMS 07/01/2022 - 06/30/2024
CLABSI	4.6%	0.761	0.616	0.300	0.066	0.186	0.261	0.140	0.884	0.198	0.284	0.490	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
CAUTI	4.7%	0.320	0.199	0.000	0.059	0.143	0.196	0.342	0.472	0.000	0.387	0.115	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
SSI: Colon	3.4%	0.653	0.582	0.750	0.231	1.222	0.237	0.223	0.000	0.884	0.749	0.964	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
MRSA	4.4%	0.546	0.697	0.741	0.344	0.514	0.442	0.385	0.726	0.530	0.000	0.267	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
C. Diff	4.5%	0.585	0.016	0.126	0.016	0.039	0.016	0.180	0.139	0.000	0.168	0.253	0.060	2025 LF Survey 07/01/2024 - 06/30/2025
PSI 4: Death rate among surgical inpatients with serious treatable conditions	2.0%	177.93	147.38	118.27	178.36	161.09	151.86	163.85	170.07	168.84	170.84	158.25	N/A	CMS 07/01/2022 - 06/30/2024
CMS Medicare PSI 90: Patient safety and adverse events composite	15.0%	1.04	1.04	0.91	1.13	0.89	1.03	0.99	0.89	0.88	1.22	1.02	0.85	CMS 07/01/2022 - 06/30/2024
LEAPFROG SCORE		**2.8748**	**2.6744**	**3.1747**	**3.0728**	**3.2394**	**3.1652**	**3.2369**	**2.9291**	**3.0913**	**3.2342**	**3.1241**	**3.4366**	
LEAPFROG Spring 2026 Grade		C	C	B	B	A	B	A	C	B	A	B	A	
Fall 2025 Grade		C	C	A	A	A	C	B	C	B	C	B	A	

Spring 2026 Cut-Off Points

Grade	Safety Grade Criteria *(at or above cut point)*	Count of Hospitals	Percentage of Hospitals
A	≥ 3.202	917	33%
B	≥ 2.991	740	26%
C	≥ 2.401	646	23%
D	≥ 1.837	55	2%
F	< 1.837	5	<1%
Total Graded		2,363	
GNA		450	16%
Grand Total		2,813	

Higher is Better



Spring 2026 Compare Hospital Counts	
A	4
B	5
C	3
D	0
F	0

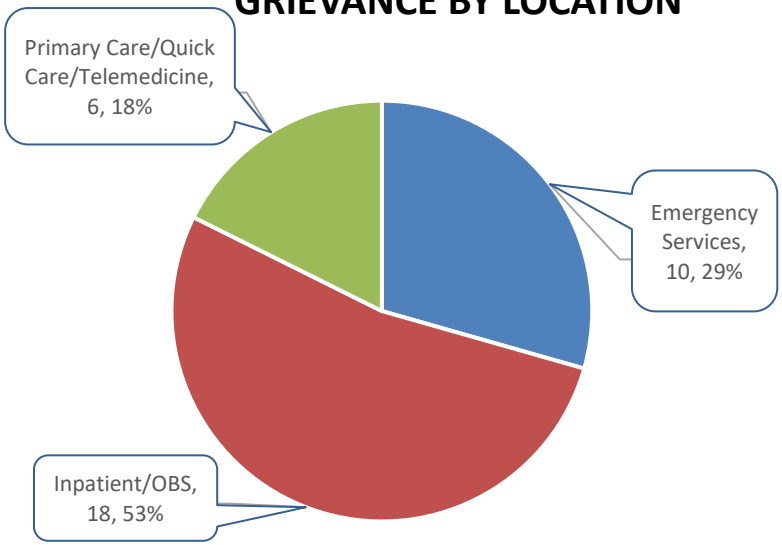
1st Quarter 2026 Sentinel Events – Reported to State

Event	2025	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total	Comments
Fall with Injury	4	0				0	
Pressure Injury - 3/4/Unstage	27	12				12	CCU-5; 3W-1; 5S-1; 1400-1; BCU-1; MICU-2; TICU-1
Retained Foreign Object	2	0				0	
Wrong Side Surgery/Procedure	3	0				0	
Wrong Site Surgery/Procedure	0	0				0	
Burn	1	1				1	OR
Self Harm	1	0				0	
TOTAL	**38**	13				**13**	

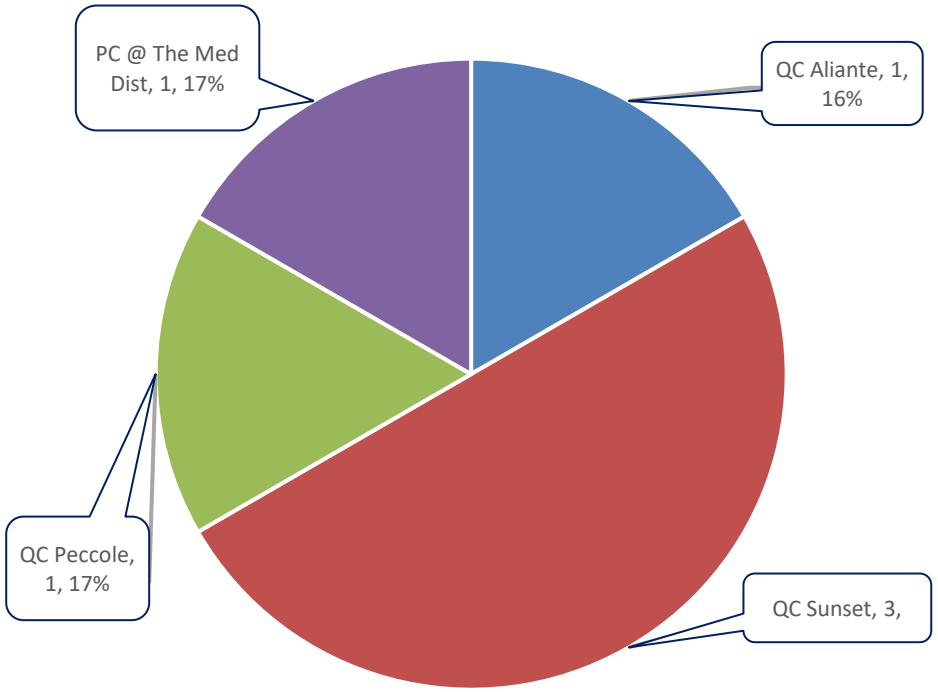
- 13 events reported
- All cases reported within required state timeframes
- RCA with actions taken on all cases
- Monitoring for sustainment through Hospital Quality/Safety Committee

Grievances 1Q - 2026

GRIEVANCE BY LOCATION



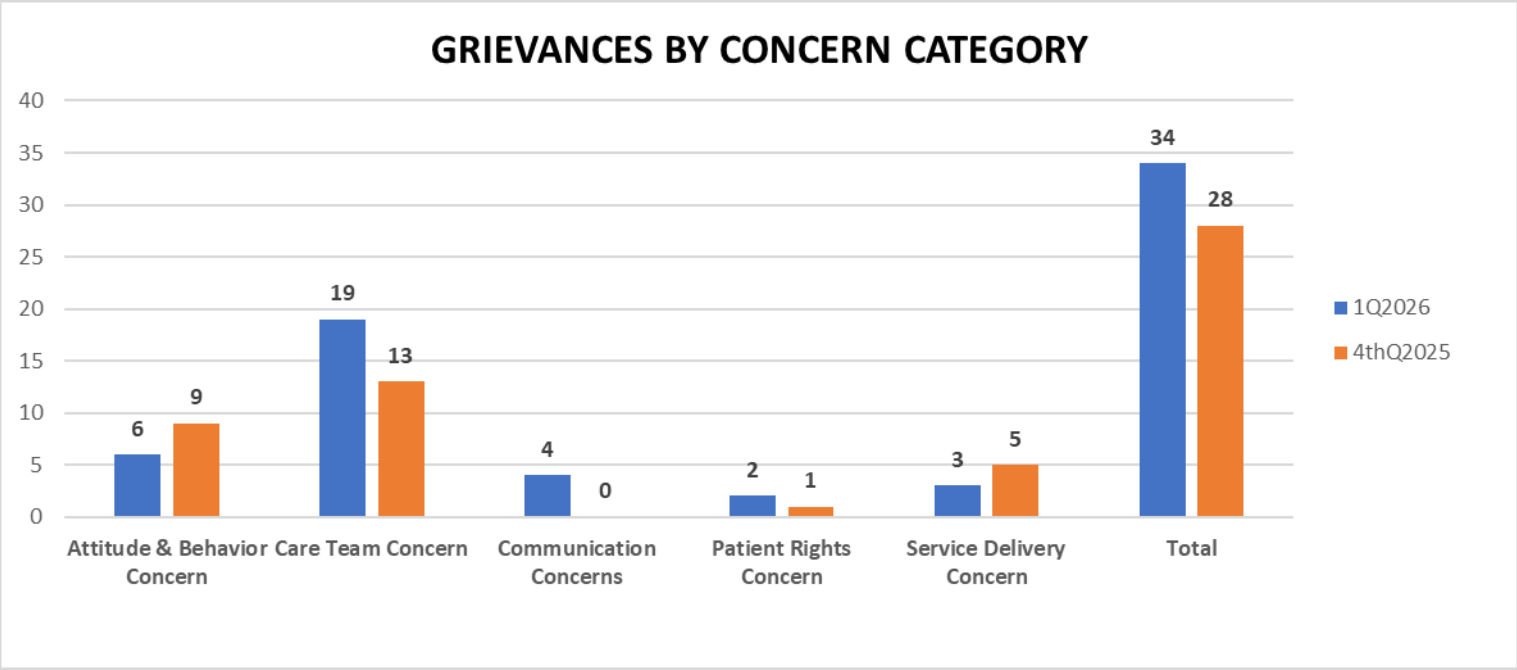
GRIEVANCES QC/PC/Telemedicine – 6



Emergency Services – 10
Inpatient/OBS - 18

- Critical Care – 2
- Maternal Child – 1
- Cardiovascular Services – 1
- Med/Surg/IMC – 11
- Surgical Services – 2
- Other Services (Pt Experience/Pt Access) – 1

Grievances 4th Q 2025 – 1st Q 2026



34 total grievances were received over 4 reported concern categories. 6 grievances could be substantiated.

- ✓ **Care Team** accounted for 56% of reported concerns; included in this category: Communication/Explanation, Coordination of Care Team, Diagnosis Related, Pain Management, Patient Care.
- ✓ **Attitude & Behavior** accounted for 18% of reported concerns; included in this category: Lack of Concern/Uncaring, Rude or Unprofessional Behavior, Not Helpful.
- ✓ **Communication** accounted for 12% of reported concerns; included in this category: Communication with family members, Explanation of plan of care, Financial charges.
- ✓ **Service Delivery** accounted for 9% of reported concerns; included in this category: Appointment/Procedure Cancellation, Wait Time.
- ✓ **Patient Rights** accounted for 6% of reported concerns.

Grievance Rate per 1000 Discharges/Encounter

Patient Type	Quarter	Total Discharges/ Encounters	Total Grievances Received	Rate Per 1000
Inpatient/OBS	1Q25	7735	9	1.16
	2Q25	7786	13	1.67
	3Q25	7646	8	1.05
	4Q25	7813	5	0.64
	1Q26	7771	18	2.32
Emergency Department	1Q25	28072	2	0.07
	2Q25	28538	5	0.18
	3Q25	28759	8	0.28
	4Q25	28493	11	0.39
	1Q26	30010	10	0.33
Quick Care/Primary Care/Telemedicine	1Q25	93607	11	0.12
	2Q25	83322	8	0.10
	3Q25	80655	13	0.16
	4Q25	84284	12	0.14
	1Q26	81702	6	0.07
Overall Totals	1Q25	129414	22	0.17
	2Q25	119646	26	0.22
	3Q25	117060	29	0.25
	4Q25	120590	28	0.23
	1Q26	119483	34	0.28

Hospital Compare Measures	UMC	Sunrise	Southern Hills	MT View	Spring Valley
Overall Hospital Star Rating	★★	★★	★★★★	★★★★	★★★
HCAHPS Star Rating	★★	★★	★★★	★★★	★★
HCAHPS					
Patients who reported that their nurses "Always" communicated well H-COMP-1	68%	70%	75%	76%	77%
				Nevada Average = 76%	
Patients who reported that their doctors "Always" communicated well H-COMP-2	69%	65%	73%	70%	72%
				Nevada Average = 74%	
Patients who reported that staff "Always" explained about medicines before giving it to them H-COMP-5	49%	53%	53%	54%	56%
				Nevada Average = 59%	
Patients who reported that their room and bathroom were "Always" clean H-CLEAN-HSP	60%	68%	79%	71%	67%
				Nevada Average = 72%	
Patients who reported that the area around their room was "Always" quiet at night H-QUIET-HSP	42%	49%	59%	56%	52%
				Nevada Average = 55%	
[illegible]	81%	79%	82%	84%	82%

Patients who reported that YES, they were given information about what to do during their recovery at home **CARE TRANSITION**					**Nevada Average = 84%**
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) **H-HSP-RATING / H-RECMND**	**58%**	**60%**	**72%**	**70%**	**67%**
					Nevada Average = 68%
Patients who reported YES, they would definitely recommend the hospital **H-HSP-RATING / H-RECMND**	**60%**	**60%**	**75%**	**68%**	**69%**
					Nevada Average = 67%

UMC CMS Comparison to Las Vegas Acute Care Hospitals

**Data Last Updated May 13, 2026*

Valley	Centennial Hills	Summerlin	Henderson	St. Rose DeLima
★★	★★	★★★	★★	NA
★★	★★	★★	★★	NA
70%	69%	73%	69%	NA
70%	69%	68%	67%	NA
58%	51%	53%	54%	NA
61%	64%	70%	72%	NA
49%	53%	54%	51%	NA
80%	79%	81%	79%	NA

Nationa

Nationa

Nationa

Nationa

Nationa

				Nationa
56%	59%	64%	60%	NA
				Nationa
57%	59%	64%	61%	NA
				Nationa

St. Rose San Martin	St. Rose Siena	North Vista	Reporting Period
★★★★	★★★	★★★	
★★★	★★★	★★	
82%	76%	67%	
al Average = 80%			07/01/2024 - 06/30/2025
80%	69%	70%	
al Average = 80%			07/01/2024 - 06/30/2025
63%	61%	52%	
al Average = 62%			07/01/2024 - 06/30/2025
71%	64%	64%	
al Average = 74%			07/01/2024 - 06/30/2025
56%	54%	43%	
al Average = 60%			07/01/2024 - 06/30/2025
85%	85%	78%	

al Average = 87%			07/01/2024 - 06/30/2025
78%	67%	55%	
al Average = 72%			07/01/2024 - 06/30/2025
81%	67%	58%	
al Average = 71%			07/01/2024 - 06/30/2025

Hospital Compare Measures	UMC
Overall Hospital Star Rating	★★
HCAHPS Star Rating	★★
Sepsis Care	
Percentage of patients who received appropriate care for severe sepsis and septic shock (SEP-1) *higher percentages are better* **SEP-1**	**80%** **(N=326)**
Colonoscopy Follow-up	
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy **ASC-9**	**68%** **(N=60)**
Emergency Department Care	
Emergency Department Volume	**Very High**
Percentage of patients who left the emergency department before being seen *lower percentages are better*	**2%** **(N= 109011)**
Average (median) time patients spent in the emergency department before leaving from the visit *lower number of minutes is better*	**244 min** **(N= 387)**
Volume Legend (Patients Annually)	
Preventative Care	
Healthcare workers given influenza vaccination IMM-3 *higher percentages are better*	**77%** **(N= 6831)**
Safe Use of Opioids	
Proportion of inpatient hospitalizations for	**12%**

patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge *lower percentages are better*	
Surgical Complications	
Serious complications PSI-90 Composite	**1.04** **(No different than the national value)**
Death among patients with serious treatable complications after surgery (PSI-4) **PSI-04**	**177.93** **(No different than the national rate)**
Rate of complications for hip/knee replacement patients **COMP-HIP-KNEE**	**3.5%** **(No different than the national rate)** **(N=32)**
Infections	
Central line-associated bloodstream infections (CLABSI) in ICUs and select wards **HAI-1** *Lower numbers are better*	**0.761** **(No different than the national benchmark)**
Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards **HAI-2** *Lower numbers are better*	**0.320** **(Better than the national benchmark)**
Surgical site infections (SSI) from colon surgery **HAI-3** *Lower numbers are better*	**0.653** **(No different than national benchmark)**
Surgical site infections (SSI) from abdominal hysterectomy **HAI-4**	**NA**

Lower numbers are better	
Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections **HAI-5** *Lower numbers are better*	**0.546** **(No different than the national benchmark)**
Clostridium difficile (C.diff.) intestinal infections (HAI-6) **HAI-6** *Lower numbers are better*	**0.583** **(Better than the national benchmark)**
Mortalities	
Death rate for COPD patients **MORT-30-COPD**	**7.6%** **(No different than the national rate)** **(N=70)**
Death rate for heart attack patients **MORT-30-AMI**	**12.4%** **(No different than the national rate)** **(N=33)**
Death rate for heart failure patients **MORT-30-HF**	**9.2%** **(No different than the national rate)** **(N=143)**
Death rate for pneumonia patients **MORT-30-PN**	**17.3%** **(No different than the national rate)** **(N=170)**
Death rate for stroke patients **MORT-30-STK**	**12.2%** **(No different than the national rate)** **(N=100)**
Death rate for CABG surgery patients **MORT-30-CABG**	**2.3%** **(No different than the national rate)** **(N=62)**

Death rate for patients (Hospital-Wide)	**4.1% (No different than the national rate) (N=932)**
Readmissions	
Rate of readmission for chronic obstructive pulmonary disease (COPD) patient **READM-30-COPD**	**20.1% (No different than the national rate) (N=89)**
Rate of readmission for heart attack patients **READM-30-AMI**	**13.4% (No different than the national rate) (N=37)**
Rate of readmission for heart failure patients **READM-30-HF**	**21.8% (No different than the national rate) (N=169)**
Rate of readmission for pneumonia patients **READM-30-PN**	**15.7% (No different than the national rate) (N=171)**
Rate of readmission for coronary artery bypass graft (CABG) surgery patients **READM-30-CABG**	**11.6% (No different than the national rate) (N=61)**
Rate of readmission after hip/knee replacement **READM-30-HIP-KNEE**	**4.4% (No different than the national rate) (N=28)**
Rate of readmission after discharge from hospital (Hospital-Wide) **READM-30-IPF**	**15.6% (No different than the national rate) (N=1600)**

Sunrise	Southern Hills	Mountain View
★★	★★★★	★★★★
★★	★★★	★★★
64%	76%	55%

Nevada Average = 70%

NA	96%	67%

Nevada Average = 74%

Very High	Very High	Very High
0%	0%	0%

Nevada Average = 1%

171 mins	108 mins	165 mins

Nevada Average *(other very high volume hos*

68%	79%	77%

Nevada Average = 71%

13%	16%	18%

Nevada Average = 14%

1.04 (No different than the national value)	0.91 (No different than the national value)	1.13 (No different than the national value)
147.38 (No different than the national rate)	118.27 (Better than the national rate)	178.36 (No different than the national rate)
4.6% (No different than the national rate)	2.7% (No different than the national rate)	2.9% (No different than the national rate)
0.616 (Better than the national benchmark)	0.152 (Better than the national benchmark)	0.066 (Better than the national benchmark)
0.199 (Better than the national benchmark)	0.167 (Better than the national benchmark)	0.059 (Better than the national benchmark)
0.582 (No different than the national benchmark)	0.723 (No different than national benchmark)	0.231 (Better than the national benchmark)
0.000 (No different than national benchmark)	NA	0.416 (No different than the national benchmark)

0.676 (No different than national benchmark)	1.572 (No difference than national benchmark)	0.329 (Better than the national benchmark)
0.016 (Better than the national benchmark)	0.124 (Better than the national benchmark)	0.016 (Better than the national benchmark)
11.0% (No different that the national rate)	8.6% (No different that the national rate)	10.2% (No different than the national rate)
11.8% (No different than the national rate)	11.7% (No different that the national rate)	9.6% (No different than the national rate)
8.3% (Better than the national rate)	7.7% (Better than the national rate)	6.2% (Better than the national rate)
15.8% (No different than the national rate)	14.2% (No different than the national rate)	13.2% (Better than the national rate)
14.3% (No different than the national rate)	14.5% No different than the national rate)	14.6% (No different than the national rate)
2.8% (No different than the national rate)	NA	2.5% (No different than the national rate)

3.5% (Better than the national rate)	**3.8% (No different than the national rate)**	**3.1% (Better than the national rate)**
17.8% (No different than the national rate)	**17.8% (No different than the national rate)**	**19.0% (No different than the national rate)**
14.0% (No different than the national rate)	**12.9% (No different than the national rate)**	**14.7% (No different than the national rate)**
21.7% (No different than the national rate)	**19.1% (No different than the national rate)**	**18.5% (No different than the national rate)**
16.1% (No different than the national rate)	**17.8% (No different than the national rate)**	**16.7% (No different than the national rate)**
11.8% (No different than the national rate)	**NA**	**11.5% (No different than the national rate)**
5.2% (No different than the national rate)	**4.7% (No different than the national rate)**	**4.1% (No different than national rate)**
15.4% (No different than the national rate)	**16.0% (No different than the national rate)**	**15.1% (No different than national rate)**

UMC CMS Comparison to Las Vegas Acute Care H		
Spring Valley	Valley	Centennial Hills
★★★	★★	★★
★★	★★	★★
48%	80%	59%
79%	95%	96%
Very High	Very High	High
0%	0%	0%
186 mins	188 mins	172 mins

spitals) = 168 mins

		Low: 0 - 19,999 Medium: 20,000 - 39,999 **High: 40,000 - 59,999** **Very High: 60,000+**
76%	82%	42%
12%	16%	14%

1.03 (No different than the national value)	0.89 (No different than the national value)	0.89 (No different than the national value)

National Average = 1.00

151.86 (No different than the national rate)	161.09 (No different than the national rate)	170.07 (No different than the national rate)

National Average = 173.30

3.5% (No different than the national rate)	4.1% (No different than the national rate)	3.1% (No different than the national rate)

National Average = 3.6%

0.261 (Better than the national benchmark)	0.186 (Better than the national benchmark)	0.884 (No different than the national benchmark)

National Benchmark = 1.00

0.196 (Better than the national benchmark)	0.143 (Better than the national benchmark)	0.472 (No different than the national benchmark)

National Benchmark = 1.00

0.237 (No different than the national benchmark)	1.222 (No different than the national benchmark)	0.000 (Better than the national benchmark)

National Benchmark = 1.00

NA	NA	0.000 (No different than the national benchmark)

National Benchmark = 1.00

0.441 (No different than the national benchmark)	0.514 (No different than the national benchmark)	0.545 (No different than the national benchmark)

National Benchmark = 1.00

0.016 (Better than the national benchmark)	0.039 (Better than the national benchmark)	0.139 (Better than the national benchmark)

National Benchmark = 1.00

7.3% (No different than the national rate)	8.9% (No different than the national rate)	10.9% (No different than the national rate)

National Average = 8.8%

13.0% (No different than the national rate)	11.0% (No different than the national rate)	13.3% (No different than the national rate)

National Average = 12.2%

12.5% (No different than the national rate)	11.0% (No different than the national rate)	12.5% (No different than the national rate)

National Average = 11.6%

17.0% (No different than the national rate)	14.0% (No different tan the national rate)	18.0% (No different than the national rate)

National Average = 16.2%

18.1% (Worse than the national rate)	15.5% (No different than the national rate)	16.2% (No different than the national rate)

National Average = 13.3%

1.9% (No different than the national rate)	3.3% (No different than the national rate)	NA

National Average = 2.6%

4.6% (No different than the national rate)	4.5% (No different than the national rate)	4.1% (No different than the national rate)

National Average = 4.2%

19.0% (No different than national rate)	17.9% (No different than national rate)	19.1% (No different than the national rate)

National Average = 18.2%

13.1% (No different than the national rate)	13.5% (No different than the national rate)	13.3% (No different than the national rate)

National Average = 13.6%

21.2% (No different than the national rate)	21.3% (No different than the national rate)	18.8% (No different than the national rate)

National Average = 19.7%

17.6% (No different than the national rate)	16.0% (No different than the national rate)	17.4% (No different than the national rate)

National Average = 16.0%

9.8% (No different than the national rate)	11.4% (No different than the national rate)	NA

National Average = 10.6%

4.5% (No different than national rate)	5.2% (No different than the national rate)	5.0% (No different than the national rate)

National Average = 4.8%

15.6% (No different than the national rate)	16.9% (Worse than the national rate)	14.6% (No different than the national rate)

National Average = 15.0%

lospitals

Summerlin	Henderson	St. Rose DeLima
★★★	★★	NA
★★	★★	NA
58%	54%	NA

National Av

100%	100%	NA

National Av

Very High	Very High	Low
0%	0%	1%

National Av

210 mins	166 mins	115 mins

National Average *(other very hig*

76%	51%	58%

National Av

11%	14%	50%

		National Av
0.99 (No different than the national value)	0.88 (No different than the national value)	NA
163.85 (No different than the national rate)	168.84 (No different that the national rate)	NA
NA	4.1% (No different than the national rate)	NA
0.140 (Better than than the national benchmark)	0.198 (Better than national benchmark)	NA
0		
0.342 (Better than the national benchmark)	0.000 (Better than the national benchmark)	NA
0		
0.000 Better than the national benchmark)	0.884 (No different than the national benchmark)	NA
0		
0.000 (No different than the national benchmark)	NA	NA

0

0.385 (No different than the national benchmark)	0.530 (No different than the national benchmark)	NA

0

0.180 (Better than the national benchmark)	0.000 (Better than the national benchmark)	NA

0

7.3% (No different than the national rate)	7.5% (No different than the national rate)	NA
13.3% (No different than the national rate)	12.6% (No different than the national rate)	NA
10.3% (No different than the national rate)	10.6% (No different than the national rate)	NA
13.0% (Better than the national rate)	14.3% (No different than the national rate)	NA
11.0% (No different than the national rate)	14.1% (No different than the national rate)	NA
3.0% (No different than the national rate)	NA	NA

4.3% (No different than the national rate)	4.1% (No different than the national rate)	NA
18.5% (No different than the national rate)	19.4% (No different than the national rate)	NA
14.6% (No different than the national rate)	14.7% (No different than the national rate)	NA
20.6% (No different than the national rate)	22.4% (No different than the national rate)	NA
18.7% (Worse than the national rate)	16.6% (No different that the national rate)	NA
10.5% (No different than the national rate)	NA	NA
NA	4.6% (No different than the national rate)	NA
16.0% (No different than the national rate)	16.4% (Worse than the national rate)	NA

St. Rose San Martin	St. Rose Siena	North Vista
★★★★	★★★	★★★
★★★	★★★	★★
57%	66%	77%

erage = 64%

40%	30%	NA

erage = 93%

Medium	Very High	High
0%	1%	2%

verage = 2%

171 mins	181 mins	136 mins

gh volume hospitals) = 203 mins

64%	70%	67%

erage = 78%

17%	13%	5%

erage = 15%

1.22 (No different than the national value)	1.02 (No different that the national value)	0.85 (No different than the national value)
170.84 (No different than the national rate)	158.25 (No different than the national rate)	NA
NA	4.5% (No different than the national rate)	NA
0.284 (No different than the national benchmark)	0.478 (Better than the national benchmark)	0.000 (Better than the national benchmark)
0.387 (No different than the national benchmark)	0.107 (Better than the national benchmark)	0.000 (No different than the national benchmark)
0.749 (No different than the national benchmark)	0.964 (No different than the national benchmark)	0.000 (No different than the national benchmark)
NA	NA	NA

0.000 (No different than the national benchmark)	0.267 (Better than the national benchmark)	0.000 (No different than the national benchmark)
0.168 (Better than the national benchmark)	0.253 (Better than the national benchmark)	0.060 (Better than the national benchmark)
7.9% (No different than the national rate)	9.4% (No different that the national rate)	8.0% (No different than the national rate)
11.9% (No different than the national rate)	12.3% (No different than the national rate)	NA
12.1% (No different than the national rate)	11.2% (No different than the national rate)	8.6% (No different than the national rate)
21.0% (Worse than the national rate)	15.1% (No different than the national rate)	15.3% (No different than the national rate)
12.9% (No different than the national rate)	11.9% (No different than the national rate)	NA
3.2% (No different than the national rate)	4.0% (No different than the national rate)	NA

4.2% (No different than the national rate)	**4.5% (No different than the national rate)**	**4.4% (No different than the national rate)**
17.7% (No different than the national rate)	**17.0% (No different than the national rate)**	**18.7% (No different than the national rate)**
13.1% (No different than the national rate)	**12.9% (No different than the national rate)**	**NA**
20.0% (No different than the national rate)	**20.5% (No different than the national rate)**	**21.8% (No different than the national rate)**
16.4% (No different than the national rate)	**18.1% Worse than the national rate)**	**16.6% (No different than the national rate)**
12.4% (No different than the national rate)	**8.4% (No different than the national rate)**	**NA**
NA	**4.5% (No different than the national rate)**	**NA**
15.4% (No different than the national rate)	**15.2% (No different than the national rate)**	**15.8% (No different than the national rate)**

Reporting Period
07/01/2024-06/30/2025
01/01/2024-12/31/2024

Reporting Period
01/01/2024- 12/31/2024
10/1/2024- 03/31/2025

01/01/2024-12/31/2024
07/01/2022-06/30/2024
07/01/2022-06/30/2024
04/01/2021-03/31/2024
07/01/2024-06/30/2025
07/01/2024-06/30/2025
07/01/2024-06/30/2025
07/01/2024-06/30/2025

07/01/2024- **06/30/2025**
07/01/2024- **06/30/2025**
07/01/2021- **06/30/2024**
07/01/2021- **06/30/2024**
07/01/2021- **06/30/2024**
07/01/2021- **06/30/2024**
07/01/2021- **06/30/2024**
07/01/2021- **06/30/2024**

07/01/2023- 06/30/2024 *(Hybrid_HWM)*
07/01/2021- 06/30/2024
07/01/2021- 06/30/2024
07/01/2021- 06/30/2024
07/01/2021- 06/30/2024
07/01/2021- 06/30/2024
07/01/2021- 06/30/2024
07/01/2022- 06/30/2024

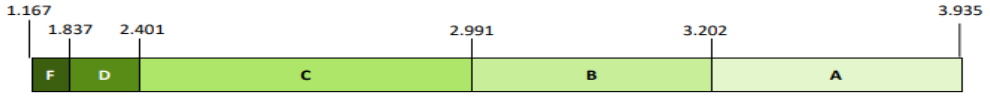
UMC Leapfrog Individual Measure - Compare

	LEAPFROG				UMC																	
	Measures Contributing to LF Score	Best Score Possible	Standard Weight	Mean	UMC Trend	Spring 2026	Fall 2025	Spring 2025	Fall 2024	Spring 2024	Fall 2023	Spring 2023	Fall 2022	Spring 2022	Fall 2021	Spring 2021	Fall 2020	Spring 2020	Fall 2019	Spring 2019	Fall 2018	Spring 2018	Fall 2017
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	6.1%	83.51		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Bar Code Medication Administration (BCMA)	100	5.9%	86.11		100	100	100	100	100	100	100	100	100	100	100	45	100	100	100	100		
	ICU Physician Staffing (IPS)	100	6.8%	68.93		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Safe Practice 1 : Culture of Leadership Structures and Systems	120	3.1%	117.78		120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120
	Safe Practice 2: Culture Measurement , Feedback & Intervention	120	3.2%	117.68		120	120	120	120	120	120	120	120	120	120	120	120	120	120	92.31	92.31	120	120
	Total Nursing Care Hours Per Patient Day	100	4.7%	79.68		70	70	40	40	N/A	N/A												
	Hand Hygiene	100	4.9%	78.18		70	70	100	100	100	100	100	100	100	100	N/A	N/A	60	60	60	60	60	60
	H-COMP-1 - Nurse Communication	100	3.0%	90.55		87	87	86	86	86	86	86	87	87	88	88	87	86	84	84	84	84	83
	H-COMP-2 - Doctor Communication	100	3.0%	90.11		86	86	86	86	86	85	86	87	87	87	87	86	84	84	84	85	84	84
	H-COMP-3 - Staff Responsiveness	100	3.1%	82.06		78	79	80	79	78	78	79	80	81	80	80	80	80	78	76	76	76	74
	H-COMP-5 - Communication about Medicines	100	3.1%	74.83		69	69	68	67	70	70	70	69	70	72	72	70	69	69	68	68	68	68
	H-COMP-6 - Discharge Information	100	3.1%	85.65		82	81	81	82	82	82	82	82	82	81	81	80	79	78	80	81	80	79
Outcome Measures	Foreign Object Retained	0.00	4.2%	0.011		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	Air Embolism	0.00	2.4%	0.001		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	Falls and Trauma	0.00	4.9%	0.339		0.172	0.172	0.000	0.000	0.169	0.169	0.221	0.000	0.000	0.281	0.281	0.281	0.437	0.437	0.180	0.180	0.580	0.580
	CLABSI	0.00	4.6%	0.549		0.761	0.764	0.861	1.075	1.195	1.060	1.097	1.181	1.175	1.047	0.765	0.879	1.008	1.128	0.887	0.786	1.006	0.555
	CAUTI	0.00	4.7%	0.497		0.320	0.413	0.855	1.310	1.167	1.134	0.959	0.787	1.330	1.479	1.123	1.164	1.122	1.578	0.932	0.584	0.707	0.725
	SSI: Colon	0.00	3.4%	0.820		0.653	0.566	1.580	2.103	2.403	2.081	1.819	1.239	1.309	2.545	2.204	2.701	2.033	1.774	1.036	1.503	2.286	2.946
	MRSA	0.00	4.4%	0.657		0.546	0.802	0.966	0.919	1.332	1.460	1.702	2.594	2.124	1.934	1.684	1.655	1.416	0.879	1.004	0.919	1.451	1.659
	C. Diff	0.00	4.5%	0.347		0.585	0.616	0.661	0.650	0.482	0.310	0.585	1.002	1.183	1.083	1.116	1.086	1.045	1.098	1.013	0.936	1.061	1.186
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	0.00	2.0%	173.37		177.93	180.38	180.38	191.91	191.91	159.17	159.17	160.80	160.80	160.80	202.90	202.94	205.14	205.14	176.75	176.75	158.99	168.360
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.00	15.0%	1.00		1.04	0.97	0.97	0.97	0.97	0.81	0.81	1.18	1.18									
	LEAPFROG SCORE					2.8748	2.9347	2.8759	2.8105	2.8708	3.0796	3.0978	2.8115	2.7593	2.5619	2.5016	2.2297	2.3737	2.3528	2.4860	2.5612	2.4493	2.3328
	LEAPFROG Grade					C	C	C	C	C	B	B	C	C	C	D	D	D	D	D	C	D	D

Spring 2026 Cut-Off Points

Grade	Safety Grade Criteria *(at or above cut point)*	Count of Hospitals	Percentage of Hospitals
A	≥ 3.202	917	33%
B	≥ 2.991	740	26%
C	≥ 2.401	646	23%
D	≥ 1.837	55	2%
F	< 1.837	5	<1%
Total Graded		2,363	
GNA		450	16%
Grand Total		2,813	

Higher is Better



	Better than previous reporting period
	Same as previous reporting period
	Worse than previous period
	N/A in previous reporting period

Measures Contributing to LF Score	Standard Weight	UMC	Sunrise	Southern Hills	MT View	Valley	Spring Valley	Summerlin	Centennial Hills	Henderson	St. Rose San Martin	St. Rose Siena	North Vista	Source & Timeframe
Computerized Physician Order Entry (CPOE)	6.1%	100	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
Bar Code Medication Administration (BCMA)	5.9%	100	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
ICU Physician Staffing (IPS)	6.8%	100	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
Safe Practice 1: Culture of Leadership Structures and Systems	3.1%	120	120	120	120	120	120	120	120	120	120	120	120	2025 LF Survey
Safe Practice 2: Culture Measurement, Feedback, & Intervention	3.2%	120	120	120	120	120	120	120	120	120	120	120	120	2025 LF Survey
Total Nursing Care Hours per Patient Day	4.7%	70	15	15	15	100	70	70	70	70	100	70	100	2025 LF Survey 01/01/2024 - 12/31/2024 or 07/01/2024 - 06/30/2025
Hand Hygiene	4.9%	70	100	100	100	100	100	100	100	100	100	100	100	2025 LF Survey
H-COMP-1: Nurse Communication	3.0%	87	84	89	89	87	88	90	85	86	93	89	87	CMS 01/01/2024 - 12/31/2024
H-COMP-2: Doctor Communication	3.0%	86	81	88	86	87	86	87	83	83	91	86	88	CMS 01/01/2024 - 12/31/2024
H-COMP-3: Staff Responsiveness	3.1%	78	74	79	82	80	80	80	75	75	85	80	76	CMS 01/01/2024 - 12/31/2024
H-COMP-5: Communication about Medicines	3.1%	69	65	69	70	74	71	73	68	69	76	73	72	CMS 01/01/2024 - 12/31/2024
H-COMP-6: Discharge Information	3.1%	82	78	81	84	83	82	84	81	79	85	84	81	CMS 01/01/2024 - 12/31/2024
Foreign Object Retained	4.2%	0.000	0.086	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2022 - 06/30/2024
Air Embolism	2.4%	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2022 - 06/30/2024
Falls and Trauma	4.9%	0.172	0.171	0.000	0.082	0.578	0.171	0.150	0.638	0.297	0.305	0.301	0.000	CMS 07/01/2022 - 06/30/2024
CLABSI	4.6%	0.761	0.616	0.300	0.066	0.186	0.261	0.140	0.884	0.198	0.284	0.490	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
CAUTI	4.7%	0.320	0.199	0.000	0.059	0.143	0.196	0.342	0.472	0.000	0.387	0.115	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
SSI: Colon	3.4%	0.653	0.582	0.750	0.231	1.222	0.237	0.223	0.000	0.884	0.749	0.964	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
MRSA	4.4%	0.546	0.697	0.741	0.344	0.514	0.442	0.385	0.726	0.530	0.000	0.267	0.000	2025 LF Survey 07/01/2024 - 06/30/2025
C. Diff	4.5%	0.585	0.016	0.126	0.016	0.039	0.016	0.180	0.139	0.000	0.168	0.253	0.060	2025 LF Survey 07/01/2024 - 06/30/2025
PSI 4: Death rate among surgical inpatients with serious treatable conditions	2.0%	177.93	147.38	118.27	178.36	161.09	151.86	163.85	170.07	168.84	170.84	158.25	N/A	CMS 07/01/2022 - 06/30/2024
CMS Medicare PSI 90: Patient safety and adverse events composite	15.0%	1.04	1.04	0.91	1.13	0.89	1.03	0.99	0.89	0.88	1.22	1.02	0.85	CMS 07/01/2022 - 06/30/2024
LEAPFROG SCORE		**2.8748**	**2.6744**	**3.1747**	**3.0728**	**3.2394**	**3.1652**	**3.2369**	**2.9291**	**3.0913**	**3.2342**	**3.1241**	**3.4366**	
LEAPFROG Spring 2026 Grade		**C**	**C**	**B**	**B**	**A**	**B**	**A**	**C**	**B**	**A**	**B**	**A**	
Fall 2025 Grade		**C**	**C**	**A**	**A**	**A**	**C**	**B**	**C**	**B**	**C**	**B**	**A**	

N/A	Not Applicable

	Not Publicly Reported

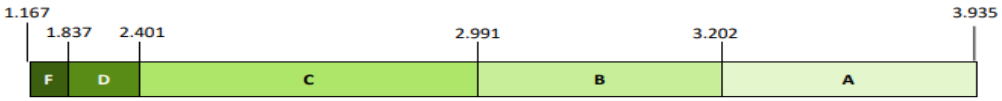
Spring 2026 Cut-Off Points

Grade	Safety Grade Criteria *(at or above cut point)*	Count of Hospitals	Percentage of Hospitals
A	≥ 3.202	917	33%
B	≥ 2.991	740	26%
C	≥ 2.401	646	23%
D	≥ 1.837	55	2%
F	< 1.837	5	<1%
Total Graded		2,363	
GNA		450	16%

Spring 2026 Compare Hospital Counts	
A	4
B	5
C	3
D	0
F	0

Grand Total	2,813

Higher is Better



UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue: **FY26 Organizational Improvement Goals Update**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	
Recommendation: **That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on the FY26 Organizational Improvement Goals from Patty Scott, Quality/Safety/Regulatory Officer; and take any action deemed appropriate.** ***(For possible action)***	

FISCAL IMPACT:

None

BACKGROUND:

The Clinical Quality Committee will receive an update on the UMC Organizational goals for FY26.

Cleared for Agenda
June 1, 2026

Agenda Item #

6

UNIVERSITY MEDICAL CENTER

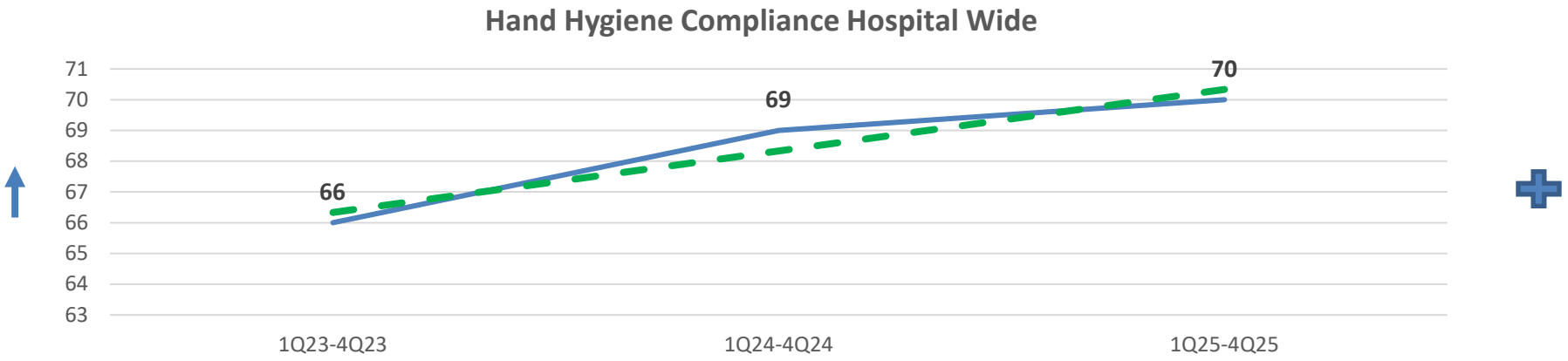
Quality/Safety Performance Objectives FY26

Approved by the Governing Board

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:



Measure	Goal Met
Finalize vendor selection, budgeting, and obtain contract approval for electronic Hand Hygiene Surveillance System	Swipesense May 11 – 25, 2026
Develop, implement, and execute a campaign to improve the Hand Hygiene Program	Program Developed Launching: 4/20/26

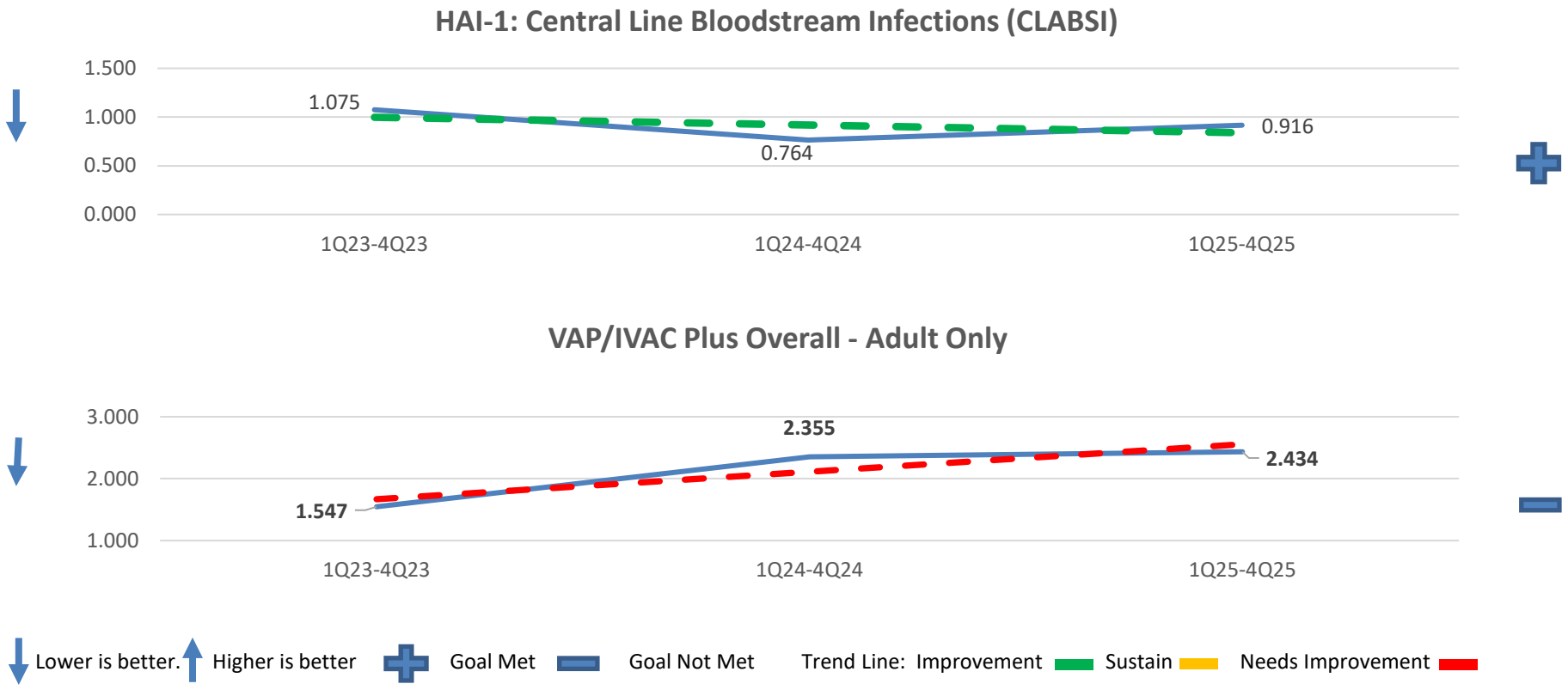
Lower is better. Higher is better Goal Met Goal Not Met Trend Line: Improvement Sustain Needs Improvement

Source: Infection Control Department, Hand Hygiene Observations.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period or remain under the national index of 1.0 for the following inpatient quality/safety measures:

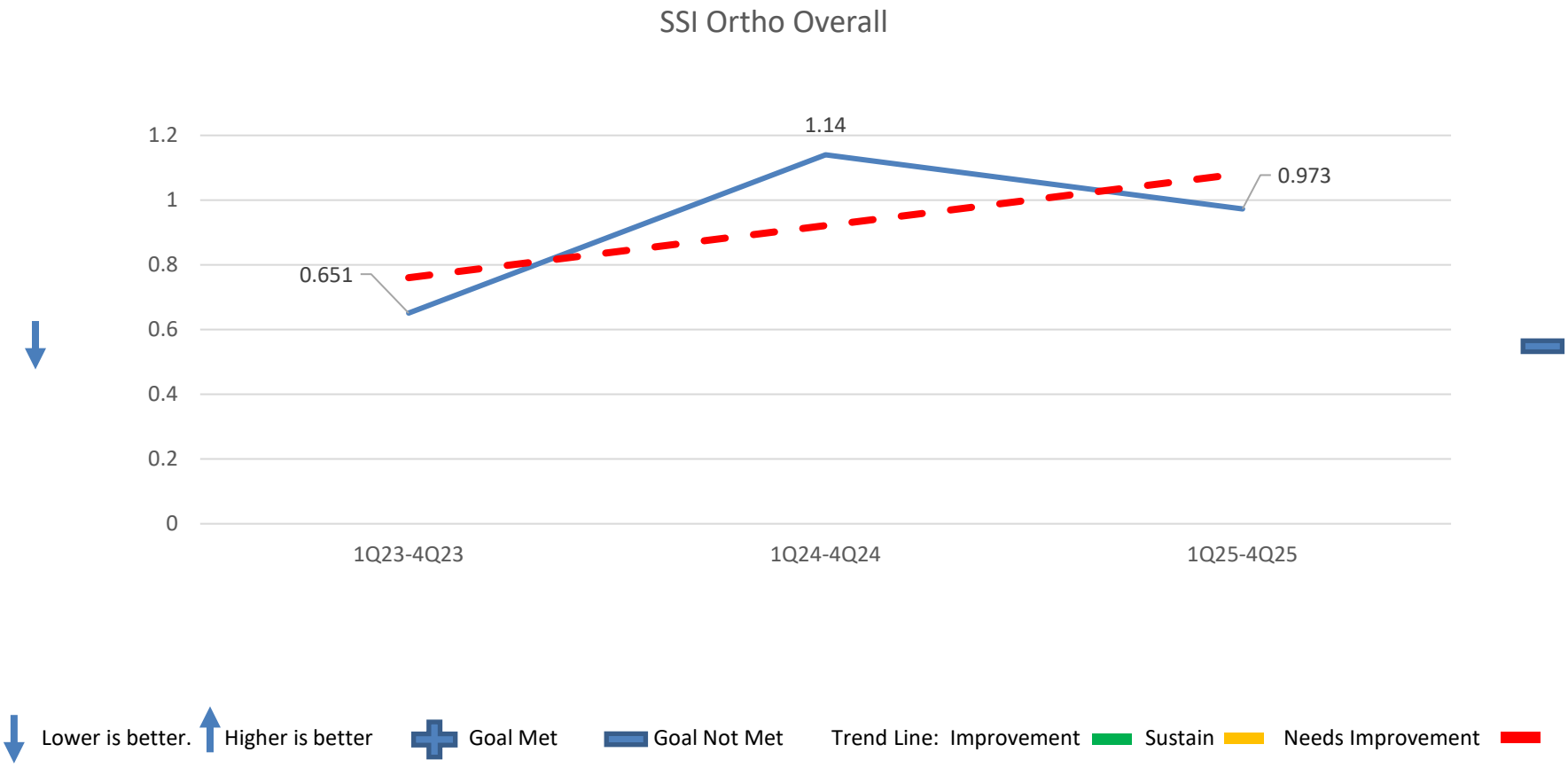


Source: UMC Infection Control Department – NHSN

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:

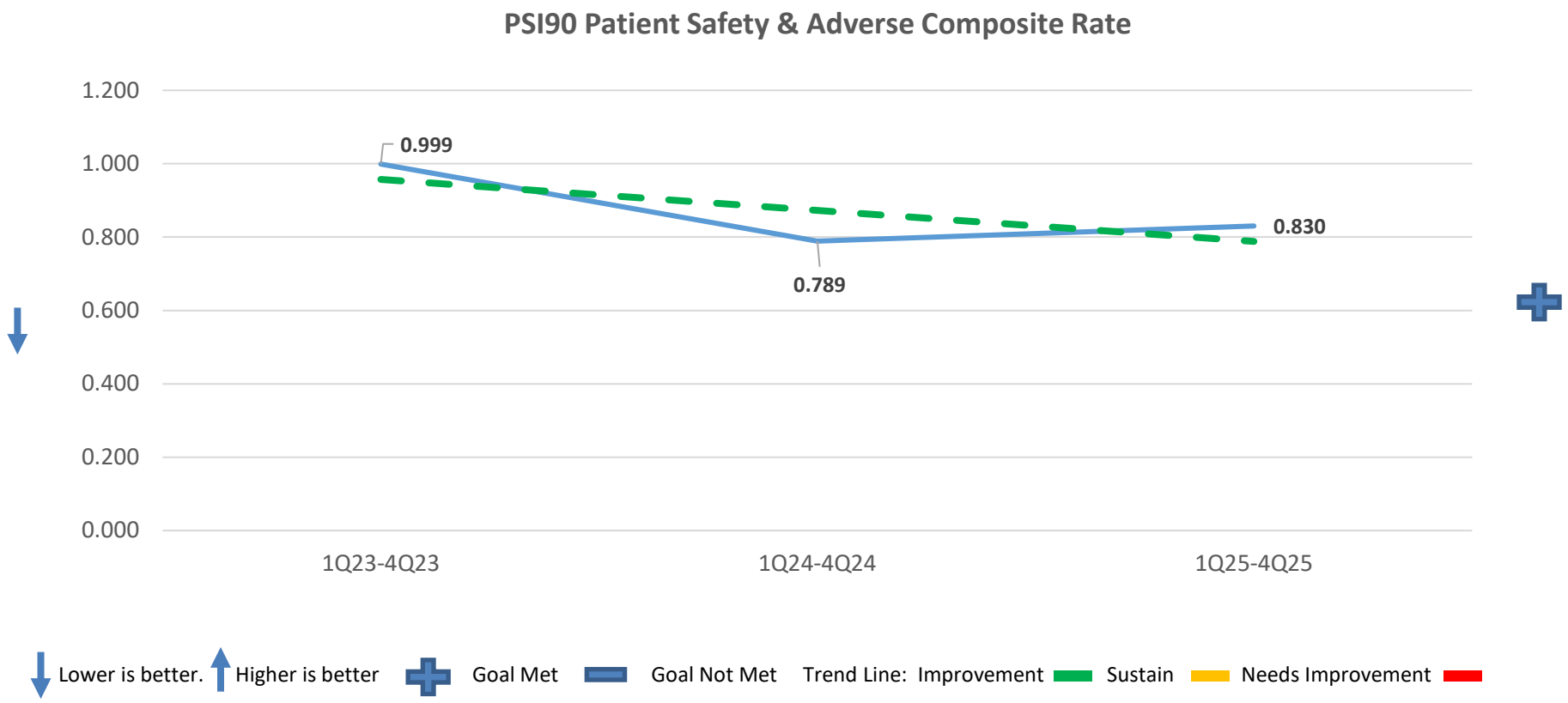


Source: UMC Infection Control Department - NHSN. SSI Ortho - NHSN reporting process, one quarter lag.
SSI Rate, percent of total procedures. Hip, Knee, Spinal Fusion and Laminectomy

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period or remain under the national index of 1.0 for the following inpatient quality/safety measures:



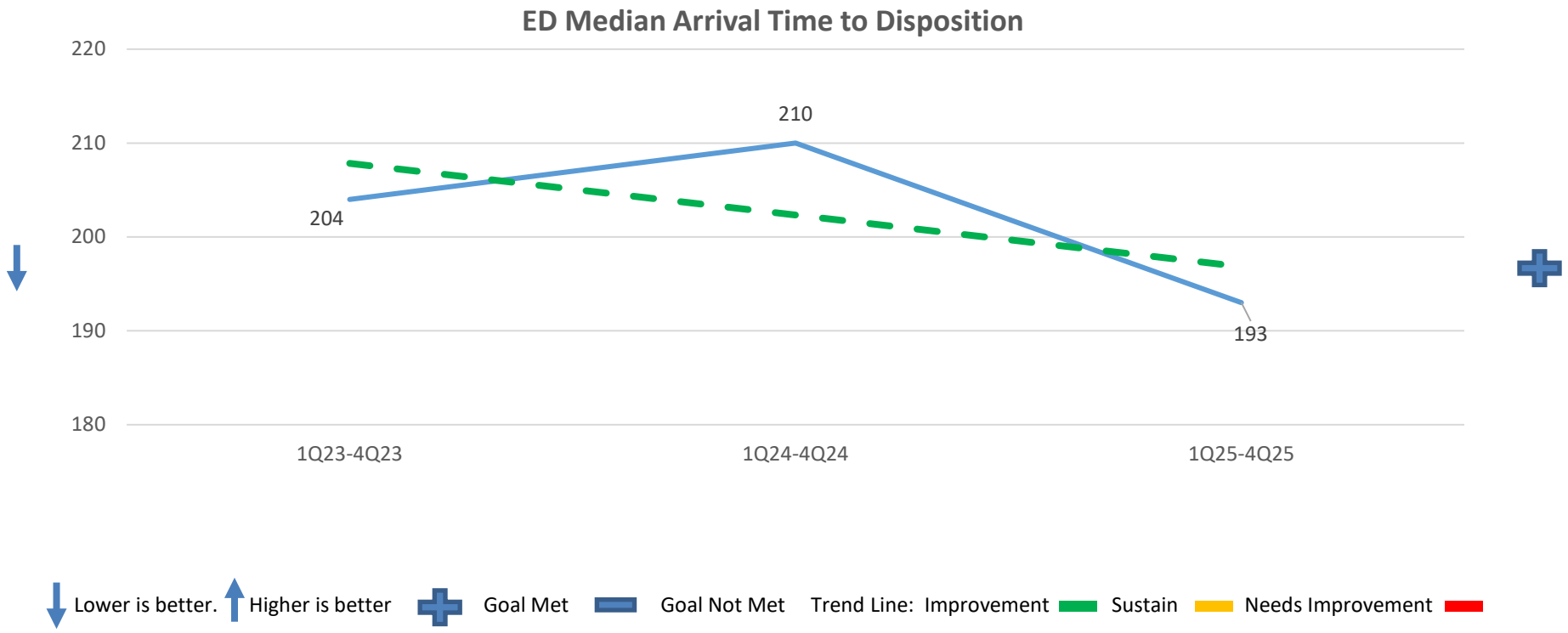
Source: Vizient Clinical Database

PSI 90 is a composite of the following 10, PSI indicators: pressure ulcers, iatrogenic pneumothorax, fall with hip fracture, peri-operative hemorrhage/hematoma, peri-operative metabolic complications, post-op respiratory failure, peri-op pulmonary embolism/deep vein thrombosis, post-op sepsis, post-op wound dehiscence, & accidental puncture/laceration.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following quality/safety measures:

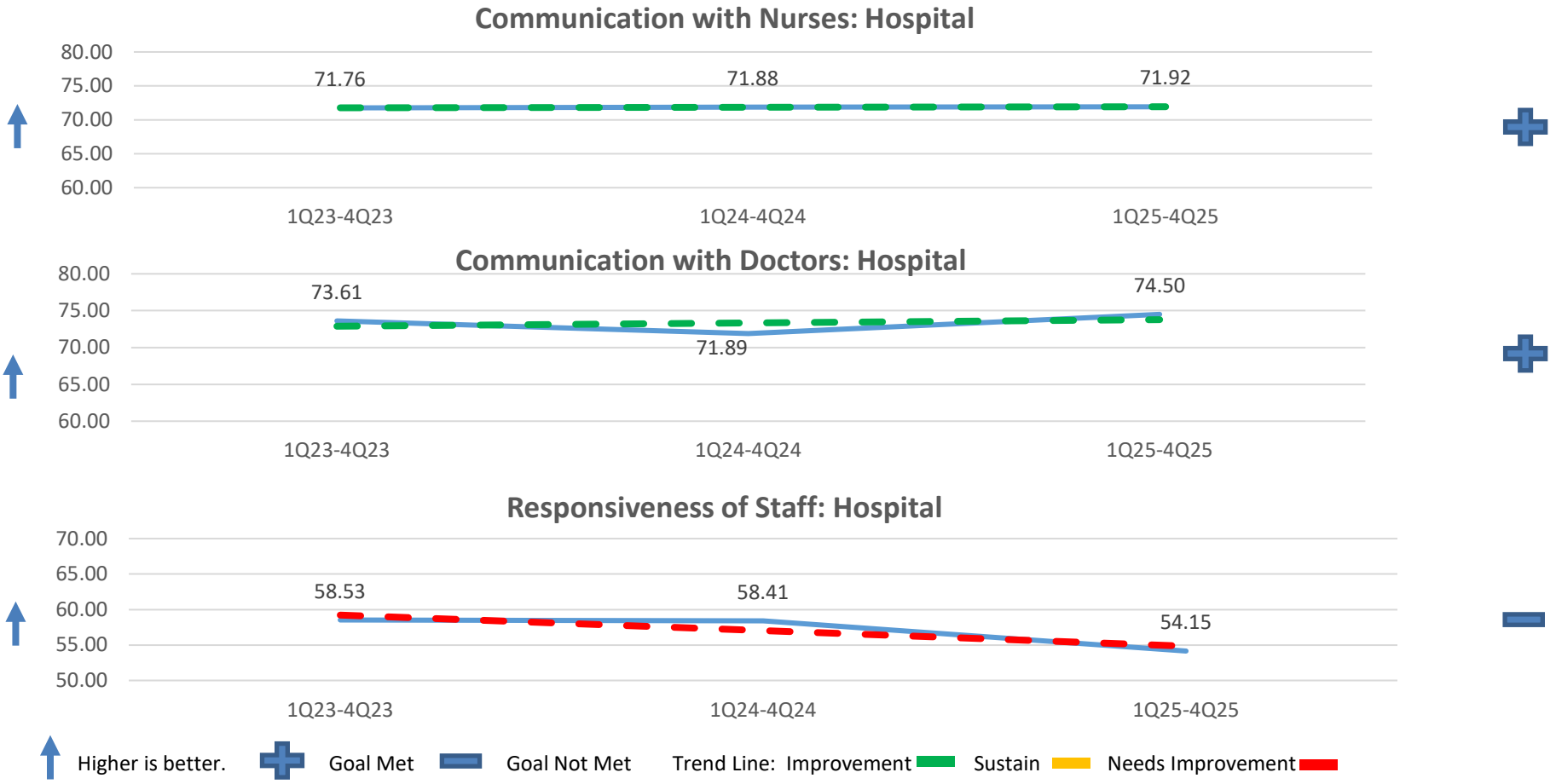


ED Median Arrival to Disposition: Epic Slicer Dicer. The median time (in minutes) from when the patient arrived until ED disposition was recorded. Adult, Peds, Trauma Resus.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (IP):

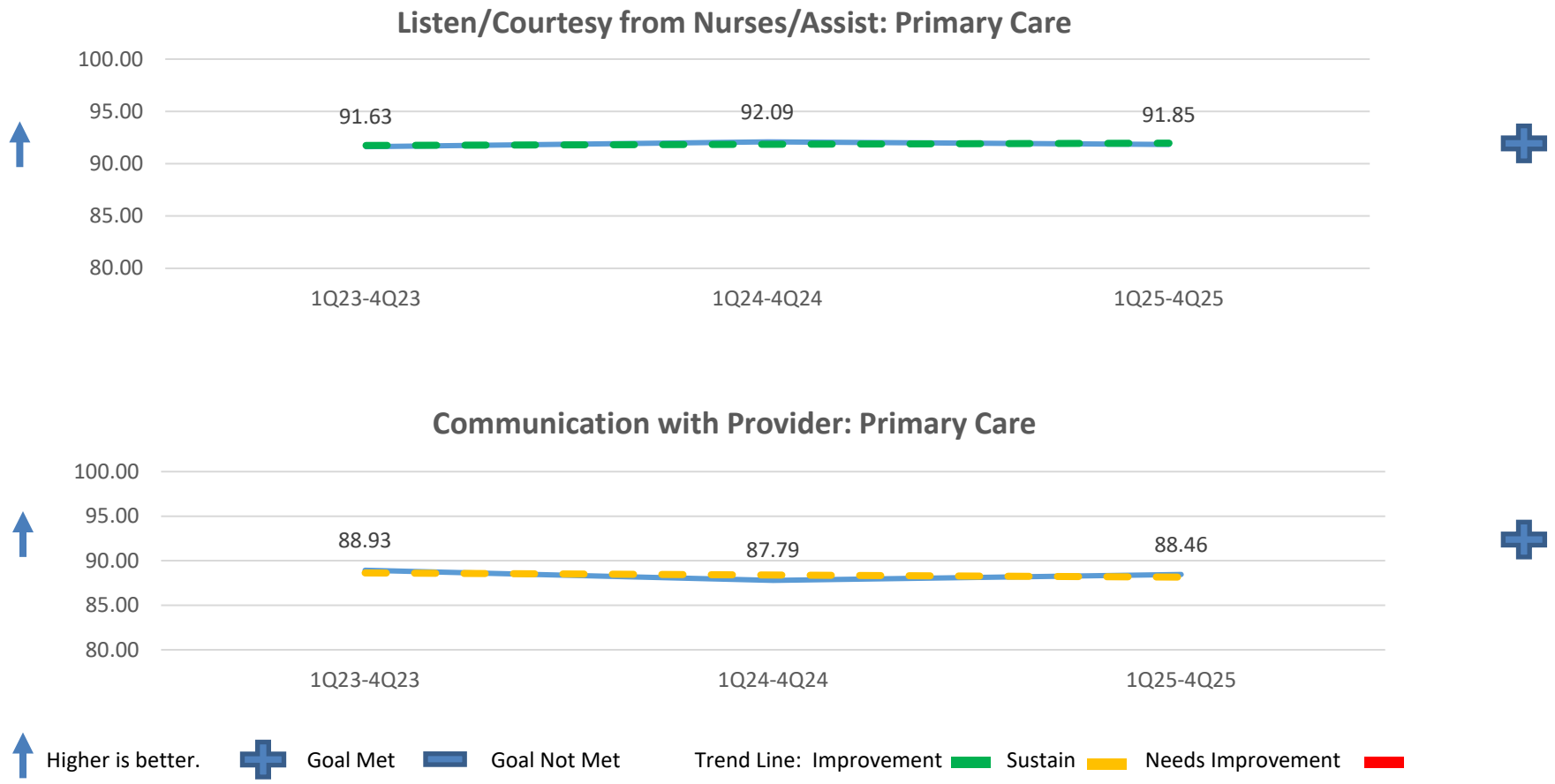


Source: HCAHPS Measures by Service Date - Press Ganey - Top Box by Service Date

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (OP):

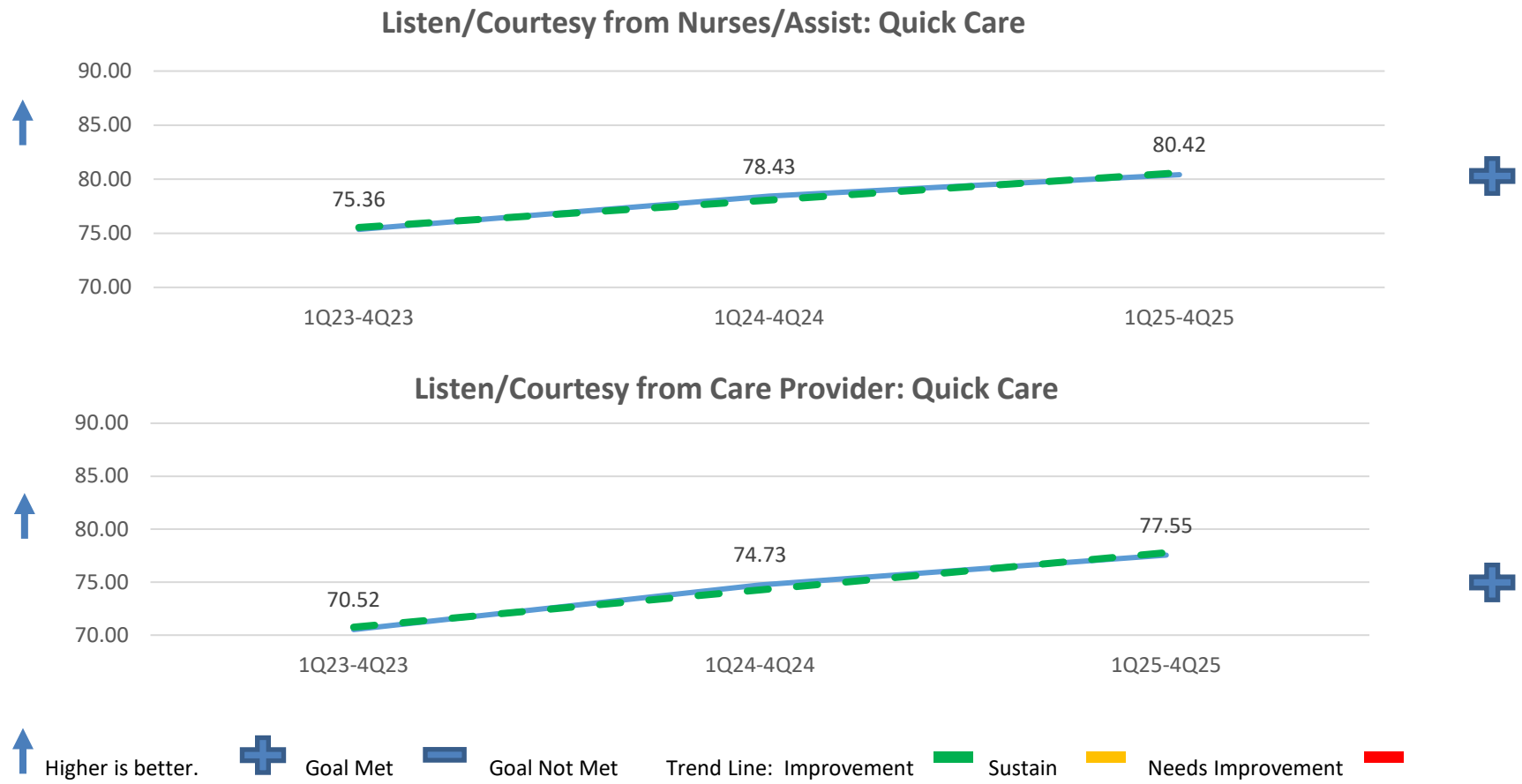


Source: HCAHPS Measures by Service Date - Press Ganey - Top Box by Service Date.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (OP):



Source: HCAHPS Measures by Service Date - Press Ganey Top Box by Service Date.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

Develop, implement, and execute plans/campaigns to support and improve the following performance goals/programs during FY26:

Measure	Goal Met
Communication with Physicians	100%
Unit of the Week Rounding to Identify Areas in Need of Repair (# of repair opportunities identified within areas reviewed / # corrected on validation of area)	94%*

* % completed as of 4/17/26

Source: Patient Experience

DISCUSSION / QUESTIONS?

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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue: **UMC Policies and Procedures**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee review and recommend for approval by Governing Board, the UMC Policies and Procedures Committee's activities of April1, 2026 and May 6, 2026, including, the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 1, 2026

Agenda Item #
7

Regulatory Updates

Policies & Procedures

Regulatory Update; Policy/Procedures

- Regulatory / Accreditation Surveys
  - DNV Comprehensive Stroke – May 14 – 15, 2025

- Policy / Procedures for Approval:
  - Timeframe: April 1, 2026 & May 6, 2026
  - Total approved: 71
  - Total retired: 3
  - Approved through Hospital P/P, Quality, MEC

DISCUSSION / QUESTIONS?

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April 1, 2026 Hospital Policy / Procedure Committee
As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.
Total of 22 Approved, 2 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Metrasens Screening (Ferrous Metal Detector)	New	Approved as Submitted	New Policy. Vetted by Public Safety, Risk Management, EOC Committee, WPV Committee.
Person & Property Searches	Revised	Approved as Submitted	Included verbiage: "NOTE: Similar processes also apply to behavioral health check-ins at the Trauma Resus and Pediatric Emergency Room departments with slight variations due to department layout." to show process is applicable to Trauma Resus and Peds ER. Vetted by Public Safety, WPV Committee and Critical Care Leadership.
Management of Patient Property and Valuables	Revised	Approved as Submitted	Update to "Policy" noting that bloodied, soiled clothing will be disposed of instead of storing until PT discharge. Minor changes to verbiage throughout the policy to assist with flow and clarity.
Post Anesthesia Care Unit (PACU) Discharge Criteria	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PACU Manager, ACNO, Anesthesia Medical Director and Surgical Services Medical Director.
Medical & Dental Staff Peer Review Policy	Revised	Approved as Submitted	Updated PIC compositions to a minimum of 16 voting members, added three members-at-large, Pathology by consultation exception, and language allowing the Chief of Staff, in collaboration with department Chiefs, to appoint additional members based on workload or case volume. Revised to allow second review as designee PIC voting member for Appropriate Care ratings. Removed "Exemplary Care" rating to align with current practice. Updated references, vetted by Quality/Safety/Regulatory Officer; PI Program Manager; PIC Committee.
Copy Fees for Patient Records	Revised	Approved as Submitted	Updated Manual designation from Compliance and Privacy to Privacy. Updated Purpose section to include federal HIPAA and Nevada law. Reorganized and elaborated on existing policy language to improve clarity, readability, and flow without changing substantive requirements. Updated ROI roles, regulatory references, and policy formatting; no material

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			change to compliance obligations. Referenced law were checked. Policy was vetted by HIM leadership and Privacy Officer.
Requests for Restrictions on Use or Disclosure of PHI	Revised	Approved as Submitted	Scheduled review. Manual changed from Compliance and Privacy to just Privacy. Non-substantive edits made to improve language clarity, structure, and alignment with current policy formatting standards. No changes to policy scope, requirements, or operational practices. Reviewed and approved by the Privacy Officer and the HIM department leadership.
CRRT: Nursing Management of the Patient	Revised	Approved as Submitted	Verbiage added in Policy E,#3,4,5 ,References updated to AACN 8th edition ,Oct 2023.Vetted by Critical Care Directors and Managers and ACNO.
Prone Positioning-Adult	Revised	Approved with Revisions	New verbiage added to scope and purpose of the policy. Deleted physician order language in 1.c and supine to minimum of 4 hours. Vetted by Critical Care Directors and Managers and ACNO.
Trials and Evaluations	Revised	Approved as Submitted	Enhanced to emphasize contract compliance and vendor accountability. Adds CMS billing requirements for trial and no-cost devices to ensure consistent patient charging, proper coding, and regulatory compliance. Vetted by Supply Chain Services Director and CFO.
Modified Infant Bathing for Fractured Humerus or Shoulder Dystocia	Revised	Approved with Revisions	Updated from a policy to a guideline. Vetted by Rehab Services Director and ACNO.
Orthopaedic Surgery Contingency Plan	Revised	Approved with Revisions	Updated from a guideline to a policy. Vetted by Trauma Program Manager, Director Critical Care Services and ACNO.
Cardiovascular Surgery Contingency Plan	Revised	Approved as Submitted	Reviewed for compliance with ACS verification requirements. Vetted by stakeholders, Trauma Program Manager, Director Critical Care Services and ACNO.
Trauma Response Team – Respiratory Therapy	Revised	Approved as Submitted	Added "Venous Blood Gasses (VBGs)" to 4th bullet point. Vetted by Trauma Program Manager, Director Critical Care Services and ACNO.
Trauma Team – Intermediate Activation	Revised	Approved as Submitted	Added "Seatbelt sign in pediatric patients <15 years old." Vetted by key stakeholders, including Trauma Surgery, Adult EM, and Pediatric EM. Vetted by Trauma Program

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			Manager, Director Critical Care Services and ACNO.
Occupational Safety and Health (OSH) Policy	Revised	Approved as Submitted	Updated punctuation and grammar. Replaced the Joint Commission with Det Norske Veritas (DNV) and Physical Environment. Vetted by Hospital Safety Program Manager.
2026 Utility Systems Management Plan	Revised	Approved as Submitted	Minor changes. Reviewed and approved by the EOC Committee.
2026 Hazardous Materials and Waste Management Plan	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
2026 Safety Management Plan	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
2025 Safety Management Plan Evaluation	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
2026 Medical Equipment Management Plan	Revised	Approved with Revisions	Minor changes to formatting and verbiage. Removed JC references and removed "annually" under Staff responsibilities for equipment training. Vetted by Director of Clinical Engineering.
2026 Emergency Preparedness Management Plan	Revised	Approved as Submitted	Updated Plan to reflect 2025 DNV Standards. Vetted by Emergency Preparedness Coordinator.

May 6, 2026 Hospital Policy / Procedure Committee
As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.
Total of 49 Approved, 1 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Code White Pathway for Adult ED and Inpatients	Revised	Approved as Submitted	Updated "saturation ≥ 94%" to "saturation > 94%". Vetted by Cardiology Program Coordinator and Stroke Program Coordinator.
Patient Refusal of Medical Care; Leaving Against Medical Advice (AMA)	Revised	Approved as Submitted	Scheduled review. No changes. Vetted by CQPS.
Adult Code Blue, Emergency Response	Revised	Approved as Submitted	Scheduled review, Updated definitions. Removed MERT process in policy section, Code team: updated physician role, updated notes section, updated airway management, updated disposition, updated references. Vetted by Response Team Supervisor, Critical Care Director and ACNO.
Fresenius - Hemodialysis Policies for Contracted Services – Memo	Revised	Approved as Submitted	Updated 2026 memo. Vetted by Surgical Services Director, Critical Care Director and ACNO.
Linkage to Care (Wellness)	New	Approved as Submitted	New policy. Vetted by Amy Runge, Sharon Brown Warren, Isabel Muller, Dr. Asad.
Epic EMP (account) Record Activation	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by EHR Services Director and Executive Director of IT.
Physician-Owned Distributorship (POD)	Revised	Approved as Submitted	Removed the reference to Medical Staff Services Conflict of Interest Policy (MSS-361). The policy was retired. It was replaced in the policy with the Vendor Relations and Conflicts of Interest policy. Removed the reference to Contracting department and Director of Contracts Management and replaced with the Legal department. Currently contracting is a function of the Legal department and not a separate department. Vetted by Compliance Officer.
Facilitated Tours & Visitors Safeguards	Revised	Approved as Submitted	Scheduled review. Manual changed from Compliance and Privacy to just Privacy. Non-substantive edits made to improve language clarity, structure, and alignment with current policy formatting standards. No changes to policy scope, requirements, or operational

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			practices. Reviewed and approved by Patient Experience and Privacy Officer.
Use and Disclosure of PHI for Payment & Healthcare Operations	Revised	Approved as Submitted	Scheduled Review. Manual changed from Compliance/Privacy to Privacy. Non-substantive revisions made for clarity, readability, and consistency, including minor wording edits and removal of regulatory cross-references. No change to policy intent or requirements. Vetted by Privacy Officer.
Photography, Recordings and Mobile Device Use	Revised	Approved as Submitted	Reorganized and refined policy language for clarity, consistency, and flow without altering substantive requirements. Added a new section addressing Patient-Requested Photography and Recordings Without a HIPAA Authorization to distinguish patient-directed activities from authorization-based uses. Added provisions addressing Perinatal Unit and NICU newborn and bereavement memorialization to establish clear, HIPAA-compliant parameters for this limited, patient-requested activity. Vetted by Privacy Officer.
Vendor Access Roles and Responsibilities	Revised	Approved as Submitted	Expanded vendor and non-vendor access categories, added Urgent Same-Day Access Protocol, clarified OPO and nonemployee access classifications, and added Appendix A – Nonemployee access matrix and Appendix B – Access Decision Flowchart for operational guidance. Vetted by Supply Chain Services Director and CFO.
Disposition of UMC Property	Revised	Approved as Submitted	Clarified departmental responsibilities, defined separation of asset management vs. waste handling, and aligned with current regulatory and operational standards. Vetted by Director of Supply Chain Services and CFO.
Value Analysis Program	Revised	Approved as Submitted	Policy extensively revised to reflect current operational practices including expanded governance structure of the Value Analysis Program, clarification of House wide and Ad Hoc Value Analysis Teams (VAT), integration with the Capital Product and Equipment review process, addition of the Product Additions process formal inclusion of the Trials and Evaluation Form, addition of Unauthorized Product Introduction controls, and updated vendor participation requirements. Vetted by Supply Chain Director and CFO.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Accounting for Expired, Obsolete and Damaged Goods	Revised	Approved with Revisions	Policy revised to align with CMS, DNV/JC, and FDA guidelines; enhanced inventory monitoring frequency; strengthening financial controls including 1% waste threshold and GL reconciliation; clarified roles and accountability across departments; added quarantine, recall management, and sustainability best practices to improve compliance, patient safety and inventory efficiency. Vetted by Director of Supply Chain Services and CFO.
Tissue Management	Revised	Approved as Submitted	Minor updates to enhance compliance and patient safety, including defined adverse event reporting timelines, staff competency validation, downtime procedures, improved quarantine controls, temperature excursion evaluation, two-person verification, and added audit and monitoring processes. Vetted by Supply Chain Services Director and CFO.
Environmental Services Department Quality Inspection	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by EVS Director, Director of Infection Control and Executive Director of Support Services.
Security Management Plan	Revised	Approved as Submitted	Removed reference to the Joint Commission. Reformatted to NIOH interpretive guidelines. Vetted by EOC Committee.
Life Safety Management System Plan	Revised	Approved as Submitted	Minor changes. Reviewed and approved by EOC Committee.
Structured Return to Work and Worker's Compensation	Revised	Approved as Submitted	Various changes made to the existing policy, and procedures outlined therein. Vetted by HR Director and Chief HR Officer.
False Cost Reporting	Revised	Approved as Submitted	Triennial review – no changes. Vetted by Assistant Controller, Controller and CFO.
Renal Dosing	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Pharmacy.
Miscellaneous Medication Monitoring	Revised	Approved with Revisions	Added enoxaparin, famotidine, and ketorolac to the protocol. Vetted by Director of Pharmacy.
Ebola/Viral Hemorrhagic Fever	Revised	Approved as Submitted	Updated to include viral hemorrhagic fever. Hyperlinks updated. U-tube videos for donning/doffing added. Departmental Plans were reviewed and vetted by Department Directors.
Intravenous Contrast	Revised	Approved with Revisions	Updated Premedication Protocols Prior to Administration of Contrast Media Guideline: "Arrangements should be made for a

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			physician member of the ordering provider's team to be present while the patient receives contrast, and during transportation back to the unit/floor." Vetted by Director of Imaging Services.
Medical Staff Credentialing Credit Card Processing Fee	Revised	Approved as Submitted	Revision of verbiage - Procedure: Fee structure – Removal of Initial Application Expedited Credit Care fee: $15.00 and removal of APP, replaced with Achieving Volume. Vetted by Medical Staff Director.
Pre-Operative Pregnancy Test	Revised	Approved as Submitted	Added verbiage - "Female patients who are admitted as in-patients and have tested negative for pregnancy at the time of their admission."; Revision verbiage - If serum pregnancy test has not been done within 3 days of surgery, perform pregnancy testing on the day of the surgery for all female patients with child bearing potential scheduled for any surgical procedure. Inform Anesthesiologist if result is positive. – Input from Dr. Burns, Chief of Pathology, Dr. Levy and Dr. Flores.
Capacity Management Plan	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Patient Placement Center Director and ACNO.
Negative Pressure Wound Therapy	Revised	Approved as Submitted	Added the Phyiscal Therapist to the list of staff that can apply the NPWT. He is an addition to the team to apply NPWT. Vetted by Clinical Manager of Burn Care Therapy, Rehab Services Director, Critical Care Services Clinical Director and ACNO.
Patient Refrigerator and Freezer Daily Log and Maintenance	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Clinical Nutrition Manager, Director of Food and Nutrition and ACNO.
Guidelines for In-line One-Way Speaking Valve Application for Tracheostomy on the Ventilator	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Rehabilitation Services Director and ACNO.
Guardianship/Conservatorship/ Adult Wards of Clark County	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Care Management Director and CFO.
Pre-Admission Testing and Preoperative Unit: Pre-Anesthesia	Revised	Approved with Revisions	Scheduled review, no changes. Vetted by Clinical Manager PACU, Surgical Services Medical Director, ACNO and Dr. Hu.
PAT Pre-Anesthesia High Risk Patient Screening	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PACU Clinical Manager, Surgical Services Medical Director, ACNO and Dr. Hu.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Prevention of Fire in an Oxygen-Enriched Atmosphere	Revised	Approved as Submitted	Added: Using flammable skin preparation agents for cases. Vetted by Perioperative Services Manager, Surgical Services Medical Director and ACNO.
Safe Transport of Endoscopes	Revised	Approved as Submitted	Updated to current process. Vetted by Perioperative Manager, Sterile Processing Manager and Surgical Services Medical Director.
Infant Feeding Plans	Revised	Approved as Submitted	New algorithm. Removed sentence about going home on slow flow. Vetted by NICU Clinical Manager, Rehab Clinical Supervisor, Maternal Child Services Director and ACNO.
Neonatal Intensive Care Unit Nursing Standards of Care/Practice Guidelines	Revised	Approved as Submitted	Removed wording specific to Alaris pumps, updated weight to <1800 gms for inside isolette. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO.
Release of Pediatric Patient on Discharge	Revised	Approved as Submitted	Remains current practice. Vetted by Manager of PICU and NICU, Clinical Director Maternal Child and ACNO.
Donor Human Milk	Revised	Approved as Submitted	Remains current. Vetted by NICU manager, Dietician and Medical Director, Maternal Child Director and ACNO.
Glucose Gel in the Newborn	Revised	Approved as Submitted	Remains current practice and dose. Vetted by NICU Clinical Manager, Pharmacy, Medical Director, Maternal Child Director and ACNO.
Opioid Withdrawal in Infants	Revised	Approved as Submitted	Remains current practice. Vetted by Manager, Pharmacy, Charge Nurses, Medical Director, Maternal Child Director and ACNO.
Reduction/Negotiated Settlement Requests	New	Approved as Submitted	Updated to reflect the current process for reductions and negotiated settlements. Revised to align with the current policy template. Removed references to resident self-pay, charity discounts, or county-approved rates, which are no longer applicable. Vetted by UMC Attorney, Director of Patient Accounting and CFO.
Oxytocin Administration for Induction and Augmentation of Labor	Revised	Approved with Revisions	Guideline reviewed, no changes. Vetted by Perinatal Manager, Maternal Child Director and ACNO.
Group B Streptococcal Screening and Prophylaxis for Maternal and Newborn Patients	Revised	Approved as Submitted	References reviewed and updated. Rapid GBS (PCR) test added as an option for screening for GBS in triage or on admission to L&D. Vetted by Perinatal Clinical Manager, NICU Clinical Manager, Maternal Child Services Clinical Director, ACNO, Drs Matsunaga-Kirgan, Levy and Banfro.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Respiratory - Airway Clearance Sputum Induction and Lung Expansion	Revised	Approved as Submitted	Reviewed. Reflects current practice. No edits required. Vetted by Cardiopulmonary Services Director and ACNO.
Respiratory – Staffing Guidelines	Revised	Approved as Submitted	Reviewed. Reflects current staffing practice. No edits necessary. Vetted by Cardiopulmonary Services Director and ACNO.
Respiratory – NICU/PICU – Nasal Bubble CPAP	Revised	Approved as Submitted	Reviewed. Reflects current practice. No edits required. Vetted by Cardiopulmonary Services Director and ACNO.
Disposable Bedside Bronchoscopy in Critical Care Units	Revised	Approved as Submitted	No change with the current Guidelines. Vetted by Medical Director of Critical Care Services, Director of Respiratory Services, Clinical Director of Critical Care Services and ACNO.
Delinquent Medical Record	Revised	Approved as Submitted	Changed TJC references to DNV. Updated timeline on voluntary resignation of privileges. Added DNV reference. Vetted by HIM Manager and HIM Director.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue: **Emerging Issues**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	
Recommendation: **That the Governing Board Clinical Quality and Professional Affairs Committee identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly. (*For possible action)***	

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 1, 2026

Agenda Item #

8