UMC Clinical Quality and Professional Affairs Committee Meeting

Monday, April 7, 2025 2:00PM

UMC Trauma Building - Providence Suite - 5th Floor

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
April 7, 2025 2:00 p.m.
800 Hope Place, Las Vegas, Nevada
UMC Trauma Building, Providence Suite (5th 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 University Medical Center 1800 W. Charleston Blvd. Las Vegas, NV (Principal Office)

- 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 February 3, 2025. *(For possible action)*

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

SECTION 2. BUSINESS ITEMS

4. Receive a presentation regarding the need for electronic hand hygiene technology from Kathy Johnson, Infection Prevention Director; and direct staff accordingly. *(For possible action)*

5. 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)*

6. Receive an update on Magnet including associated financial costs from Deb Fox, Chief Nursing Officer (CNO); and direct staff accordingly. *(For possible action)*

7. Receive an update on the FY25 Organizational Improvement Goals from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action)*

8. Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of February 5, 2025 and March 5, 2025 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

9. 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
February 3, 2025

UMC Providence Conference Room
Trauma Building, 5th Floor
800 Hope Place
Las Vegas, Clark County, Nevada
February 3, 2025 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 2:03 p.m. by Chair Dr. Donald Mackay and the following members were present, which constituted a quorum of the members thereof:

CALL TO ORDER

Board Members:

Present:
Dr. Mackay – Chair
Laura Lopez-Hobbs
Renee Franklin
Steve Weitman (Ex-Officio) (WebEx)

Absent:
None

Also Present:
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Dr. Frederick Lippmann, Chief Medical Officer
Danita Cohen, Chief Experience Officer
Dave Bustos, Director of Public Safety
DeeDee McBride, Executive Director of Med Staff, Managed Care, Credentialing
James Conway, Assistant General Counsel
Stephanie Ceccarelli, Board Secretary

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

Chair Dr. Mackay 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 December 2, 2024. *(For possible action)*

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

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

Item 4 was tabled, to be heard at a future meeting.

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

SECTION 2. BUSINESS ITEMS

ITEM NO. 4 Receive an update on the Nursing Division and Magnet journey from Deb Fox, CNO; and direct staff accordingly. *(For possible action).*

DOCUMENT(S) SUBMITTED**:**
- Power Point Presentation

DISCUSSION:

This item was tabled and will be heard at a future meeting.

FINAL ACTION TAKEN:

None

ITEM NO. 5 Receive an update on the Workplace Violence Prevention Program from Dave Bustos, Director of Public Safety and Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action).*

DOCUMENT(S) SUBMITTED**:**
-Power Point

DISCUSSION:

The Committee received an update from Dave Bustos and Patty Scott on the Workplace Violence Prevention program at UMC.

Ms. Scott shared components of the program, highlighting the policy and procedures, reporting process, follow-up and support process, annual worksite analysis, monitoring and evaluation and training and education resources. She commented that OSHA surveys hospitals throughout the valley to ensure programs are in place. There has been an increase in incidents between 2021 through 2024, possibly due to increased reporting. In 2024, there were approximately 358 incidents reported. She added that the incidents could be represented in various patient/staff/visitor interactions. A graph depicting physical vs. verbal interactions occurring between the 2021 – 2024 timeframe was shown.

The highest percentage of interactions occur between patient to staff, staff to staff, and family representatives to staff encounters. The majority of events are directed toward nursing staff, primarily in emergency department, ICU and ambulatory.

The Committee asked what disciplinary measures are in place, primarily in staff-to-staff interactions. Mr. Bustos responded that HR and public safety investigate these matters to determine whether they meet the elements of workplace violence and could result in verbal and written discipline, up to and including termination.

Member Hobbs stated that there should be zero tolerance for this type of behavior. Mr. Conway added that this type of conduct could be grounds for immediate termination.

Events reported by the reporting department are primarily from the nursing department, followed by public safety. Ms. Scott noted that in 2024, the majority of events were reported from the med/surg and emergency departments. Improved reporting has resulted in an increase year over year between 2021 and 2024 in reported events.

Events per 1000 discharges or encounters in 2024 was 0.57%.

Mr. Conway informed the Committee that legislative change in the statute expanded to include volunteers, student interns and public safety officers, which provides additional protections to healthcare workers.

Mr. Bustos reviewed the actions that are being taken to enhance the workplace violence program, including strengthening education, reporting, additional security officer presence, and deployment of metal detectors and surveillance equipment. There was continued discussion regarding zero tolerance education and messaging to staff, as well as patients and guests of the hospital.

FINAL ACTION TAKEN:

ITEM NO. 6 Receive an update on the Quality, Safety, and Regulatory Program, including completed contract evaluations from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. *(For possible action)*

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

DISCUSSION:

Ms. Scott reviewed the quality, safety, and regulatory program.

Patient safety events reported in 2024 included 29 reported events. All cases were reported within the required state timeframes and monitored through the Hospital Quality/Safety Committee. RCAs with actions were taken on all cases. A listing of the sentinel events in 2024 were reviewed. A lengthy discussion ensued regarding the root cause of process failures and how to improve outcomes.

Ms. Scott next reviewed grievances by location for calendar year 2024. Quick care/primary care/telemedicine had 31%, emergency services had 27%, and 42% of grievances were from various departments. In total, 139 grievances were reported in seven different categories. The majority of grievances were concerns

with communication with the care team or attitude and behavior from staff. The grievance rate was .28 per 100 discharges, representing a slight increase over prior years. Ms. Scott stressed the importance of reviewing each grievance and providing service recovery. There was continued discussion in how the grievances relate to the issues with workplace violence.

OSHA, Federal Emtala complaint and State complaint surveys were discussed. UMC is in the window for the DNV survey for hospital accreditation and the Comprehensive stroke certification survey is scheduled for May 20th and 21st.

Contract performance evaluations were reviewed and all evaluation performance standards were met.

FINAL ACTION TAKEN:

None

ITEM NO. 7 Receive an update on the FY25 Organizational Improvement/CEO Goals from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. ***(For possible action)***

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

DISCUSSION:

Ms. Scott briefly reviewed the organizational goals for FY25. All goals were met with the exception of hand hygiene compliance and communication with doctors. The employed physician engagement and alignment measures met established goals and are still in progress.

There was continued discussion regarding concerns with hand hygiene compliance and staff is reviewing initiatives to implement at the facility in an effort to track and improve this behavior.

FINAL ACTION TAKEN:

None

ITEM NO. 8 Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of December 4, 2024 and January 2, 2025 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 December 4, 2024 & January 2, 2025 were reviewed.

There were a total of 75 approved and 12 were retired. All were approved through the hospital Policy and Procedures Committee, Quality and MEC.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to approve that the UMC Policies and Procedures Committee's activities of December 6, 2023 and January 3, 2024 and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

SECTION 3. EMERGING ISSUES

ITEM NO. 9 Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly

DISCUSSION:

Update on hand hygiene and electronic hand hygiene technology.

FINAL ACTION TAKEN:

None

COMMENTS BY THE GENERAL PUBLIC:

At this time, Chair Dr. Mackay asked if any persons were 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 3:10 p.m., Chair Mackay 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: **Hand Hygiene Update**	**Back-up:**
Petitioner: Patricia Scott, Quality Patient Safety and Regulatory Officer	
Recommendation: **That the Governing Board Clinical Quality and Professional Affairs Committee receive a presentation regarding the need for electronic hand hygiene technology from Kathy Johnson, Infection Prevention Director; and direct staff accordingly.** ***(For possible action)***	

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
April 7, 2025

Agenda Item #

4

Hand Hygiene Surveillance

Infection Prevention/Control

Why Hand Hygiene?

- The overall direct cost of HAIs to hospitals range from $28 to $45 billion annually
- Hand hygiene (HH) is the cornerstone of infection prevention, and improvement in compliance has been associated with reduced HAIs and pathogen transmission
- It is estimated that one-third of HAIs can be prevented by better hand hygiene
- Leapfrog/CMS requires a robust hand hygiene program (more HH audits, the better Leapfrog rating)

Types of Hand Hygiene Audit Tools

- The ideal approach to monitoring HH compliance should be bias-free, provide real-time feedback, not interfere with Healthcare worker (HCW) behavior, and capture each HH episode:
  - Direct Observation
  - Product Consumption Evaluation
  - Self -Reporting
  - Electronic HH Monitoring System (EHHMSs)

Direct Observation

- Advantages:
  - Most common approach… gold standard
  - Trained observer provides immediate feedback and coaching
  - Current UMC practice
- Disadvantages:
  - Time-consuming and labor-intensive process (20 min)
  - **Captures a small proportion (<1-3%) of all HH** opportunities
  - Frequently excludes nights and weekends
  - Poor inter-user reliability
  - Peer reporting of HH compliance is considered unreliable with over-estimation, subject to observation bias

Product Consumption

Monitors product use (soap, paper towels, quantity of alcohol-based hand rub)

- Advantages:
  - Incorporates days and nights
  - Utilizes less manpower
  - Minimizes bias
- Disadvantages:
  - Provides only an estimation
  - Does not assess the number of HH opportunities

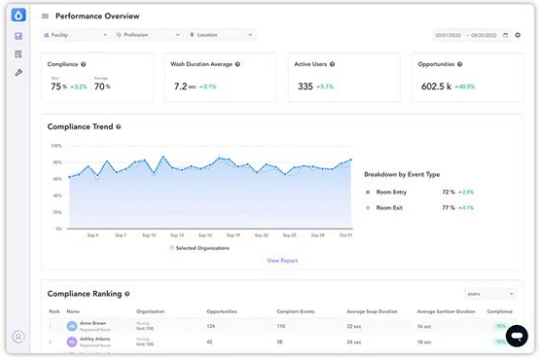
Self Reporting of Hand Hygiene

Everyone is 100% ?!?

Electronic HH Monitoring Systems

- Advantages:
  - Provides realistic compliance rates with 24/7 monitoring
  - Real-time data drives improvement processes
  - Utilizes less manpower
  - Meets regulatory compliance

- Disadvantages:
  - Employee resistance/ compliance
  - Technical issues
    - RFID, ultrasound, infrared
    - Batteries?
  - High cost
    - $500-2000/bed initial
    - Monthly/Annual Rate



UMC Direct Observation for HH

- Collected by unit-based secret shoppers, infection prevention team, and light duty staff
- 53,000 observations in 2024
- Time/cost estimation
  - (53,000/10 audits per 20 min) = 106,000 minutes or 1,766 hours spent on HH audits 2024 = 44 weeks
  - $ 88,300 ($50/hr)

UMC Direct Observation for HH

- 2024 HH Rate = 68%

	Total HH Observations	HH Yes	HH Compliance
IPs HH Audits	13821	6324	46%
Other HH Audits	39291	30109	77%

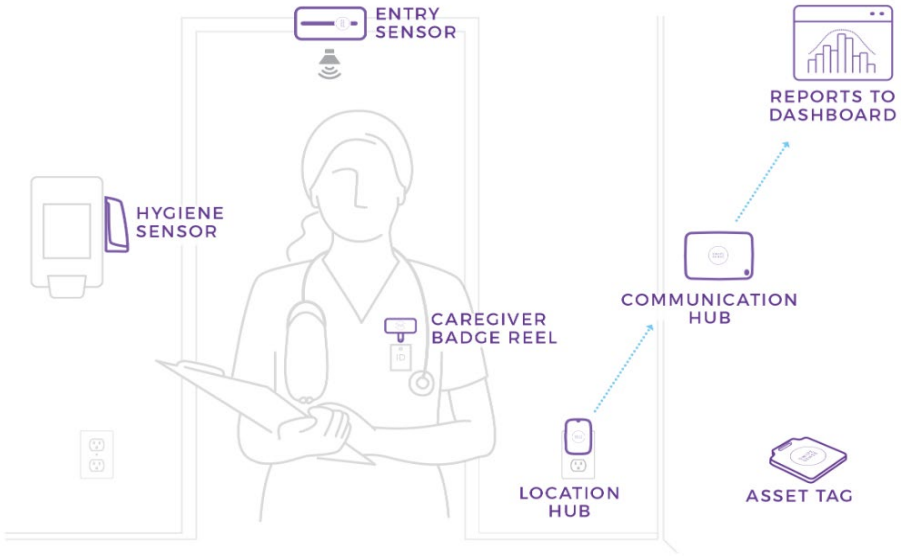
- Leap Frog Metric for "A" rating
  - 200 HH/month/unit
  - 7/21 units met Leap Frog metric

Why EHHMS?

- National Patient Safety Goal and Leapfrog put a strong emphasis on HH programs in order to reduce HAIs
- Hand hygiene is the cornerstone of infection prevention, and compliance has been associated with reducing HAIs and pathogen transmission
- 1 out of 10 patients are affected by HAIs
- 10% improvement in HH has been associated with 6% reduction in overall HAIs

Next Steps

- Evaluate 4 EHHMS with an interdisciplinary team:
  - —Technology
  - —Accuracy
  - —Cost / Maintenance
  - —Types of Reports



References

- Sickbert-Bennett, E. E., DiBiase, L. M., Schade Willis, T. M., Wolak, E. S., Weber, D. J., & Rutala, W. A. (2016). Reduction of Healthcare-Associated Infections by Exceeding High Compliance with Hand Hygiene Practices. *Emerging Infectious Diseases*, *22*(9), 1628. https://doi.org/10.3201/eid2209.151440
- Wang, C., Jiang, W., Yang, K., Yu, D., Newn, J., Sarsenbayeva, Z., Goncalves, J., & Kostakos, V. (2021). Electronic Monitoring Systems for Hand Hygiene: Systematic Review of Technology. *Journal of Medical Internet Research*, *23*(11), e27880. https://doi.org/10.2196/27880
- McMullen, K., Diesel, G., The Advantages and Disadvantages of Using Hand Hygiene Monitoring System. *Infection Control Today, 27(40),* The Advantages and Disadvantages of Using a Hand Hygiene Monitoring System.

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

Issue:	**Annual Infection Prevention Program Evaluation and Plan 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 Annual Infection Prevention Program Evaluation and Plan from Kathy Johnson, Director of Infection Prevention; and direct staff accordingly.** ***(For possible action)***		

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
April 7, 2025

Agenda Item #
5

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

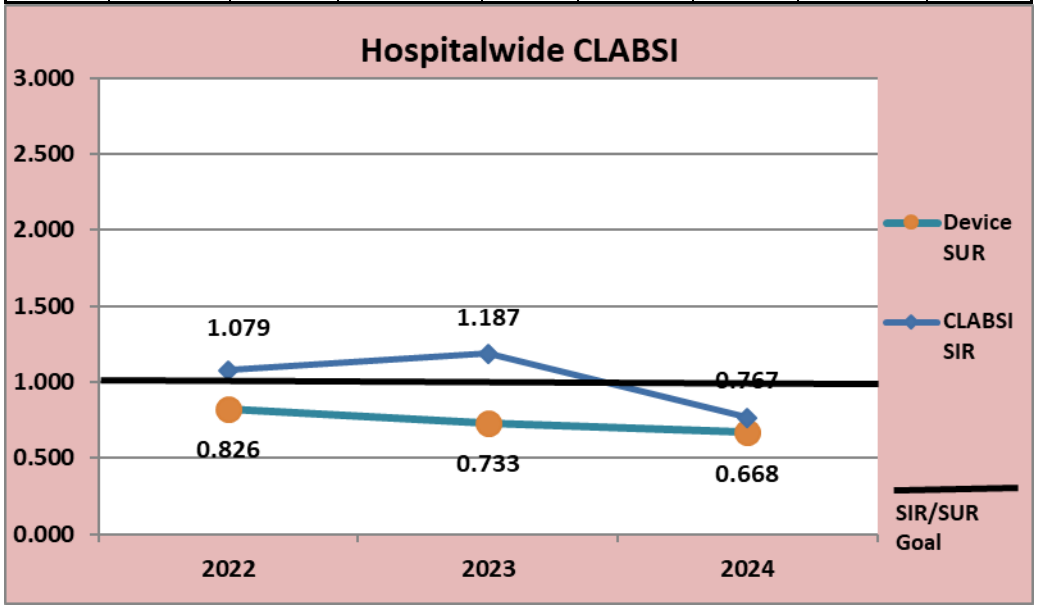
Decrease CLABSI (Central Line Associated Bloodstream Infection)

Tier 1 Goal:
- Decrease 2024 CLABSI events < 2023 CLABSI events

Tier 2 Goal:
- Reduce 2024 CLABSI to achieve CLABSI SIR <1.000

NHSN = National Health Safety Network
HHS = Department of Health and Human Services

CLABSI Year	Patient Days	Central Line Days	Device Utilization	Device SUR	Total CLABSIs	CLABSI Rate	Expected CLABSIs	CLABSI SIR
2022	172435	35986	21%	0.826	47	1.31	43.556	1.079
2023	158372	27472	17%	0.733	39	1.42	32.844	1.187
2024	148523	23878	16%	0.668	22	0.92	28.695	0.767



Tier 1 Goal: Met/ No Met

- ↓ by **17** events from 2023
- Device utilization ↓with SUR = 0.668

Tier 2 Goal: Met / Not Met

- ↓2024 CLABSI annual
- 2024 SIR = 0.767

See 2025 Infection Prevention Control (IPC) Plan for reduction strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

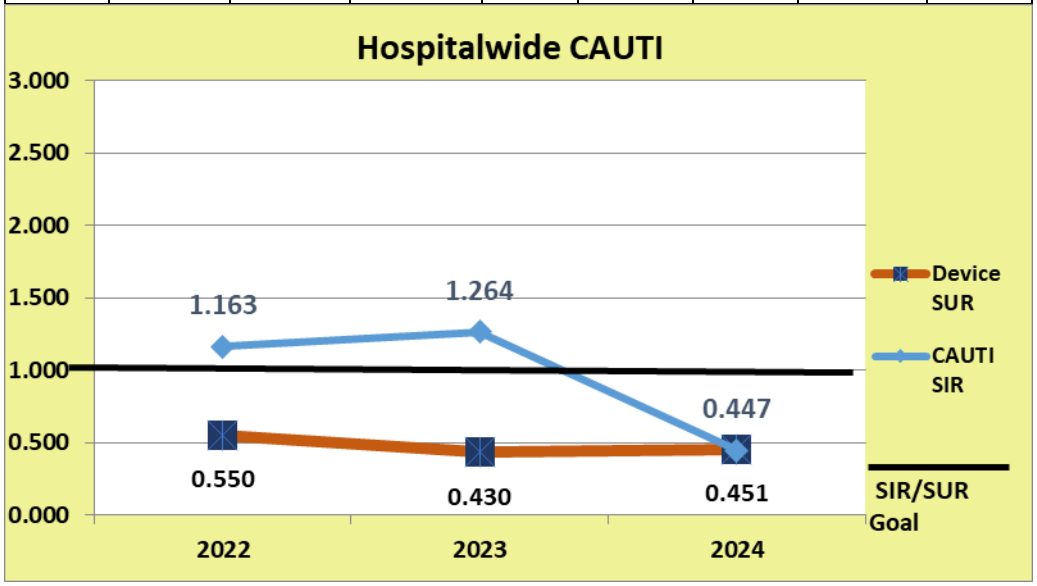
Decrease CAUTI (Catheter Associated Urinary Tract Infections)

Tier 1 Goal:
- Decrease 2024 CAUTI events < 2023 CAUTI events

Tier 2 Goal:
- Reduce 2024 CAUTI events to achieve CAUTI SIR < 1.000

NHSN = National Health Safety Network
HHS = Department of Health and Human Services

CAUTI Year	Patient Days	Foley Catheter Days	Device Utilization	Device SUR	Total CAUTIs	CAUTI Rate	Expected CAUTIs	CAUTI SIR
2022	165075	20835	13%	0.550	39	1.87	33.546	1.163
2023	152030	15355	10%	0.430	31	2.02	24.519	1.264
2024	141563	15349	11%	0.451	11	0.72	24.605	0.447



Tier 1 Goal: Met / Not Met

- ↓ by **20** events from 2023
- Device utilization <1.0
  SUR = 0.451 slight increase

Tier 2 Goal: Met / Not Met

- ↓ 2024 CAUTI annual SIR
- 2024 SIR = 0.447

See 2025 Infection Prevention Control (IPC) Plan for reduction strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

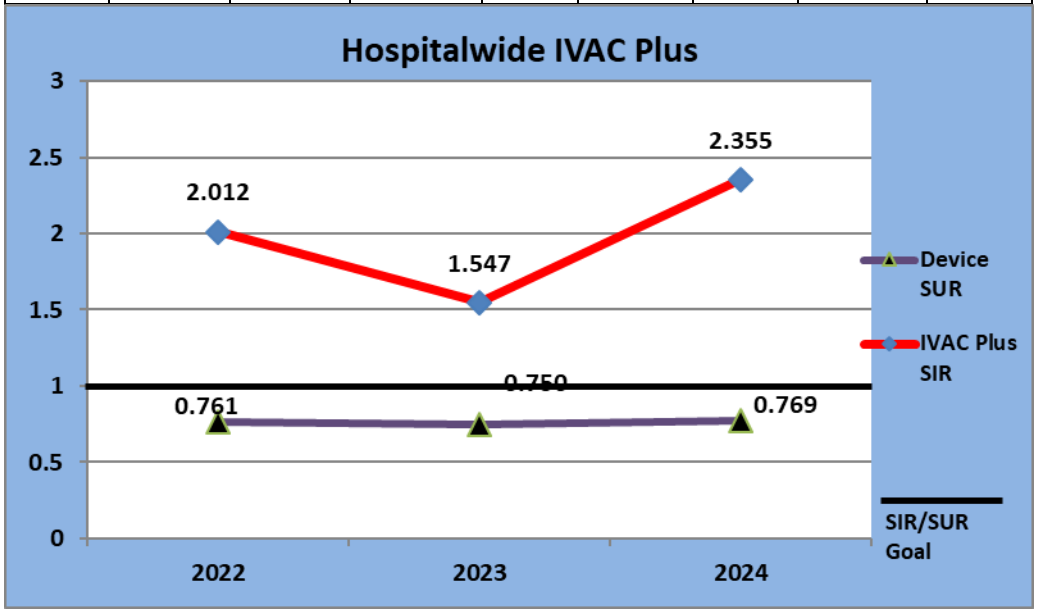
Ventilator Associated Events (VAE) – IVAC Plus

Decrease IVAC Plus for adults (Infection Related Ventilator Associated Complication/Possible Ventilator Associated Pneumonia)

Tier 1 Goal:
- Decrease 2024 adult IVAC Plus < 2023 events

Tier 2 Goal:
- Reduce 2024 IVAC Plus events to achieve IVAC Plus SIR < 1.000

IVAC Plus Year	Patient Days	Ventilator Days	Device Utilization	Device SUR	Total IVAC Plus	IVAC Plus Rate	Expected IVAC Plus	IVAC Plus SIR
2022	154365	12056	8%	0.761	91	7.51	45.222	2.012
2023	143308	11051	8%	0.750	55	4.98	35.557	1.547
2024	133248	10724	8%	0.769	97	9.05	41.189	2.355



Tier 1 Goal: Met / Not Met

- ↑ by 42 events from 2023
- Device utilization similar SUR = 0.769

Tier 2 Goal: Met / Not Met

- ↑ IVAC Plus annual 2024 SIR = 2.355 well above 1.000

See 2025 Infection Prevention Control (IPC) Plan for reduction strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

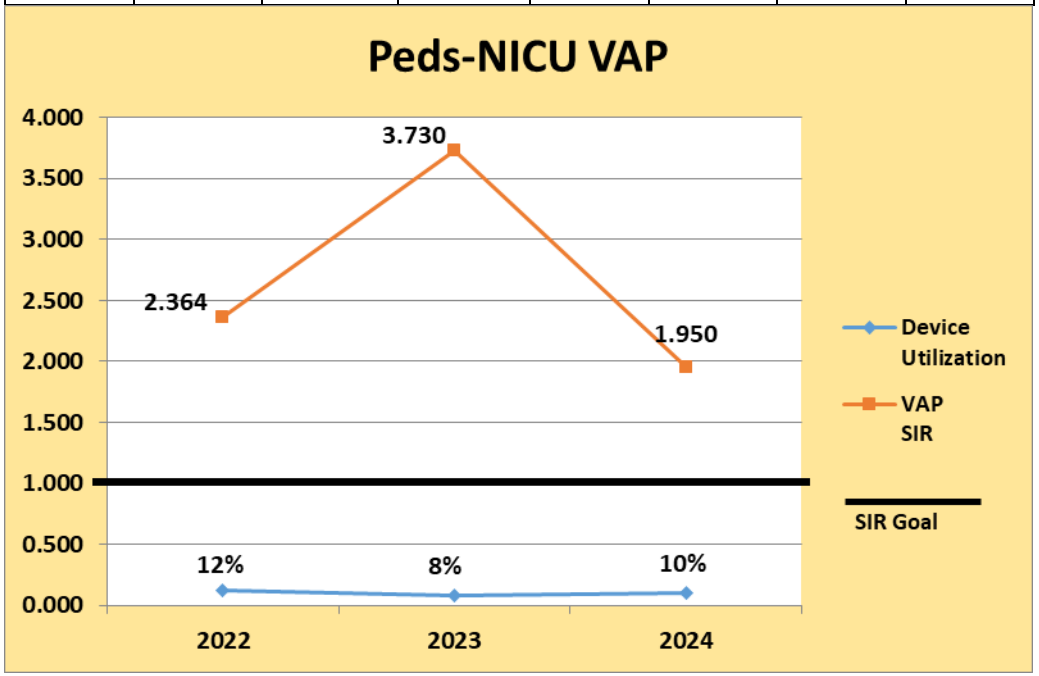
Ventilator Associated Pneumonia (VAP) for Pediatrics

Pediatric, age 1-18 years VAP

Tier 1 Goal:
- Decrease 2024 Pediatric VAPs < 2023 events

Tier 2 Goal:
- Reduce 2024 Pediatric VAP events to achieve VAP SIR ≤ 1.000

VAP Peds Year	Patient Days	Total Ventilator Days	Device Utilization	Total VAPs	VAP Rate	Expected VAPs	VAP SIR
2022	18070	2226	12%	5	2.24	2.115	2.364
2023	15064	1280	8%	4	3.13	1.072	3.730
2024	15275	1598	10%	3	1.88	1.538	1.950



Tier 1 Goal: Met / Not Met

- ↓ by 1 Peds VAP events from 2023
- ↑ device utilization decreased by 2% from 2023

Tier 2 Goal: Met / Not Met

- ↓ Peds VAP SIR annual SIR = 1.950 but remains above 1.000

See 2025 Infection Prevention Control (IPC) Plan for reduction strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

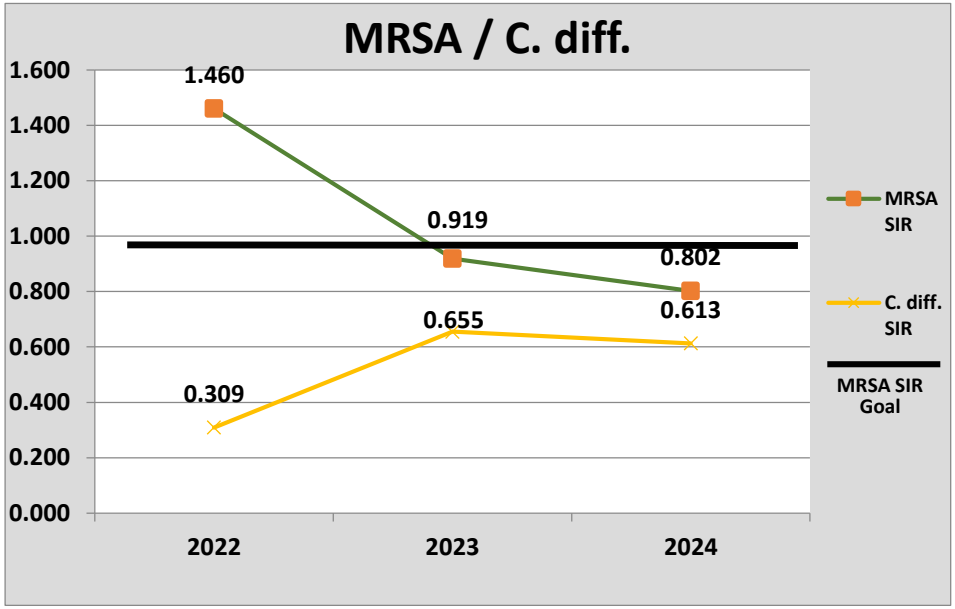
Prevent transmission of Multi-drug resistant pathogens

MRSA:
- Tier 1 Goal:
  - Decrease 2024 MRSA events < 2023 MRSA events
- Tier 2 Goal:
  - Reduce 2024 MRSA events to achieve SIR < 1.000

C. diff.:
- Tier 1 Goal:
  - Maintain C. diff events SIR below < 0.700 national benchmark

NHSN = National Health Safety Network
HHS = Department of Health and Human Services

Lab ID Event	2022	2023	2024
MRSA Events	18	11	9
MRSA SIR	1.460	0.919	0.802
C. diff Events	37	58	41
C. diff SIR	0.309	0.655	0.613



MRSA:

Tier 1 Goal: Met / Not Met

- ↓ by **2** MRSA Events from 2023

Tier 2 Goal: Met / Not Met

- ↓ 2024 MRSA SIR = 0.802

C. diff:

Tier 1: Met / Not Met

- ↓ by **17** C. diff. Events from 2023
- 2024 SIR = 0.613

See 2025 Infection Prevention Control (IPC) Plan for reduction strategies

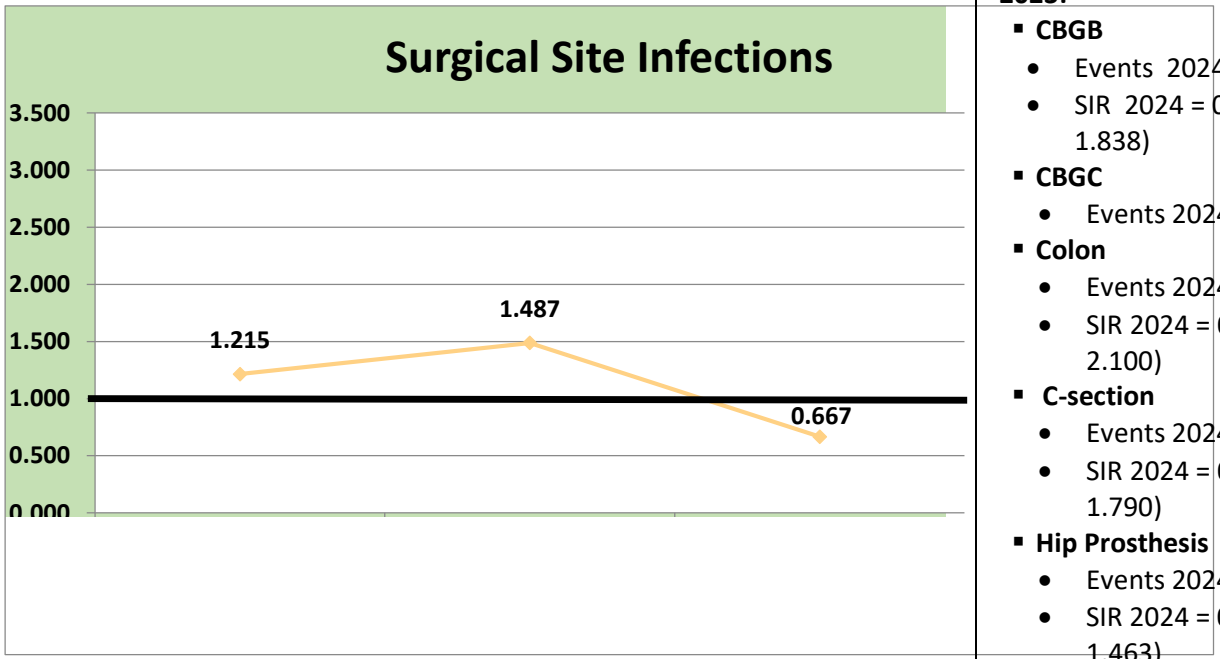
2024 Goals Measurable Objectives	2024 Data	Met/Not Met

Limit the transmission of infection associated with procedures
SSI (Surgical Site Infection)

- Tier 1 Goal:
- 2024 SSI events < 2023 events

- Tier 2 Goal:
  - Maintain or reduce SIR <1.000 for defined surgical procedures

		2022	2023	2024 (YTD)
All Surgical Procedures	Procedures	1743	1897	1307
	Predicted	37.047	37.671	25.481
	Infections	45	56	17
	SIR	**1.215**	**1.487**	**0.667**



Tier 1 Goal: Met / Not Met

- ↓ **by 39** SSI events from 2023

Tier 2 Goal: Met / Not Met

↓Overall 2024 (YTD)
SSI SIR = 0.667 from 1.487 (2023)

2024 (YTD) Procedures with decreased SSI events & SIR from 2023:

- **CBGB**
  - Events 2024 = 2 (2023 = 9)
  - SIR 2024 = 0.757 (2023 = 1.838)
- **CBGC**
  - Events 2024 =0 (2023=0)
- **Colon**
  - Events 2024= 3 (2023 = 27)
  - SIR 2024 = 0.391 (2023 = 2.100)
- **C-section**
  - Events 2024 = 1 (2023 = 7)
  - SIR 2024 = 0.415 (2023 = 1.790)
- **Hip Prosthesis**
  - Events 2024 = 3 (2023 = 7)
  - SIR 2024 = 0.835 (2023 = 1.463)
- **Total Abdominal**

2024 Goals Measurable Objectives	2024 Data	Met/Not Met
		Hysterectomy • Events 2024 = 1 (2023 = 1) • SIR 2024 = 0.916 (2023 = 0.787) ▪ **Kidney Transplant** events • Events 2024= 0 (2023 = 0) ▪ **Laminectomy** • Events 2024= 0 (2023 = 2) • SIR 2024= N/A (2023 = 1.673) **Procedures with increased events from 2023 & SIR >1.00 :** ▪ **Spinal Fusion** • Events 2024 = 4 (2023= 2) • SIR 2024 = 1.436 (2023 = 0.625) ▪ **Knee Prosthesis** events • Events 2024= 3 (2023 = 1) • SIR 2024 = 2.306 (2023 = 0.486) (YTD) - 4th qtr. 2024 data is not yet available See 2025 Infection Prevention Control (IPC) Plan for reduction strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

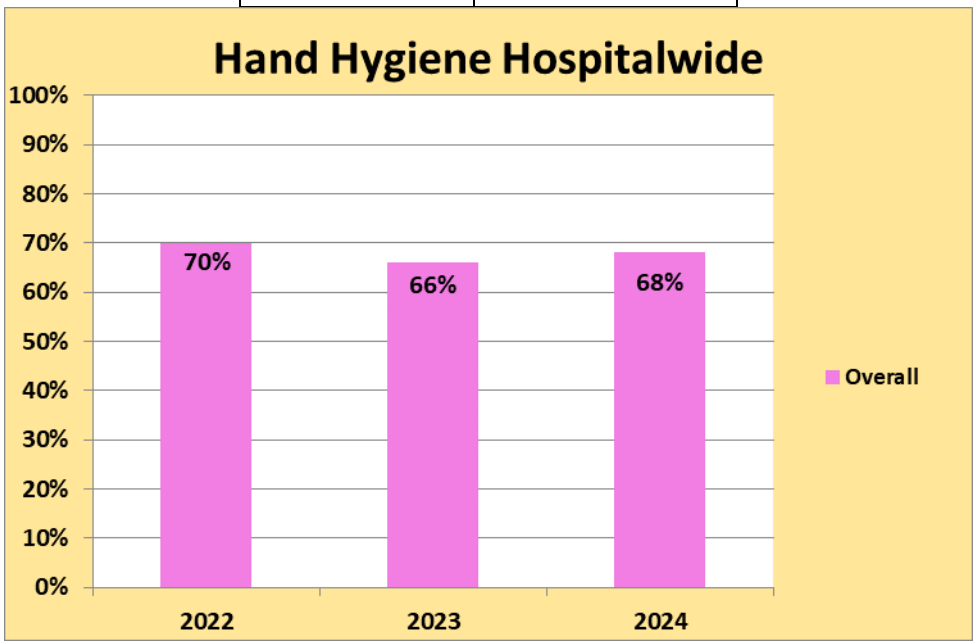
Hand Hygiene - Improve compliance (CDC guidance) based on CDC guidelines to the goal of above national average

Goals:

- Tier 1:
- Increase overall 2024 hand hygiene compliance > 2023 overall annual rate

- Tier 2:
- Increase 2024 overall hand hygiene rate > 90%

HH Year	Overall Compliance
2022	70%
2023	66%
2024	68%



Tier 1 Goals: Met / Not Met

- ↑ compliance by 2%

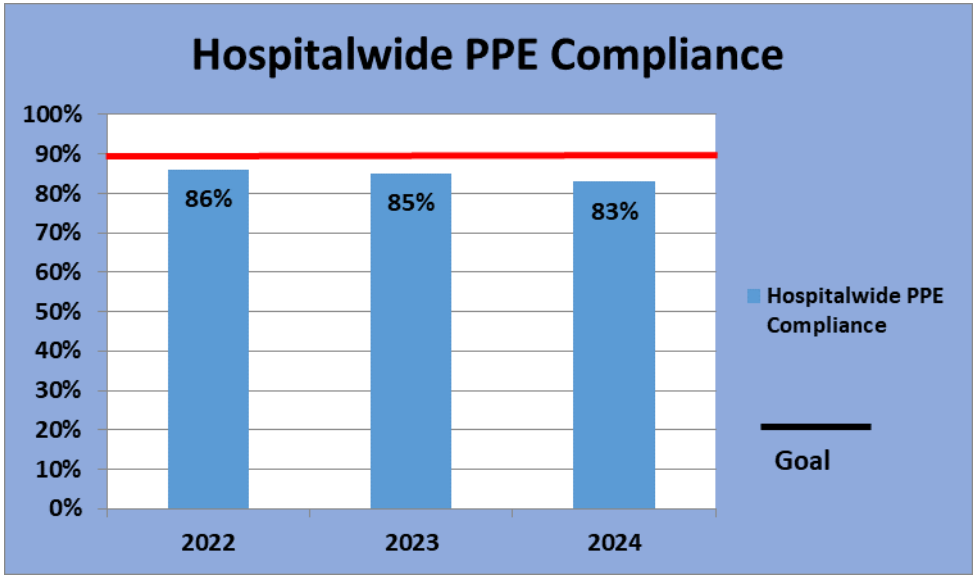
Tier 2 Goals: Met / Not Met

- 2024 = 68%
- Increase education on hand hygiene related to pandemic; included in yearly education

See 2025 Infection Prevention Control (IPC) Plan for compliance strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met
PPE Compliance: **Limit unprotected exposure to transmission based pathogens/diseases** ○ Tier 1 Goal: ○ Increase 2024 PPE compliance > 2023 ○ Tier 2 Goal: ○ > 90% PPE Annual Compliance ○ 100% compliance on Infection Control education for healthcare workers		Tier 1 Goals: Met / Not Met ▪ ↓ **2%** in compliance from 2023 Tier 2 Goals: Met / Not Met ▪ 2024 = 83% Goals: Met / Not Met: ▪ Mandatory infection control education done yearly via LMS See 2025 Infection Prevention Control (IPC) Plan for compliance strategies

PPE Year	PPE Compliance
2022	86%
2023	85%
2024	83%

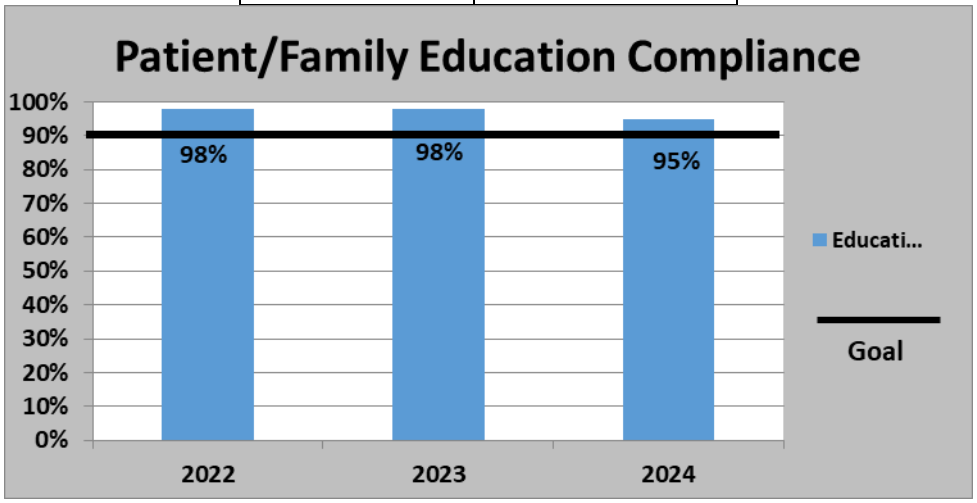


2024 Goals Measurable Objectives	2024 Data	Met/Not Met

Provide Patient and Visitor/Family education regarding Infection Prevention/Control issues and isolation procedures

Goal:
- >90% documentation in EHR for patient, family education

Year	Overall Compliance
2022	98%
2023	98%
2024	95%



Goal: Met / Not Met

- 2024 = 95%

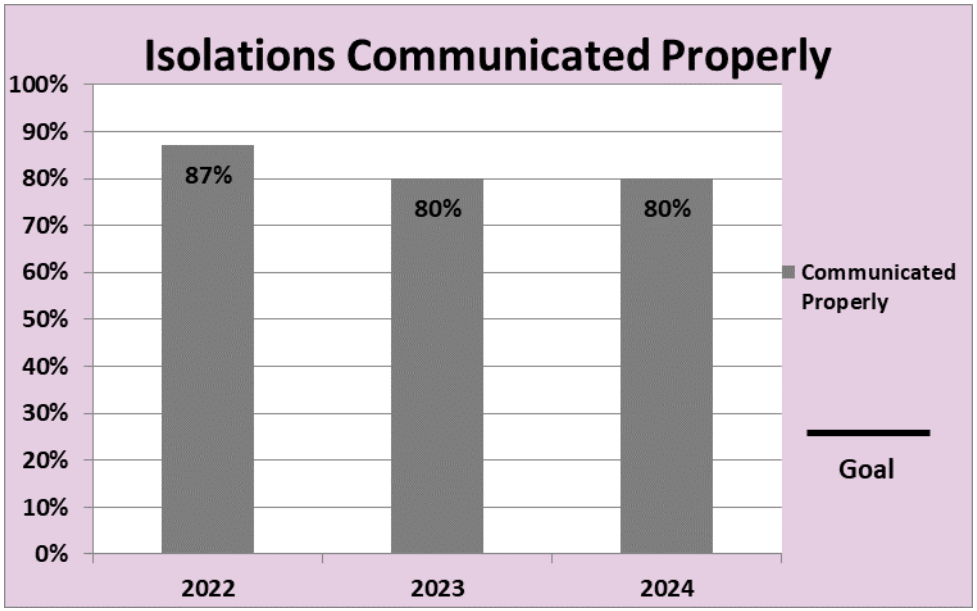
See 2025 Infection Prevention Control (IPC) Plan for compliance strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

Communicate transmission based precautions status to receiving facilities

Goal:
- >90% documentation of transmission based precaution status upon transfer

Year	Overall Communication Compliance
2022	87%
2023	80%
2024	80%



Goal: Met / Not Met

- 2024 = 80% same as 2023
- AVS Epic audit
- State Mandate

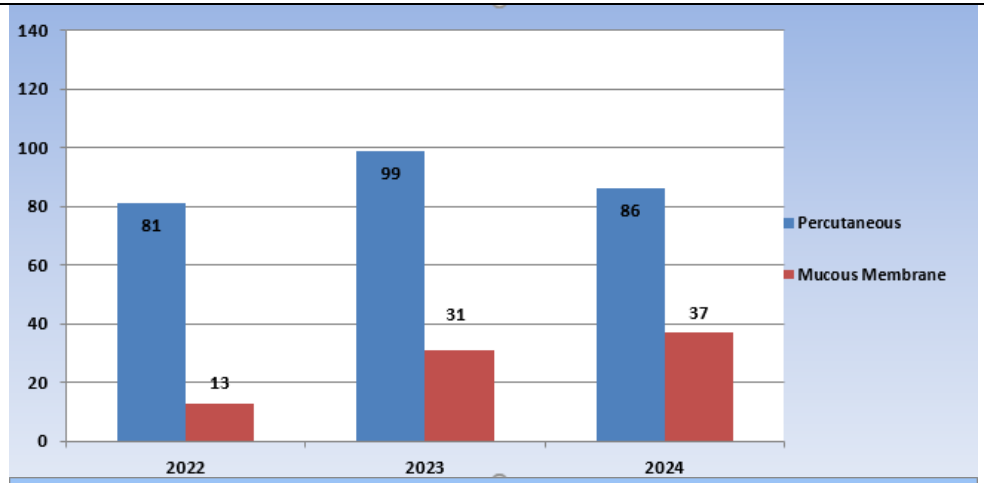
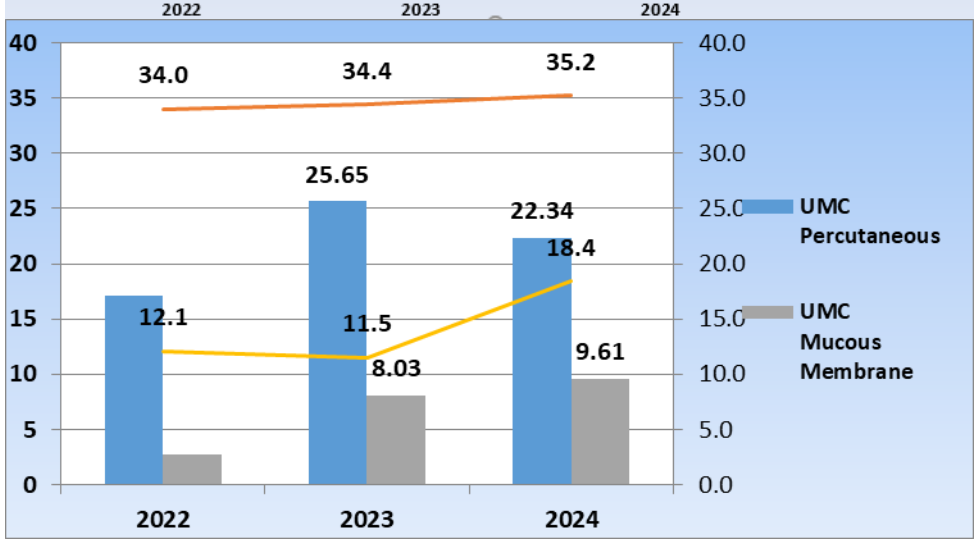
See 2025 Infection Prevention Control (IPC) Plan for compliance strategies

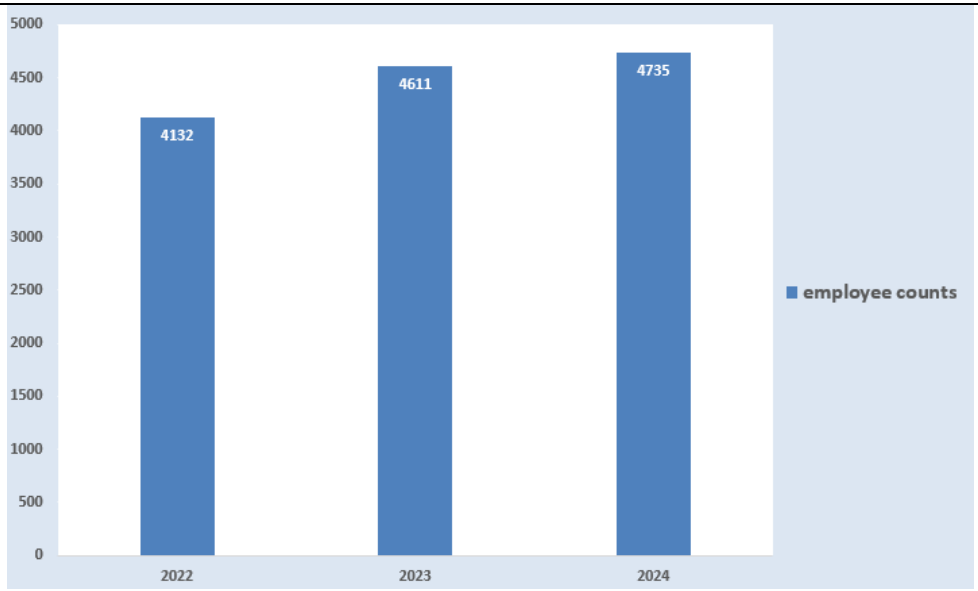
2024 Goals Measurable Objectives	2024 Data	Met/Not Met
Limit the transmission of infections associated with the use of medical equipment, devices and supplies Goals: ○ >90% compliance with receipt of logs for review (Dialysis Logs, Trophon Logs, Sterile Processing logs (SPD)) ○ Zero outbreaks related to medical equipment	100% compliance with HLD Logs, SPD logs No identified outbreaks No graphs No graphs	Goal: Met / Not Met ▪ All logs received and reviewed Goal: Met / Not Met ▪ Zero outbreaks identified
Prepare to respond to highly infectious disease including bioterrorism Goals: ○ > 90% IC staff participation Emergency Preparedness (EP) activities in 2024 ○ 100% compliance on Infection Control education related to influx of infectious patients for healthcare workers ○ > 90% completion of advanced PPE training	Infection Control Director member of EP committee 100 % attendance to invited EP exercises and/or HICs No graph	Goal: Met / Not Met ▪ IC participation in EP ▪ Mandatory education completed Goal: Met / Not Met ▪ Add advanced training to 2025 goal See 2025 Infection Prevention Control (IPC) Plan for reduction strategies/education strategies

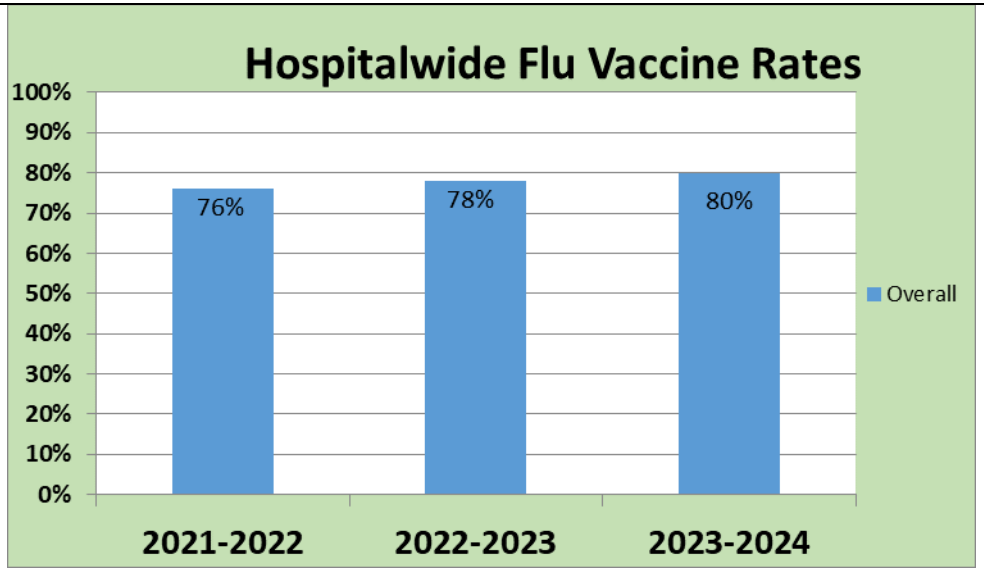
2024 Goals Measurable Objectives	2024 Data	Met/Not Met
Maintain a clean and safe environment for patients, visitors and employees Goals: ○ Increase 2024 black lighting events of the environment by IP > 2023 events ○ 100% Compliance in IC Education for healthcare workers on environmental cleaning ○ Establish screening protocol for Candida auris	No graph	Goal: Met / Not Met ▪ 109 black light room audits in 2024 from 178 (down IP 6 months) ▪ **Cleaning =66.34 %** Goal: Met / Not Met ▪ 100% Mandatory education ▪ Candida auris screen established
Prevent risk of transmission of pathogens from construction/ renovation within the facility ○ > 90% IP monitoring/rounding of construction sites with timely notification to Engineering when breaches identified	No graph	Goal: Met / Not Met ▪ > 90% construction rounds done by IPs with email or telephone notification on deficits sent to Engineering

2024 Goals Measurable Objectives	2024 Data	Met/Not Met

	Employee Health Program	
Limit unprotected exposure to transmission based pathogens/disease MTB ○ 100 % compliance for IP monitoring of negative air flow in AIIR with corrective action when AIIR does not meet standard (Plant Operations) ○ 100% Compliance for employees with latent TB assessment and surveillance ○ 100% Compliance Annual Employee Health education (includes education on TB, BBP, etc.) ○ 100% compliance on annual Fit Testing or PAPR Training	*Healthcare MTB conversions remain below Benchmark of 0.04* *Negative Airflow Room checks done daily by Engineering*	Goal: Met / Not Met ▪ 100% IP monitoring for compliance of AIIR checks by engineering ▪ 0% MTB Conversion Rate with 7 HCW MTB exposures with 1 investigation still ongoing Goal: Met / Not Met ▪ Latent TB assessments Goal: Met / Not Met ▪ Annual TB education is mandatory Goal: Met / Not Met ▪ Annual Fit testing/PAPR training -98.9% compliance (FMLA/LOA)

2024 Goals Measurable Objectives	2024 Data	Met/Not Met
Continue compliance with BBP exposures Goals: ○ Maintain or Decrease number of needlesticks/percutaneous exposures to remain at/below the National (EpiNet) Benchmark ○ Decrease number of events occurring with unknown associated HCWS from 2023	 	Goal: Met / Not Met ▪ **Percutaneous**: ↓ by 13 events from 2023 Lower than national yearly Epinet rate/100 ADC Goal: Met / Not Met ▪ **Mucous Membrane**: ↑ by 6 events from 2023 Lower than national yearly Epinet rate / 100ADC See 2025 Infection Prevention Control (IPC) Plan for reduction strategies

2024 Goals Measurable Objectives	2024 Data	Met/Not Met
Employee Outbreak: Goal: ○ Monitor for clusters of COVID-19 occurring within UMC hospital and clinics to stop spread of disease ○ Monitor for other contagious diseases occurring within departments/clinics to prevent cluster outbreaks *Vaccination for Healthcare Workers:* ○ Increase hospital wide Influenza vaccination rate above the 2022-2023 rate ○ Monitor COVID-19 vaccinations rates for employees for NHSN reporting		Goal: Met / Not Met ▪ 183 (2024) vs 348 (2023) COVID positive employees reported with follow-up to unit leadership Goal: Met / Not Met ▪ No further outbreaks identified

2024 Goals Measurable Objectives	2024 Data	Met/Not Met
		Goal: Met / Not Met ▪ 2023-2024 Vaccination rate increased from 78% to 80%- goal met Goal: Met / Not Met ▪ COVID vaccination rates reported to NHSN See 2025 Infection Prevention Control (IPC) Plan for reduction strategies
Decrease risk for Transmission-based pathogens/diseases Goals: ▪ 100% of all new hires will have their MMR, varicella, hepatitis B, COVID-19 and Tdap vaccination status assessed ▪ Any employee exposed to BBP will have their Hepatitis B vaccine status assess post exposure with goal >90%	No graphs	Goal: Met / Not Met ▪ 1047 HCW workers on boarded through Employee Health and completed New Hire processing. ▪ Policy changed to include assessment of COVID vaccination. Mandatory COVID vaccination no longer required. Goal: Met / Not Met ▪ Hep B immunity is part of BBP exposure work-up.

2024 Goals Measurable Objectives	2024 Data	Met/Not Met
		▪ 90% Hep B vaccine status assessed. 10% declined bloodwork-not met
	Antibiotic Stewardship	
Antibiotic Stewardship	See separate goals provided by antibiotic stewardship	

Attachment #5

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

Issue:	**Nursing Report and Magnet 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 Magnet including associated financial costs from Deb Fox, Chief Nursing Officer (CNO); and direct staff accordingly. ***(For possible action)***		

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
April 7, 2025

Agenda Item #

6

UMC BOARD QUALITY COMMITTEE
4-7-2025

MAGNET JOURNEY TO EXCELLENCE

SPECIAL INTRODUCTIONS

- AUDREY JOHNSON- MAGNET & SHARED GOVERNANCE COORDINATOR
- LISA RENFRO- AMBULATORY SERVICES
- DANESSA REBELLO- MEDICAL-SURGICAL SERVICES
- NICOLE PLAZA- PERI-OPERATIVE SERVICES
- CHERI FILEWOOD- CRITICAL CARE/BURN SERVICES
- DIANE KNAPP- ACNO PROFESSIONAL PRACTICE

PROCESS OVERVIEW

PROCESS TIMELINE

- APPLICATION- 10-28-2024 (COMPLETED)
- QUALITY/EXPERIENCE DATA- 04-30-2025 (COMPLETED)
- RN SATISFACTION SURVEY- 10-31-2023 (COMPLETED)
- PRE-SUBMISSION CALL WITH MAGNET OFFICE- 04-02-2025 (COMPLETED)
- DOCUMENT SUBMISSION- 06-02-2025 (IN PROCESS)
- SITE VISIT- 01 TO 02-2026 (OUTSTANDING)
- DESIGNATION DECISION- 04 TO 05-2026 (OUTSTANDING)

DATA SUMMARY

- RN Engagement in the 60th percentile (Final)
- Inpatient Nurse Sensitive Indicators (through 3rd Quarter, 2024)
  - Required
    - Falls with Injury in the 60th percentile
    - HAPI Stage 2 and Above in the 70th percentile
  - 2 Electives at 100% each Exemplar
    - Medical Device Related HAPI
    - MRSA
    - Pediatric PIV Infiltrates
- Outpatient Nurse Sensitive Indicators (through 3rd Quarter, 2024)
  - Falls with Injury in the 90th percentile
  - Patient Burns 100% Exemplar
  - Surgical Errors 100% Exemplar
- Inpatient Patient Satisfaction 1Q2023 – 4Q2024
  - Care Coordination 67%
  - Courtesy & Respect 58%
  - Responsiveness 59%
  - Safety 61%
- Outpatient Patient Satisfaction 1Q2023 – 4Q2024
  - Careful Listening 55%
  - Courtesy & Respect 55%
  - Patient Education 60%
  - Responsiveness 52%

- WAITING FOR 1ST QUARTER 2025 TO DO FINAL LOCK DOWN OF DATA

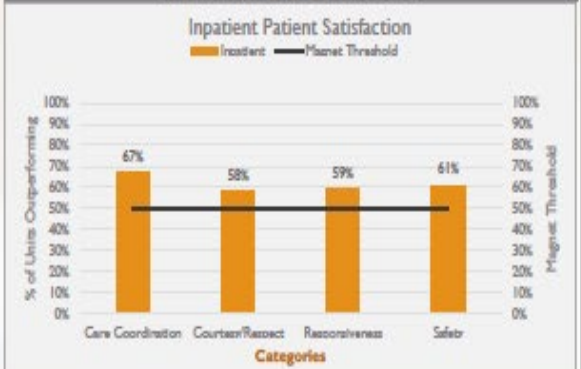
MAGNET DASHBOARD

HealthLinx

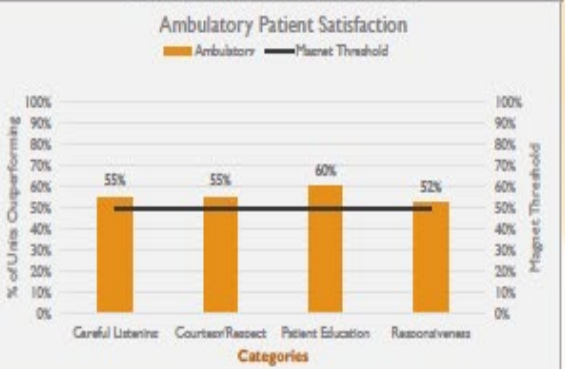
Magnet® Dashboard

Magnet® Journey Submission: June 2025
Patient Satisfaction Data Submission Quarters: 2023Q1 – 2024Q4
NSI Data Submission Quarters: 2023Q1 – 2024Q4

Inpatient Patient Satisfaction



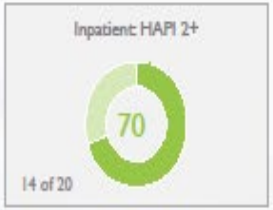
Ambulatory Patient Satisfaction

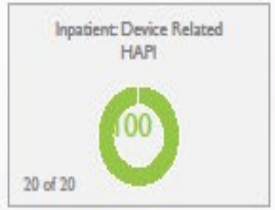


RN Engagement

Dashboard reflects performance from 2022Q4 – 2024Q3 for NSI's and Patient Satisfaction (including 2023 RN survey)

Inpatient NSI's





Ambulatory NSI's

DOCUMENT OVERVIEW

Magnet Progress March 2025

OO	TL	SE	EP	NK
OO1	TL1	SE1EOa	EP1EOa	NK1
OO2	TL2	SE1EOb	EP1EOb	NK2
OO3	TL3EO	SE2EOa	EP2	NK3a
OO4	TL4a	SE2EOb	EP3EO	NK3b
OO5	TL4b	SE3	EP4	NK4
OO6	TL5a	SE4EO	EP5EO	NK5a
OO7	TL5b	SE5	EP6a	NK5b
OO8	TL6	SE6EO	EP6b/c	NK6
OO9	TL7	SE7	EP7EO	NK7
OO10	TL8EO	SE8EO	EP8EOa	NK8EOa
OO11	TL9a	SE9EO	EP8EOb	NK8EOb
	TL9b/c/d/e	SE10EOa	EP9EO	NK9EOa
	TL10a	SE10EOb	EP10a	NK9EOb
	TL10d	SE11a	EP10b	
	TL11EO	SE11b/c	EP11	
	TL12	SE11d/e/f	EP12EO	
	TL13EOa/b	SE12a	EP13a	
	TL13EOc	SE12b	EP13b	
		SE13a	EP13c	
		SE13b	EP14	
		SE14a	EP15	
		SE14b	EP16EO	
		SE15	EP17EO	
			EP18	
			EP19EOa	
			EP19EOb	
			EP19EOc	
			EP19EOd	
			EP20EOa	
			EP20EOb	
			EP20EOc	
			EP21EOa	
			EP21EOb	
			EP21EOc	
			EP21EOd	
			EP22EOa	
			EP22EOb	
			EP22EOc	
			EP22EOd	

DOCUMENT AWARENESS

- PTAP DESIGNATED TRANSITION INTO PRACTICE RESIDENCY PROGRAM
- PATHWAY TO EXCELLENCE DESIGNATION
- RN SATISFACTION MUST MEET OR EXCEED THRESHOLD
- ALL ORGANIZATIONAL OVERVIEW REQUIREMENTS MUST BE MET
- ALL SUPPLEMENTAL INFORMATION SUBMISSIONS MUST BE PROVIDED AND HAVE NO GAPS
- ALL ACNO, DIRECTOR, AND MANAGER LEVEL POSITIONS IN NURSING MUST POSSESS A BSN
- CNO MUST POSSESS A MINIMUM OF A MASTERS DEGREE, DOCTORATE PREFERRED. EITHER THE MASTER'S OR BACHELOR'S DEGREE MUST BE IN NURSING
- THE DOCUMENT DETAILS MUST HAVE NO PHI. THREE WARNINGS LEVELS A $500.00 FINE.

DOCUMENT SPECIFICS

- HEALTHLINX FINALIZES EDITORIAL REVIEW
- HEALTHLINX FINAIZES DATA GRAPHICS
- UMC UPLOADS DOCUMENT INTO ADAM PLATFORM 06-02-2025
- TWO WEEKS PRIOR TO DOCUMENT SUBMISSION:
  - SUBMIT AVP/DIRECTOR/MANAGER TABLE (VERIFICATION EDUCATION ELIGIBILITY REQUIREMENTS ARE MET
  - RESEARCH TABLE UPLOAD (VERIFIES ALL STUDY PI/CO-PI/SITE PI ARE UMC NURSES)
  - ORGANIZATIONAL CHART UPDATES/NURSING ORGANIZATIONAL CHART (VERIFIES ALL RN'S ACROSS THE ENTERPRISE REPORT UP TO THE CNO)
  - UNIT-LEVEL DATA CROSSWALK (VERIFIES WHERE NURSE SATISFACTION, PATIENT ENGAGEMENT, NURSE-SENSITIVE QUALITY DATA ARE AVAILABLE, WHERE AND WHY MISSING DATA, WHERE YOUR VENDOR AGGREGATES DATA)
  - RECEIVE, REVIEW, SCRATCH LIST OF ASSIGNED MAGNET APPRAISERS (3)
- DEMOGRAPHIC DATA COLLECTION TOOL (DDCT) (VERIFIES ALL NURSING DEPARTMENT DEMOGRAPHICS OF IMPORTANCE) 05-15-2025
- INVOICE FOR $41,350.00
- SHOW STOPPERS TO MOVING FORWARD
- 5-DAYS TO PROVIDE ANYTHING MISSING

MAGNET PRIORITIES

- COMPLETE DOCUMENT
- COMPLETE DDCT
- COMPLETE ALL SUPPLEMENTAL INFORMATION
- REVIEW AND VERIFY ACCPETANCE OF 3 MAGNET DOCUMENT APPRAISERS
- MEET MILESTONE DATES:
  - DOCUMENT COMPLETED 05-01-2025 TO HEALTHLINX
  - SUPPLEMENTAL INFORMATION AND DDCT SUBMISSION NO LATER 05-15-2025
  - APPRAISER REVIEW COMPLETED 05-15-2025
  - FINAL DOCUMENT UPLOADED INTO ADAM PLATFORM BETWEEN 05-26 AND 06-02-2025
- WAIT UP TO 10-14 WEEKS FOR DOCUMENT REVIEW
- ACCEPTED, REQUEST ADDED INFORMATION
- CLOCK STARTS RUNNING OUT TO OBTAIN DATE FOR SITE VISIT (3-4 DAY VISIT)

QUESTIONS
GUEST DISCUSSION

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

Issue: **FY25 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 FY25 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 FY25.

Cleared for Agenda
April 7, 2025

Agenda Item #
7

UNIVERSITY MEDICAL CENTER

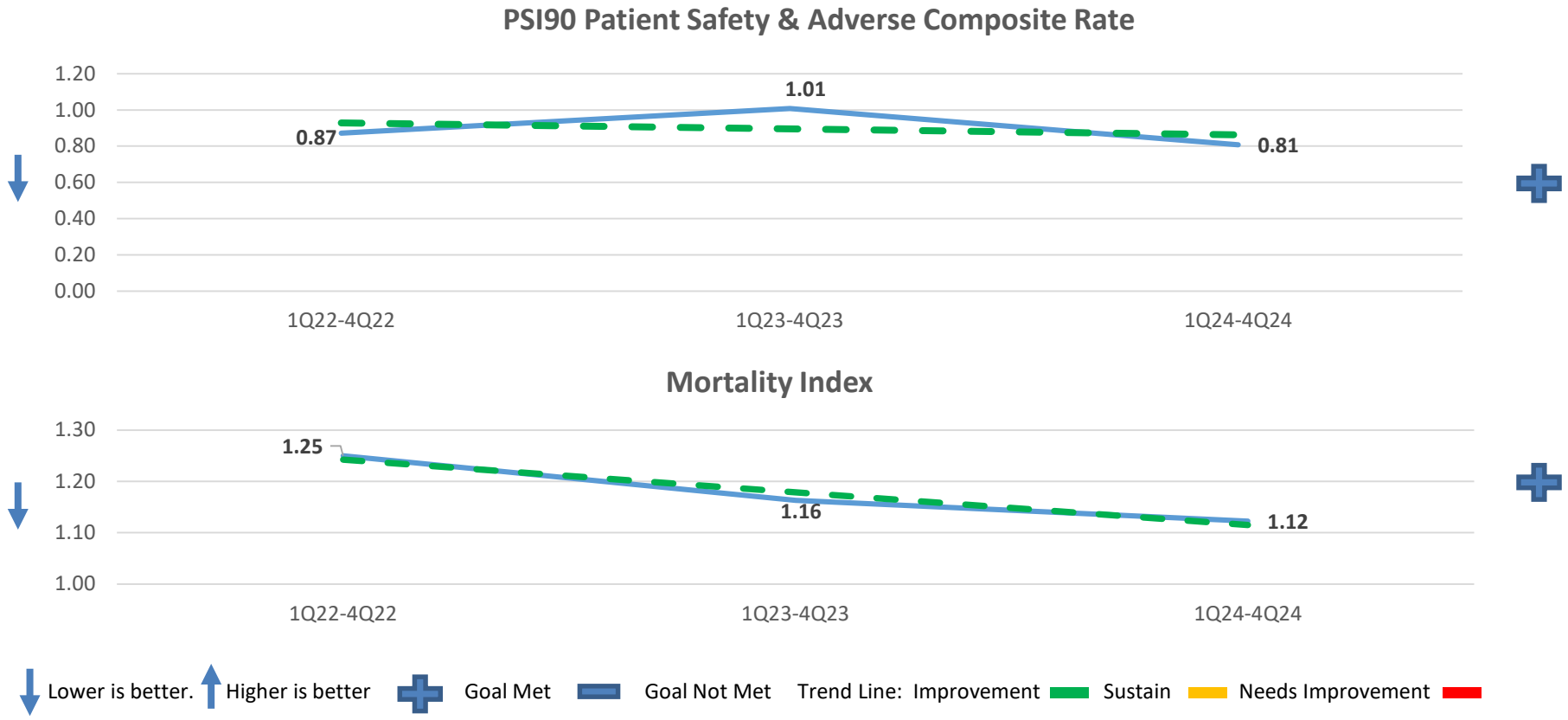
Quality Performance Objectives – FY25

Approved by the Governing Board

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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



Data Source: Vizient Clinical Database

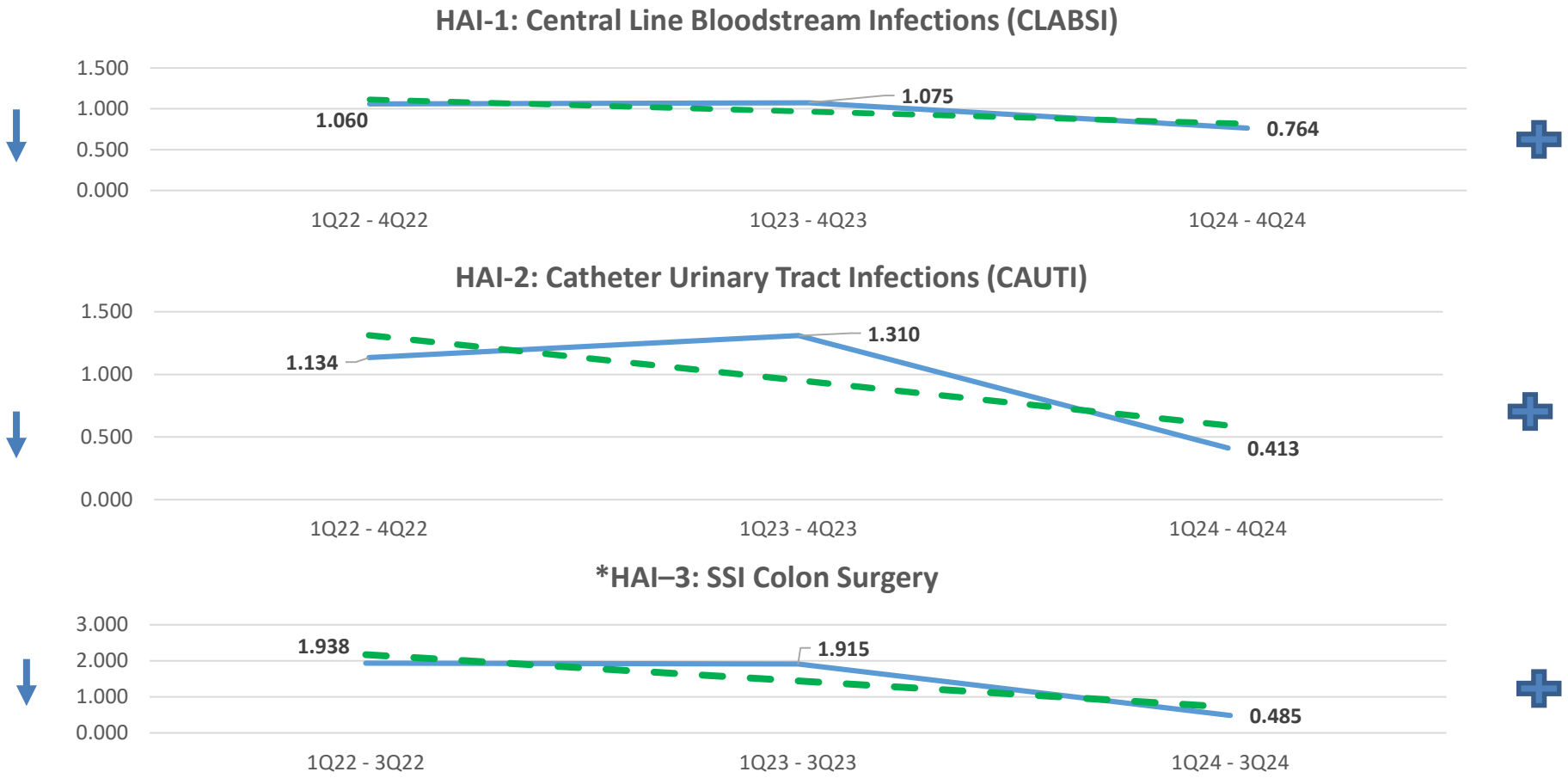
PSI 90 is a composite of the following 10, PSI indicators: pressure ulcers, iatrogenic pneumothorax, fall with hip fracture, peri-operative hemorrhage/hematoma, peri-operative metabolic complications, post-op respiratory failure, peri-op pulmonary embolism/deep vein thrombosis, post-op sepsis, post-op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

Mortality O/E - The ratio of Observed to Expected mortality. An O/E ratio **above** 1.0 indicates observed mortality higher than the Vizient expected value. All data sets are compared with Vizient's AMC 2024 Risk Adjusted Methodology. All payors, all patients.

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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



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

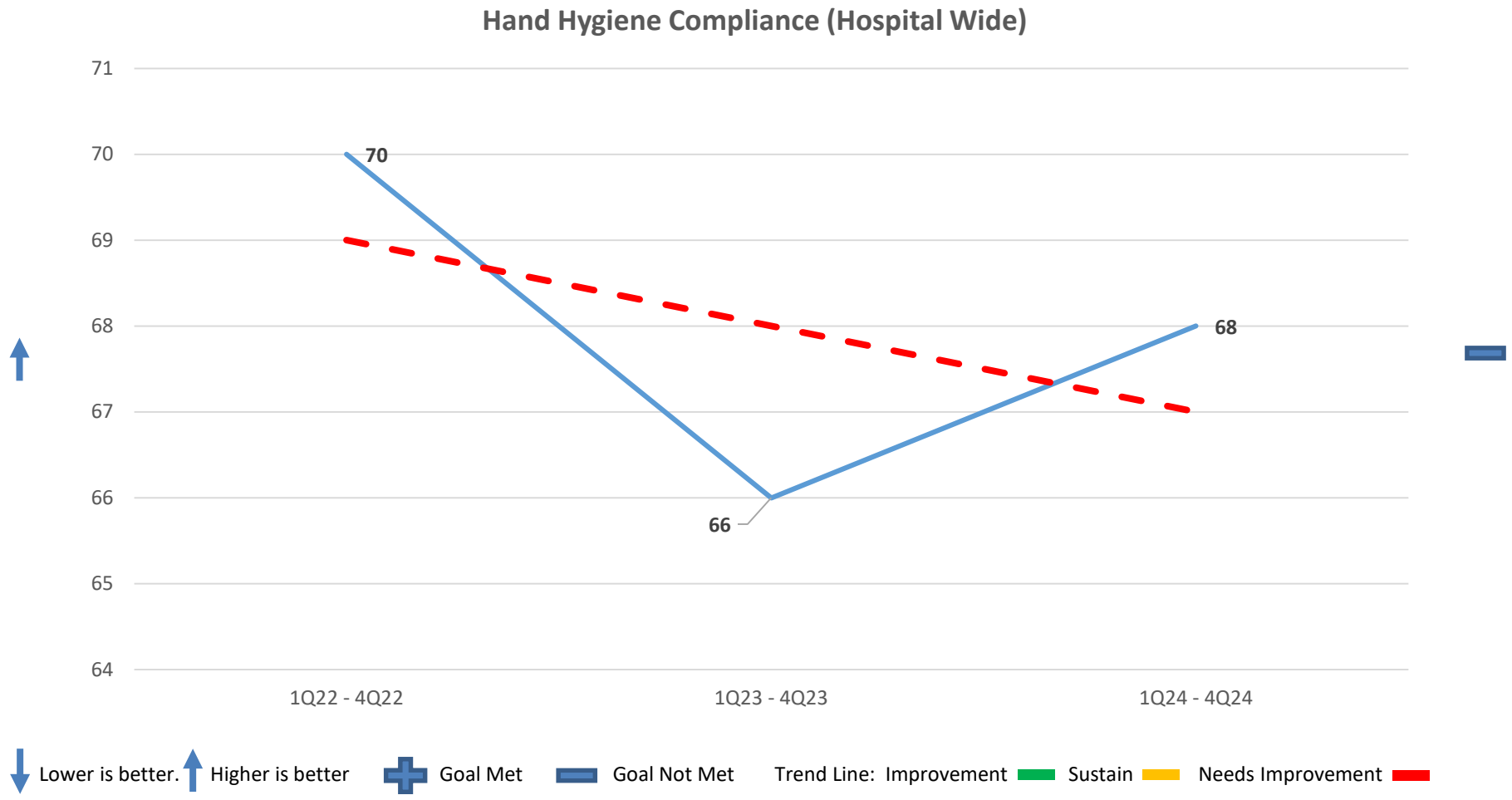
Data Source: UMC Infection Control Department – NHSN

*SSI Colon Surgery - NHSN reporting process, one quarter lag.

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

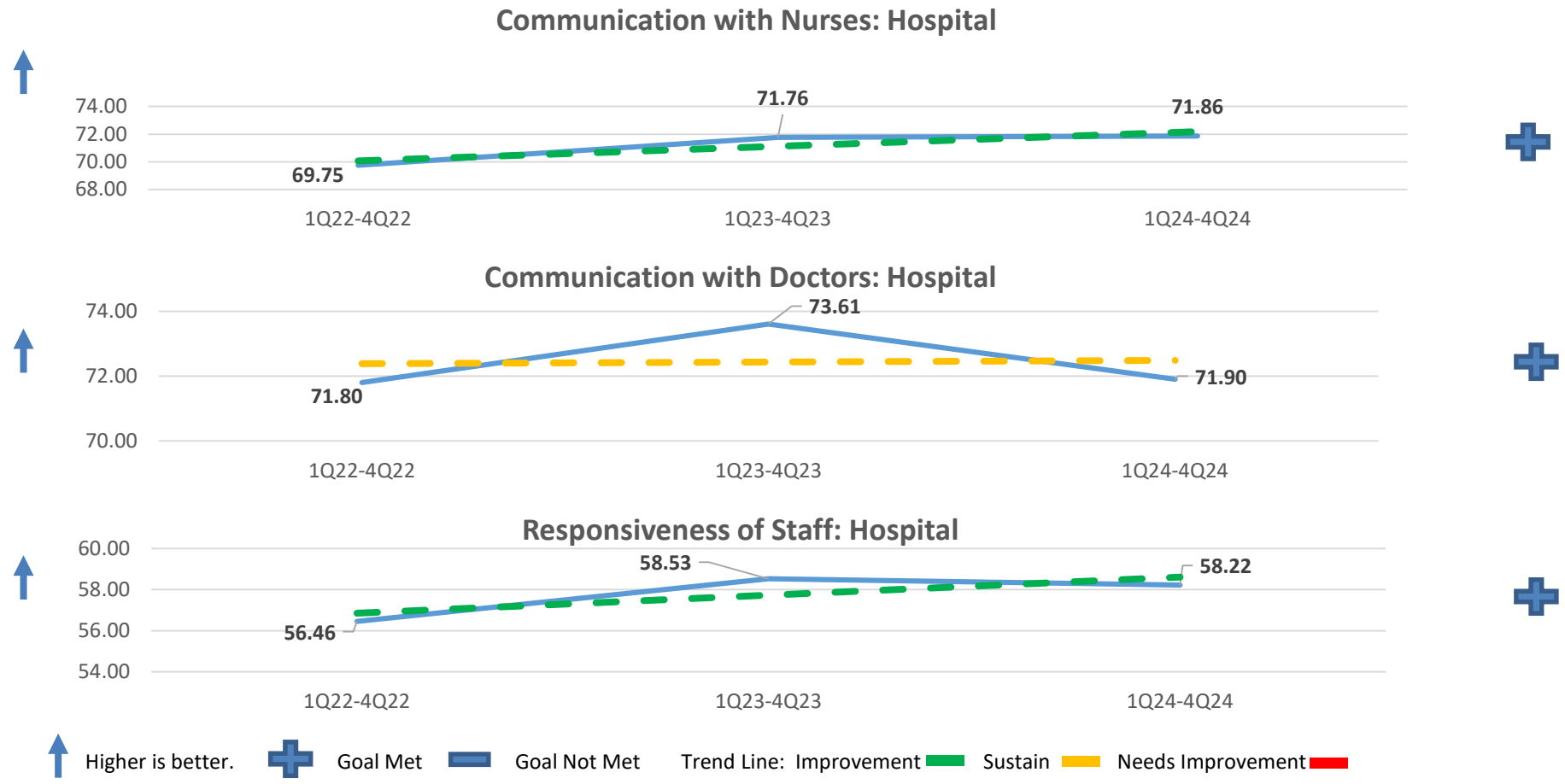


Data Source: UMC Infection Control Department - NHSN

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

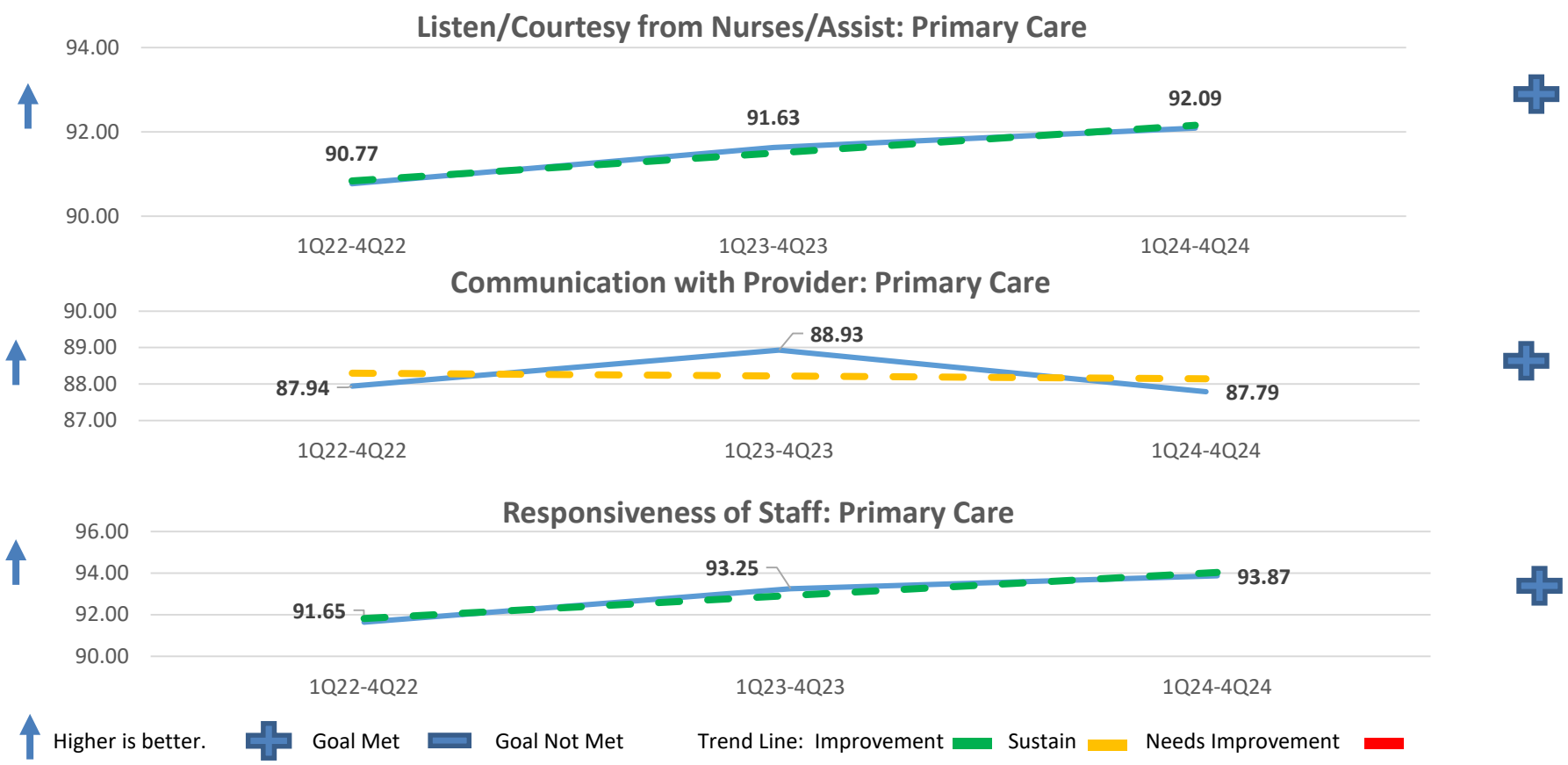


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

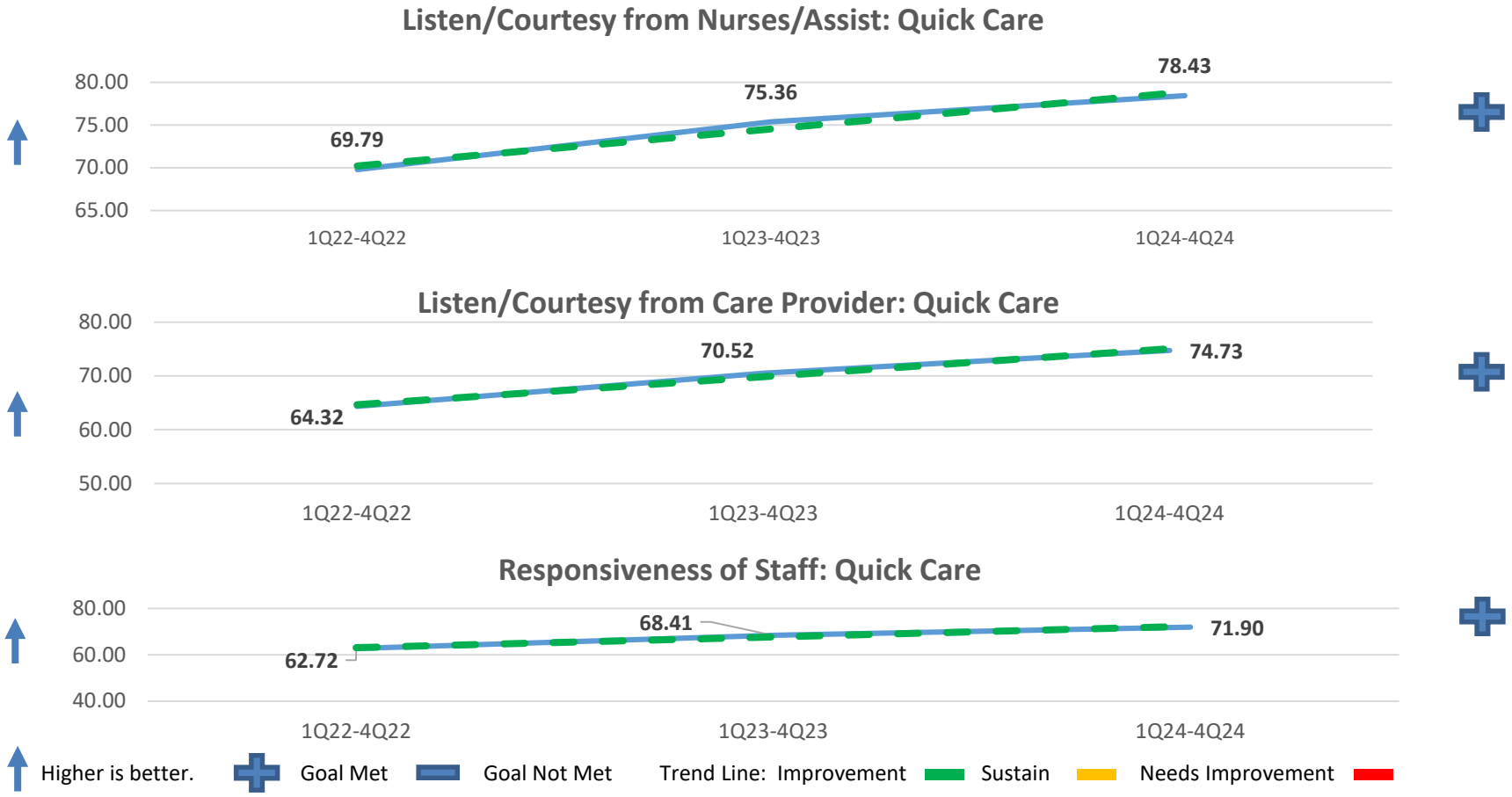


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

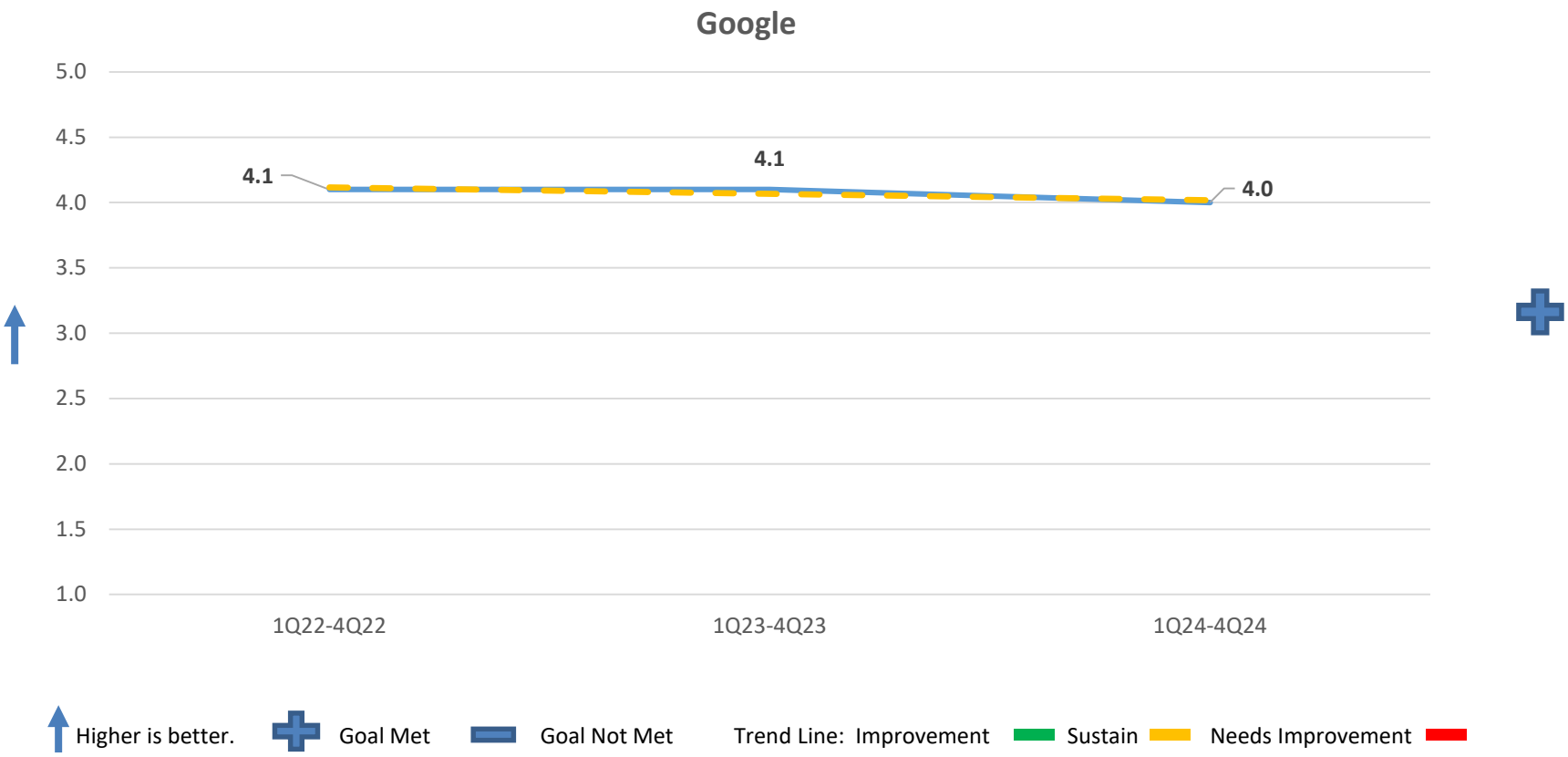


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date.
*Response not available for 1Q-2Q 2021 Press Ganey Survey.

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement (utilizing the Star Ratings) over the last three (3) year trending period in the overall patient perception of care (OP):

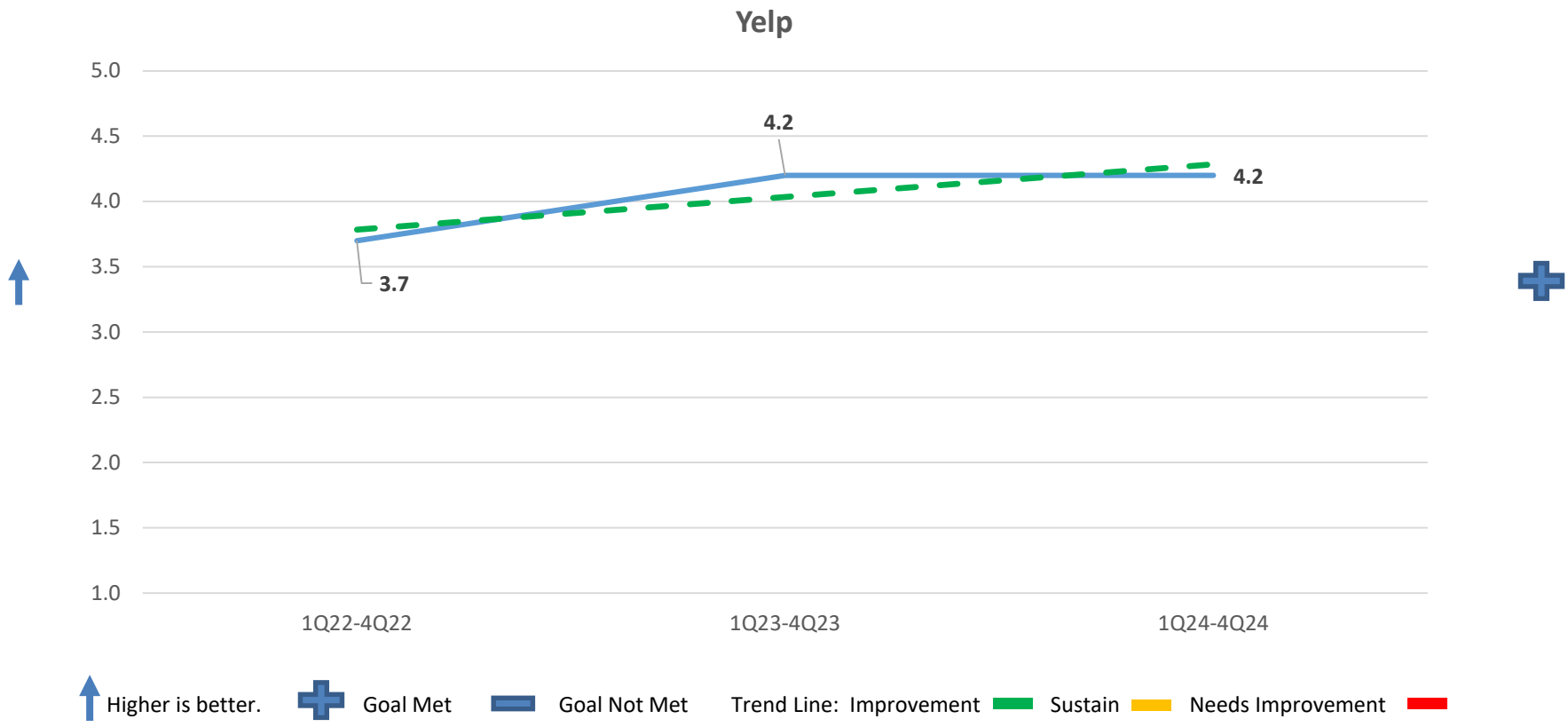


Date Source: UMC Experience Department, Yelp and Google websites. Average Star Score and Total Reviews during time period.
Score Range: 1-5 (5 Being the Highest)

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Improve or sustain improvement (utilizing the Star Ratings) over the last three (3) year trending period in the overall patient perception of care (OP):



Date Source: UMC Experience Department, Yelp and Google websites. Average Star Score and Total Reviews during time period.
Score Range: 1-5 (5 Being the Highest)

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

Employed physician & employee engagement / alignment measures (FY25):

Measure	Goal Met
Attain 100% onboarding attendance compliance with all UMC employed physicians. Onboarding is defined by the following two components: attends hospital/provider orientation; provided with performance metric expectations.	In Progress
Attain 90% physician engagement / alignment survey participation, utilizing information gained to develop plans for improvement as other providers join the organization / service line.	In Progress
Reach 80% of UMC employees with additional ICARE training specifically focused on service recovery.	In Progress

Data provided by Patient Experience

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 December 4, 2024 and January 2, 2025 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
April 7, 2025

Agenda Item #
8

February 5, 2024 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 64 Approved, 13 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Handling of Deceased Patients	Revised	Approved as Submitted	Modifications made to template; formatted and edited language; added references to other pertinent UMC policies/procedures. Vetted by CQPS and Public Safety.
Quality Management System: 2025 Quality Assurance and Performance Improvement Program Plan (QAPI)	Revised	Approved as Submitted	Updated to align to annual organizational and Governing Board QAPI Priorities; Revised reporting schedule due to leadership changes and changes to registry deadlines. Vetted by Quality, Patient Safety, & Regulatory Officer; Chair of Hospital Quality and Safety Committee.
Restraints	Revised	Approved as Submitted	Updated to include mandatory reporting of denial of rights. Vetted by CQPS.
Qualifications for Hire for Clinical Areas	Revised	Approved as Submitted	Added Case Management, MERT, Infusion and BCT qualification language. Vetted by Case Management Director, ACNO.
Pediatric Cervical Spine Imaging	New	Approved as Submitted	New guideline. Vetted by Pediatric Department.
Blood Transfusion Guidelines, Neonatal and Pediatric	Revised	Approved as Submitted	Reviewed and updated a few dosages. Removed using blood warmer for administering PRBC's. Vetted by Neo and NNP Managers.
Late Patient Arrival	Revised	Approved as Submitted	Scheduled review. No changes to guideline. Vetted by Ambulatory Clinical and Primary Care Medical Directors.
Ambulatory Care Scanning/Importing	Revised	Approved as Submitted	Changed 2cii for update in protocol. Vetted by Director of Ambulatory Patient Access Services and Executive Director PAS & Ambulatory Care.
Patient Identification	Revised	Approved as Submitted	Verbiage to clarify the patient involvement in the patient identification policy, including that the patient will verbally state their full name and DOB whenever possible; added distribution of patient diets to examples of when the patient identification process must occur. Vetted by Director of Patient Safety.
Patient Safety Plan	Revised	Approved as Submitted	Reviewed. Added DNV Patient Safety Systems chapter as reference; minor grammatical changes. Vetted by Director of Patient Safety.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Directory of Hospital Patients	Revised	Approved as Submitted	Changed scope to Hospital-wide. Purpose Statement shortened to make it more concise. Added "promote patient and staff safety" to the Policy Statement. Added UMC workforce and changes hospital to facility in the first bullet of the UMC Imposed Directory Restrictions section. Added NFP and Workforce member to the Definitions section. Vetted by Administrative Services, Patient Access Services, Patient Experience, and Patient Safety.
PHI Disclosures for Health Oversight Activities	Revised	Approved as Submitted	Added language to the procedure, reference, and definitions sections referencing the HIPAA Support of Reproductive Health Care Privacy policy and defining reproductive health care in order to align the policy with updated HIPAA rules concerning uses and disclosures of PHI containing reproductive health care information. Vetted by Privacy Officer.
PHI Disclosures for Law Enforcement	Revised	Approved as Submitted	Minor formatting changes completed. Added language to the procedure and definitions sections referencing the HIPAA Support of Reproductive Health Care Privacy policy and defining reproductive health care in order to align the policy with updated HIPAA rules concerning uses and disclosures of PHI containing reproductive health care information. Pg. 3, 2nd paragraph, 2nd sentence under Disclosures to Avert a Serious Threat to Health or Safety: Paragraph was separated changed to bullets. "is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat." Pg. 4 heading Court Order & Grand Jury Subpoenas change to Court Order & Grand Jury Subpoenas Served by Law Enforcement. Pg. 4 heading Patient Authorized Disclosures changed to Law Enforcement Disclosure Request Accompanied by a Patient Authorization.
PHI Disclosures for Other Specialized Activities	Revised	Approved as Submitted	Minor formatting changes made. Added language to the Disclosures to Coroners or Medical Examiners and Reference sections to reference HIPAA Support of Reproductive Health Care Privacy policy to align with updated HIPAA rules concerning uses and disclosures of PHI containing reproductive health care. Vetted by Privacy Officer.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Provider Charge Changes Process	New	Approved as Submitted	New policy, vetted by HIM Director and CFO.
Adult ICU – Bedside Percutaneous Tracheostomy Performed in Intensive Care Unit (ICU PT)	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Critical Care Services, Dr. Arthur Romero and ACNO.
Productivity and Quality Monitoring	Revised	Approved as Submitted	Updates to department policy for measuring productivity and quality benchmarks, added Remote Work Program. Vetted by Assistant Director, Patient Accounting, Patient Accounting Managers and Director Patient Accounting.
Settlement Check Processing	Revised	Approved as Submitted	Scheduled review, updates to current process. Transfer to current template. Vetted by Assistant Director Patient Accounting, Patient Account Manager, Patient Accounting and Director Patient Accounting.
Mail-Incoming	Revised	Approved as Submitted	Update to current process. Update to new template. Vetted by Assistant Director, Patient Accounting, Patient Account Manager, Patient Accounting and Director, Patient Accounting.
Trauma Response Team – Social Services	Revised	Approved as Submitted	Transcribed to updated format. Changed verbiage to "on-call Case Management leader" from "Social Service Director". Vetted by Trauma Program Manager, Clinical Director Critical Care Services, Assistant Director Case Management and ACNO.
Trauma Response Team – Trauma Physician Team Leader	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Trauma Clinical Manager, Clinical Director Critical Care Services and ACNO.
Adult Massive Transfusion	Revised	Approved as Submitted	Updated to current practice. Vetted by Trauma Team.
Adult Whole Blood Massive Transfusion Guideline in Trauma Patients	Revised	Approved as Submitted	Scheduled review and added Adult Rh+ Females age 18 – 49 to Guideline. Vetted by Trauma Program Manager.
Treatment Guidelines for Orthopaedic Injuries	Revised	Approved as Submitted	Reviewed and approved as revised by Chief and Vice-Chief of Trauma Surgery, and Dr. Abby Howenstein, Orthopaedic Surgery.
Hazardous Material and Waste Spill Response	Revised	Approved with Revisions	Policy re-write to add content specific to large spill response with removal of spill team and adding definitions. Updated to match Code Orange policy and clarify EVS responsibilities. Added references. Review of policy for addition to the Emergency Operations Plan for 2025.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			Vetted by Safety Manager and Emergency Preparedness Coordinator.
Personal Use Items	Revised	Approved as Submitted	Reviewed for changes to appliance usage in business occupancy. Vetted by Safety Program Manager.
Bed Bug	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Infection Control and Medical Director Infectious Disease Services.
Bloodborne Pathogen Exposure Control Plan (ECP)	Revised	Approved as Submitted	Yearly review minimal changes grammar and formatting; no content change. Vetted by Director of Infection Prevention/Control and Medical Director Inpatient & Outpatient Infectious Disease Services.
Disposable and Reusable Curtain Removal/Replacement	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of EVS, Director of Infection Control and Executive Director of Support Services.
Employee Assistance Program	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Human Resources Director and Chief Human Resources Officer.
Kidney Donor Profile Index (KDPI) >85%	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Quality & PI Coordinator – Transplant and Transplant Services Director.
Transplant Scope of Services	Revised	Approved as Submitted	Removed "kidney" due to doing both kidney and pancreas. Removed Pediatric and Adolescent. Removed top diagnoses. Added advanced provider. Vetted by Quality & PI Coordinator – Transplant and Transplant Services Director.
Center for Transplantation Cost Finding; Time & Motion	Revised	Approved as Submitted	Reviewed and updated hyperlinks. Vetted by Quality & PI Coordinator – Transplant and Transplant Services Director.
Transplant - Grievance Policy	Revised	Approved as Submitted	Updated Grievance/Complaint notification. Vetted by Quality & PI Coordinator – Transplant and Transplant Services Director.
Scheduling For Testing At The HLA Laboratory	Revised	Approved as Submitted	Updated method of report/forms transmission. Vetted by Quality & PI Coordinator – Transplant and Transplant Services Director.
United Network of Organ Sharing (UNOS) Membership	Revised	Approved as Submitted	Updated OPTN Bylaws edition. Vetted by Quality & PI Coordinator – Transplant and Transplant Services Director.
Medical Record (Legal)	Revised	Approved as Submitted	Updated HIM personnel titles and revised definitions. Vetted by HIM Manager, Director of HIM and CFO.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Controlled Substances: Inter-facility Transport of the Critically Ill Patient	Revised	Approved as Submitted	Included requirement to name the Critical Care Transport Company in MAR comment for record keeping. Reworded "uninstalled" to "new/ unopened" to be more clear.
Adult Pneumococcal/Influenza Vaccination Standing Order	Revised	Approved as Submitted	Updated screening age to align with CDC/APIC recommendations. Vetted by Director of Pharmacy.
Wellness Center-Human Immunodeficiency Virus (HIV) Screening Guidelines	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Ambulatory Clinical Manager/Wellness, Medical Director Wellness and Executive Director PAS & Ambulatory Care.
On Call Physician	Revised	Approved as Submitted	#12, letter b – Second Offense will result to loss of stipend, and a letter of reprimand, which may include consequence(s) approved by the MEC. #15 – added a timeframe of "within seven days" for the one time follow up evaluation following the emergency department visit. Vetted by Director of Medical Staff.
Medical Staff Professional Code of Conduct	Revised	Approved with Revisions	Updated Procedure: Letter A. Reporting - In the event that an incident is reported to a leader, that leader may enter the report in the Incident Tracking System instead of having the Medical Staff Office enter the report as previously stated. Letter B Validation of Reported Incident: 1 b – streamlined the process of sending letters of inquiry to match practice. Letter D Management of Inappropriate Conduct and Disruptive Behavior by UMC Medical Staff Leaders, #s 3 and 4 - streamlined the processes to match practice. Vetted by Director of Medical Staff, COS and Legal.
Outpatient Infusion Clinic Protocol	New	Approved as Submitted	New Protocol. Added References and Adds under bucket point For Severs Allergic Reactions. Vetted by Pharmacy and Director of Clinical Support Services.
Infant Safe Sleep	Revised	Approved as Submitted	Updated references and added detailed educational elements. Vetted by Perinatal Manager and Perinatal Educator.
Hypertensive Disorders of Pregnancy (Gestational Hypertension/Preeclampsia/ Eclampsia)	Revised	Approved with Revisions	Updated magnesium sulfate ranges and references. Added "per Licensed Practitioner order" where administration of medications is described. Vetted by Perinatal Clinical Manager and OBGYN Chief.
NICU/PICU - Extubations	Revised	Approved as Submitted	No substantive changes. Added NICU to purpose section of policy as it was not previously included. Added language to indicate

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			RT must document assessment findings and extubation date and time in EMR. Vetted by Director Respiratory Services.
NICU / PICU – Surfactant Replacement	Revised	Approved as Submitted	Reviewed. No changes to policy. Vetted by Director of Respiratory Services.
Personnel Managing the Ventilator	Revised	Approved as Submitted	Reviewed and updated to reflect current practice. Incorporated language regarding military personnel. Vetted by Director of Respiratory Services.
Respiratory – Medical Director Responsibilities & Qualifications	Revised	Approved as Submitted	Reviewed. No substantive changes. Added language about participating in accreditation or regulatory surveys. Vetted by Director of Respiratory Services.
NICU/PICU – Bio-Medical MVP-10 Neonatal / Transport Ventilator	Revised	Approved as Submitted	Reviewed. No substantive changes. Vetted by Director of Respiratory Services.
Respiratory – Non-Invasive Ventilation	Revised	Approved as Submitted	Reviewed. Updated to language clarification. Also inserted FiO2 requirements for ICU placement. Vetted by Director of Respiratory Services.
Respiratory – Securing and Care of the Endotracheal Tube	Revised	Approved as Submitted	Reviewed. Updated to reflect commercial ETT holder vs referencing a specific device. Clarified healthcare provider will be an RT. Updated to reflect commercial ETT holder vs referencing a specific device. Clarified healthcare provider will be an RT. Vetted by Director of Respiratory Services.
Respiratory Lab – Validation Protocol	Revised	Approved as Submitted	Reviewed. No updates required. Adheres to CAP standards. Vetted by Director of Respiratory Services.
Respiratory - Infection Control Guidelines	Revised	Approved as Submitted	Reviewed. No updated required. Vetted by Director of Respiratory Services.
Respiratory – The Use and Management of Oxygen	Revised	Approved as Submitted	Reviewed. Updated to reflect need for titration within order set. Vetted by Director of Respiratory Services.
Revital-Ox RESERT High Level Disinfectant	New	Approved as Submitted	New policy. Vetted by Director of Peri-Operative Service, Endoscopy CN and Director of Infection Prevention/Control.
Code Black – Bomb Threat	Revised	Approved as Submitted	Revised purpose and policy. Updated procedure and notification format, streamlining both for clearer procedure flow. Added use of UMC Emergency Preparedness & Response Quick Reference and checklist. Vetted by Public Safety Office Supervisor.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Code Orange	Revised	Approved with Revisions	Updated purpose and policy. Updated policy format. Removed UMC Spill Team listing. Updated reference policy title. Vetted by Public Safety Office Supervisor.
Medication Management: Administration and Monitoring	Revised	Approved as Submitted	New format; minor wording changes. Vetted by Director of Pharmacy.
PGR-10 Rotation Selection – Pharmacy Residency	Revised	Approved as Submitted	Updated rotations based upon current availability. Updated nomenclature of rotations for consistency. Vetted by Director of Pharmacy.

March 5, 2024 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 66 Approved, 1 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
EMTALA	Revised	Approved as Submitted	Added language relative to "operating hours" for Quick Care locations, Added QMP to include CSC RN's and guidance relative to patient's arriving at CSC on a mental health crisis hold (L2K, Legal 2000), Updated references. Vetted by Quality/Safety/Regulatory Officer.
Kangaroo Care	Revised	Approved as Submitted	Added to new template, updated the excluded pts., updated references and added the Lippincott procedures link. Vetted by NICU Clinical Manager and Pediatric Department.
Infant Massage	Revised	Approved as Submitted	Modified with Lippincott hyperlink, updated the weight, and corrected typos. Vetted by NICU Clinical Manager and Pediatric Department.
Thermoregulation for Neonates	Revised	Approved as Submitted	Updated weight to <1000 grams instead of 1500 per NANN in the humidity section. Updated references. Vetted by NICU Clinical Manager and Pediatric Department.
Naso-Jejunal Feedings	Revised	Approved as Submitted	Placement verified by x-ray, Lippincott hyperlink and updated to current template. Vetted by NICU Clinical Manager and Pediatric Department.
Alternative Feeding Methods for the Breastfed Infant	Revised	Approved as Submitted	Updated wording, corrected typos and updated the References with the Lippincott procedure link. Vetted by NICU Nurses, NICU Clinical Manager, Neonatologist and Pediatric Department.
Induced Hypothermia for Neonatal Encephalopathy	Revised	Approved as Submitted	Updated to new template, updated wording for VS monitoring and typos. Vetted by NICU Nurses, NICU Clinical Manager, Neonatal and Pediatric Department.
Respiratory - NICU/PICU - RAM Cannula Device	Revised	Approved as Submitted	Reviewed. No substantive changes made. Vetted by Director of Respiratory Services.
Respiratory - Disaster Notification Plan	Revised	Approved as Submitted	Reviewed. No changes necessary. Vetted by Director of Respiratory Services.
NICU / PICU – Infant T-Piece Resuscitator Devices	Revised	Approved as Submitted	Cleaned up for content and to eliminate references to a specific Neonatal T-Piece Resuscitator device. Defined scope to RTs

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			working in NICU/PICU. Vetted by Director of Respiratory Services.
NICU / PICU – SVN and Oxygen Criteria for Patients Admitted to Pediatric Med/Surg Unit	Revised	Approved as Submitted	Cleaned up for content to specify scope for Respiratory Therapists working PICU and Peds units. No substantive changes. Reflects current practice. Vetted by Director of Respiratory Services.
NICU / PICU – Chest Physiotherapy	Revised	Approved as Submitted	Changed to guideline for CPT, rather than a defined policy. Cleaned up for content. Reflects current practice/process. Vetted by Director of Respiratory Services.
NICU / PICU – Nasal / Bubble CPAP	Revised	Approved as Submitted	Clarified this device is for use by RTs assigned to NICU/PICU. Cleared reference to specific manufacturer. No substantive changes to content. Changed to guideline from policy. Vetted by Director of Respiratory Services.
NICU / PICU – Respiratory Coverage for Labor and Delivery	Revised	Approved as Submitted	Cleaned up for content. Provided clarity to assignments and to include Nevada requirements for Respiratory coverage for Level III nursery. Vetted by Director of Respiratory Services
NICU / PICU – Life Pulse High Frequency Jet Ventilator	Revised	Approved as Submitted	Cleaned up for content. Clarified specific respiratory personnel within scope. No substantive changes. Matches current practice. Vetted by Director of Respiratory Services.
Respiratory – Cardiopulmonary Exercise Testing	Revised	Approved as Submitted	Removed verbiage to specific equipment manufacturer. Reflects current practice. No substantive changes. Vetted by Director of Respiratory Services.
Discontinuation of Acute Care Therapy Services	Revised	Approved as Submitted	No major content changes. Vetted by Director of Rehabilitation Services.
Rehab - Staffing and Productivity	Revised	Approved as Submitted	Added the Time Spent in Patient Care metric as a departmental productivity requirement. Consolidated the Prioritization Model into a single model applicable to all 3 Rehab disciplines. Vetted by Rehabilitation Services Director.
Rehab – Patient Instructions	Revised	Approved as Submitted	Policy name change from "Patient Family Instructions" to "Patient Instructions". Added to new template. Vetted by Rehabilitation Services Director and ACNO.
Rehab Cross Training Mechanism	Revised	Approved as Submitted	Minor verbiage changes; no content/substance changes; new template. Vetted by Rehab Services Director and ACNO.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Rehabilitation Services Organizational Chart/Emergency Call Tree	Revised	Approved as Submitted	Updated the leadership and reporting structure. Vetted by Rehab Services Director.
Physical Therapy Assistant, Student and Provisional Licensee Supervision	Revised	Approved as Submitted	Removed "If the Physical Therapist Assistant has less than 2,000 hours of experience as a Physical Therapist Assistant, the supervising Physical Therapist must be on the premises when any procedures or activities of Physical Therapy are performed by the Physical Therapist Assistant." – NV PT Board removed the requirements for the on-site supervision of PTAs with less than 2000 hours of experience.
Anticoagulation Reversal	Revised	Approved as Submitted	Scheduled review. Vetted by Trauma Program Manager, Clinical Director Critical Care Services and ACNO.
Controlled Substances: Patient Controlled Analgesia (PCA)	Revised	Approved as Submitted	Added to new template. Changed from Guideline to Policy. Removed information contained in High Alert Policy. Added every 4 hour monitoring requirement. Changed telemetry requirement to only patients receiving basal rate infusions. Vetted by Jennifer Millet, Yuliya Peet and Director of Pharmacy.
Medication Management: Security and Storage of Pharmaceuticals	Revised	Approved as Submitted	Added section on waste within 30 minutes. Added a comment specifically for controlled substance waste. Changed patient cassette to patient specific medication bin. Added section to prohibit personal bags in medication storage areas with controlled substances. Vetted by Director of Pharmacy.
IV Room Air/Surface Testing & Remediation Procedures	Revised	Approved as Submitted	Updated for current ACPH and 2022 version of USP 797; included stepwise approach to action plan development per recommendations of Nevada State Board of Pharmacy. Combined with Random Surface, Fingertip, and Air Sampling in the Sterile Compounding Area policy to retire that policy. Vetted by the Assistant Director of Pharmacy.
Maintenance and Use of Biological Safety Cabinet	New	Approved as Submitted	New Document required by NAC. Vetted by Director of Pharmacy.
Protocol for Electrolyte Replacement in Adult Patients on Parenteral Nutrition	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Pharmacy.
Protocol for Thiamine Initiation Prior to the Start of Parenteral	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Pharmacy.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Nutrition in Adults at Risk for Refeeding Syndrome			
Drug Extravasation	New	Approved as Submitted	New guideline. Vetted by ACNO and Pharmacy.
Medication Orders: Range, PRN, Multiple Routes and Medications ordered for the Same Indication	Revised	Approved as Submitted	Updated format and minor wording clarifications. Vetted by Director of Pharmacy.
Stress Ulcer Prophylaxis Stewardship	Revised	Approved as Submitted	Clarified that an active order for systemic steroids excludes a patient from this protocol. Vetted by Director of Pharmacy.
IV-to-PO Conversions	Revised	Approved as Submitted	Removed sulfamethoxazole/trimethoprim from the protocol due to imprecision in converting an intravenous dose to an oral dose rounded to the closest tablet size. Vetted by Director of Pharmacy.
Renal Dosing	Revised	Approved as Submitted	Added language to allow pharmacists to adjust drug dosing according to GFR. Added the CKD-EPI equation to the protocol. Vetted by Director of Pharmacy.
Therapeutic Interchange	Revised	Approved as Submitted	Added buprenorphine therapeutic interchange. Add inhalers to nebulization therapeutic interchange as Appendix B. Vetted by Director of Pharmacy.
PGR-01 Evaluation and Ranking of Pharmacy Residency Program Applicants	Revised	Approved as Submitted	Removed the following requirements from the phase II process: Class ranking, clinical case, and presentation. Updated references with the most recent ASHP residency standards. Vetted by Director of Pharmacy.
Miscellaneous Medication Monitoring	Revised	Approved as Submitted	Scheduled review. No updates. Vetted by Director of Pharmacy.
Pediatric Continuous Renal Replacement Therapy (CRRT) Procedures and Guideline	Revised	Approved as Submitted	Addition of TherMax pouch and auto-effluent kit in the circuit supplies. Emphasis not to stop CRRT while obtaining sample from the circuit to avoid complications (introducing air, clogging/ clotting). HD catheter flush while machine is not running for prolonged period of time to avoid complications (clotting the catheter, infection). Vetted by Pediatric Department.
Pediatric CRRT Citrate Anticoagulation	Revised	Approved with Revisions	Updates to abbreviations. Add point for titration of both calcium and citrate infusions during the blood flow rate titrations upon CRRT initiation. Changed from Protocol to Policy. Vetted by Pediatric Department.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Pediatric CRRT Nursing Management	Revised	Approved as Submitted	Updated filters and priming volumes of each Added TherMax pouch and auto-effluent as part of the therapy. Added point for setting up citrate and calcium infusions, and blood transfusions if ordered, as part of the initial setup for therapy. Vetted by Pediatric Department.
Capacity Management Plan	Revised	Approved as Submitted	Few changes with verbiage, removed Discharge Lounge as a fixed location. Removed HavBed and added EMResource. Vetted by Clinical Support Services Director, ACNO and Med Surg Director.
Weight Calibration of Gurneys with Scales	New	Approved as Submitted	New policy. Vetted by Director of Clinical Support Services.
Ambulatory Critical Results Documentation and Reporting for Primary Care During Hours of Operation	New	Approved as Submitted	Established New Guideline to align with current practices. Reviewed and vetted by Clinical Ed, Dr. Tan and Dr. Almeqbeli, PC Medical Directors.
Malignant Hyperthermia	Revised	Approved with Revisions	Scheduled review, no changes. Vetted by Dr. Hu.
Pre-Operative Pregnancy Test	Revised	Approved as Submitted	Added verbiage - "All female patients admitted to University Medical Center (UMC) and going for surgery shall follow the same procedure and shall be cared using the same standards." – Input from Dr. Hu, Anesthesia Medical Director.
PAT Pre-Anesthesia High Risk Patient Screening Protocol	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Dr. Hu.
Pre-Admission Testing and Preoperative Unit: Pre-Anesthesia	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Dr. Hu.
Red Star Security Alert	Revised	Approved as Submitted	Addition of the Contraband Search and Belongings inventory for the nursing units. Vetted by Public Safety and Med Surg Clinical Director.
Patient Directed & Authorized Disclosures	Revised	Approved as Submitted	Change dept. to Privacy. Added table of contents. Added a Standards sections and relocated content from Procedure Section to the Standards section. Added new content to the Procedure section. In Standards sections: • Updated Access & inspection of records from 5 days to 10 days to align with NV Law. • Changed "conditioned" and "conditioning" to "Withhold[ing] or Deny[ing]" for clarity.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			• Added Refernces to Confidentiality Of Substance Use Disorder Patient Records (42 CFR Part 2). Additional formatting and content rearrangement to assist with policy presentation and structure.
General Information Privacy & Security Safeguards	Revised	Approved as Submitted	Policy section common language changes made. Language reallocated from the Procedure section to Standards. Additional standard language added. Additions, deletions, and modifications made to example safeguards list. Procedure section was reduced to indicate where modified to indicate where to report information privacy & security safeguard issues, concerns, and/or violations to. Definition section modifications made to include removal of definition no longer applicable and modification to Minimum Necessary and PHI definitions for standardization. Vetted by Privacy Officer and Information Security Officer.
Court Order & Subpoena Disclosures of Protected Health Information (PHI)	Revised	Approved as Submitted	Updated Standard and Procedure section to cover the Prohibited Lawful Reproductive Health Care Disclosures Requirements. 45 CFR 164.502(a)(5)(3). Vetted by Privacy Officer.
Written Workplace Safety Program	New	Approved as Submitted	New policy. Vetted by Safety Program Manager, EOC Committee and Human Resources.
Fire and Smoke Barrier Penetration	New	Approved as Submitted	New policy. Vetted by EOC Committee and Director of Facilities.
Safety and Health During Construction	Revised	Approved as Submitted	Minor updates to the policy and references. Vetted by EOC Committee and Director of Facilities.
Alternative Life Safety Measure (ALSM)	Revised	Approved as Submitted	Minor changes. ILSM format updated to reflect ALSM verbiage. Vetted by EOC Committee and Director of Facilities.
Discharging Patients from the Adult Emergency Department	Revised	Approved as Submitted	No changes made. Vetted by Adult ED Director and Adult ED Medical Directors.
Specimen Handling: Products of Conception	Revised	Approved with Revisions	Added requirement for tissue disposal order for lab. Vetted by Adult ED Director and Adult ED Medical Directors.
Forensic Assault Patient Protocol	Revised	Approved as Submitted	Added #15 Human Bite. Vetted by Jeri Dermanelian, SANE RN, Dr. Jerad Eldred, Physician Champion, Dr. David Obert and Dr. Ketan Patel, Adult ED Medical Directors, Lisa Phan ED PharmD, Jayme Patel PharmD Clinical

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			Specialist, Dr. Shadaba Asad Medical Director Infectious Diseases.
Guidelines for Burn and Anesthesia	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Burn Program Manager, Burn Care Unit Manager, Interim Burn Medical Director and ACNO.
2025 Infection Prevention/Control Risk Assessment & Plan	Revised	Approved as Submitted	Scheduled yearly review and update to plan added new language from TJC updates and DNV. Vetted by Director of Infection Prevention.
Oxytocin Administration for Induction and Augmentation of Labor	Revised	Approved with Revisions	Policy updated to reflect the max dose of Oxytocin of 30milliunits/min if the IUPC is in place; Uncoordinated Uterine Activity language removed. Vetted by Clinical Manager, Perinatal Unit, Clinical Director – Maternal-Child Services and Chairman of the OB/GYN Department.
Utilization Management Plan	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Care Management and CFO.
Standards of Basic Nursing Care - PICU	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Clinical Manager.
Histology Gross Only Specimens	New	Approved as Submitted	New policy. Vetted by General Laboratory Services Manager Pathology.
Termination of Primary Care Relationship	Revised	Approved as Submitted	Updated "Patients discharged under this policy are eligible to reestablish a primary care relationship with another UMC provider, or after one year from the date of notification of their discharge with their original primary care provider by approval." Vetted by Ambulatory Care Executive Director and Dr. Lippmann.
Cyber Security/Information Security	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Information Security Officer.

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
April 7, 2025

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