UMC Clinical Quality and Professional Affairs Committee Meeting

Tuesday, December 16, 2025 - 2:00 pm

Delta Point Building - Sapphire Conference Room

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
December 16, 2025 2:00 p.m.
901 Rancho Lane, Las Vegas, Nevada
Delta Point Building, Sapphire 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 October 6, 2025. *(For possible action)*

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

SECTION 2. BUSINESS ITEMS

4. Receive an update from Ronald Roemer, Director of Clinical Research & Compliance regarding the Clinical Trials and Institutional Review Board activities at UMC; and direct staff accordingly. (For possible action)

5. Receive an update from Patty Scott, Quality/Safety Regulatory Officer on the FY26 Organizational Performance Goals; and direct staff accordingly. (For possible action)

6. Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of October 1, 2025 and November 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

7. 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
October 6, 2025

Ruby Conference Room
Delta Point Building, 1st Floor
901 S. Rancho Lane
Las Vegas, Clark County, Nevada
October 6, 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 2:05 p.m. by Chair Renee 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

Absent:
None

Also Present:
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Deb Fox, Chief Nursing Officer
Tory Begay, Emergency Preparedness Coordinator
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 August 11, 2025. *(For possible action)*

FINAL ACTION: A motion was made by Member Lopez-Hobbs 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 and educational presentation from Tory Begay, Emergency Preparedness Coordinator regarding the Emergency Preparedness Program at UMC; and direct staff accordingly. (For possible action).

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

DISCUSSION:

Tori Begay, Emergency Preparedness Program Coordinator, provided a high-level overview of the program's operations at UMC, as well as an update on lessons learned from the Formula One event.

The program is committed to providing a safe, accessible, effective, and responsible environment of care consistent with UMC's mission, services, and applicable governmental requirements. The program is designed to protect patients and staff, as well as ensure the hospital is prepared to manage and recover from a disaster. The Program also utilizes best practices from healthcare and emergency management, ensuring compatibility with other emergency management programs, the National Incident Management System and compliance with The Joint Commission.

UMC has an Emergency Preparedness Committee composed of an interdisciplinary team of staff from various hospital departments. Ms. Begay continued the discussion by highlighting the committee's roles and responsibilities, including participating in the activation of emergency operation plans, monthly test notifications, and involvement in real-world incidents and exercises.

Communication is essential in the event an incident occurs; key individuals are notified via email, text, or phone. The discussion continued regarding the responses needed to engage committee activation. Mr. Van Houweling added that there is always an on-duty administrator at the hospital, and a conversation ensued regarding the coordination of emergency management exercises along with Clark County and other entities throughout the city.

Preparedness includes set-up of an incident command center, UMC/Clark County exercises, Clark County joint meetings, and National Guard engagement.

Ms. Begay continued the discussion by sharing the process for preparing for the recent Formula 1 and Super Bowl events, lessons learned, and any financial impacts incurred by UMC. Exercises and collaboration with community partners have been planned in preparation for the race this year.

Ms. Begay highlighted that many hours were spent in advance planning and preparation for the events. A list of strengths and opportunities for improvement learned from these events were reviewed.

Costs associated with program preparation include hours spent in collaboration and planning, trainings, exercises, logistics, meeting attendance, as well as the engagement of internal and external resources. Although there were no major financial impacts from these events, there were program costs and an increase in staffing to assist with the events. She noted if there were a real-world incident, the financial impact could be different.

A discussion ensued regarding active community awareness and involvement in emergency preparedness.

FINAL ACTION TAKEN:

None

ITEM NO. 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).

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

DISCUSSION:

Ms. Scott reviewed the quality, safety, infection prevention, and regulatory program for Q2 of 2025.

Readmissions – 30-day all-cause rates remain stable overall in the second quarter, with UMC rated better than national comparison hospitals and the same by CMS Compare (Medicare) data. The 7-day all-cause has decreased quarter over quarter.

The inpatient mortality index has consistently decreased year over year. The risk-adjusted mortality rate was 1.05. Hospital-wide deaths and overall inpatient discharges slightly increased in Q2 of 2025. She added that the gap continues to narrow between the observed and expected rates due to improvements in ongoing clinical documentation. Leadership will continue to monitor these measures closely for improvement.

PSI – 90 Composite continues to perform well, showing a decline over the past year. Severe hypoglycemia measures from the 2nd quarter showed a current rate of 2.36, which was better than the UMC compare group rate of 2.61. Severe hyperglycemia measures from the 2nd quarter recorded a rate of 0.09, which was the same as the UMC compare group and better than the CMS national rate. There was continued discussion regarding the difference in the delta between the hypo and hyperglycemic rates. Ms. Scott explained that there are different criteria in the measures. Discussions with the medical staff are ongoing to explore opportunities for further improvement.

Total hip and knee complication rates for inpatient and outpatient cases were reviewed on a quarter-over-quarter basis. A lengthy discussion ensued regarding the cause of the spike in complications.

In patient safety, 11 events were reported to the state registry in the 2nd quarter. All cases were reported within the required state timeframes, and RCAs with actions were taken on all cases. Monitoring for sustainment of actions is done through the Hospital Quality and Patient Safety Committee. A brief review of the types of injuries was reported.

There were a total of 48 grievances in the first two quarters of 2025; 7 were substantiated. Breakdown by location was presented with 38% in quick and primary care locations, 36% in the hospital, and 26% in emergency locations. The majority of grievances were care team related concerns, followed by attitude/behavior, service delivery, and patient concerns. The overall totals of grievance rate per 1000 discharges/encounters was .22.

FINAL ACTION TAKEN:

None

ITEM NO. 6 Receive an update from Patty Scott, Quality/Safety Regulatory Officer on the FY26 Organizational Performance Goals; and direct staff accordingly. (For possible action)

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

DISCUSSION:

Ms. Scott provided an update on the FY26 Organizational goals.

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

   Progress is being made to develop and implement an electronic monitoring system for hand hygiene compliance. A vendor has been selected and will be onsite to implement the pilot program. Hand hygiene has improved since the last reporting. A discussion ensued regarding the feedback received from staff regarding the new hand hygiene program.

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:**

   Three of the five measures have shown improvement over previous reporting timeframes. Teams are working on the two measures that did not show improvement.

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

   PSI90 and ED median arrival time measures met or maintained the established goals. A lengthy discussion followed about improving processes

and the progress made in streamlining patient care in the quick care and primary care settings.

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

   Two of the three inpatient experience measures were met. Responsiveness of staff is being monitored for improvement.

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

   Three of the four outpatient experience measures were met. Communication with the provider is being monitored for improvement.

6. **Develop, implement, and execute plans/campaigns to support and improve the following performance goals/programs during FY26:** These measures are in progress.

FINAL ACTION TAKEN:

None

ITEM NO. 7 **Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of August 6, 2025 and September 3, 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 August 6, 2025 & September 3, 2025 were reviewed.

There were a total of 118 approved, 2 were retired. All were approved through the hospital Policy and Procedures Committee, Hospital Quality and Safety Committee and the Medical Executive Committee.

FINAL ACTION TAKEN:

A motion was made by Member Mackay to approve that the UMC Policies and Procedures Committee's activities of August 6, 2025 and September 3, 2025 and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

ITEM NO. 8 **Review and recommend for approval by the Board of Hospital Trustees, the proposed amendments to the UMC Medical and Dental Staff Bylaws and Rules & Regulations, as approved and recommended by the Medical**

Executive Committee at its July 22, 2025 meeting; and take any action deemed appropriate. *(For possible action)*

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

DISCUSSION:

The Committee members reviewed and approved the proposed amendments to the UMC Medical and Dental Staff Bylaws and Rules and Regulations. Staff informed the Committee that the recommended revisions were well vetted through the Medical Executive Committee.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to recommend approval of the Medical and Dental Staff Bylaws Rules and Regulations and recommend for approval to the Board of Hospital Trustees. 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:

The Committee would like to receive an update on federal changes related to clinical trials, grant-funded programs, and their impacts on UMC and UNLV at a future meeting.

FINAL ACTION TAKEN:

None

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 3:36 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: **Clinical Trials 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 from Ronald Roemer, Director of Clinical Research & Compliance regarding the Clinical Trials and Institutional Review Board activities at UMC; and direct staff accordingly *(For possible action)***	

FISCAL IMPACT:

None

BACKGROUND:

The Committee will receive an educational update on the activities of the Clinical Trials program at UMC.

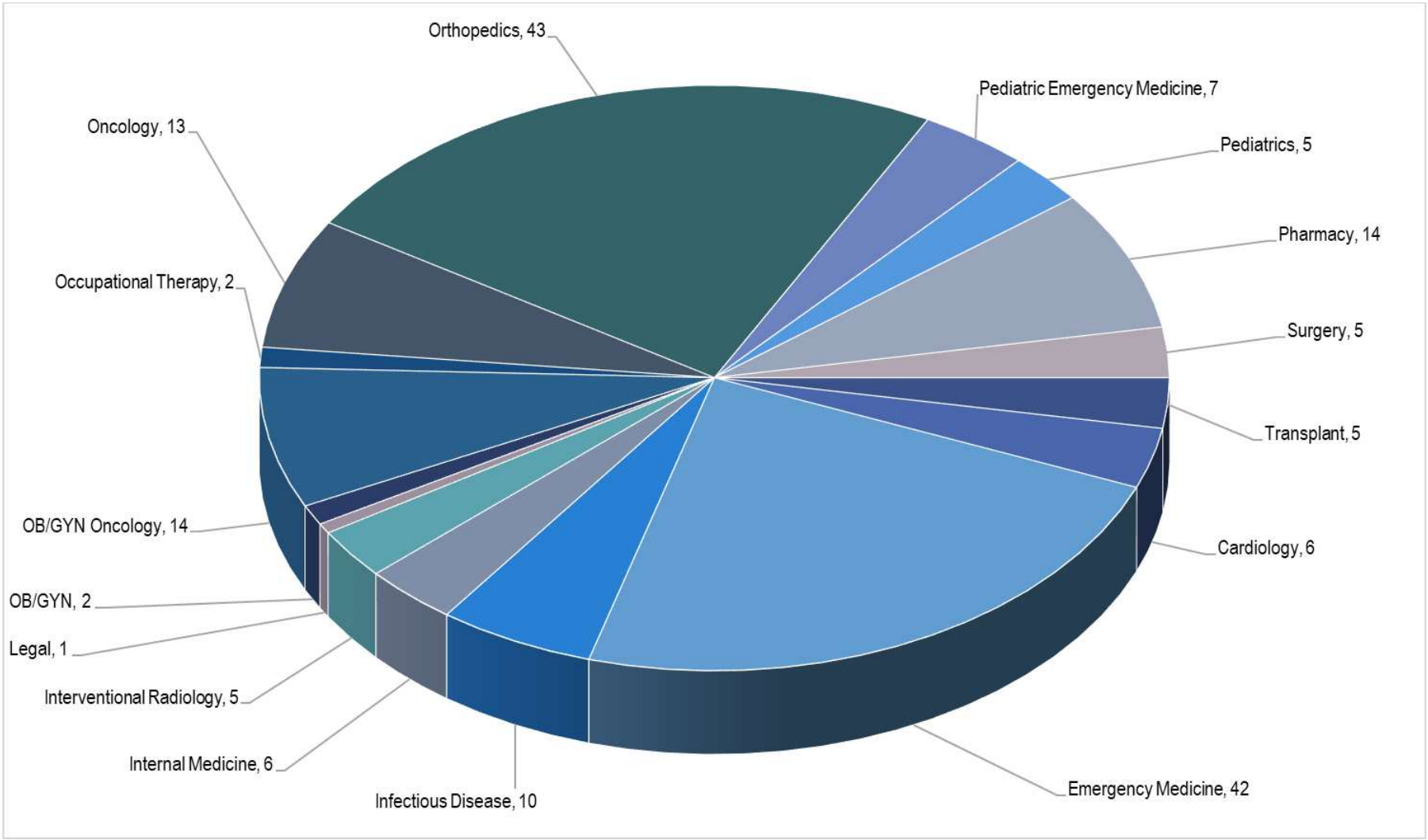
Cleared for Agenda
December 16, 2025

Agenda Item #

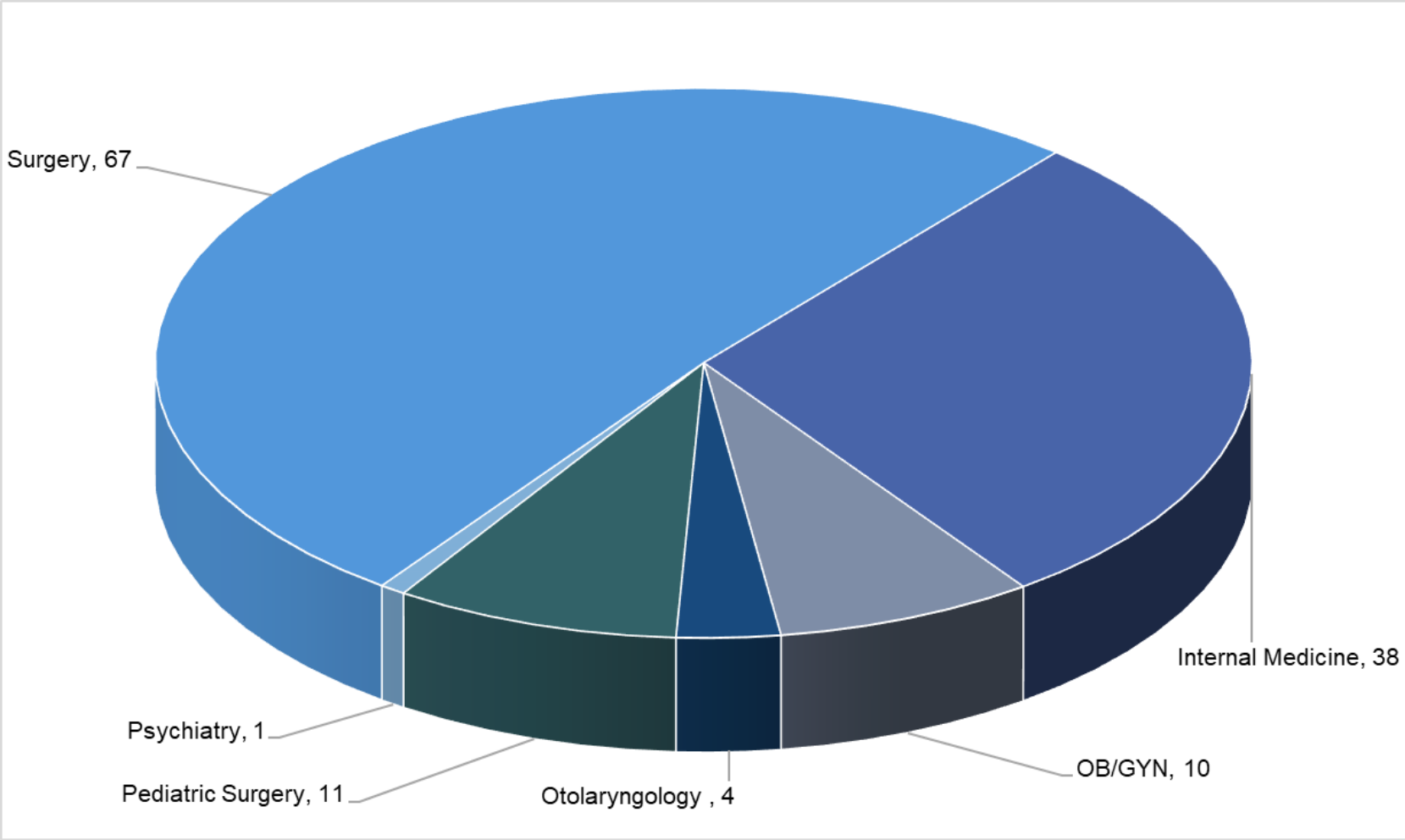
4

Institutional Review Board
Clinical Trials Office
2025 Annual Report

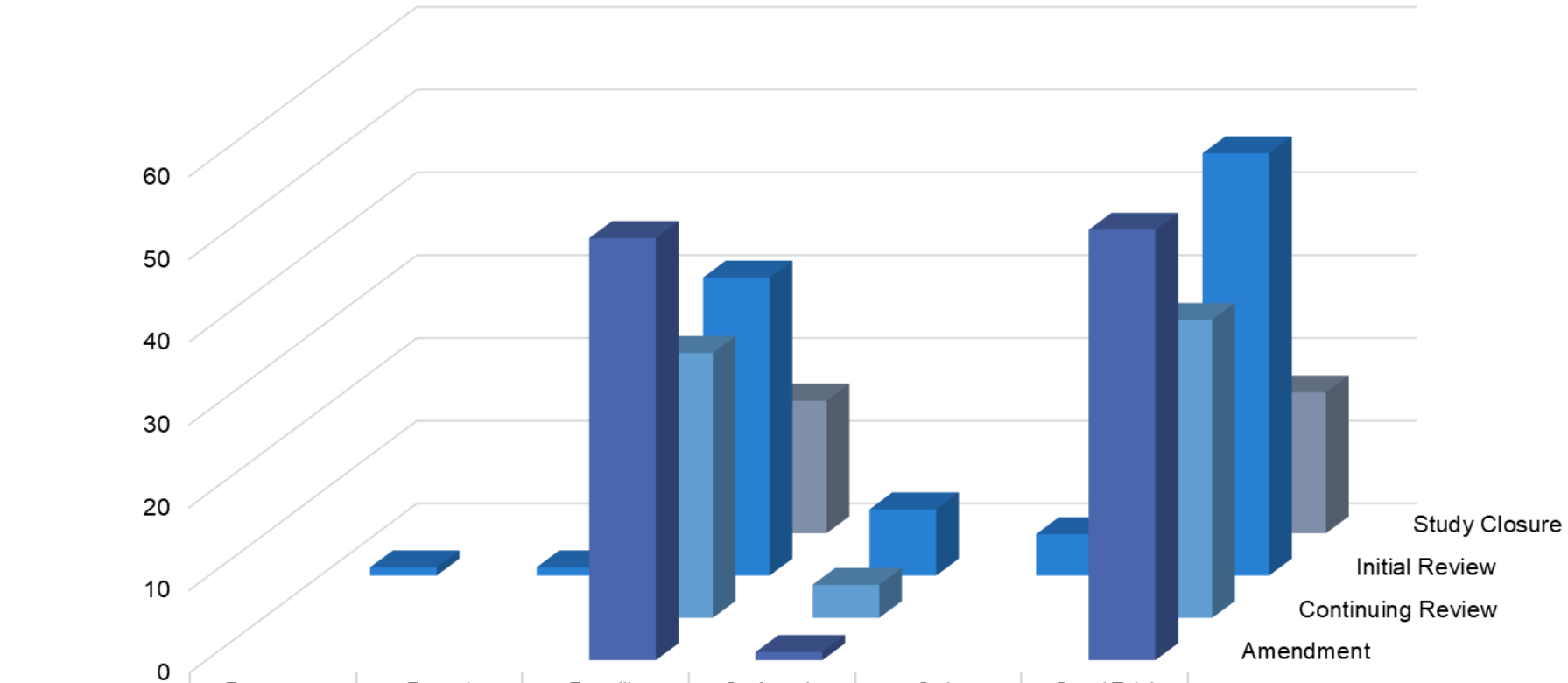
UMC Studies by Department



UNLV Studies by Department



Review Submission



	Emergency Use	Exempt	Expedite	On Agenda	Cede Oversight	Grand Total
Amendment			51	1		52
Continuing Review			32	4		36
Initial Review	1	1	36	8	5	51
Study Closure		1	16			17

Open Studies

Principal Investigator	Short Title	Department	Sponsor
Ayoola Adekile, M.D.	PROACTIVE	Transplant	Natera
Chowdhury Ahsan, M.D.	DALCOR	Cardiology	DalCor Pharmaceuticals
Chowdhury Ahsan, M.D.	ARTEMIS	Cardiology	DCRI & Novo Nordisk
Chowdhury Ahsan, M.D.	TRANSFORM	Cardiology	ACCF/Biofourmis
Chowdhury Ahsan, M.D.	Librexia Trial	Cardiology	Janssen Research
Chowdhury Ahsan, M.D.	Librexia EHR Pilot Study	Cardiology	Janssen Research
Francis Banfro, M.D.	PRISM study	NICU	Duke Clinical Research Institute
Richard Baynosa, M.D.	Abbvie	Surgery	Abbvie
Albert J. Cook M.D.	ReMEDy2	Interventional Radiology	DiaMedica
Nadia Gomez, M.D.	MIRA	OB/GYN	Virtual Incision
Erik Kubiak, M.D.	Beads vs Vac	Orthopedics	University of Maryland, Baltimore
Erik Kubiak, M.D.	HIP-ATTACK-2	Orthopedics	Population Health Research Institute
Ryan Rimer M.D.	DEFIANCE	Interventional Radiology	Inari Medical
Ryan Rimer M.D.	CLEAN-PE	Interventional Radiology	Argon Medical Devices
Ryan Rimer M.D.	PROTECTOR Study	Interventional Radiology	Inari Medical

Pipeline

Principal Investigator	Short Title	Department	Sponsor
Chowdhury Ahsan, M.D.	ICONIC-HF	Cardiology	Pharmacosmos
Chowdhury Ahsan, M.D.	VICTORION-INTERVENTION	Cardiology	Novartis
Chowdhury Ahsan, M.D.	RECOVER-HF	Cardiology	VisCardia Inc.
Chowdhury Ahsan, M.D.	ALLAY-HF HFrEF	Cardiology	Alleviant Medical
Chowdhury Ahsan, M.D.	ALLAY-HF HFpEF	Cardiology	Alleviant Medical
Chowdhury Ahsan, M.D.	MOCA-II	Cardiology	CorFlow Therapeutics AG
Chowdhury Ahsan, M.D.	NN9490-8266	Cardiology	Novo Nordisk
Chowdhury Ahsan, M.D.	Recurrent Pericarditis	Cardiology	Syneos Health CRO
Shadaba Asad, M.D.	Hep B Rapid Test study	Infectious Disease	Meridian Bioscience
Shadaba Asad, M.D.	Abbott Repertory Sample Study	Infectious Disease	Abbott
Shadaba Asad, M.D.	ALPCO Syphilis Study	Infectious Disease	ALPCO
Don Bell, M.D.	KANEKA iCURE study	Interventional Radiology	Kaneka
Don Bell, M.D.	SUMMIT-RISE Study	Interventional Radiology	Route 92 Medical, Inc.
Carmen Flores, M.D.	Cohealyx burn study	Trauma Burn/Wound	Avita Medical
Keyvan Heshmati, MD	CAPTIVA	Interventional Radiology	StrokeNet
Ryan Rimer M.D.	CLEAR-VIEW XT	Interventional Radiology	Argon Medical
Brandon Romero M.D.	Shoulder Innovations	Orthopedic Surgery	Shoulder Innovations
Rita Shah, M.D.	SAPTALIS Pediatric Study	Pediatrics	BNZ Research

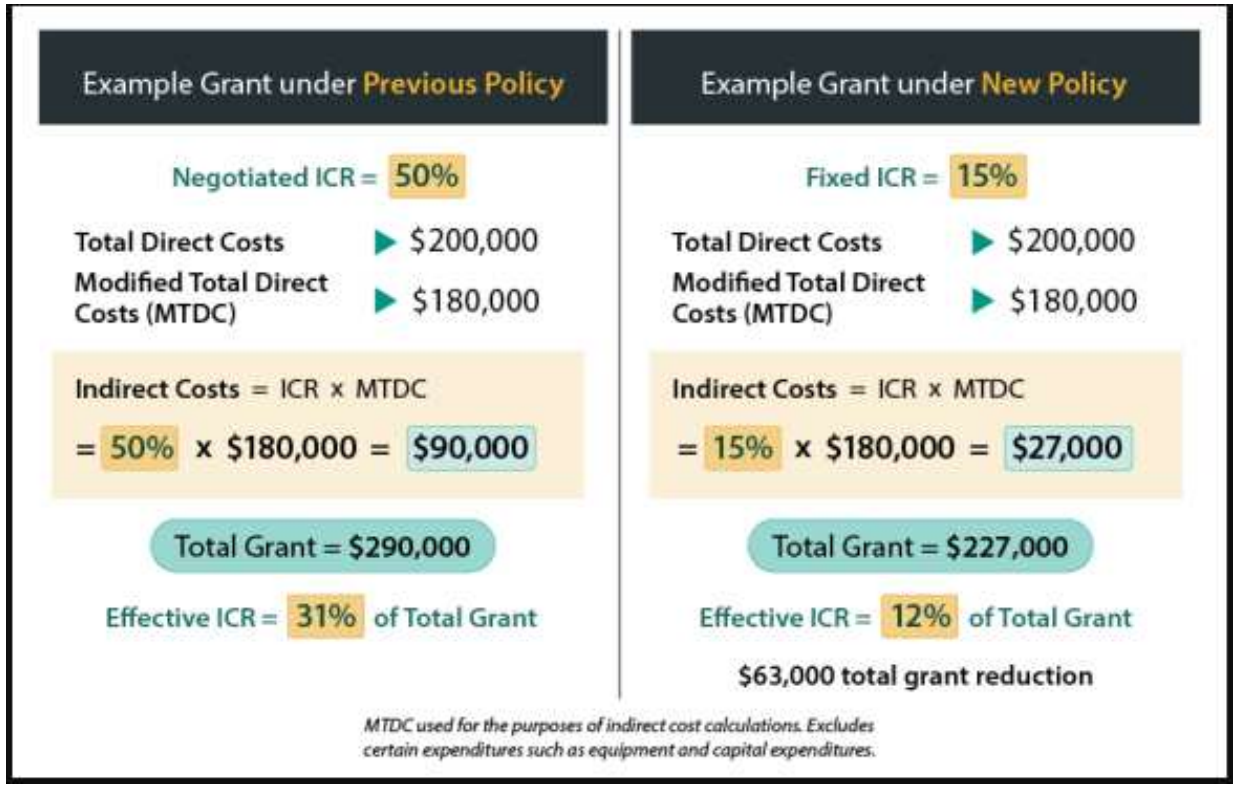
Research Indirect Cost Rate

- Indirect costs – Expenses of doing business that are not readily identified with a specific grant, contract or project
- February 7, 2025 the Federal Indirect Rate was cut to 15%
- Previously between 25% and 70%
- Government justified cuts
- Institutions claim direct impact to research

*Data from National Institute of Health (NIH) and National Education Association (NEA)

Negotiated ICR Versus Fixed

Congress.GOV – NIH Indirect Policy for Research Grans published 12/09/2025



Impact

- UMC's indirect rate 30%
- Federally funded research projects
  - Direct support
  - Secondary support
- Industry sponsored research
- Currently – No direct impact to research at UMC
- Policy Status

Questions/Comments/Discussion

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

Issue: **FY26 Organizational Improvement/CEO 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 from Patty Scott, Quality/Safety/Regulatory Officer, on the FY26 Organizational Performance Goals; 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
December 16, 2025

Agenda Item #
5

UNIVERSITY MEDICAL CENTER

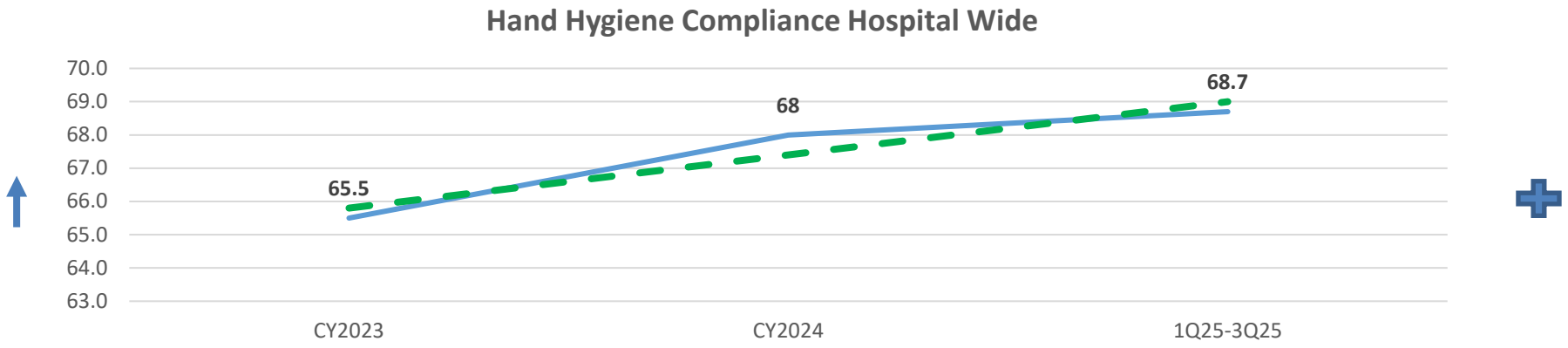
Quality Performance Objectives – FY26

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 Selected Contract With Legal, Processing
Develop, implement, and execute a campaign to improve the Hand Hygiene Program	In Progress

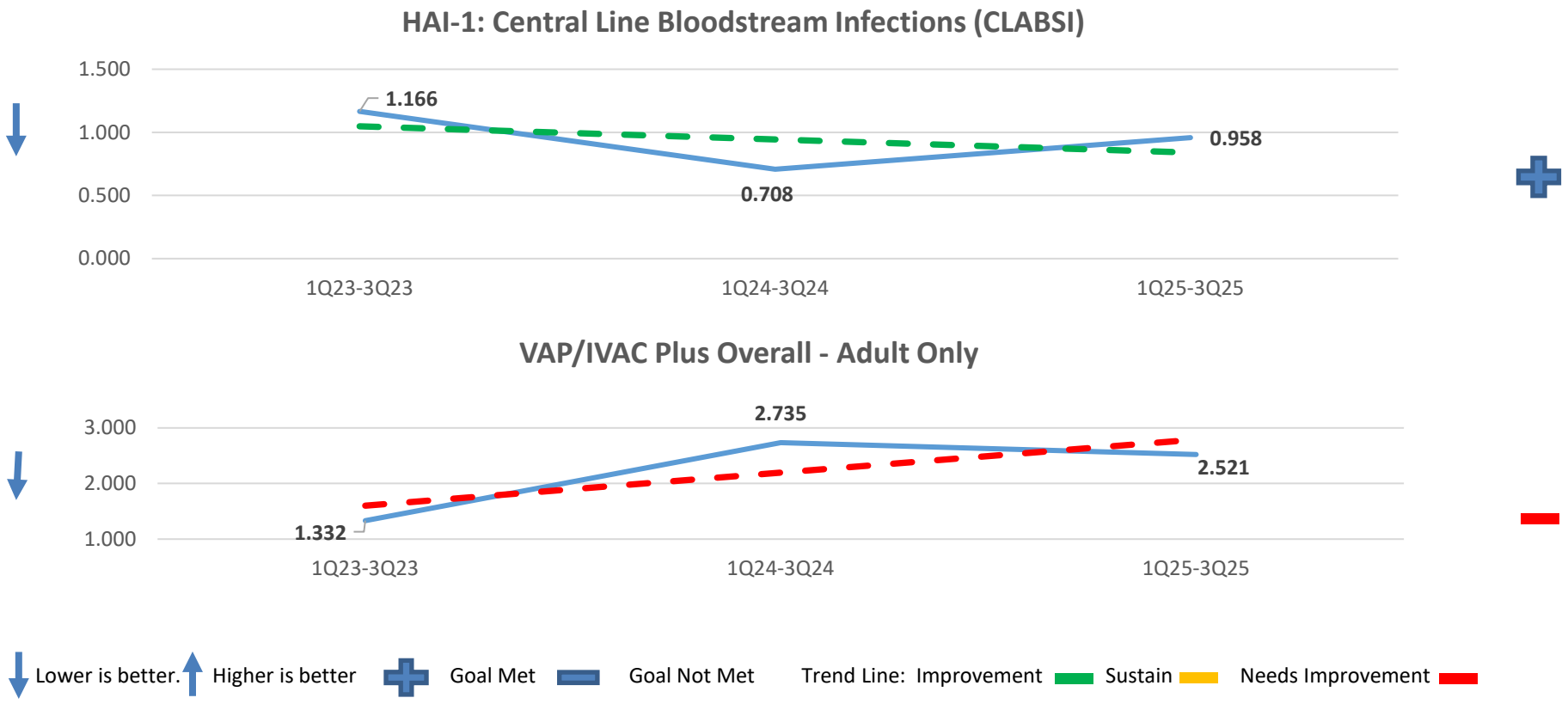
Lower is better. Higher is better Goal Met Goal Not Met Trend Line: Improvement Sustain Needs Improvement

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:

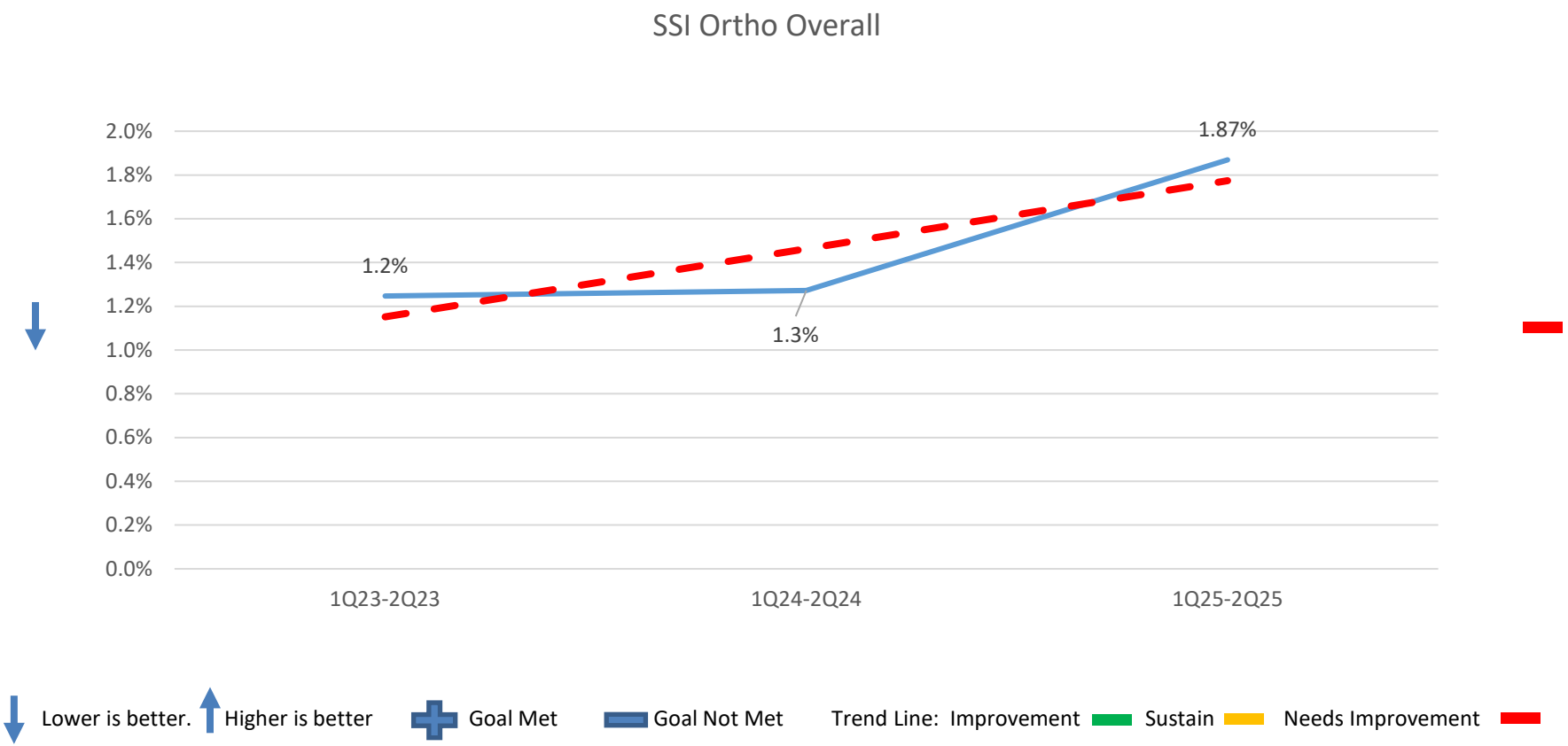


Source: UMC Infection Control Department – NHSN

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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

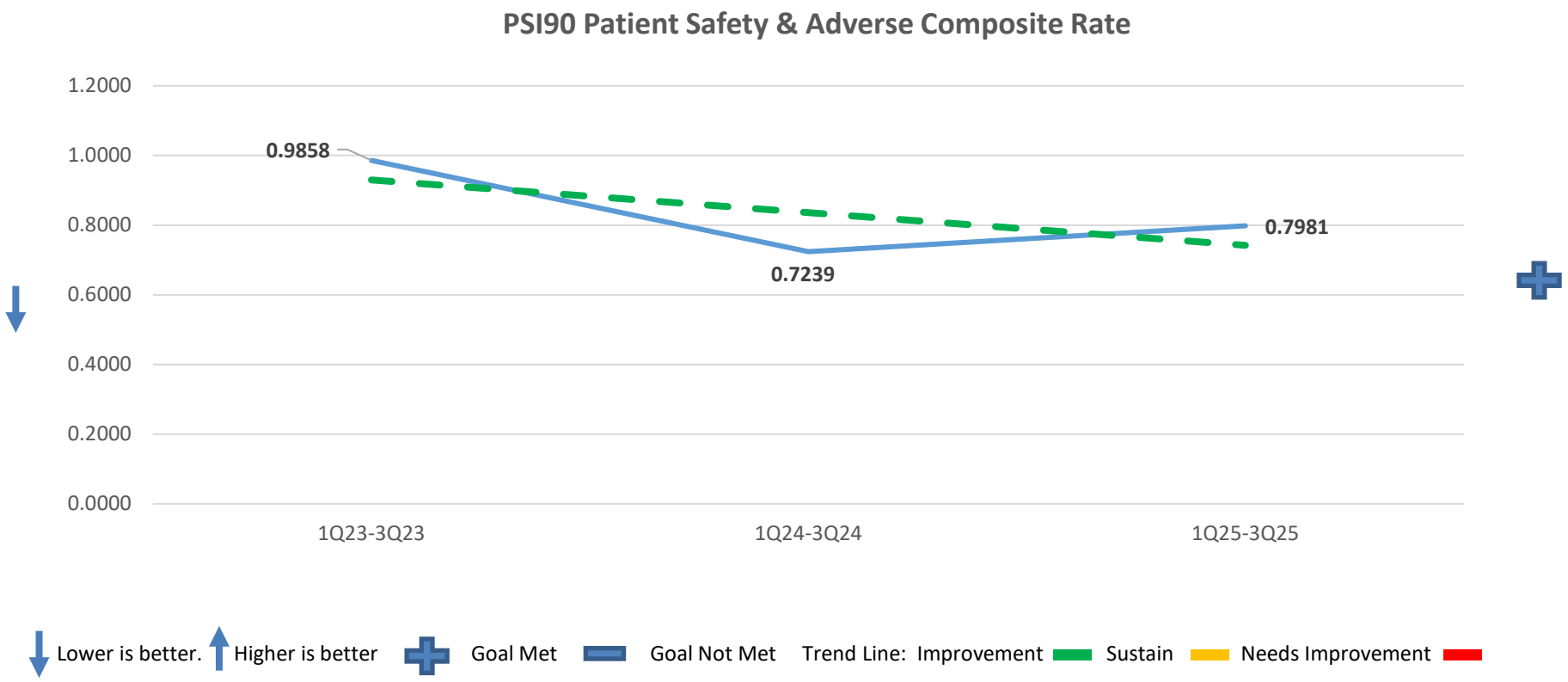


Source: UMC Infection Control Department - NHSN. SSI Ortho - NHSN reporting process, one quarter lag.
SSI Rate, percent of total procedures. Hip, Knee, Spinal Fusion and Laminectomy

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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



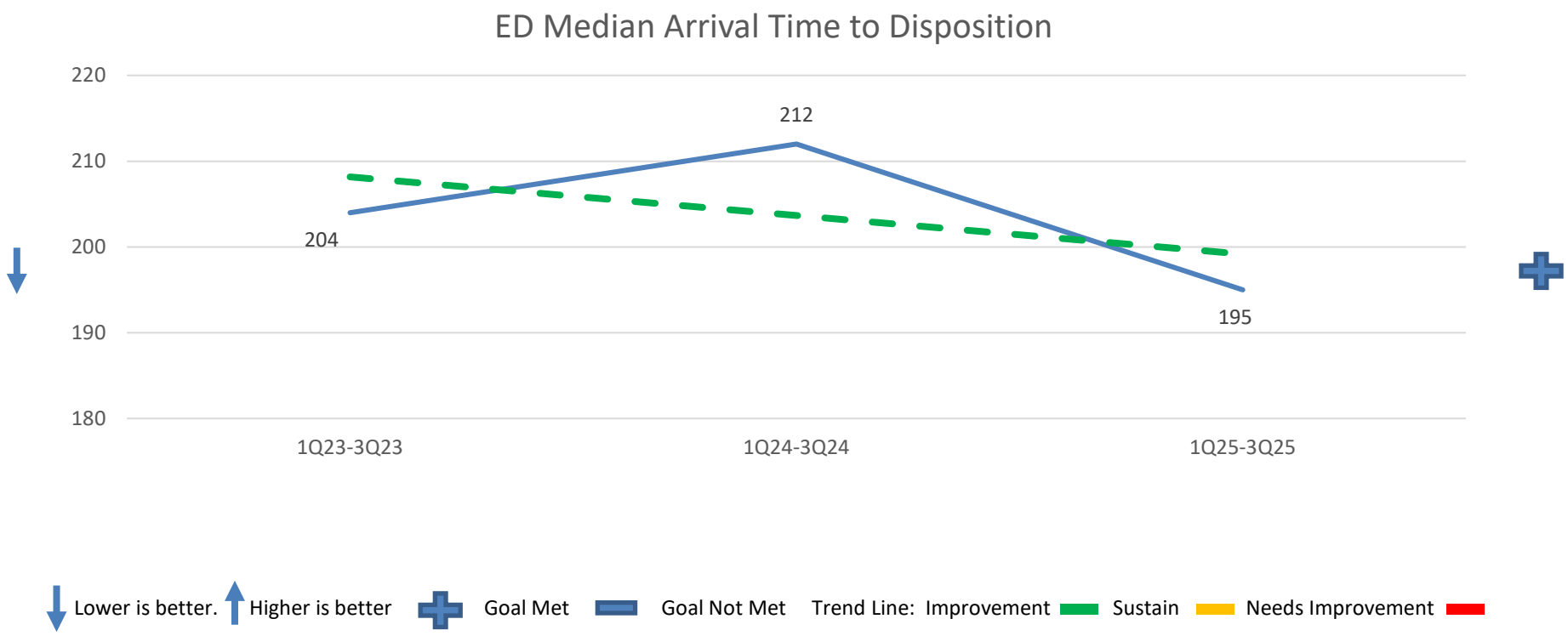
Source: Vizient Clinical Database

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:

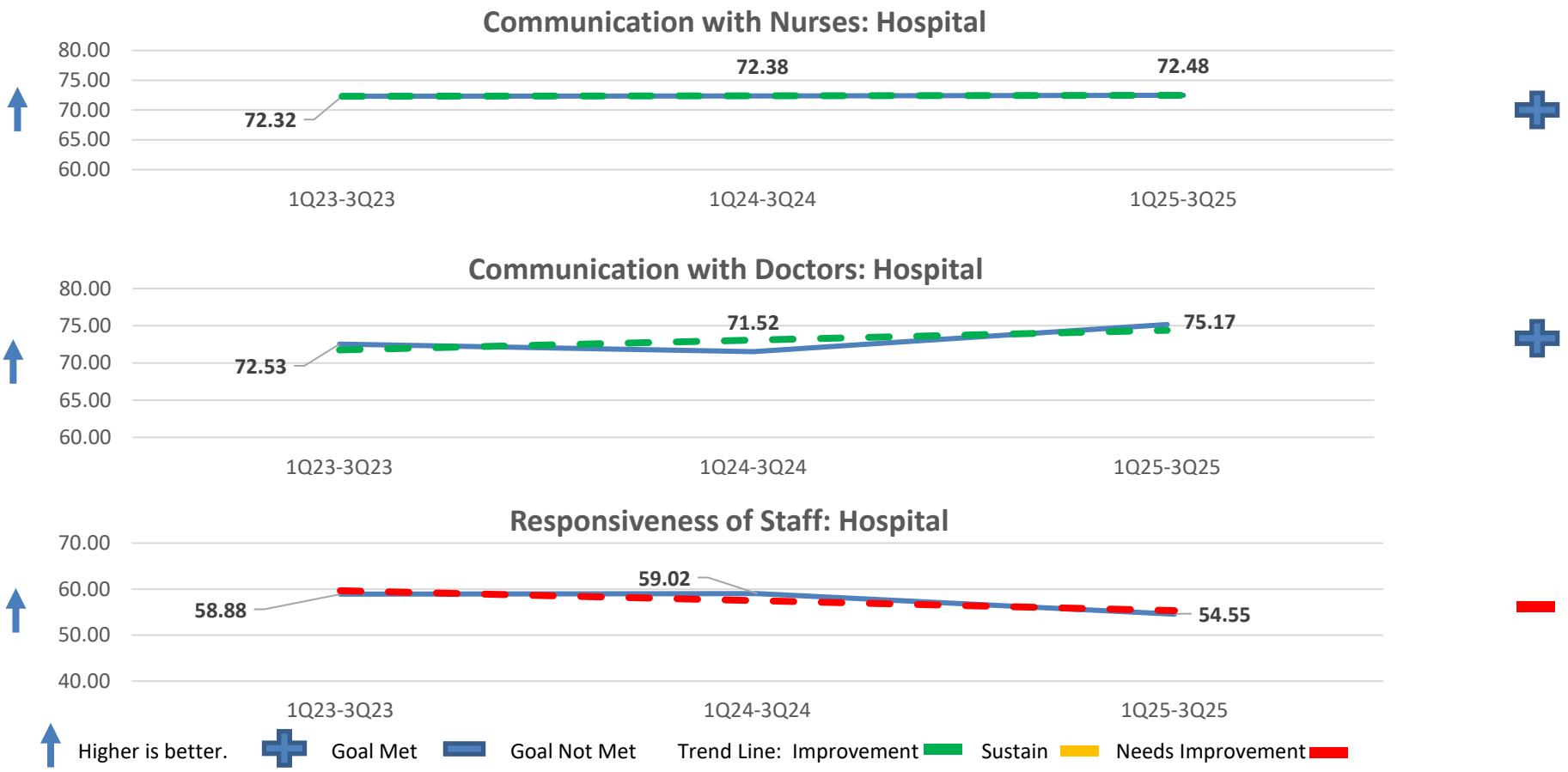


ED Median Arrival to Disposition: Epic Slicer Dicer. The median time (in minutes) from when the patient arrived until ED disposition was recorded. Adult, Peds, Trauma Resus.

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):

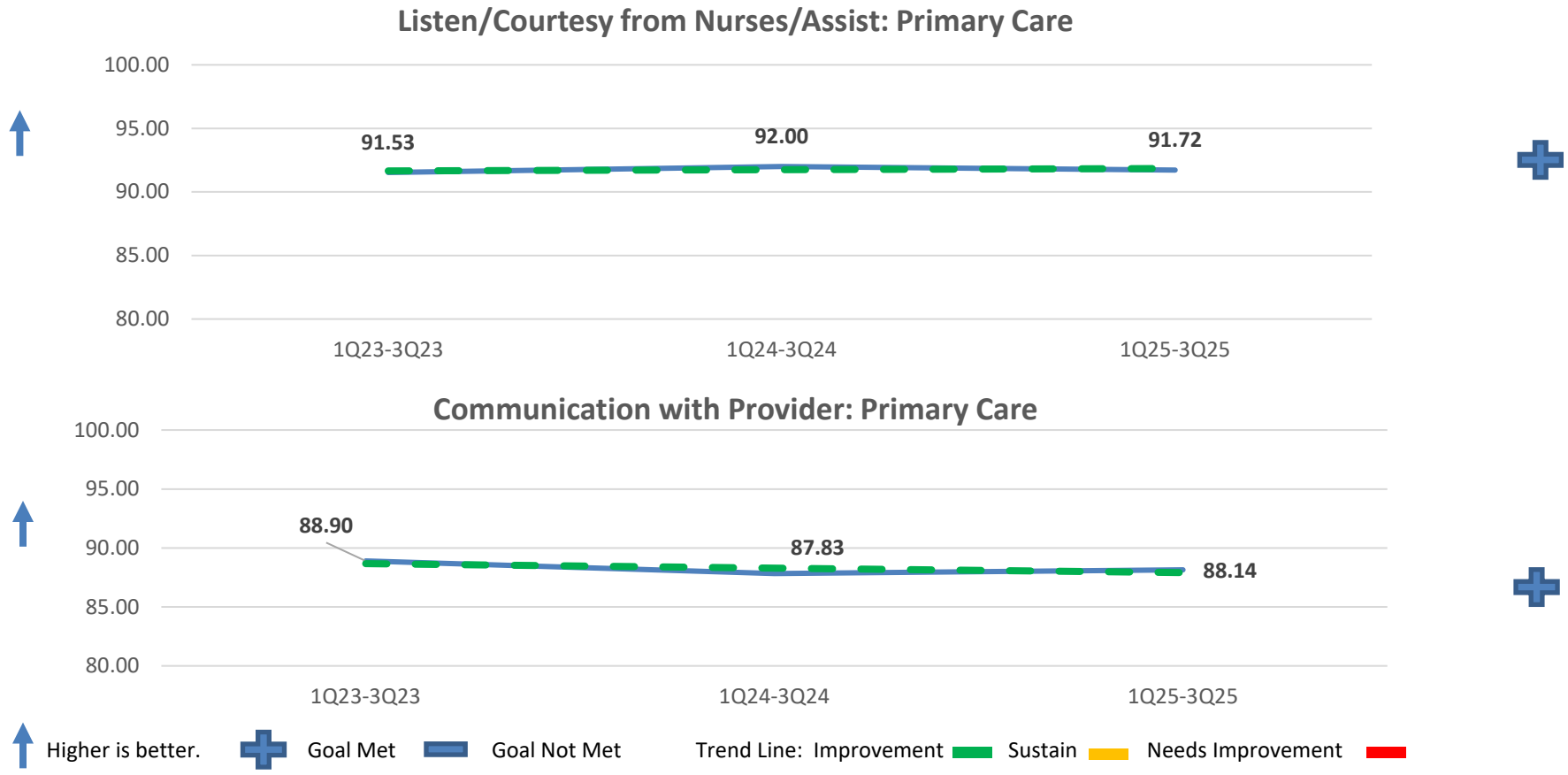


Source: HCAHPS Measures by Service Date - Press Ganey - Top Box by Service Date

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):

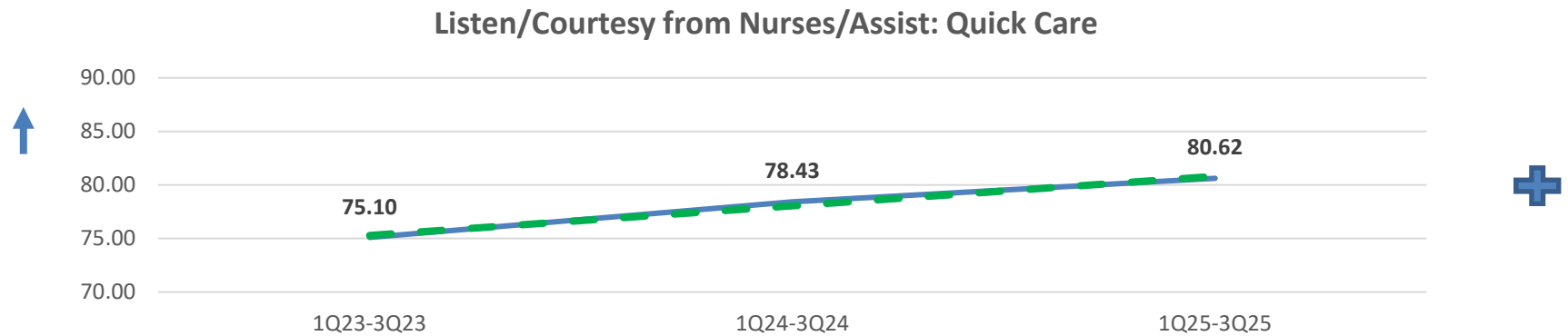


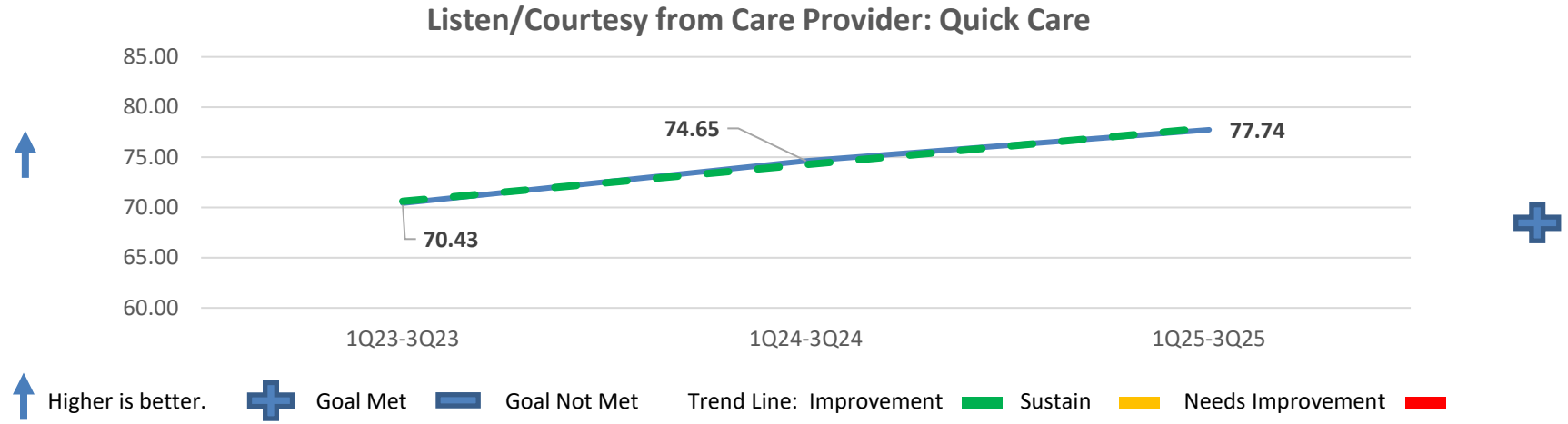
Source: HCAHPS Measures by Service Date - Press Ganey - Top Box by Service Date.

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):





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

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	In Progress
Unit of the Week Rounding to Identify Areas in Need of Repair (# of repair opportunities identified within areas reviewed / # corrected on validation of area)	In Progress

Source: Patient Experience

DISCUSSION / QUESTIONS?

Patricia Scott, MSNA, BSN, RN, RHIA, CPHQ, CCDS, CPHRM, CLSSBB
Quality, Patient Safety, & Regulatory Officer
Patricia.Scott@umcsn.com
702-207-8257 (Office)
702-303-3921 (Cell)

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 October 1, 2025 and November 5, 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
December 16, 2025

Agenda Item #

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October 1, 2025 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 43 Approved, 0 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Patient Complaint and Grievance Process	Revised	Approved as Submitted	Alignment with DNV guidance, removed references to insurance inquiries, made grammatical and clarity edits. Vetted by Quality/Safety/Regulatory Officer; PI Program Manager
Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)	Revised	Approved as Submitted	Revised monitoring requirements as delineated by DNV. Moved to 12-month rolling period for OPPE. Truncated language relative to providers exceeding established performance thresholds. Vetted by Quality/Safety/Regulatory Officer; PI Program Manager; PIC Committee.
Respiratory – Bronchodilator Protocol	Revised	Approved as Submitted	Removed attachment showing old paper protocol as new protocol is now in EMR. No changes needed, as this reflects current practice. Vetted by Respiratory Services Director.
Neonatal Parenteral Nutrition Guidance	Revised	Approved as Submitted	Updated protein percentage under weaning from 15% to 10%. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO.
NICU Oral Care with Colostrum or Expressed Human Milk	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by NICU Manager, Maternal Child Services Director and ACNO.
Transcutaneous Jaundice Meter	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Maternal Child Services Director and ACNO.
Disaster Evacuation in the Obstetrical/Neonatal Areas	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO.
OB Emergency Response	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO.
Pediatric Critical Care Transport Team Education and Training	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by NICU Clinical Manager, Maternal Child Services Director and ACNO.
Categorizations of Patients	Revised	Approved as Submitted	Added the notification of the Nevada Donor Network at the beginning of discussion for any change in categorization on ventilated patients. POLST was added.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Reporting of Trauma Registry Data	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Trauma Program Manager, Clinical Director Critical Care Services - Trauma and ACNO.
Trauma Nurse Team Leader - Trauma Response Team	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Trauma Program Manager, Clinical Director Critical Care Services – Trauma and ACNO.
Trauma Response Team – Unit Secretary/Office Technician	Revised	Approved as Submitted	Approved with changes made. B. added to section 2 and E. added to the section below D. to address documentation needs of consult calls, consult call backs, and consult arrival time when applicable. Vetted by Trauma Program Manager, Clinical Director Critical Care Services – Trauma and ACNO.
Emergency Airway Management Guideline	Revised	Approved as Submitted	Updated language referring to providers. Vetted by Trauma Program Manager, Clinical Director Critical Care Services – Trauma and ACNO.
ACLS Boxes in TICU	Revised	Approved as Submitted	Updated item 1. under Policy. Vetted by Trauma Program Manager, Clinical Director Critical Care Services – Trauma and ACNO.
Controlled Substances: Witness/Chain-of-Custody Validation Requirements	Revised	Approved as Submitted	Clarified that continuous infusion waste includes the contents inside the IV tubing. Added hand-off under required chain of custody signature. Added definition of chain of custody and hand-off. Vetted by Director of Pharmacy.
Controlled Substances: Key Control	Revised	Approved as Submitted	Replaced Pyxis with ADC. Added bullet point about medication-related keys exclusively maintained by pharmacy. Added lost key should be reported immediately. Vetted by Director of Pharmacy.
Access to Automated Dispensing Cabinets (ADC)	New	Approved as Submitted	New policy. Vetted by Assistant Director, Pharmacy.
Drug Extravasation	Revised	Approved as Submitted	Turned into a protocol. Antidote dosing ranges and antidote repeat dosing were replaced with specific doses. Listed one first-line antidote and removed alternatives. Specified route for hyaluronidase. Nurse will place an order per protocol for the antidote listed in table 1.
Wound Care Treatment	New	Approved with Revisions	New Protocol; vetted by WOC Team, Skin Council, & Critical Care, Clinical Director, Skin Task Force, UBCC Council, WOCN Manager and Dr. Nizamani.
Guidelines for Early Palliative Care Consultation in the Burn Patient	Revised	Approved as Submitted	Changed to Revised Baux score. Changed age. Added medical problems and examples. Approved in August Burn Multidisciplinary Meeting.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Pediatric Mental Health Screening and Referral for Burn Patients	New	Approved as Submitted	New burn guideline. Created to match current process with trauma and implemented in the burn population. Approved in August Burn Multidisciplinary Meeting and Pediatric Department.
Adult Mental Health Screening and Referral for Burn Patients	New	Approved as Submitted	New burn guideline. Created to match current process with trauma and implemented in the burn population. Approved in August Burn Multidisciplinary Meeting.
Initial Fluid Management for Large Burn Patients	Revised	Approved as Submitted	Updated fluid resuscitation initial rate calculation, albumin start time and rate, and hourly titration. Removed attachment. Approved in Trauma Multidisciplinary Meeting.
Administration of the Burn Center	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Burn Clinical Manager, Critical Care Director and ACNO.
Burn Medical Director, Role and Responsibility	Revised	Approved as Submitted	Changed to American Burn Association. Updated American Burn Association, and Medical Staff Bylaws references. Vetted by Burn Clinical Manager, Critical Care Director and ACNO.
Fire Prevention, Response & Life Safety Management Program	Revised	Approved as Submitted	Updated policy with changes to the regulatory body, DNV, and ALSM. Minor grammatical and content changes. Vetted by EOC Committee.
Radioactive Pharmaceutical Y-90 Brachytherapy	New	Approved with Revisions	New policy. Vetted by Director of Imaging Services.
Y-90 TheraSpheres Liver Ablation	New	Approved as Submitted	New policy. Vetted by Director of Imaging Services.
Y-90 TheraSpheres	New	Approved as Submitted	New protocol. Vetted by Director of Imaging Services.
Work flow for the Administration of Y-90 TheraSpheres	New	Approved as Submitted	New protocol. Vetted by Director of Imaging Services.
Standards of Basic Nursing Care Medical-Surgical-Telemetry	Revised	Approved as Submitted	Updated references and citations. Vetted by Clinical Directors of Med Surg and ACNO.
Telemetry Downtime Process	Revised	Approved as Submitted	Updated procedure for Telemetry to include who to contact when system is down, if it effects one station vs. the whole room, and follow-up communication once restored.
CHON Multisystem Inflammatory Syndrome in Children (MIS-C) Treatment	Revised	Approved as Submitted	Updated information and therapies based on new guidelines. Vetted by Pediatric Department.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
CHON Pediatrics COVID-19 Treatment	Revised	Approved as Submitted	Updated information and therapies based on new guidelines. Vetted by Pediatric Department.
PICU Clinical Pathway for the Care of Children Post-CPR	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Services Director, ACNO and Pediatric Department.
Post-Cardiac Arrest Prognostication - Pediatrics	Revised	Approved as Submitted	Minor verbiage changes and updates to current practice. Vetted by Pediatric Department.
Pediatric ICU Early Mobility Protocol	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Manager, Maternal Child Director and ACNO.
Pediatric Massive Transfusion	Revised	Approved as Submitted	Updated to current practice. Vetted by Pediatric Department.
PICU Standards of Nursing Care	Revised	Approved as Submitted	Added Standard VIII – Respiratory Therapy section. Vetted by PICU Clinical Manager and Director of Respiratory Services.
Guideline for CORTRAK Enteral Feeding System Use in the Pediatric Population	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Pediatric Clinical Manager, PICU Manager, Maternal Child Director and ACNO.
Tracheostomy Patient Maintenance Infant Child & Adolescent	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Pediatric Clinical Manager, PICU Manager, Maternal Child Director and ACNO.
Administration of Blood and Blood Products	Revised	Approved as Submitted	All references to Blood Track Tx have been removed, and BPAM has been implemented for blood administration. Vetted by Clinical Laboratory Supervisor, Blood Bank Manager and Laboratory Services Director.

November 5, 2025 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 40 Approved, 4 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Proactive Hourly Rounding	Revised	Approved as submitted	Revised to include information related to frequency of rounding for awake hours and quiet at nigh hours, patient toileting assistance and definitions for clarity, use of safety badge locator, NO PASS ZONE, and, scripting added to guide staff with communication during hourly rounding.
Patient Safety Checklists	Revised	Approved as submitted	Reviewed- no changes. Vetted by Director of Patient Safety and Quality/Safety/Regulatory Officer.
Practitioner Health and Wellness	Revised	Approved as submitted	Scheduled review, no changes. Vetted by Medical Staff Director.
Nursing Responsibilities related to Interventional Radiology	New	Approved as submitted	Edited language. Expanded clinical expectations for the review of medical history, recent labs, ventilator settings, and sedation orders. Reviewed P/P against hospital P/P's and education/training/competency for sedation by nursing staff. Renamed referenced P/P to current specific titles.
Influx of Infectious Patients Plan	Revised	Approved as submitted	Yearly review. Minimal changes and edits; updated hyperlinks. Vetted by Dir.of ICP, Medical Director Inpatient & Outpatient Infectious Disease Services and CQPS.
Formaldehyde Use Policy	New	Approved as submitted	New policy to address OSHA Standard 1910.1048. Vetted through EOC.
Gurneys with Scales	New	Approved as submitted	New Process; vetted with Engineering and Transport
Transplantation Evaluation	Revised	Approved as submitted	Removed the term kidney/pancreas and replaced with transplantation to include all transplantation organs (kidney, pancreas and upcoming Liver), Change title to Transplantation Evaluation, changed to current format. Vetted by Transplant Quality & PI Coordinator, Transplant Services Director and ACNO.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Pancreas Transplant After Kidney (PAK) Evaluation	Revised	Approved as submitted	Reviewed with no changes just formatting. Vetted by Transplant Quality & PI Coordinator, Transplant Services Director and ACNO.
Pancreas Transplant Alone Evaluation	Revised	Approved as submitted	Reviewed with no changes just formatting. Vetted by Transplant Quality & PI Coordinator, Transplant Services Director and ACNO.
Transplant Quality Assurance & Performance Improvement	New	Approved as submitted	Revised Hospital QAPI plan to be specific to Transplant. Transplant QAPI meets quarterly vs monthly, added performance measures and aligned with CMS/UNOS. Reviewed and vetted by Transplant Director, Transplant Medical Director, Hospital Quality, Pt Safety & Regulatory Officer and Transplant Quality Committee.
Transplant – Downtime & Emergency Preparedness	Revised	Approved as submitted	Updated purpose statement, Annex to coincide with the Hospital's online Emergency Plan, removed Hard copies of medical records for listed patients availability is not current practice, tote location is in copy room vetted by Transplant Quality Committee and Medical Director.
Transplant – Sending Personal Health Information (PHI) to Patients	Revised	Approved as submitted	Added/updated references/hyperlinks. Reviewed and vetted by Transplant Quality Committee and Medical Director.
Timely Pre-Transplant Evaluation	Revised	Approved as submitted	Removed the term kidney and replaced with transplantation to include all transplantation organs (kidney, pancreas and upcoming Liver), changed to current format. Reviewed and vetted by Transplant Quality Committee and Medical Director.
Patient Follow-up Post Transplant	Revised	Approved as submitted	Frequency of f/u is no longer performed post 24 months. Reviewed and vetted by Transplant Quality Committee and Medical Director.
Inquiries to the Transplant Center	Revised	Approved as submitted	Reviewed and approved by Transplant Quality Committee, Medical Director.
Initiation of Pre-Transplant Evaluation Pancreas	Revised	Approved as submitted	Added Pancreas to the title being this is specific to Pancreas, Vetted by Quality Committee & Medical Director.
Transplant Selection Committee	Revised	Approved as submitted	Changed to current practice & current format. Reviewed and vetted by Transplant Quality Committee and Medical Director.
Transplant - Living Donor	Revised	Approved as submitted	Process change/verbiage removed. We are now testing multiple donors at a time for any recipient. Removed verbiage under C1 – "If the recipient has multiple donors, the recipient and

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			donors will prioritize the candidates and decide which donor will be the first to begin the medical evaluation (one donor at a time)." To reflect current process. Vetted by Living Donor Coordinator, Transplant Team, Transplant QAPI Committee & Transplant Medical Director.
Initial Listing to UNOS Wait List	Revised	Approved as submitted	Reviewed with no changes just formatting. Vetted by Transplant Quality Committee and Medical Director
Multiple Listing and Waiting Time Transfer	Revised	Approved as submitted	Added policy statement, change to current policy format. Vetted by Transplant Quality Committee & Medical Director.
Independent Living Donor Advocate	Revised	Approved as submitted	Hyperlinked to State Operations Manual: CMS X-121, changed to current policy format. Vetted by Transplant Quality Committee & Medical Director.
Proper Disposal of Urine Cups with Sharps Mechanism	Revised	Approved as submitted	Vetted by Director of EVS, Director of Infection Prevention and Executive Director of Support Services.
Between Case Cleaning	Revised	Approved as submitted	New policy. Vetted by EVS Director, Infection Control Director and Executive Director of Support Services.
Speaking Valve Management	Revised	Approved as submitted	Scheduled review, no changes. Vetted by Rebab Services Director and ACNO.
Expiratory Muscle Strength Training	Revised	Approved as submitted	Scheduled review, no changes. Vetted by Rehab Services Director and ACNO.
Exchange Transfusion	Revised	Approved as submitted	Scheduled review. No changes.
Materials Management Information System	Revised	Approved as submitted	Revised to move ownership of MMIS Item Add/Change process from Revenue Integrity to Supply Chain; Revenue Integrity limited to shell code assignment. Changed HEMM number to UMC Item Number.
Durable Medical Equipment Policy	Revised	Approved as submitted	New Policy. Comprehensive integration of hospital and outpatient DME workflows; inclusion of vendor-managed storage and Motion MD ordering process; expanded policy section for regulatory compliance, documentation standards, vendor accountability, for audit readiness.
Neonatal Skin Assessment and Care	Revised	Approved as submitted	Scheduled Review; No changes

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Nutritional Support Breastfeeding	Revised	Approved as submitted	Scheduled review, no changes.
Gastric Gavage 2025	Revised	Approved as submitted	Scheduled review, no changes.
NICU Sibling Visitation	Revised	Approved as submitted	Removed need to provide immunization status for Siblings.
Pediatric Stroke Policy	Revised	Approved as submitted	Revised; approved through Pediatric Department Meeting
Pediatric Stroke Protocol	Revised	Approved as submitted	Revised; approved through Pediatric Department Meeting
CT Reconstruction Protocols	Revised	Approved as submitted	Scheduled review, no changes.
Trauma Response Team - Imaging	Revised	Approved as submitted	Scheduled review, no changes.
Imaging CD Release at the Quick Care	Revised	Approved as submitted	Scheduled review, no changes.
IV Contrast Policy	Revised	Approved as submitted	Updated to current practice and workflows.
Hazardous Materials Radioactive	Revised	Approved as submitted	Scheduled review, no changes.

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
December 16, 2025

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