# UMC Clinical Quality and Professional Affairs Committee Meeting

Monday, August 11, 2025 2:00PM

Delta Point Building - Ruby Conference Room - 1st Floor

901 Rancho Lane

Las Vegas

# AGENDA

**University Medical Center of Southern Nevada**
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
August 11, 2025 2:00 p.m.
901 Rancho Lane, Las Vegas, Nevada
Delta Point Building, Ruby 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 June 2, 2025. *(For possible action)*

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

## SECTION 2. BUSINESS ITEMS

4. Review the Governing Board Policies and Procedures, as they relate to the Governing Board Clinical Quality and Professional Affairs Committee; and direct staff accordingly. *(For possible action)*

5. Receive an educational presentation from Sabrina Holloway, HIM Director, regarding the death certificate process at UMC; and direct staff accordingly. *(For possible action)*

6. Review, discuss, and score the outcomes of the FY25 Organizational Performance Goals as they relate to the Clinical Quality and Professional Affairs Committee; and make a recommendation to the Human Resources and Executive Compensation Committee; and direct staff accordingly. *(For possible action)*

7. Review and discuss the proposed FY26 Organizational Performance Goals as they relate to the Clinical Quality and Professional Affairs Committee; and make a recommendation to the Human Resources and Executive Compensation Committee; 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 June 4, 2025 and July 2, 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***
***June 2, 2025***

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UMC Providence Conference Room
Trauma Building, 5th Floor
800 Hope Place
Las Vegas, Clark County, Nevada
June 2, 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 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. Mackay (WebEx)

Absent:
None

Also Present:
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Deb Fox, Chief Nursing Officer
Frederick Lippmann, Chief Medical Officer
Danita Cohen, Chief Experience Officer
Jeff Castillo, Director of Patient Experience
James Conway, Assistant General Counsel
Stephanie Ceccarelli, Board Secretary

## SECTION 1. OPENING CEREMONIES

### ITEM NO. 1 PUBLIC COMMENT

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

Speaker(s): None

### ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee meeting on April 7, 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 Lopez-Hobbs that the agenda be approved as recommended. Motion carried by unanimous vote.

**SECTION 2. BUSINESS ITEMS**

**ITEM NO. 4 Receive an update on HCAPHS/CCAPHS/ICARE4U Program from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. *(For possible action)***

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

DISCUSSION:

Jeff Castillo, Director of Patient Experience, provided an overview of the HCAPHS, CCAPHS, and ICRE4U Programs.

The team delivered The Art of ICare interactive training to all hospital staff. This standardized service recovery model provides simple and practical ways for staff to engage patients, visitors, and colleagues. The training is unique to UMC and highlights examples, the impact of our experiences, and the importance of culture.

He added that the overall goal is to treat others the way you want your most cherished loved ones to be treated if you weren't there to protect them. The training is valuable for all employees, both clinical and non-clinical, at the hospital and ambulatory locations.

The acronym ART stands for:

**A**cknowledge the feedback

**R**espond to the issue

**T**ake ownership

Chair Franklin emphasized the importance of listening to the needs of patients, visitors, and staff, and highlighted the significance of timing in service recovery.

Next, Mr. Castillo reviewed the improvements in the Quick Care to ED experience. A series of meetings has been held with stakeholders to identify opportunities for improvement, and a standard workflow has been created for easy reference and process alignment. A slide showing the flowchart for patients coming from Quick Care locations to the hospital was displayed.

The team developed a new method for identifying patients arriving from quick cares and created scripts for senders and receivers. A brief discussion continued with instructions given to patients and staff members.

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**:**
-Power Point

DISCUSSION:

Ms. Scott provided the following update on the Quality, Safety, and Regulatory program.

Leapfrog:
The spring safety grades were issued, and UMC kept a C rating with an improved score of 2.8759. Most hospitals in the area continued to receive a C grade. Opportunities for improvement remain in discharge information, MRSA in infection control, Cdiff infections, and UV lighting. Ms. Scott provided the board with a detailed breakdown of the survey results and hospital comparisons across the valley.

Safety Reporting:
The sentinel events for the first quarter of 2025 were reviewed. Nine events were reported. All cases were reported within the required state timeframes, and RCAs with actions were taken on all cases. The events are monitored for sustainment through the Hospital Quality and Safety Committee. There was continued discussion regarding events that have occurred, process improvements, and litigation risks.

Regulatory Update:

The initial Hospital Accreditation survey with DNV occurred April 1st - 3rd. The plan of correction has been submitted and approved. Additional process surveys will continue throughout the year, and the annual survey will occur next year.

The hospital completed a successful Comprehensive Stroke survey on May 20th and 21st. The plan of correction has been submitted. Cardiac Centers of Excellence survey is anticipated for November 2025. The discussion continued regarding other centers of excellence survey opportunities.

FINAL ACTION TAKEN:

None

**ITEM NO. 6 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)***

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

DISCUSSION:

Ms. Scott provided the following update regarding the FY25 Organizational goals:

1. **Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:**
   Five of the measures have shown improvement and met benchmarks. Ms. Scott added that physician engagement has positively impacted overall outcomes. The discussion continued on identifying root causes and cultural changes that can improve results. Deb Fox added that staff have become more involved in finding solutions to enhance outcomes.

   The Committee was excited about the significant improvements.

   Hand hygiene compliance continues to be a struggle but has increased slightly.

2. **Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (IP):** All measures have met or sustained the established goals.

3. **Improve or sustain improvement (utilizing the Star Ratings) over the last three (3) year trending period in the overall patient perception of care (OP):** All measures have met or sustained the established goals.

4. **Google and Yelp:** These goals have been met.

5. **Employed physician & employee engagement / alignment measures (FY25):**
   These measures are in progress.

Ms. Scott will bring the final goal statistics to the next meeting. There was ongoing discussion about the goal related to hand hygiene and developing incentives to improve this metric.

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 April 2, 2025 and May 7, 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 April 2, 2025 & May 7, 2025 were reviewed.

There were a total of 107 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 Lopez-Hobbs to approve that the UMC Policies and Procedures Committee's activities of April 2, 2025 and May 7, 2025 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:

The Committee would like to review the continued improvement in infection control and hand hygiene.

Education regarding process analysis and improvements in metrics related to quality safety measures.

Magnet documents have been submitted and accepted. The team anticipates a site visit in the coming months.

FINAL ACTION TAKEN:

None

## COMMENTS BY THE GENERAL PUBLIC:

At this time, Acting 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 3:078 p.m., Acting Chair Franklin adjourned the meeting.

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

# UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
# GOVERNING BOARD STRATEGIC PLANNING COMMITTEE
# AGENDA ITEM

| | | |
|---|---|---|
| **Issue:** | **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 the Governing Board Policies and Procedures, as they relate to the Governing Board Clinical Quality and Professional Affairs Committee; and direct staff accordingly.** ***(For possible action)***

**FISCAL IMPACT:**

None

**BACKGROUND:**

The Committee will review and discuss the section of the UMC Governing Board Policies and Procedures related to the responsibilities and activities of the Clinical Quality and Professional Affairs Committee:

## CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE

### Purpose and Responsibilities

The Clinical Quality and Professional Affairs Committee shall, with the assistance of outside advisors, be responsible for reviewing and evaluating the patient safety and quality programs of UMC including: (a) the quality assurance and performance improvement process for UMC; (b) patient services in order to improve the quality of care of patients; (c) infection control programs ~~malpractice prevention programs~~; (d) ~~utilization of information gathered pursuant to the programs to review and to~~ the approval of ~~revise~~ policies and procedures as recommended by the hospital and the medical staff; (e) the progress of UMC toward meeting appropriate goals and objectives related to its health care programs; (f) approval of policies and procedures related to the credentialing of physicians, as recommended by the medical staff; (g) research and ongoing clinical trials conducted at the hospital ~~development and implementation of medical education programs~~; (h) the development or amendment of bylaws of the medical staff of UMC; and (i) the medical staff's on-going review and evaluation of the quality of professional care rendered at UMC and review the medical staff's reports on such activities and their results.

### Meetings

The Clinical Quality and Professional Affairs Committee shall meet at the call of the Chair of the Committee and as requested by the Board, but not less than quarterly.

Cleared for Agenda
August 11, 2025

Agenda Item #

**4**

**UMC**
**GOVERNING BOARD**
**POLICIES AND PROCEDURES**

**Approved: February 12, 2014**
**Revised: June 21, 2017**
**Revised: October 28, 2020**
**Reviewed: July 27, 2022**
**Revised: _____**

In support of the University Medical Center of Southern Nevada's ("UMC") mission, the UMC Governing Board (the "Governing Board") hereby adopts the following Policies and Procedures:

## I. BOARD COMMITTEES

To efficiently discharge its responsibilities, the Governing Board will support a division of authority and responsibility delegating and entrusting specific work to be performed by Governing Board committees, in support of the Governing Board's decisions and actions. Such committees of the Governing Board shall be Standing Committees or Special Committees (each a "Committee" and collectively, "Committees").

A Standing Committee is one whose functions are determined by a continuous need. Members of Standing Committees of the Governing Board will be appointed at a regular meeting of the Governing Board to serve for a term of one year. Each Standing Committee shall include at least two (2) Governing Board members, including a Chair of the Committee as appointed by the Chair of the Board, provided that if a Standing Committee has only two (2) Governing Board members, the Chair of the Board shall serve as a third Governing Board member of such Committee.

The Governing Board may additionally appoint both voting and non-voting public members to such Standing Committees, provided that members of the Governing Board shall constitute a majority of voting members of such Standing Committees and that a member of the Governing Board shall chair all such Standing Committees. Public members shall be advisory to the Standing Committee and shall have no vote, unless otherwise authorized by the Governing Board.

A Special Committee is one whose function and duration shall be determined by its specific assignment, as stated in a resolution of the Governing Board creating it. Special Committees may be created from time to time for specific purposes, including but not limited to receiving community advisory input on new programs or activities. Appointments to Special Committees need not be Governing Board members, provided that a member of the Governing Board shall chair any such Special Committee. Although a member of the Governing Board will chair any such Special Committee, it is anticipated that the majority of the members of any Special Committee would be public members. The goal of any Special Committee shall be to provide the

opportunity for broader, specialized and/or community input. Special Committees are not generally intended to be permanent, but rather are most often intended to provide advice to the Governing Board on specific matters within a limited period of time.

There will be strong reliance on highly effective and focused Committees. Committees shall be working Committees, performing background work and specialized tasks, whose output supports the full Governing Board. Minutes of Committee meetings shall be in form of reports to the Governing Board and shall be submitted to the next subsequent regular meeting of the Governing Board for consideration and action. Work of and between Committees will be coordinated and integrated but not duplicated.

The UMC Governing Board shall be knowledgeable about the content and operation of compliance and ethics program and shall exercise reasonable oversight with respect to the implementation of the compliance and ethics program. It shall have oversight to evaluate the effectiveness of the compliance program, including the receipt of quarterly reports from the Compliance Officer regarding compliance and the state of the compliance program; mechanism and process for compliance issue-reporting within UMC; the compliance programs approach to identifying regulatory risk; and methods used to encourage enterprise-wide accountability for achievement of compliance goals and objectives.

The Governing Board may approve the appointment of the following Standing Committees: Audit and Finance Committee, Clinical Quality and Professional Affairs Committee, Strategic Planning Committee and Human Resources and Executive Compensation Committee.

## AUDIT AND FINANCE COMMITTEE

### Purpose and Responsibilities

The Audit and Finance Committee shall be responsible for reviewing contractual agreements and evaluating the financial results, plans and audits of UMC for the purpose of assessing the overall financial risks and capacities of UMC and the congruity of the financial management, plans and objectives of UMC. The Audit and Finance Committee shall review and evaluate: (a) with the assistance of outside auditors, the financial records of UMC and the preparation and maintenance of the same in accordance with Generally Accepted Accounting Principles; (b) the preparation of annual operating and capital budgets; (c) periodic financial reports of UMC and receive explanations regarding variations from capital and operating budgets; (d) the audit process and review the results of internal and external audits; (e) the financial aspects of the strategic plans of UMC; (f) the contracts and arrangements for goods and services; and (g) coordinate issues of strategy with the Strategic Planning Committee.

### Meetings

The Audit and Finance Committee shall meet at the call of the Chair of the Committee and as requested by the Board, but not less than quarterly.

## CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE

### Purpose and Responsibilities

The Clinical Quality and Professional Affairs Committee shall, with the assistance of outside advisors, be responsible for reviewing and evaluating the patient safety and quality programs of UMC including: (a) the quality assurance and performance improvement process for UMC; (b) patient services in order to improve the quality of care of patients; (c) infection control programs ~~malpractice prevention programs~~; (d) ~~utilization of information gathered pursuant to the programs to review and to~~ the approval of ~~revise~~ policies and procedures as recommended by the hospital and the medical staff; (e) the progress of UMC toward meeting appropriate goals and objectives related to its health care programs; (f) approval of policies and procedures related to the credentialing of physicians, as recommended by the medical staff; (g) research and ongoing clinical trials conducted at the hospital ~~development and implementation of medical education programs~~; (h) the development or amendment of bylaws of the medical staff of UMC; and (i) the medical staff's on-going review and evaluation of the quality of professional care rendered at UMC and review the medical staff's reports on such activities and their results.

### Meetings

The Clinical Quality and Professional Affairs Committee shall meet at the call of the Chair of the Committee and as requested by the Board, but not less than quarterly.

## STRATEGIC PLANNING COMMITTEE

### Purpose and Responsibilities

The Strategic Planning Committee shall be responsible, with the assistance of outside advisors, for reviewing, evaluating and making recommendations to the Governing Board concerning UMC's mission and vision, strategic goals and capital planning including: (a) UMC leadership in examining the health care environment of Clark County and the strategic programmatic plans and annual business plans designed to meet the health care needs of the citizens of Clark County; (b) UMC development of and monitoring long-term and strategic plans which are consistent with its mission and which reflect the needs of the population; (c) UMC review of the current and future healthcare reimbursement horizon and appropriate program development; (d) UMC's plans and processes to gain cooperation of most or all healthcare constituencies within Clark County; (e) UMC coordination with the County relating to County-wide healthcare concerns; and (g) review and recommend consideration and/or action on potential strategic partnerships and affiliations.

### Meetings

The Strategic Planning Committee shall meet at the call of the Chair of the Committee and as requested by the Board, but not less than quarterly.

## HUMAN RESOURCES AND EXECUTIVE COMPENSATION COMMITTEE

### Purpose and Responsibilities

The Human Resources and Executive Compensation Committee shall engage in oversight of the development of personnel policies and procedures for employees of the Hospital.

The Committee shall advise the Governing Board and executive management with respect to employee compensation and benefit structures for employees who are members of a bargaining unit, employees who are not members of a bargaining unit, and management employees. The Committee shall advise the Governing Board and executive management with respect to:
(a) strategic high level workforce planning, including oversight of education and training programs; (b) strategies for recruitment and retention of highly trained, motivated and skilled employees; and (c)the promotion of employee satisfaction, efficiency and teamwork throughout UMC.

The Committee shall oversee the annual evaluation of the UMC Chief Executive Officer and senior management. The Committee shall then, based upon the evaluation and market metrics in comparable health care systems, make a compensation recommendation to the Governing Board for approval. In conducting this review, the Committee, may, but need not, use outside advisers.

### Meetings

The Human Resources and Executive Compensation Committee shall meet at the call of the Chair of the Committee as often as necessary, but not less than quarterly.

## II. MEETINGS

Meetings will be designed to focus on major strategic or policy issues and action items, and will encourage productive dialogue specific to issues under consideration. Each Governing Board member shall:

- Prepare for and actively participate at Governing Board meetings and meetings for those Committees on which the member serves: ask questions, take responsibility, and follow through.

- Review agenda and supporting materials prior to Governing Board and Committee meetings.

- Discuss any additional items to be added to the proposed meeting agendas with the Board Chair or Chair of the Committee, as applicable.

- Make every reasonable effort to attend all meetings, as applicable, in order to effectively participate in the governance of UMC.

The Governing Board will focus its energies primarily on strategic and policy issues, and not on operational details. To facilitate this focus, timely information and reports will be made available to all Governing Board members and all information to be considered in a Governing Board meeting will be made available, to the extent reasonably possible, at least three (3) working days in advance of each meeting, except in the case of emergencies.

The Chair of the Board will be responsible for prioritizing agenda items, and critical items will receive priority placement, or if appropriate called out of order, on the agenda. To the extent possible a consent agenda will be used for minutes, some Committee reports and other items determined to be routine in nature. Individual items may be removed from the consent agenda by request of any Governing Board member, the chief executive officer, or as otherwise provided in the Nevada Open Meeting Law, as discussed below.

To the extent Committee reports are presented to the full Governing Board, members will be presumed to have read them in advance of the meeting. They are to be presented in reasonably concise summaries. Governing Board meeting minutes will also be presented concisely, with the primary emphasis on actions taken.

Meetings of the Governing Board and its Committees shall be conducted in compliance with the Nevada Open Meeting Law (Nevada Revised Statutes Chapter 241). The following procedures shall apply to all meetings:

Notice. Except in an emergency, written notice of all meetings must be given at least three (3) working days before the meeting. The content and manner of notice shall comply with the Nevada Open Meeting Law.

Agendas. The Chair of the Board shall coordinate preparation of a clear and complete agenda of all topics to be considered at meetings of the Governing Board in accordance with the Nevada Open Meeting Law. The Chair of the Committee shall coordinate preparation of a clear and complete agenda of all topics to be considered at Committee meetings in accordance with the Nevada Open Meeting Law. Agenda items shall be prioritized with critical items receiving priority placement or, as reasonably required, called out of order. No item of business shall be considered at a meeting unless it first shall have been entered upon the agenda for that meeting; provided, however, that items not appearing on the agenda may be taken up when it has been determined that the matter is an emergency or otherwise as permitted under the Nevada Open Meeting Law.

Remote Communication. Members of the Governing Board and its Committees may participate in a meeting by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. Participation in a meeting pursuant to this method shall constitute presence in person at such meeting. In the event that all members of the Governing Board or its Committee participate by means of teleconference or videoconference, a physical location will be designated for the meeting to permit for members of the public to attend and participate in the meeting.

Parliamentary Authority. Where consistent with Nevada law and not otherwise provided in these Policies and Procedures, the conduct of the meetings shall be governed by the rules and procedures adopted by County Commission for the Hospital Board of Trustees, modified as appropriate to meet the needs of the Governing Board.

Order of Business. The Chair of the Board, for purposes of preparing the agenda, shall determine the order of business at each meeting of the Governing Board. The Chair of the Committee, for purposes of preparing the agenda, shall determine the order of business at each Committee meeting. During a meeting, agenda items may be taken out of the order presented on the agenda; combined for consideration; or removed from the agenda at the discretion of the Chair of the Board or Chair of the Committee, as applicable, unless the agenda item has been given a day or time certain.

Minutes. The Governing Board and its Committees shall keep written minutes of meetings in accordance with the Nevada Open Meeting Law. Minutes of meetings shall be complete, shall reflect deliberations of members as well as action taken. All materials submitted for the information of the Governing Board or Committee shall, to the extent required by law, be included with the permanent minute record so as to constitute a permanent record of all proceedings.

Audio Recordings. The Governing Board and its Committees shall, for each of their meetings, whether public or closed, record the meeting on audiotape or another means of sound reproduction or cause the meeting to be transcribed by a court reporter. Audio recordings will be maintained for the greater of three (3) years or such other amount of time which may be required by Nevada law or Clark County policy.

Closed Session. The Governing Board and its Committees may hold closed sessions if specifically authorized by the Nevada Open Meeting Law. All closed sessions shall be conducted in full compliance with the Nevada Open Meeting Law. Notice of a closed session shall be placed upon the agenda in the same manner as any other agenda item with the exception of an emergency closed session. Any motion to close a meeting to the public must set forth the subject matter or nature of the business to be considered at the closed meeting. Only the subject matter or business identified in the motion to close an open session may be discussed in a closed session.

Attendance. The Governing Board shall adhere to the attendance policy set forth in Clark County Ordinance 3.01.10. Such policy provides that, except in the case of an emergency, a Governing Board member's absence at a Governing Board meeting will be considered "unexcused" if the Governing Board member failed to notify, in writing or by phone, the Chair of the Board or an assigned staff member prior to the meeting that he or she will not be attending. Excused and unexcused absences must be noted in the minutes of the meeting. Three unexcused absences by a Governing Board member from regular Governing Board meetings during a calendar year shall be deemed grounds for mandatory removal from the Governing Board for good cause or neglect of duty. The Chair of the Board or an assigned staff member shall immediately notify the county manager or his designee when a member of the Governing Board is charged with his or her third unexcused absence, and the county manager or his or her designee shall provide that information to the Board of County Commissioners. Within thirty days of receipt of the

information, the Board of County Commissioners shall remove the Governing Board member and the procedures for the appointment of his or her replacement shall be commenced in accordance with the UMC Governing Board Bylaws. If the Board of County Commissioners does not act within the thirty-day period, the Governing Board member shall be automatically removed and a vacancy declared on the Governing Board.

## III. BOARD EDUCATION

The Governing Board, and each of its members, with the support of UMC executive management, shall be responsible for being educated in both the general knowledge of UMC policies, programs, services and financial situation and the general situation of UMC within the local and national healthcare industry. The Governing Board shall plan and implement orientation and continuing education programs.

## IV. BOARD EVALUATION

The Governing Board, with the support and assistance of executive management, shall be responsible for conducting periodic self-evaluation of the Board's role and its effectiveness in carrying out its duties and responsibilities with respect to that role. The Governing Board shall, in conjunction with individual Governing Board members, conduct an annual review of Governing Board performance.

## V. CONFIDENTIALITY

The Governing Board, and each of its members, shall maintain the confidentiality of any and all information that has been discussed in closed session. No individual member of the Governing Board has the authority to waive the confidentiality of a matter discussed in closed session.

## VI. HOSPITAL POLICIES

Each Governing Board member shall be generally knowledgeable of UMC administrative policies to the extent necessary to provide guidance and oversight as needed to the CEO and hospital management. A table of contents of UMC administrative policies is attached hereto as Appendix A.

## VII. REVIEW OF BYLAWS AND POLICIES AND PROCEDURES

The Governing Board shall review the Bylaws and these Policies and Procedures and recommend revisions as necessary (and at least every two (2) years) to comply with applicable statutes, regulations, and accreditation requirements.

## VIII. AMENDMENT

These Policies and Procedures may be amended from time to time by a majority vote of the Governing Board.

UMC Governing Board Policies and Procedures APPROVED and ADOPTED this ~~28th~~ _____ day of ~~October,~~ 202~~0~~5.

UMC GOVERNING BOARD:

_____

By: John F. O'Reilly, Chair

ATTEST:

_____

By: Stephanie Ceccarelli, Board Secretary

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

| | | |
|---|---|---|
| **Issue:** | **Death Certificate Process** | **Back-up:** |
| **Petitioner:** | Patricia Scott, Quality Patient Safety and Regulatory Officer | |
| **Recommendation:**<br><br>**That the Governing Board Clinical Quality and Professional Affairs Committee receive an educational presentation from Sabrina Holloway, HIM Director, regarding the death certificate process at UMC; and direct staff accordingly.** ***(For possible action)*** | | |

**FISCAL IMPACT:**

None

**BACKGROUND:**

The will receive an educational update on the death certificate process at UMC from Sabrina Hollaway, Health Information Management Director.

Cleared for Agenda
August 11, 2025

Agenda Item #

**5**

# Death Certificate Process

- Patient expires
- Nursing enters correct attending physician's name or APRN, on the Body Release Authorization Form
    - The resident (if involved) and/or Charge RN/Clinical Manager will identify the correct provider name to be placed on the Body Release Authorization Form and enter on the form
        - The correct name is the Attending or the Attending covering at the time of death. This individual should be the one managing the patient's care at the time
            - Nursing created a process to be referred to, to ensure accurate entry
- Funeral home picks up deceased and the Body Release Authorization Form
- Funeral home initiates the death certificate in the Nevada Electronic Death Registry System (EDRS) and enters the name of the provider located on the Body Release form
- EDRS sends entered provider the notification to complete a death certificate
- Provider logs into EDRS and completes required information
- When a death certificate has not been completed timely, funeral homes will contact the HIM department and/or Medical Staff Services for assistance
    - Both areas will attempt to reach assigned provider
        - If assigned provider still does not complete (and HIM/Med Staff Services is notified) it will be escalated to the Department Chief and they are expected to complete
            - If Department Chief does not have it reassigned or completed (and HIM/Med Staff Services is notified), it will be escalated to the Chief of Staff and they are expected to complete
                - Corrected provider will be called to funeral home by HIM or Med Staff Services, to update in EDRS
- In the event the provider initially assigned by resident/nursing, is determined to be incorrect, funeral home must be contacted, to update EDRS

- Per Nevada statutes (NAC 440.160, 440.162, 440.165, 440.170, 440.180), the cause of death must be completed within 48 hours from being assigned.
  - The named provider is to complete the required fields for the death certificate
    - All providers must register in the EDRS and provide accurate contact information so that the Nevada Department of Health can contact them electronically
      - All UMCSN providers have been provided this information and it is also presented at new provider orientation
- Per UMCSN By-Laws

  4.7.2 Certifying the Cause of Death Practitioners shall complete death certificates in accordance with Nevada law and the applicable Hospital policy. If the attending physician or advanced practice registered nurse will not be available within twenty-four (24) hours of death, the certificate shall be completed by an associate physician who has access to the deceased patient's medical records, the Department Chief, or the Chief of Staff before the end of the next business day once assigned as the certifier. In cases of death within the emergency department, the emergency physician will be responsible for certifying the cause of death and completing the death certificate in accordance with Nevada laws and regulations.

# MEMORANDUM

**MEDICAL STAFF SERVICES**

TO: **Members, Medicine Department**

FROM: **Chowdhury Ahsan, M.D., Department Chief**

SUBJECT: **Death Certificates**

DATE: **July 24, 2023**

Dear Colleagues:

It has been brought to my attention that UMC continues to experience delays in signing Death Certificates. It is causing undue grief and hardship to family members. The Bylaws and State Regulations require that ***the attending physician or Advanced Practice Registered Nurse is responsible for certifying the cause of death, and authenticating the Death Certificate within forty-eight (48) hours of death. If the attending physician or Advanced Practice Registered Nurse will not be available within forty-eight (48) hours of death, the certificate shall be completed by an associate physician who has access to the deceased patient's medical records.***

***It is imperative that the CORRECT Attending Physician's NAME is written on the Body Release Authorization Form at the time when the patient's body is picked up by the funeral home staff.*** This will prevent confusion and facilitate the timely signing of the Death Certificate. At the time of death, the Resident (if there is one involved) will work with the Charge Nurse to determine the CORRECT PHYSICIAN NAME (i.e. the covering Attending at the time of death, the surgeon if s/he is the one managing the patient at that time, etc.) Please educate your Residents regarding this process.

**Ms. Debra Fox, CNO will send a Memo and educate the Nursing staff about this process.**

**If you are not able to comply with the 48 hour requirement, please ensure that you have appointed another physician to certify the death certificate in your absence. Please immediately notify the HIM Department at (702) 383-2505 or email at HIMDCR@umcsn.com regarding the change.**

I appreciate your compliance and cooperation.

Thank you.

**DEPARTMENT OF NURSING**

**MEMORANDUM**

**TO: All Nurse Leaders**

**All Nursing Staff**

**All House Supervisors**

**FROM: Debra Fox, Chief Nursing Officer**

**REGARDING: Death Certificate Process**

**DATE: 7-27-2023**

**CC: Dr. C. Ahsan, Department Chief**

**Dr. M. Vohra, Chief of Medical Staff**

**Dr. Fred Lippmann, CMO**

**Mason Van Houweling, CEO**

Colleagues,

Attached you will find a memorandum from Dr. Chowdhury Ahsan representing the Medical Staff. The medical staff has requested our assistance to ensure that patient death certificates are managed in a timely, efficient, and most of all accurate manner for our patients and their families.

**Death certificates must be authenticated, including certifying the cause of death, within 48-hours of death. To prevent delays in this process it is imperative that the CORRECT Attending Physician's name is written on the Body Release Authorization Form prior to the patient's body being released to funeral home staff at the time of pick-up.**

**The process will be that at the time of death the resident (if involved) and/or Charge RN/Clinical Manager will identify the CORRECT PHYSICIAN NAME to be placed on the Body Release Authorization Form. That NAME IS TO BE TRANSCRIBED ON THE FORM. The correct physician is the Attending Physician or the Attending Physician covering at the time of death. This individual should be the one managing the patient's care at the time**. Charge RN's should immediately **seek out their Clinical Manager or the POD Nurse Leader if there is uncertainty of who the correct physician is** whose name must appear on the authorization form. **If unable to contact a nurse leader then reach out immediately to the House Supervisor** on duty for help.

This process is effective immediately. Please reach out if you have any questions.

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

| | |
|---|---|
| **Issue:** **FY25 Organizational Improvement/CEO Goals** | **Back-up:** |
| **Petitioner:** Patricia Scott, Quality, Patient Safety and Regulatory Officer | |

**Recommendation:**

**That the Governing Board Clinical Quality and Professional Affairs Committee Review, discuss, and score the outcomes of the FY25 Organizational Performance Goals as they relate to the Clinical Quality and Professional Affairs Committee; and make a recommendation to the Human Resources and Executive Compensation Committee; and direct staff accordingly.** ***(For possible action)***

**FISCAL IMPACT:**

None

**BACKGROUND:**

The Clinical Quality committee will review the UMC Organizational goals for FY25 and recommend to the HR Committee for approval.

Cleared for Agenda
June 2, 2025

Agenda Item #
**6**

UNIVERSITY MEDICAL CENTER

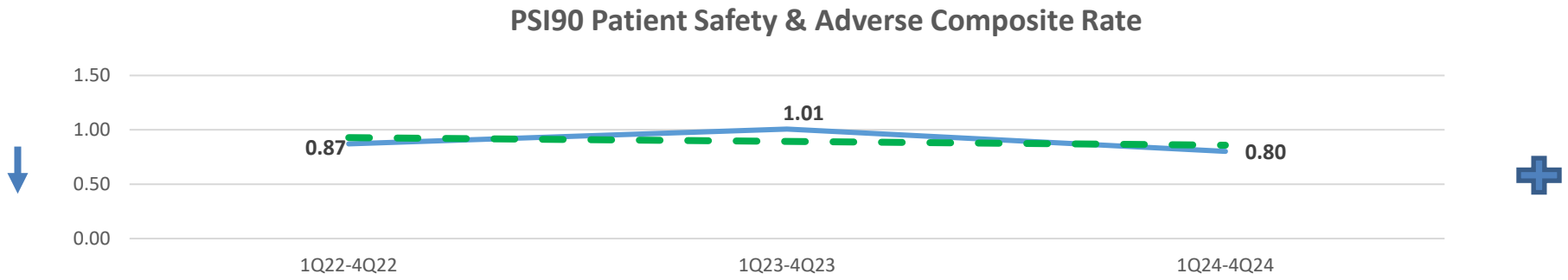
# Quality Performance Objectives – FY25

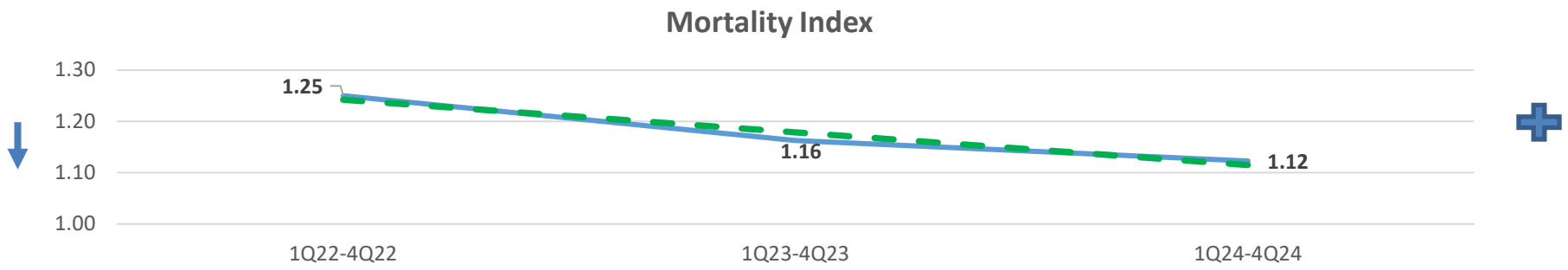
Approved by the Governing Board

# 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:**




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

Data Source: Vizient Clinical Database

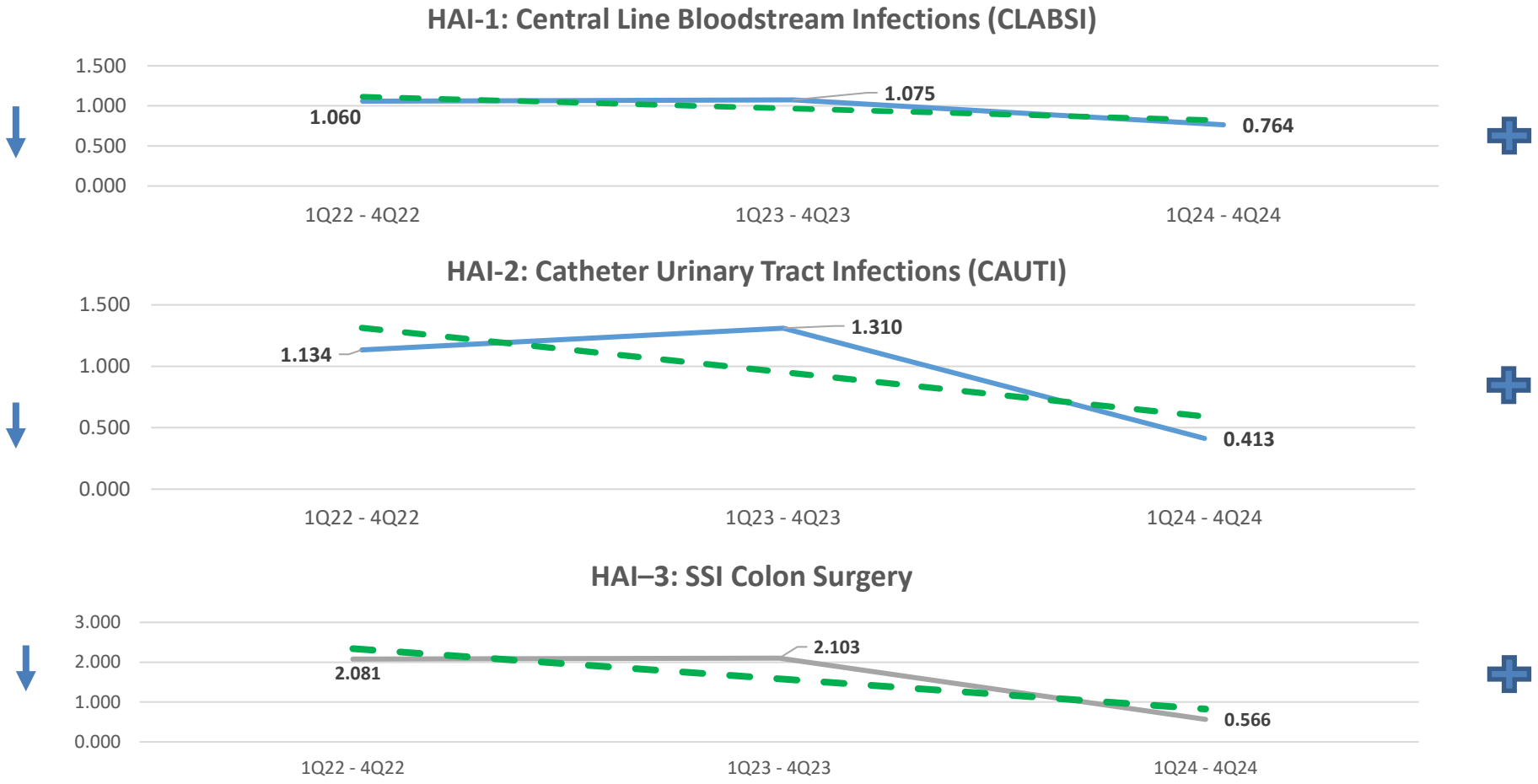
PSI 90 is a composite of the following 10, PSI indicators: pressure ulcers, iatrogenic pneumothorax, fall with hip fracture, peri-operative hemorrhage/hematoma, peri-operative metabolic complications, post-op respiratory failure, peri-op pulmonary embolism/deep vein thrombosis, post-op sepsis, post-op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





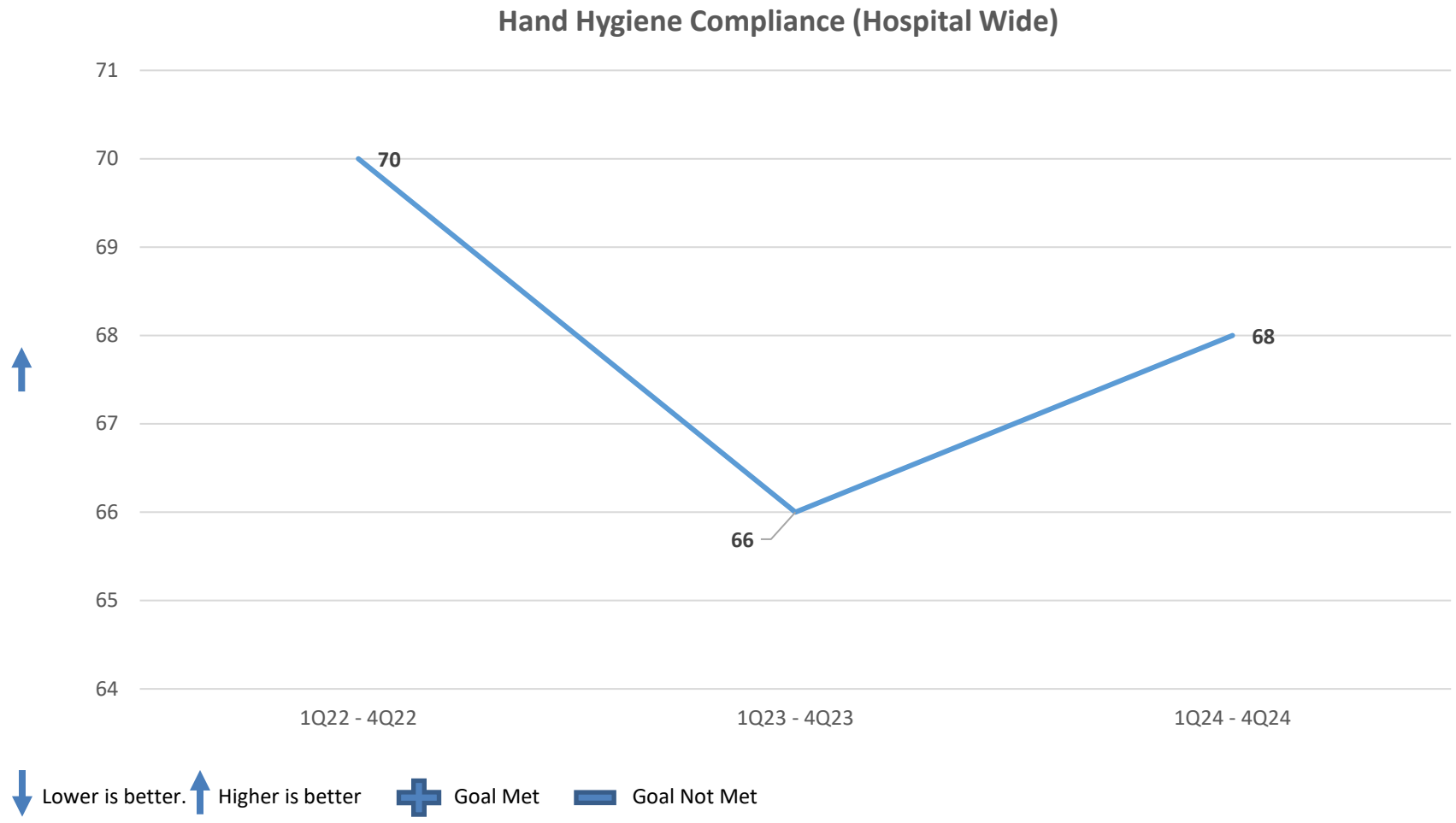

Data Source: UMC Infection Control Department – NHSN

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:**

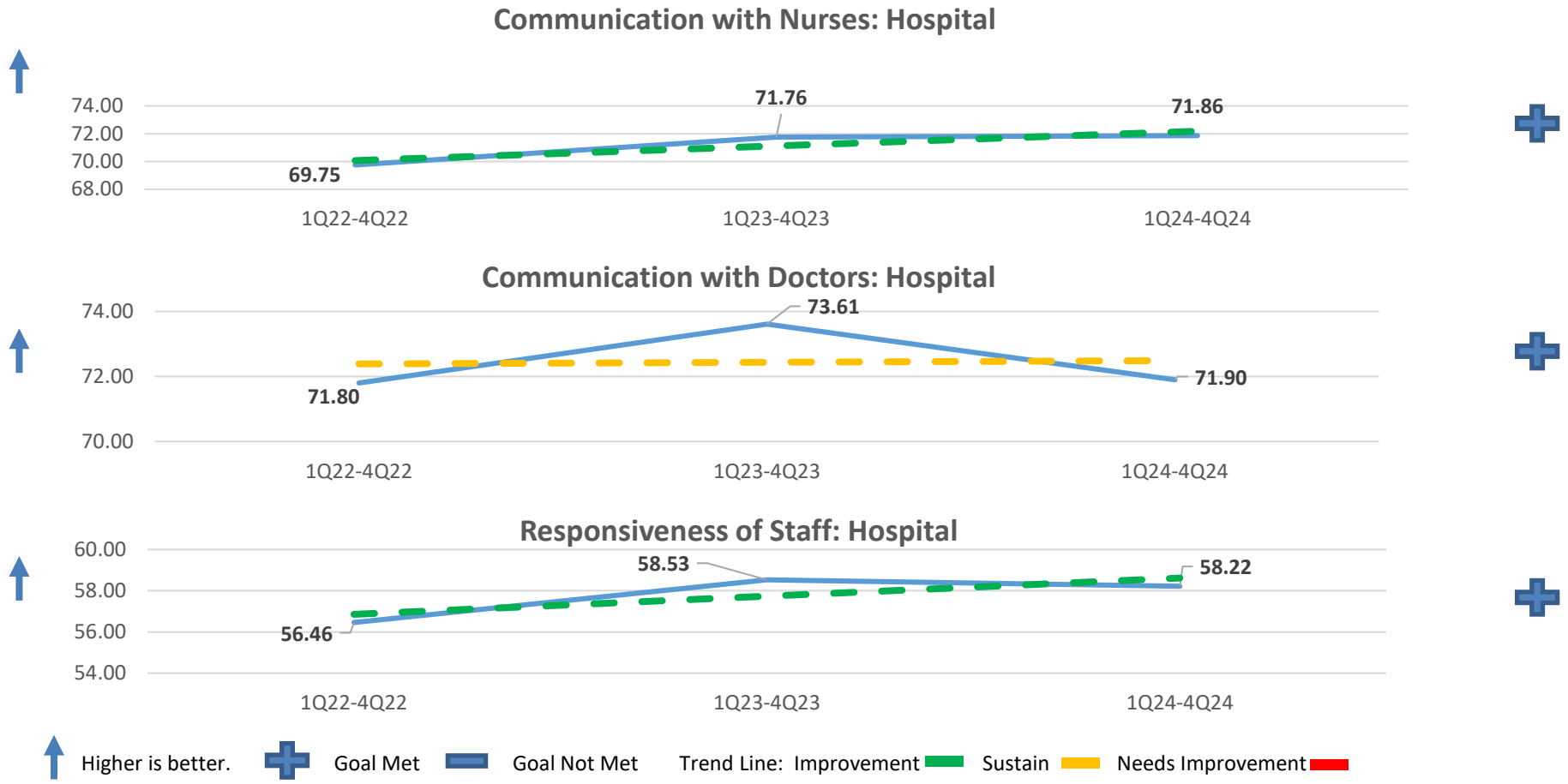



Data Source: UMC Infection Control Department

# 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):**

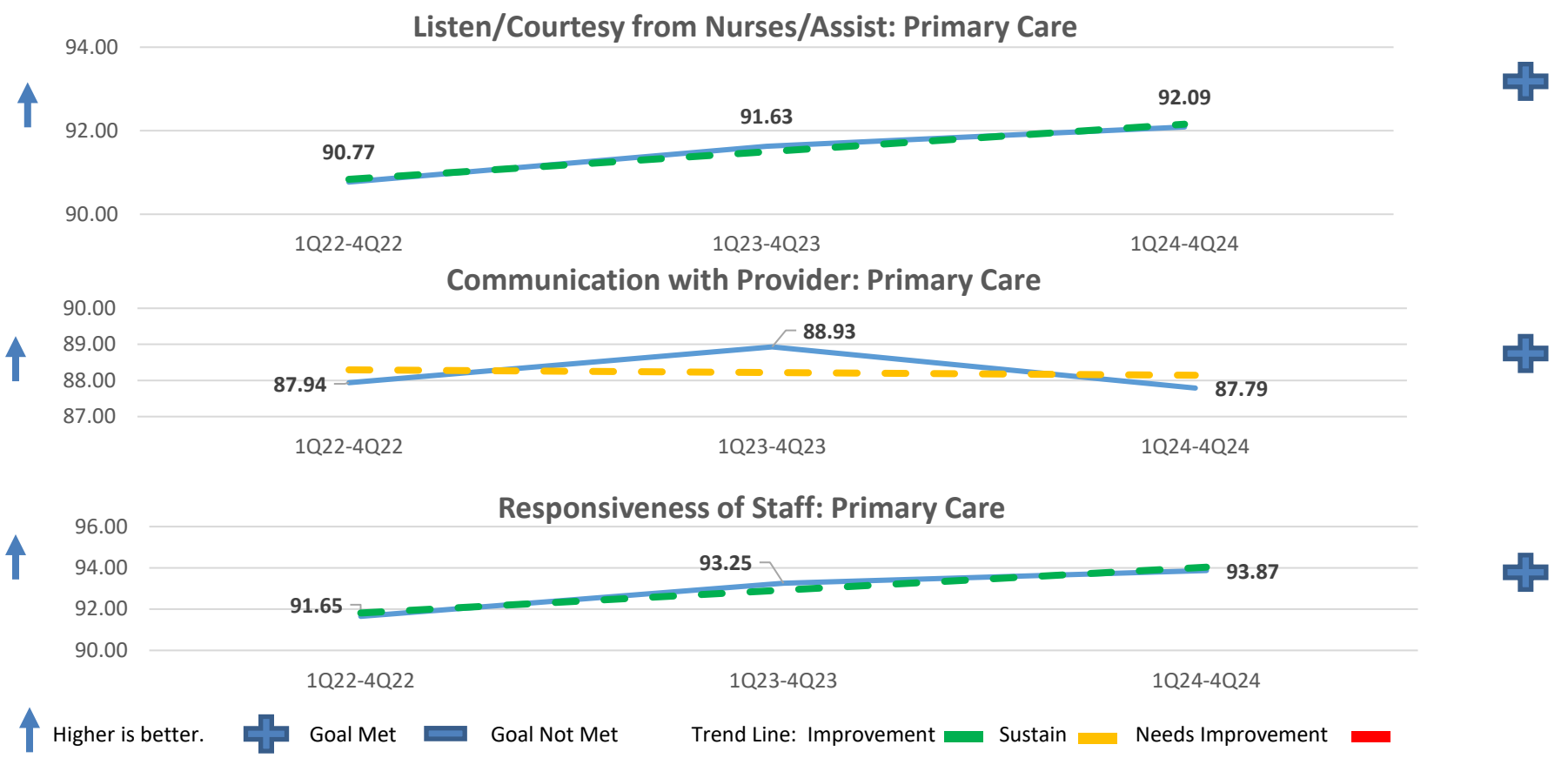



Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date

# 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):**

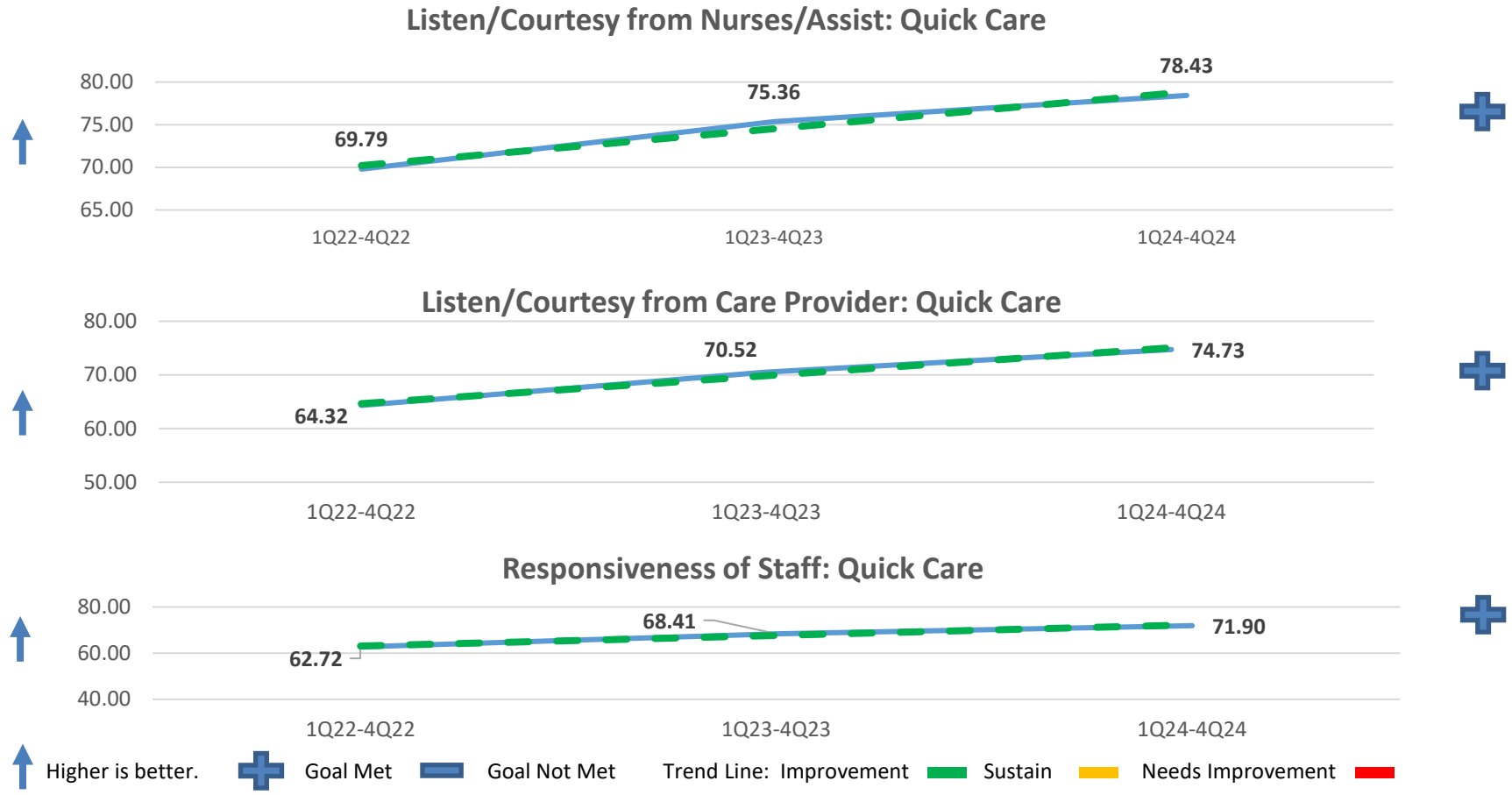



Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date

# 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):**

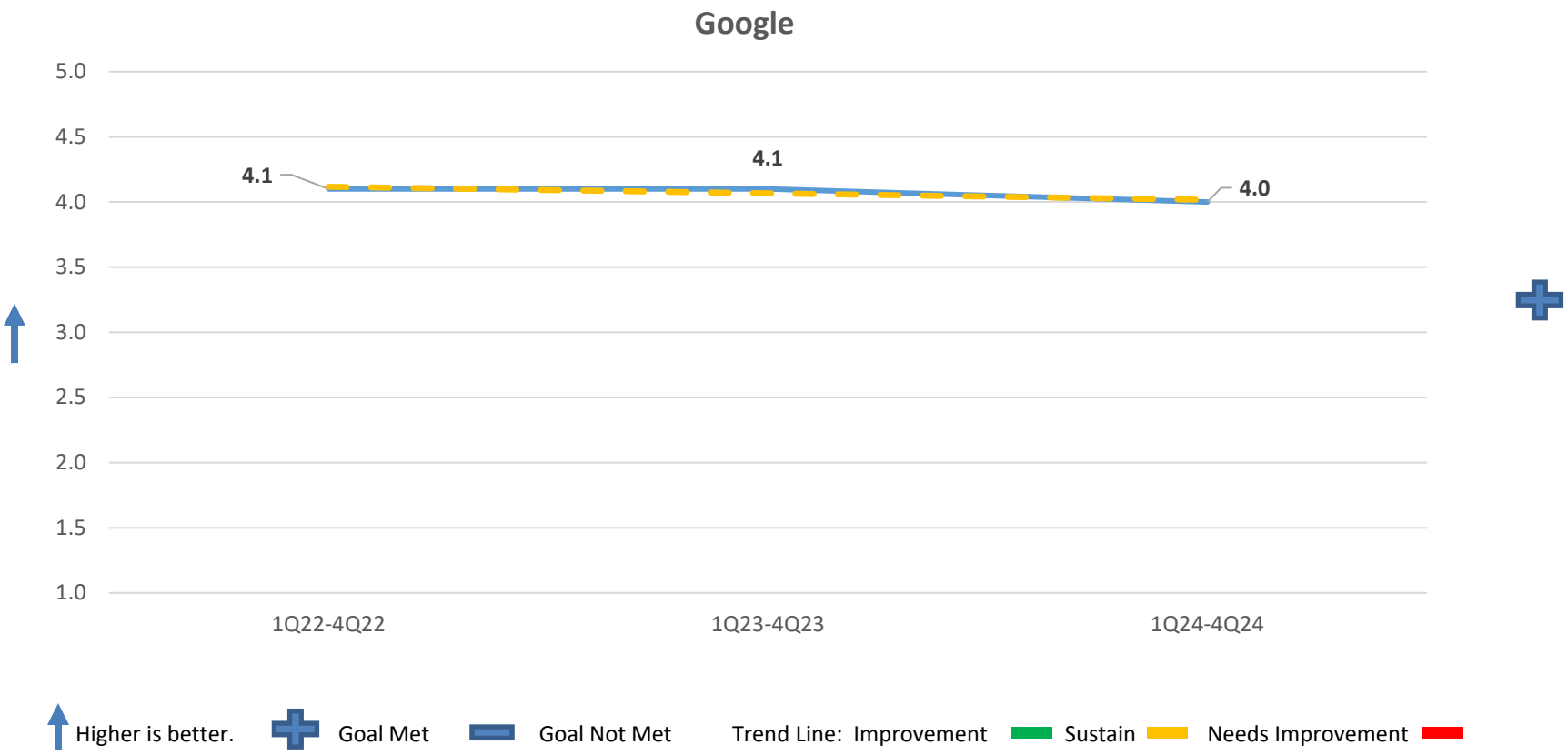



Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date.

# 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):**

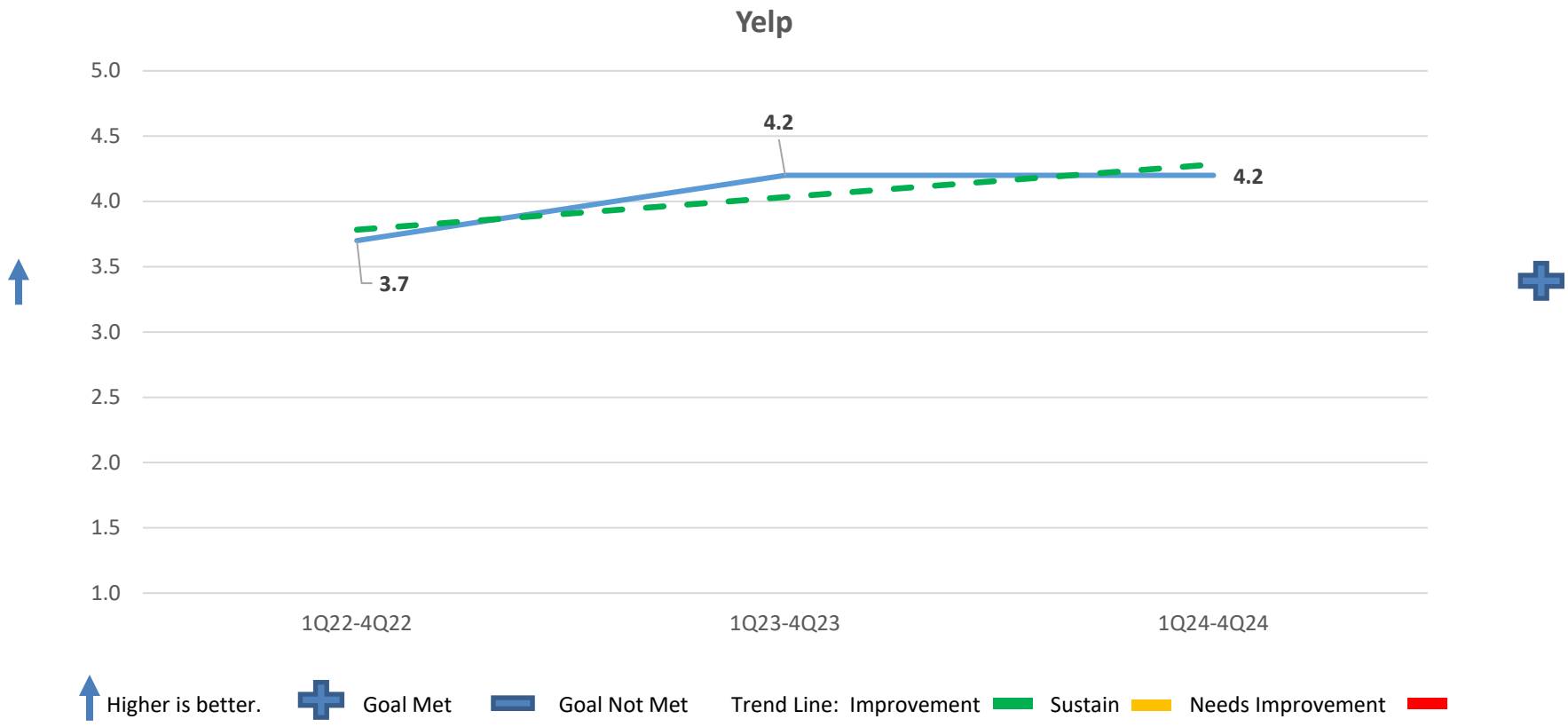



Date Source: UMC Experience Department, Yelp and Google websites. Average Star Score and Total Reviews during time period.
Score Range: 1-5 (5 Being the Highest)

# 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. | 100% |
| Attain 90% physician engagement / alignment survey participation, utilizing information gained to develop plans for improvement as other providers join the organization / service line. | 92% |
| Reach 80% of UMC employees with additional ICARE training specifically focused on service recovery. | 93% |

Data provided by Patient Experience

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

| | |
|---|---|
| **Issue:** **FY26 Organizational Improvement/CEO Goals** | **Back-up:** |
| **Petitioner:** Patricia Scott, Quality, Patient Safety and Regulatory Officer | |
| **Recommendation:**<br><br>**That the Governing Board Clinical Quality and Professional Affairs Committee Review and discuss the proposed FY26 Organizational Performance Goals as they relate to the Clinical Quality and Professional Affairs Committee; and make a recommendation to the Human Resources and Executive Compensation Committee; and take any action deemed appropriate.** ***(For possible action)*** | |

**FISCAL IMPACT:**

None

**BACKGROUND:**

The Clinical Quality Committee will review the proposed UMC Organizational goals for FY26 for reccommendation to the HR Committee.

Cleared for Agenda
August 11, 2025

Agenda Item #
**7**

**PROPOSED UMC FY26 ORGANIZATIONAL PERFORMANCE GOALS**
**CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE OF THE GOVERNING BOARD**

1. Improve or sustain improvement over the last three (3) year trending period for the following inpatient/outpatient **quality/safety measures**:
   - CLABSI
   - SSI – ORTHO (Hip, Knee, Spine)
   - VAP – OVERALL (Adults)
   - Hand Hygiene Compliance (Overall)
   - PSI-90
   - Adult ED Median Arrival Time to Disposition

2. Improve or sustain improvement over the last (1) year trending period for the following **patient experience** measures (IP / OP):
   - Communication with Nurses
   - Communication with Physicians
   - Responsiveness of Staff (IP)

3. Develop, implement, and **execute plans/campaigns to support and improve the following performance goals/programs** during FY26:
   - Hand Hygiene
   - Communication with Physicians
   - Unit of the Week Rounding to Identify Areas in Need of Repair (# of repair opportunities identified within areas reviewed / # corrected on validation of area)

# 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 June 4, 2025 and July 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
August 11, 2025

Agenda Item #

**8**

**June 4, 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 37 Approved, 0 Retired**

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Autopsy | Revised | Approved as Submitted | Updated "Attachment A" to reflect updates to Clark County Ordinance #2.12.060. Vetted by CQPS. |
| Observation and Monitoring - Crisis Stabilization Center (CSC) | New | Approved as Submitted | Created by CSC multi-disciplinary P/P working group. Reviewed with editorial changes made by Quality, Safety, & Regulatory Officer. |
| Critical Tests/Critical Results Reporting | Revised | Approved with Revisions | Added Respiratory Services manufacturer ranges, reportable ranges and Critical Values. Vetted by CQPS and Director of Respiratory. |
| ECMO Management of Skin Integrity | Revised | Approved with Revisions | Removed bed reference. Vetted by PICU Clinical Manager and Pediatric Department. |
| ECMO Nursing Documentation for Patient | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Director, ACNO and Pediatric Department. |
| ECMO Pediatric Mouth Care | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Director, ACNO and Pediatric Department. |
| Droplet Precautions | Revised | Approved as Submitted | Minimal change; removed MDI comment; updated high touch surfaces. Updated references. Vetted by Director of Infection Prevention and Medical Director Infectious Disease. |
| Reporting of Communicable Diseases & Conditions to Local, State or Federal Agencies | Revised | Approved as Submitted | Title and verbiage change to include local, state and federal agencies; Biosense specifics removed; stronger language on use of Epicare Link. Vetted by Microbiology Manager, Director of Infection Prevention and Medical Director Infectious Disease. |
| Special Procedural Cart | Revised | Approved with Revisions | Annual Review. CIMC unit added to policy. No further changes required. |
| Guideline for the Management of the Adult Patient on EndoTool IV: Glucose Management System | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Critical Care Director and ACNO. |
| Fresenius Memo | Revised | Approved as Submitted | Updated contract. Vetted by Director of Med Surg Services. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| Capital Equipment Lifecycle | New | Approved as Submitted | New policy. Vetted by Director of Supply Chain Services, Controller, Clinical Engineering, IT. |
| PGR-02 Extended Leave – Pharmacy Residents | Revised | Approved as Submitted | Updated to 27 days of CAL based upon new collective bargaining agreement. Updated number of education leave days to 8 based upon length of conferences that residents attend. Added language stating that the length of residency may not be extended to accommodate prolonged leave and that residents will not receive a certificate of completion if they take leave beyond what is described in this policy. Vetted by Director of HR and Director of Pharmacy. |
| PGR-03 Minimum Completion Requirements – Pharmacy Residency Program(s) | Revised | Approved as Submitted | Updated presentation requirement and removed expectation of verifying 20 orders per day outside of staffing hours. Reviewed policy to make sure it aligns with the 2025 ASHP residency accreditation standards. Vetted by Director of Pharmacy. |
| PGR- 04 Duty-Hour/Moonlighting – Pharmacy Residency Program | Revised | Approved as Submitted | Added maximum number of allowable moonlighting hours. Reviewed policy to make sure it aligns with the 2025 ASHP residency accreditation standards. Vetted by Director of Pharmacy. |
| PGR-05 Staffing/Stewardship – Pharmacy Residents | Revised | Approved as Submitted | Retitled as Staffing/Stewardship. Changed requirement of verifying 20 orders per day to stating that the resident must verify orders while on rotation. Vetted by Director of Pharmacy. |
| PGR-06 Selection, Evaluation, and Responsibilities of Pharmacy Residency Preceptors | Revised | Approved as Submitted | Slight modifications to language to enhance clarity. Reviewed policy to make sure it aligns with the 2025 ASHP residency accreditation standards. Vetted by Director of Pharmacy. |
| PGR-08 Requirements for Licensure in the Pharmacy Residency Program | Revised | Approved as Submitted | Modified language surrounding extensions to align with current practice. Added requirement for PGY2 residents to submit their PGY1 completion certificate prior to the first day of residency. Modified language surrounding Nevada Law Exam. Vetted by Director of Pharmacy. |
| PGR-09 Residency Evaluations | Revised | Approved as Submitted | Changed language surrounding midpoint evaluations in PharmAcademic. Defined failure of clinical rotation. Vetted by Director of Pharmacy. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| PGR-12 Corrective Counseling/Progressive Discipline/Dismissal | Revised | Approved as Submitted | Updated to include definition for failure to progress, identified resident specific behavior that would trigger an investigation, clarified that UMC is unable to extend the residency program, clearly defined expectations of action plan, referenced other relevant policies. Vetted by Director of Pharmacy. |
| PGR-13 Clinical Consult Service – Pharmacy Residency Program | New | Approved as Submitted | Clarification and updates to previous on-call procedures. Renaming of on-call to clinical consult service. Clarification of consult distribution. Vetted by Director of Pharmacy. |
| Controlled Substances: Pharmacy Controlled Substance Automated Dispensing Cabinet (Vault) | Revised | Approved as Submitted | Changed 4% volume loss to expected loss when batching liquids; especially critical because small volume doses can exceed 4%. Vetted by Director of Pharmacy. |
| Pediatric Subcutaneous Rapid/Short-Acting Insulin | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Pediatric Pharmacist, Pediatric Clinical Manager, PICU Clinical Manager, Pediatric Intensivist, Director of Pharmacy. |
| Extra-Corporeal Life Support (ECLS) Guidelines for Adult Patients | Revised | Approved as Submitted | Edits made per discussion at Quality meeting. Vetted by ECMO Workgroup. |
| Appropriate Use of Information Resources | Revised | Approved as Submitted | Updated language and a few sections to strengthen the policy language, including the right to monitor for compliance. Categorized IT resources for better definitions. Updated policy owners and titles. Vetted by Information Security Officer / Director of Cybersecurity. |
| EPIC Care Link Access Management | New | Approved as Submitted | New policy. Vetted by Information Security Officer & Compliance & Privacy Officer. |
| Friction Burn Algorithm | New | Approved as Submitted | New algorithm created by burn team. Approved in Burn Multidisciplinary Committee Meeting. |
| Pavement Burn Algorithm | New | Approved as Submitted | New algorithm created by burn team. Approved in Burn Multidisciplinary Committee Meeting. |
| Face and Neck Burn | New | Approved as Submitted | New guideline. Created with Burn Director, Rehab Services Director, Rehab Services Supervisor, PT, and OT Leads and therapy team, Inpatient Burn Care Manager, Outpatient Burn Care Manager, and Burn Program Manager. Approved at Burn Multidisciplinary meeting. |
| Burn Activation | Revised | Approved as Submitted | Added "room air" to end of sentence "Inhalation injury respiratory distress as evidenced by RR above 25 or with an oxygen saturation below |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| | | | 93%." Approved at Burn Multidisciplinary Committee meeting. |
| Operating Room Case Scheduling | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Specialty Services Manager, Director of Peri-Operative Service, Surgical Services Medical Director, ACNO and CNO. |
| Perioperative Fire/Disaster Evacuation Plan | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Perioperative Services Manager, Perioperative Services Director, Surgical Services Medical Director and ACNO. |
| Pre-Admission Assessment Testing | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by PACU Clinical Manager, Anesthesia Medical Director, Surgical Services Medical Director and ACNO. |
| Workplace Violence (WPV) Risk Assessment | New | Approved as Submitted | New WPV Risk Assessment P/P and related tools utilized to conduct risk assessments both for security sensitive areas, as well as comprehensive for the organization as a whole. Added definitions and reference to OSHA 3148. Revised attachment list. |
| Respiratory – Staffing Guidelines | Revised | Approved as Submitted | Reviewed and revised to reflect staffing based on Respiratory census and to include language indicating Respiratory leadership can be utilized in clinical roles to meet staffing standards. Vetted by Director of Respiratory Services. |
| TeleSitter Continuous Video Monitoring | Revised | Approved with Revisions | Revised exclusion criteria. Vetted by Director of Med Surg Services. |
| Pediatric Malignant Hyperthermia Crisis Guide | New | Approved as Submitted | New guideline. Approved at Pediatric Department Meeting 5-22-25. Vetted by pediatric pharmacy and Director of Pharmacy. |

**July 2, 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 20 Approved, 1 Retired**

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| 340B Drug Pricing Program | Revised | Approved as Submitted | Added language for prospective purchasing. Vetted by Director of Pharmacy. |
| Filling Medications and Outdates in the Automated Dispensing Cabinet (ADC) | Revised | Approved as Submitted | Added statement regarding inventory procedure. Vetted by Director of Pharmacy. |
| Medication Management Process – Parenteral Chemotherapy/ Biotherapy | Revised | Approved as Submitted | Defined when transcription of orders is allowable. Vetted by Director of Pharmacy. |
| Conflict Management | Revised | Approved as Submitted | Updated the name of the Workplace Violence Program Policy. Vetted by HR Director and Chief HR Officer. |
| Hatch Act – Employees Seeking Political Office | Revised | Approved as Submitted | Scheuled review, no changes. Vetted by HR Director and Chief HR Officer. |
| Abbott FreeStyle Precision Pro Glucose Meter | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Lab Services Manager and Lab Services Director. |
| Communication, Hand-off/ Bedside Handoff | Revised | Approved as Submitted | Corrected grammar and removed outdated items and appendixes and attachments which are not in use. Vetted by Med Surg Director and ACNO. |
| Comprehensive Addiction and Recovery Act | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by NICU Clinical Manager, Maternal Child Director and ACNO. |
| Swaddled Bathing Guidelines | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by Pediatric Clinical Manager, Maternal Child Director and ACNO. |
| Crisis Stabilization Center Bathroom Monitoring | New | Approved as Submitted | Created by CSC multi-disciplinary P/P working group. Reviewed by Quality, Safety, & Regulatory Officer. |
| Crisis Stabilization Center Transition and Discharge | New | Approved as Submitted | Created by CSC multi-disciplinary P/P working group. Reviewed by Quality, Safety, & Regulatory Officer. |
| Crisis Stabilization Center - Management of Operational Flow and Capacity Constraints | New | Approved as Submitted | Created by CSC multi-disciplinary P/P working group. Reviewed by Quality, Safety, & Regulatory Officer. |

| POLICY NAME | NEW/ REVISED | HPP COMMITTEE DECISION | SUMMARY |
|---|---|---|---|
| K-9 (Canine) Therapy | Revised | Approved as Submitted | Added language clarifying rules for employees volunteering with their therapy dogs, made grammatical corrections, strengthened infection control language, made other minor edits throughout. Vetted by Brand and PR Director. |
| Terminal Cleaning: Operating Rooms, Invasive and Procedural/Restricted Areas | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by EVS Director, Infection Prevention Director and Executive Director, Support Services. |
| Discharge Cleaning | Revised | Approved as Submitted | Minimal change in step 7. Vetted by EVS Director, Infection Prevention Director and Executive Director, Support Services. |
| Cleaning of Equipment – General Duties and Responsibilities | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by EVS Director, Infection Prevention Director and Executive Director, Support Services. |
| Linen Resource | Revised | Approved as Submitted | Scheduled review, no changes. Vetted by EVS Director, Infection Prevention Director and Executive Director, Support Services. |
| Sharps Container Processing/Injury Prevention | Revised | Approved with Revisions | Updated title. Vetted by EVS Director, Infection Prevention Director and Executive Director, Support Services. |
| Care of the Adult ICU Status Patient Outside of PACU | Revised | Approved as Submitted | Policy name changed from Post-Op Care of the Adult ICU Status Patient Outside of the PACU to "Care of the Adult ICU Status Patient Outside of PACU". Added verbiage, "All ICU status patients will be managed by a critical care credentialed physician, designated critical care fellow, or a physician or fellow who has been granted critical care privileges within the context of their designated core privilege category in conformance with unit policy upon admission". |
| Medical and Neuroscience Surgical Intensive Care Unit (MICU/NSICU) Criteria for Triage, Admission and Discharge | Revised | Approved as Submitted | Updated criteria, which include cardiovascular and antiarrhythmic drugs administration. BIPAP support /O2 therapy requirements. Revised language to clarify that all ICU level of care patients are to be managed by a critical care credentialed physician or designated critical care fellow, or by a physician or fellow who has been granted critical care privileges within the context of their designated core privileges in conformance with unit policy. Vetted by Medical Director of Critical Care Services & Dr Kush Modi. |

# 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:**<br><br>**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
August 11, 2025

Agenda Item #
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