UMC Clinical Quality and Professional Affairs Committee Meeting

Monday, June 2, 2025 2:00 p.m.

Trauma Building - Providence Suite - 5th Floor

800 Hope Place, Las Vegas, NV

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
June 2, 2025 2:00 p.m.
800 Hope Place, Las Vegas, Nevada
UMC Trauma Building, Providence Suite (5th Floor)

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

This meeting has been properly noticed and posted online at University Medical Center of Southern Nevada's website http://www.umcsn.com and at Nevada Public Notice at https://notice.nv.gov/, and at University Medical Center 1800 W. Charleston Blvd. Las Vegas, NV (Principal Office)

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

SECTION 1. OPENING CEREMONIES

CALL TO ORDER

1. Public Comment

2. Approval of minutes of the regular meeting of the UMC Clinical Quality and Professional Affairs Committee meeting on April 7, 2025. *(For possible action)*

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

SECTION 2. BUSINESS ITEMS

4. Receive an update on HCAPHS/CCAPHS/ICARE4U Program from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. *(For possible action)*

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

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

7. 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)*

SECTION 3. EMERGING ISSUES

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

COMMENTS BY THE GENERAL PUBLIC

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

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

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

UMC Providence Conference Room
Trauma Building, 5th Floor
800 Hope Place
Las Vegas, Clark County, Nevada
April 7, 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 Acting Chair Renee Franklin and the following members were present, which constituted a quorum of the members thereof:

CALL TO ORDER

Board Members:

Present:
Dr. Mackay – Chair (WebEx)
Renee Franklin – Acting Chair

Absent:
Laura Lopez-Hobbs (Excused)
Steve Weitman (Ex-Officio)

Also Present:
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Kathy Johnson, Director of Infection Control
Deb Fox, Chief Nursing Officer
Dr. Frederick Lippmann, Chief Medical Officer
Danita Cohen, Chief Experience Officer
James Conway, Assistant General Counsel
Stephanie Ceccarelli, Board Secretary
Nursing Magnet Team

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

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

Speaker(s): None

ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee meeting on February 3, 2025. *(For possible action)*

FINAL ACTION: A motion was made by Member Mackay 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 a presentation regarding the need for electronic hand hygiene technology from Kathy Johnson, Infection Prevention Director; and direct staff accordingly. *(For possible action)*

DOCUMENT(S) SUBMITTED:
- Power Point Presentation

DISCUSSION:

Kathy Johnson, Director of Infection Control provided an update on Hand Hygiene Surveillance and the UMC Annual Infection Prevention Program Evaluation and Plan. Hand hygiene is the cornerstone of infection prevention and it is estimated that one-third of hospital acquired infections can be prevented by better hygiene. CMS and Leapfrog requires a robust hand hygiene program.

Ideally, monitoring should be bias-free, provide real-time feedback, and not interfere with daily staff behaviors. There are four ways to perform hand hygiene audits: direct observation, product consumption evaluations, self-reporting and electronic monitoring. Ms. Johnson reviewed the advantages and disadvantages of each of the categories. Direct observation is a gold standard and is currently performed at UMC. The goal for hand hygiene is 100% compliance.

There were approximately 53k observations performed by the infection prevention team at UMC in 2024. Ms. Johnson described some of the challenges in capturing and performing the observations.

In 2024, the hand hygiene rate was 68%, up 2% over prior year. To meet the metric for an “A” rating with Leapfrog requires 200 audits per month per unit. During last year’s survey, UMC had only 7 out of 21 units meet the Leapfrog metric.

Strong emphasis has been put on electronic the hand hygiene program to reduce hospital acquired infections and pathogen transmission. A 10% improvement in hand hygiene has been associated with a 6% reduction in overall hospital acquired infections.

The next step is for staff to evaluate 4 electronic surveillance tools. The discussion continued regarding the benefits of this new electronic technology and process improvements.

FINAL ACTION TAKEN:

None

ITEM NO. 5 Receive an update on the Annual Infection Prevention Program Evaluation and Plan from Kathy Johnson, Director of Infection Prevention; and direct staff accordingly. *(For possible action)*

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

DISCUSSION:

Ms. Johnson presented the review of FY2024 Infection Prevention evaluation and the plan for FY2025.

A brief overview of the accomplishments for 2024 included decreases in CLABSI and CAUDI events. Opportunities for improvement were seen due to significant increases in ventilator associated events in adults and pediatrics; this is being monitored for the root cause for the increases in ventilator events.

Reductions were seen in MRSA and C.diff. infections and surgical site infection.

Hand hygiene rates dropped slightly, from 68% in 2023 to 66% in 2024 despite ongoing monitoring and education. PPE use declined slightly, from 85% in 2023 to 83% in 2024. Education compliance for patient and family have remained above 90%. Communication to other facilities, regarding patients in isolation, remained at 80%.

Employee health measures are in compliance with all state mandates. The discussion continued briefly with compliance with BBP exposures. Goals related to COVID-19 and flu compliance were met.

The Committee thanked staff for the great progress and improvement in the metrics.

FINAL ACTION TAKEN:

None

ITEM NO. 6 Receive an update on Magnet including associated financial costs from Deb Fox, Chief Nursing Officer (CNO); and direct staff accordingly. *(For possible action)*

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

DISCUSSION:

Deb Fox, Chief Nursing Officer, provided a nursing update to the Committee on Magnet journey to excellence. Staff members who have worked in collaboration in the Magnet journey were introduced and shared their experiences with the Committee.

The process to achieve Magnet begins with application submission, followed by quality experience/RN satisfaction reports, document submission, site visit and

finally the designation decision. The team is now in the process of document submission, which is to be submitted by June 2nd. The site visit is expected in the first quarter of 2026 and the final designation decision is anticipated in the 2nd quarter of 2026.

Ms. Fox shared a data summary of the RN satisfaction and experience score thresholds, as well as the inpatient/outpatient nurse sensitive indicators and the inpatient/outpatient satisfaction. UMC is exceeding the Magnet threshold and can move into document submission. Audrey Johnson, Magnet and Shared Governance Coordinator shared the current status of the document review and stories that must be uploaded for review.

The Magnet dashboard, which includes the story submissions, will be completed by June of 2025. Ms. Fox described a list of required documents for the Committee's awareness. She explained that these requirements must be met prior to document review by Magnet. Documents details must have no PHI. The discussion continued with a review of document specifics and assistance provided through Healthlinx.

Lastly, there was a review of the remaining Magnet priorities that staff is completing.

The Committee thanked Ms. Fox and staff and appreciated the detailed presentation.

FINAL ACTION TAKEN:

None

ITEM NO. 7 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. **Inpatient Quality/Safety Measures:** Five of the measures have shown improvement and have met benchmark. Hand hygiene compliance declined slightly and did not meet benchmark.

2. **Patient Experience measures (IP/OP):** All measures have met the established goals.

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

4. **Employed Physician & Employee Engagement measures (IP/OP)**: These measures are in progress.

Member Franklin commented on patient responsiveness and noted that she has observed staff being very responsive and encourages that staff continue to be proactive in this respect.

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 February 5, 2025 and March 5, 2025 including, the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. ***(For possible action)***

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

DISCUSSION:

Policy and Procedures activities for February 5, 2025 & March 5, 2025 were reviewed.

There were a total of 130 approved, 14 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 February 5, 2025 and March 5, 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 a discussion/demonstration at a future meeting on the use of the robotic technology utilized for disinfection and surface cleaning in the interest of preventing infections

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 3:18 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 CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

Issue: **HCAPHS/CCAPHS/ICARE4U Program Updates**	**Back-up:**
Petitioner: Patricia Scott, Quality Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on HCAPHS/CCAPHS/ICARE4U Program from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 2, 2025

Agenda Item #

4

UMC
UNIVERSITY MEDICAL CENTER

The **Highest Level of Care** in Nevada

Patient Experience
06/2025

THE Art OF CARE

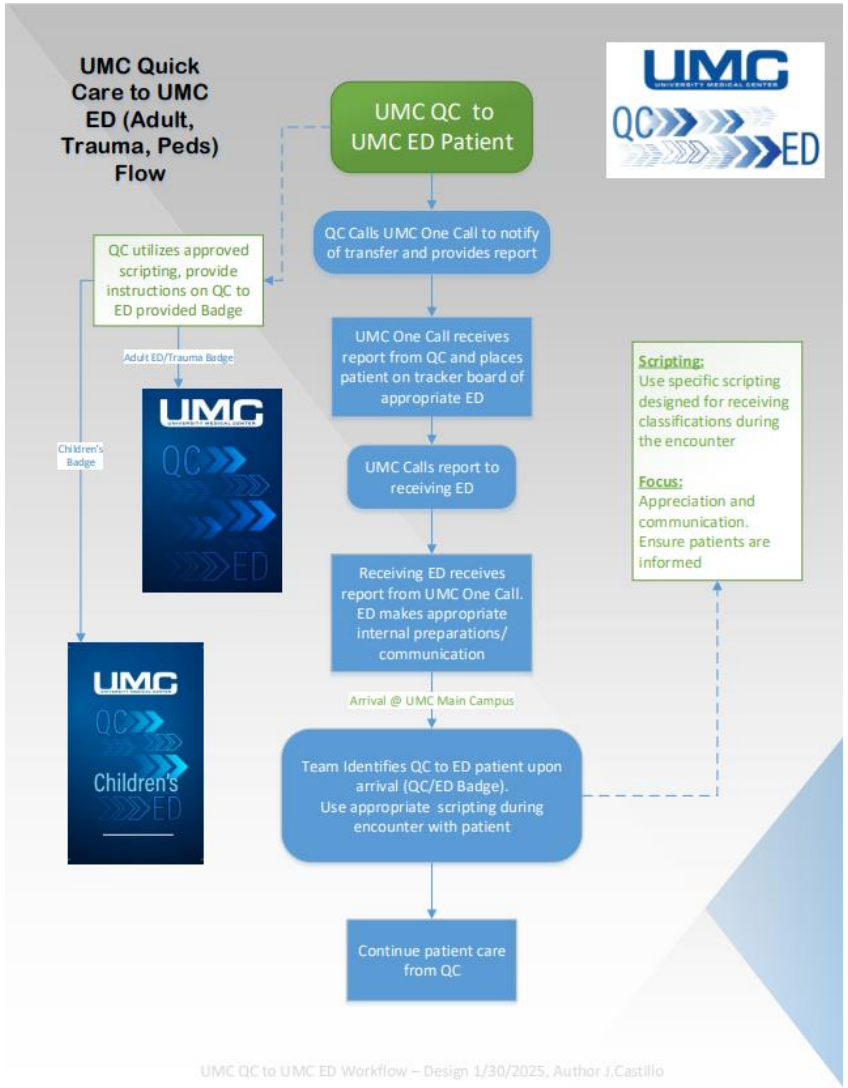
- Standardized Service Recovery Model for UMC
  - Simple and practical with patients, visitors, colleagues, etc…
- For all current UMC employees and New Hires
- Unique to UMC
- Interactive engaging delivery
- Multiple trainers with diversity in examples
- Numerous available class offerings for all staff (4,000+)
- Location-based classes for off-site teams
- Special classes for hard-to-reach audiences

- The example and the impact on our experience we have
- Importance of culture
- We are the Best!
- ICARE refresh – our principles
- ART – already being used, House Sup examples

Treat others how you want your most cherished loved ones treated if you weren't there to protect them.

Quick Care to ED - Experience

- A series of meetings with stakeholders to identify improvement opportunities
- Developed a standard workflow, for ease of reference and process alignment



Quick Care to ED - Experience

- Developed a new identifying mechanism for patients arriving from QC

- Developed scripting – senders and receivers
  - Sending Team
  - Receiving registration (UMC ED)
  - Receiving Nurse (UMC ED)
  - Receiving Provider (Physician, APP)

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

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

Recommendation:

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

FISCAL IMPACT:

None

BACKGROUND:

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

Cleared for Agenda
June 2, 2025

Agenda Item #
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Quality/Safety/Infection/Regulatory Update

UMC Governing Board Committee

Clinical Quality & Professional Affairs

June 2, 2025

Patient Safety

Leapfrog Patient Safety Grade – Spring 2025

Safety Grade Release Date	Score	Letter Grade
Spring 2025	2.8759	C
Fall 2024	2.8105	C
Spring 2024	2.8708	C
Fall 2023	3.0796	B
Spring 2023	3.0978	B
Fall 2022	2.8115	C
Spring 2022	2.7593	C
Fall 2021	2.5619	C
Spring 2021	2.5016	D

THE LEAPFROG GROUP
Giant Leaps for Patient Safety

LEAPFROG
HOSPITAL
SAFETY GRADE

1st Quarter 2025 Sentinel Events – Reported to State

Event	2024	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total	Comments
Fall with Injury	0	1	0	0	0	1	4N- fx wrist
Pressure Injury - 3/4/Unstage	24	8	0	0	0	8	MICU-2; TICU-4; 2W-1; CIMC-1
Retained Foreign Object	3	0	0	0	0	0	
Wrong Side Surgery/Procedure	1	0				0	
Wrong Site Surgery/Procedure	1	0				0	
Assault	0	0				0	
Homicide	0	0				0	
Device Failure	0	0				0	
Burn	0	0				0	
TOTAL	**29**	9				**9**	

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

Regulatory Updates

Policies & Procedures

Regulatory Update; Policy/Procedures

- Regulatory / Accreditation Surveys
  - DNV Initial Hospital Accreditation – April 1 – 3, 2025
  - DNV Comprehensive Stroke – May 20 – 21, 2025
  - DNV Cardiac Centers of Excellence – Pending November 4 – 6, 2025

- Policy / Procedures for Approval:
  - Timeframe: April 2, 2025 & May 7, 2025
  - Total approved: 101
  - Total retired: 2
  - Approved through Hospital P/P, Quality, MEC

DISCUSSION / QUESTIONS?

Patricia Scott, MSNA, BSN, RN, RHIA, CPHQ, CCDS, CPHRM, CLSSBB
Quality, Patient Safety, & Regulatory Officer
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UMC CMS Comparison to Las Vegas Acute Care Hospitals

**Data Last Updated April 30, 2025*

Hospital Compare Measures	UMC	Sunrise	Southern Hills	MT View	Spring Valley	Valley	Centennial Hills	Summerlin	Henderson	St. Rose DeLima	St. Rose San Martin	St. Rose Siena	North Vista	Reporting Period
Overall Hospital Star Rating	★★	★	★★★★	★★★★	★★	★★	★	★★	★★★	NA	★★★	★★★	★	
HCAHPS Star Rating	★★	★	★★	★★	★★	★★	★★	★★★	★	NA	★★★	★★★	★★	
HCAHPS														
Patients who reported that their nurses "Always" communicated well H-COMP-1	69%	62%	74%	72%	69%	72%	67%	77%	66%	NA	79%	74%	69%	07/01/2023 - 06/30/2024
	Nevada Average = 76%							National Average = 80%						
Patients who reported that their doctors "Always" communicated well H-COMP-2	69%	59%	71%	67%	68%	70%	62%	72%	61%	NA	78%	71%	74%	07/01/2023 - 06/30/2024
	Nevada Average = 73%							National Average = 80%						
Patients who reported that they "Always" received help as soon as they wanted H-COMP-3	56%	45%	57%	58%	53%	58%	48%	53%	49%	NA	63%	58%	49%	07/01/2023 - 06/30/2024
	Nevada Average = 62%							National Average = 67%						
Patients who reported that staff "Always" explained about medicines before giving it to them H-COMP-5	51%	45%	54%	52%	54%	58%	47%	58%	53%	NA	61%	56%	50%	07/01/2023 - 06/30/2024
	Nevada Average = 59%							National Average = 62%						
Patients who reported that their room and bathroom were "Always" clean H-CLEAN-HSP	64%	63%	74%	70%	67%	64%	64%	76%	68%	NA	76%	63%	73%	07/01/2023 - 06/30/2024
	Nevada Average = 74%							National Average = 74%						
Patients who reported that the area around their room was "Always" quiet at night H-QUIET-HSP	43%	48%	51%	53%	47%	50%	54%	57%	47%	NA	59%	51%	51%	07/01/2023 - 06/30/2024
	Nevada Average = 56%							National Average = 62%						
Patients who reported that YES, they were given information about what to do during their recovery at home CARE TRANSITION	81%	76%	82%	81%	82%	82%	81%	86%	81%	NA	85%	84%	80%	07/01/2023 - 06/30/2024
	Nevada Average = 85%							National Average = 86%						
Patients who "Strongly Agree" they understood their care when they left the hospital DISCHARGE INFORMATION	43%	37%	48%	41%	44%	43%	39%	46%	39%	NA	51%	45%	39%	07/01/2023 - 06/30/2024
	Nevada Average = 48%							National Average = 52%						
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) H-HSP-RATING / H-RECMND	60%	50%	67%	67%	60%	59%	57%	69%	56%	NA	77%	63%	63%	07/01/2023 - 06/30/2024
	Nevada Average = 66%							National Average = 72%						
Patients who reported YES, they would definitely recommend the hospital H-HSP-RATING / H-RECMND	60%	47%	71%	67%	57%	55%	58%	68%	55%	NA	80%	67%	61%	07/01/2023 - 06/30/2024
	Nevada Average = 66%							National Average = 70%						

UMC CMS Comparison to Las Vegas Acute Care Hospitals

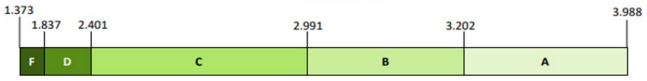
Hospital Compare Measures	UMC	Sunrise	Southern Hills	Mountain View	Spring Valley	Valley	Centennial Hills	Summerlin	Henderson	St. Rose DeLima	St. Rose San Martin	St. Rose Siena	North Vista	Reporting Period
Overall Hospital Star Rating	★★	★	★★★★	★★★★	★★	★★	★	★★	★★★	NA	★★★	★★★	★	
HCAHPS Star Rating	★★	★	★★	★★	★★	★★	★★	★★★	★	NA	★★★	★★★	★★	
Sepsis Care														
Percentage of patients who received appropriate care for severe sepsis and septic shock (SEP-1) *higher percentages are better* SEP-1	80% (N=310)	61%	74%	59%	55%	54%	56%	58%	57%	NA	68%	62%	71%	07/01/2023-06/30/2024
	Nevada Average = 66%							National Average = 63%						
Colonoscopy Follow-up														
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy ASC-9	73% (N=11)	NA	90%	38%	90%	93%	92%	100%	100%	NA	NA	64%	NA	01/01/2023-12/31/2023
	Nevada Average = 93%							National Average = 92%						
Emergency Department Care														
Emergency Department Volume	Very High	Very High	Very High	Very High	Very High	Very High	Very High	Very High	Very High	Low	Medium	Very High	High	Reporting Period
Percentage of patients who left the emergency department before being seen *lower percentages are better*	1% (N= 109624)	0%	0%	1%	0%	1%	1%	1%	0%	0%	0%	0%	2%	01/01/2023-12/31/2023
	Nevada Average = 1%							National Average = 2%						
Average (median) time patients spent in the emergency department before leaving from the visit *lower number of minutes is better*	220 min (N= 354)	165 mins	104 mins	142 mins	172 mins	190 mins	160 mins	205 mins	172 mins	104 mins	172 mins	192 mins	143 mins	
	Nevada Average *(other very high volume hospitals)* = 164 mins							National Average *(other very high volume hospitals)* = 193 mins						
Volume Legend (Patients Annually)	Low: 0 - 19,999 Medium: 20,000 - 39,999 High: 40,000 - 59,999 Very High: 60,000+													
Preventative Care														
Healthcare workers given influenza vaccination IMM-3 *higher percentages are better*	77% (N= 7310)	38%	41%	34%	81%	81%	74%	48%	77%	66%	69%	73%	58%	10/1/2023-03/31/2024
	Nevada Average = 66%							National Average = 80%						
Safe Use of Opioids														
Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge *lower percentages are better*	13%	14%	16%	18%	15%	17%	12%	12%	13%	18%	17%	12%	8%	01/01/2023-12/31/2023
	Nevada Average = 14%							National Average = 15%						
Surgical Complications														
Serious complications PSI-90 Composite	0.97 (No different than the national value)	0.88 (No different than the national value)	0.85 (No different than the national value)	0.89 (No different than the national value)	1.18 (No different than the national value)	0.86 (No different than the national value)	1.19 (No different than the national value)	1.16 (No different than the national value)	0.88 (No different than the national value)	NA	1.51 (Worse than the national value)	1.09 (No different that the national value)	0.90 (No different than the national value)	07/01/2021-06/30/2023
	National Average = 1.00													
Deaths among patients with serious treatable complications after surgery (PSI-4) PSI-04	180.38 (No different than the national rate)	127.66 (Better than the national rate)	130.68 (No different than the national rate)	161.61 (No different than the national rate)	163.64 (No different than the national rate)	146.34 (No different than the national rate)	190.95 (No different than the national rate)	138.60 (No different than the national rate)	172.52 (No different that the national rate)	NA	187.88 (No different than the national rate)	162.51 (No different than the national rate)	NA	07/01/2021-06/30/2023
	National Average = 176.55													
Rate of complications for hip/knee replacement patients COMP-HIP-KNEE	3.4% (No different than the national rate) (N=34)	4.1% (No different than the national rate)	3.0% (No different than the national rate)	3.0% (No different than the national rate)	3.0% (No different than the national rate)	4.0% (No different than the national rate)	3.4% (No different than the national rate)	NA	3.3% (No different than the national rate)	NA	NA	3.5% (No different than the national rate)	NA	07/01/2020-03/31/2023
	National Average = 3.5%													
Infections														
Central line-associated bloodstream infections (CLABSI) in ICUs and select wards HAI-1 *Lower numbers are better*	0.861 (No different than the national benchmark)	0.724 (No different than the national benchmark)	0.516 (No different than the national benchmark)	0.283 (Better than the national benchmark)	0.464 (Better than the national benchmark)	0.102 (Better than the national benchmark)	0.962 (No different than the national benchmark)	0.445 (Better than the national benchmark)	0.452 (No different than national benchmark)	NA	0.000 (Better than the national benchmark)	0.750 (No different than the national benchmark)	0.357 (No different than the national benchmark)	07/01/2023-06/30/2024
	National Benchmark = 1.000													
Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards HAI-2 *Lower numbers are better*	0.855 (No different than the national benchmark)	0.407 (Better than the national benchmark)	0.355 (No different than the national benchmark)	0.248 (Better than the national benchmark)	0.123 (Better than the national benchmark)	0.155 (Better than the national benchmark)	0.126 (Better than the national benchmark)	0.380 (Better than the national benchmark)	0.000 (Better than the national benchmark)	NA	0.000 (No different than the national benchmark)	0.315 (Better than the national benchmark)	0.000 (No different than the national benchmark)	07/01/2023-06/30/2024
	National Benchmark = 1.000													
Surgical site infections (SSI) from colon surgery HAI-3 *Lower numbers are better*	1.579 (No different than national benchmark)	0.899 (No different than the national benchmark)	0.463 (No different than national benchmark)	0.553 (No different than the national benchmark)	0.588 (No different than the national benchmark)	0.472 (No different than the national benchmark)	0.633 (No different than the national benchmark)	1.104 (No different than the national benchmark)	0.365 (No different than the national benchmark)	NA	1.119 (No different than the national benchmark)	1.516 (No different than the national benchmark)	NA	07/01/2023-06/30/2024
	National Benchmark = 1.000													
Surgical site infections (SSI) from abdominal hysterectomy HAI-4 *Lower numbers are better*	NA	0.000 (No different than national benchmark)	NA	0.490 (No different than the national benchmark)	NA	0.000 (No different than the national benchmark)	0.000 (No different than the national benchmark)	1.137 (No different than the national benchmark)	NA	NA	NA	NA	NA	07/01/2023-06/30/2024
	National Benchmark = 1.000													
Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections HAI-5 *Lower numbers are better*	0.966 (No different than the national benchmark)	1.342 (No different than national benchmark)	1.060 (No difference than national benchmark)	0.547 (No different than the national benchmark)	0.851 (No different than the national benchmark)	1.004 (No different than the national benchmark)	0.578 (No different than the national benchmark)	0.157 (Better than the national benchmark)	0.728 (No different than the national benchmark)	NA	0.699 (No different than the national benchmark)	0.669 (No different than the national benchmark)	0.000 (No than the national benchmark)	07/01/2023-06/30/2024
	National Benchmark = 1.000													
Clostridium difficile (C.diff.) intestinal infections (HAI-6) HAI-6 *Lower numbers are better*	0.662 (No different than national benchmark)	0.054 (Better than the national benchmark)	0.046 (Better than the national benchmark)	0.069 (Better than the national benchmark)	0.103 (Better than the national benchmark)	0.053 (Better than the national benchmark)	0.111 (Better than the national benchmark)	0.207 (Better than the national benchmark)	0.054 (Better than the national benchmark)	NA	0.466 (Better than the national benchmark)	0.432 (Better than the national benchmark)	0.455 (Better than the national benchmark)	07/01/2023-06/30/2024
	National Benchmark = 1.000													
Mortalities														
Death rate for COPD patients MORT-30-COPD	8.1% (No different than the national rate) (N=66)	9.7% (No different that the national rate)	9.3% (No different that the national rate)	9.4% (No different than the national rate)	8.0% (No different than the national rate)	8.8% (No different than the national rate)	12.5% (No different than the national rate)	8.4% (No different than the national rate)	8.6% (No different than the national rate)	NA	9.4% (No different than the national rate)	11.0% (No different that the national rate)	8.9% (No different than the national rate)	07/01/2020-06/30/2023
	National Average = 9.4%													
Death rate for heart attack patients MORT-30-AMI	12.7% (No different than the national rate) (N=45)	13.1% (No different than the national rate)	12.0% (No different that the national rate)	9.8% (No different than the national rate)	13.9% (No different than the national rate)	12.2% (No different than the national rate)	13.0% (No different than the national rate)	13.0% (No different than the national rate)	13.6% (No different than the national rate)	NA	13.3% (No different than the national rate)	13.2% (No different than the national rate)	13.0% (No different than the national rate)	07/01/2020-06/30/2023
	National Average = 12.6%													
Death rate for heart failure patients MORT-30-HF	9.5% (No different than the national rate) (N=152)	8.8% (Better than the national rate)	8.0% (Better than the national rate)	7.6% (Better than the national rate)	13.5% (No different than the national rate)	10.7% (No different than the national rate)	13.9% (No different than the national rate)	10.6% (No different than the national rate)	11.8% (No different than the national rate)	NA	10.7% (No different than the national rate)	12.1% (No different than the national rate)	7.7% (Better than the national rate)	07/01/2020-06/30/2023
	National Average = 11.9%													
Death rate for pneumonia patients MORT-30-PN	16.5% (No different than the national rate) (N=155)	18.5% (No different than the national rate)	14.4% (Better than the national rate)	15.4% (Better than the national rate)	20.0% (No different than the national rate)	17.4% (No different tan the national rate)	17.9% (No different than the national rate)	15.7% (No different than the national rate)	17.4% (No different than the national rate)	NA	20.8% (No different than the national rate)	16.5% (No different than the national rate)	16.1% (No different than the national rate)	07/01/2020-06/30/2023
	National Average = 17.9%													
Death rate for stroke patients MORT-30-STK	13.0% (No different than the national rate) (N=95)	14.7% (No different than the national rate)	13.3% No different than the national rate)	13.9% (No different than the national rate)	21.1% (Worse than the national rate)	16.6% (No different than the national rate)	15.8% (No different than the national rate)	13.0% (No different than the national rate)	12.7% (No different than the national rate)	NA	11.7% (No different than the national rate)	13.0% (No different than the national rate)	NA	07/01/2020-06/30/2023
	National Average = 13.9%													
Death rate for CABG surgery patients MORT-30-CABG	3.0% (No different than the national rate) (N=59)	2.9% (No different than the national rate)	NA	2.4% (No different than the national rate)	2.0% (No different than the national rate)	4.0% (No different than the national rate)	NA	4.5% (No different than the national rate)	NA	NA	4.8% (No different than the national rate)	4.5% (No different than the national rate)	NA	07/01/2020-06/30/2023
	National Average = 2.8%													
Readmissions														
Rate of readmission for chronic obstructive pulmonary disease (COPD) patient READM-30-COPD	20.7% (No different than the national rate) (N=82)	20.8% (No different than the national rate)	18.2% (No different than the national rate)	20.4% (No different than the national rate)	19.0% (No different than national rate)	18.0% (No different than national rate)	18.4% (No different than the national rate)	18.5% (No different than the national rate)	19.9% (No different than the national rate)	NA	18.7% (No different than the national rate)	18.4% (No different than the national rate)	19.0% (No different than the national rate)	07/01/2020-06/30/2023
	National Average = 18.5%													
Rate of readmission for heart attack patients (READ-30-AMI) EDAC-30-AMI	14.6% (No different than the national rate) (N=48)	14.3% (No different than the national rate)	13.3% (No different than the national rate)	13.8% (No different than the national rate)	13.9% (No different than the national rate)	14.4% (No different than the national rate)	13.4% (No different than the national rate)	15.2% (No different than the national rate)	14.4% (No different than the national rate)	NA	13.9% (No different than the national rate)	13.4% (No different than the national rate)	NA	07/01/2020-06/30/2023
	National Average = 13.7%													
Rate of readmission for heart failure patients EDAC-30-HF	21.9% (No different than the national rate) (N=185)	22.3% (No different than the national rate)	18.8% (No different than the national rate)	19.7% (No different than the national rate)	22.7% (No different than the national rate)	20.2% (No different than the national rate)	20.9% (No different than the national rate)	20.6% (No different than the national rate)	21.3% (No different than the national rate)	NA	20.0% (No different than the national rate)	21.2% (No different than the national rate)	21.8% (No different than the national rate)	07/01/2020-06/30/2023
	National Average = 19.8%													
Rate of readmission for pneumonia patients EDAC-30-PN	15.7% (No different than the national rate) (N=155)	16.4% (No different than the national rate)	17.6% (No different than the national rate)	15.9% (No different than the national rate)	18.2% (No different than the national rate)	15.7% (No different than the national rate)	18.6% (No different than the national rate)	19.1% (Worse than the national rate)	16.4% (No different that the national rate)	NA	16.8% (No different than the national rate)	18.6% Worse than the national rate)	16.5% (No different than the national rate)	07/01/2020-06/30/2023
	National Average = 16.4%													
Rate of readmission for coronary artery bypass graft (CABG) surgery patients READM-30-CABG	10.6% (No different than the national rate) (N=57)	12.2% (No different than the national rate)	NA	11.5% (No different than the national rate)	10.6% (No different than the national rate)	10.7% (No different than the national rate)	NA	10.9% (No different than the national rate)	NA	NA	11.7% (No different than the national rate)	9.8% (No different than the national rate)	NA	07/01/2020-06/30/2023
	National Average = 10.7%													
Rate of readmission after hip/knee replacement READM-30-HIP-KNEE	4.3% (No different than the national rate) (N=39)	4.6% (No different than the national rate)	4.6% (No different than the national rate)	4.2% (No different than national rate)	4.7% (No different than national rate)	4.6% (No different than the national rate)	5.2% (No different than the national rate)	NA	4.0% (No different than the national rate)	NA	NA	4.6% (No different than the national rate)	NA	07/01/2020-06/30/2023
	National Average = 4.5%													
Rate of readmission after discharge from hospital (Hospital-Wide) READM-30-HOSP-WIDE	15.2% (No different than the national rate) (N=1662)	14.9% (No different than the national rate)	15.4% (No different than the national rate)	14.5% (No different than national rate)	15.7% (No different than the national rate)	15.8% (No different than the national rate)	16.1% (Worse than the national rate)	16.0% (Worse than the national rate)	16.0% (Worse than the national rate)	NA	14.5% (No different than the national rate)	15.0% (No different than the national rate)	15.1% (No different than the national rate)	07/01/2020-06/30/2023
	National Average = 14.6%													

UMC Leapfrog Individual Measure - Compare

	LEAPFROG				UMC															
	Measures Contributing to LF Score	Best Score Possible	Standard Weight	Mean	UMC Trend	Spring 2025	Fall 2024	Spring 2024	Fall 2023	Spring 2023	Fall 2022	Spring 2022	Fall 2021	Spring 2021	Fall 2020	Spring 2020	Fall 2019	Spring 2019	Fall 2018	Spring 2018	Fall 2017
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	6.157%	80.23		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Bar Code Medication Administration (BCMA)	100	6.000%	81.87		100	100	100	100	100	100	100	100	100	45	100	100	100	100		
	ICU Physician Staffing (IPS)	100	6.881%	65.15		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Safe Practice 1 : Culture of Leadership Structures and Systems	120	3.056%	117.49		120	120	120	120	120	120	120	120	120	120	120	120	120	120	120	120
	Safe Practice 2: Culture Measurement , Feedback & Intervention	120	3.178%	116.85		120	120	120	120	120	120	120	120	120	120	120	120	92.31	92.31	120	120
	Total Nursing Care Hours Per Patient Day	100	4.729%	77.07		40	40	N/A	N/A												
	Hand Hygiene	100	4.877%	74.40		100	100	100	100	100	100	100	100	N/A	N/A	60	60	60	60	60	60
	H-COMP-1 - Nurse Communication	100	2.998%	90.19		86	86	86	86	86	87	87	88	88	87	86	84	84	84	84	83
	H-COMP-2 - Doctor Communication	100	2.997%	89.91		86	86	86	85	86	87	87	87	87	86	84	84	84	85	84	84
	H-COMP-3 - Staff Responsiveness	100	3.048%	81.63		80	79	78	78	79	80	81	80	80	80	80	78	76	76	76	74
	H-COMP-5 - Communication about Medicines	100	3.052%	74.42		68	67	70	70	70	69	70	72	72	70	69	69	68	68	68	68
	H-COMP-6 - Discharge Information	100	3.028%	85.25		81	82	82	82	82	82	82	81	81	80	79	78	80	81	80	79
Outcome Measures	Foreign Object Retained	0.00	4.208%	0.014		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	Air Embolism	0.00	2.405%	0.002		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	Falls and Trauma	0.00	4.894%	0.384		0.000	0.000	0.169	0.169	0.221	0.000	0.000	0.281	0.281	0.281	0.437	0.437	0.180	0.180	0.580	0.580
	CLABSI	0.00	4.536%	0.651		0.861	1.075	1.195	1.060	1.097	1.181	1.175	1.047	0.765	0.879	1.008	1.128	0.887	0.786	1.006	0.555
	CAUTI	0.00	4.654%	0.540		0.855	1.310	1.167	1.134	0.959	0.787	1.330	1.479	1.123	1.164	1.122	1.578	0.932	0.584	0.707	0.725
	SSI: Colon	0.00	3.400%	0.831		1.580	2.103	2.403	2.081	1.819	1.239	1.309	2.545	2.204	2.701	2.033	1.774	1.036	1.503	2.286	2.946
	MRSA	0.00	4.489%	0.719		0.966	0.919	1.332	1.460	1.702	2.594	2.124	1.934	1.684	1.655	1.416	0.879	1.004	0.919	1.451	1.659
	C. Diff	0.00	4.474%	0.401		0.661	0.650	0.482	0.310	0.585	1.002	1.183	1.083	1.116	1.086	1.045	1.098	1.013	0.936	1.061	1.186
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	0.00	1.966%	177.45		180.38	191.91	191.91	159.17	159.17	160.80	160.80	160.80	202.90	202.94	205.14	205.14	176.75	176.75	158.99	168.360
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.00	14.974%	1.00		0.97	0.97	0.97	0.81	0.81	1.18	1.18									
	LEAPFROG SCORE					2.8759	2.8105	2.8708	3.0796	3.0978	2.8115	2.7593	2.5619	2.5016	2.2297	2.3737	2.3528	2.4860	2.5612	2.4493	2.3328
	LEAPFROG Grade					C	C	C	B	B	C	C	C	D	D	D	D	D	C	D	D

Spring 2025 Cut-Off Points

Grade	Safety Grade Criteria *(at or above cut point)*	Percentage of Hospitals
A	≥ 3.202	32%
B	≥ 2.991	24%
C	≥ 2.401	35%
D	≥ 1.837	7%
F	< 1.837	<1%

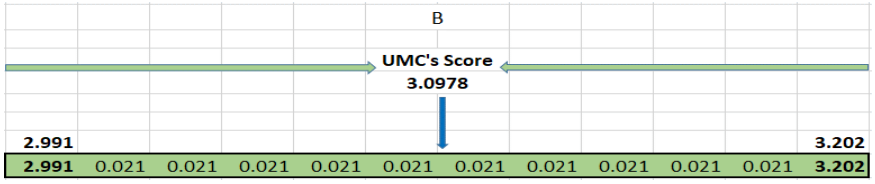


Better than previous reporting period
Same as previous reporting period
Worse than previous period
N/A in previous reporting period

UMC Leapfrog Individual Measure - Compare

Measure Domain	Measure	Hospital's Score Fall 2022	Hospital's Score Spring 2023	Trend
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	100	
	Bar Code Medication Administration (BCMA)	100	100	
	ICU Physician Staffing (IPS)	100	100	
	Safe Practice 1: Culture of Leadership Structures and Systems	120	120	
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120	120	
	Safe Practice 9: Nursing Workforce	100	100	
	Hand Hygiene	100	100	
	H-COMP-1: Nurse Communication	87	86	
	H-COMP-2: Doctor Communication	87	86	
	H-COMP-3: Staff Responsiveness	80	79	
	H-COMP-5: Communication about Medicines	69	70	
	H-COMP-6: Discharge Information	82	82	
Outcome Measures	Foreign Object Retained	0	0	
	Air Embolism	0	0	
	Falls and Trauma	0	0.221	
	CLABSI	1.181	1.097	
	CAUTI	0.787	0.959	
	SSI: Colon	1.239	1.819	
	MRSA	2.594	1.702	
	C. Diff.	1.002	0.585	
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	160.8	159.17	
	CMS Medicare PSI 90: Patient safety and adverse events composite	1.18	0.81	
Process Measure Domain Score:				
Outcome Measure Domain Score:				
Process/Outcome Domains - Combined Score:				
Normalized Numerical Score:		2.812	3.0978	
Hospital Safety Grade (Letter Grade):	Grade	C	B	

Better
Worse
No Change



Measures Contributing to LF Score	Standard Weight	UMC	Sunrise	Southern Hills	MT View	Valley	Spring Valley	Summerlin	Centennial Hills	Henderson	St. Rose San Martin	St. Rose Siena	North Vista	Source & Timeframe
Computerized Physician Order Entry (CPOE)	6.157%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
Bar Code Medication Administration (BCMA)	6.000%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
ICU Physician Staffing (IPS)	6.881%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
Safe Practice 1: Culture of Leadership Structures and Systems	3.056%	120	101.54	120	110.77	120	120	120	120	120	120	120	120	2024 LF Survey
Safe Practice 2: Culture Measurement, Feedback, & Intervention	3.178%	120	120	120	120	120	120	120	120	120	120	120	120	2024 LF Survey
Total Nursing Care Hours per Patient Day	4.729%	40	15	15	15	70	40	70	40	40	70	70	100	2024 LF Survey 01/01/2023 - 12/31/2023
Hand Hygiene	4.877%	100	100	100	100	100	100	100	100	100	100	100	100	2024 LF Survey
H-COMP-1: Nurse Communication	2.998%	86	83	89	88	87	87	89	87	85	91	90	85	CMS 01/01/2023 - 12/31/2023
H-COMP-2: Doctor Communication	2.997%	86	81	87	85	85	84	87	84	83	89	87	88	CMS 01/01/2023 - 12/31/2023
H-COMP-3: Staff Responsiveness	3.048%	80	75	82	80	79	79	79	76	76	83	83	76	CMS 01/01/2023 - 12/31/2023
H-COMP-5: Communication about Medicines	3.052%	68	64	71	70	73	70	74	67	71	74	74	66	CMS 01/01/2023 - 12/31/2023
H-COMP-6: Discharge Information	3.028%	81	77	82	79	80	82	83	80	83	85	85	78	CMS 01/01/2023 - 12/31/2023
Foreign Object Retained	4.208%	0.000	0.084	0.000	0.081	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2021 - 06/30/2023
Air Embolism	2.405%	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	CMS 07/01/2021 - 06/30/2023
Falls and Trauma	4.894%	0.000	0.000	0.169	0.322	0.368	0.503	0.283	0.642	0.152	0.555	0.509	0.333	CMS 07/01/2021 - 06/30/2023
CLABSI	4.536%	0.861	0.724	0.516	0.283	0.102	0.464	0.382	0.962	0.452	0.000	0.780	0.357	2024 LF Survey 07/01/2023 - 06/30/2024
CAUTI	4.654%	0.855	0.407	0.355	0.248	0.155	0.123	0.380	0.126	0.000	0.000	0.342	0.000	2024 LF Survey 07/01/2023 - 06/30/2024
SSI: Colon	3.400%	1.580	0.899	0.463	0.553	0.472	0.588	1.104	0.633	0.365	1.062	1.459	N/A	2024 LF Survey 07/01/2023 - 06/30/2024
MRSA	4.489%	0.966	1.293	1.082	0.547	1.004	0.854	0.168	0.578	0.728	0.692	0.536	0.000	2024 LF Survey 07/01/2023 - 06/30/2024
C. Diff	4.474%	0.661	0.052	0.046	0.069	0.053	0.104	0.207	0.111	0.054	0.466	0.432	0.455	2024 LF Survey 07/01/2023 - 06/30/2024
PSI 4: Death rate among surgical inpatients with serious treatable conditions	1.966%	180.38	127.66	130.68	161.61	146.36	163.64	138.60	190.95	172.52	187.88	162.51	N/A	CMS 07/01/2021 - 06/30/2023
CMS Medicare PSI 90: Patient safety and adverse events composite	14.974%	0.97	0.88	0.85	0.89	0.86	1.18	1.16	1.19	0.88	1.51	1.09	0.00	CMS 07/01/2021 - 06/30/2023
LEAPFROG SCORE		**2.8759**	**2.7492**	**3.2488**	**3.0450**	**3.2732**	**2.9072**	**3.1074**	**2.7773**	**3.1706**	**2.8527**	**3.0647**	**3.9838**	
LEAPFROG Spring 2025 Grade		**C**	**C**	**A**	**B**	**A**	**C**	**B**	**C**	**B**	**C**	**B**	**A**	
Fall 2024 Grade		**C**	**C**	**B**	**B**	**A**	**B**	**C**	**C**	**A**	**C**	**B**	**A**	

N/A	Not Applicable

	Not Publicly Reported

Spring 2025 Cut-Off Points

Grade	Safety Grade Criteria *(at or above cut point)*	Percentage of Hospitals
A	≥ 3.202	32%
B	≥ 2.991	24%
C	≥ 2.401	35%
D	≥ 1.837	7%
F	< 1.837	<1%

Spring 2025 Compare Hospital Counts	
A	3
B	4
C	5
D	0
F	0

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

Issue: **FY25 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 on the FY25 Organizational Improvement Goals from Patty Scott, Quality/Safety/Regulatory Officer; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

The Clinical Quality committee will receive an update on the UMC Organizational goals for FY25.

Cleared for Agenda
June 2, 2025

Agenda Item #

6

UNIVERSITY MEDICAL CENTER

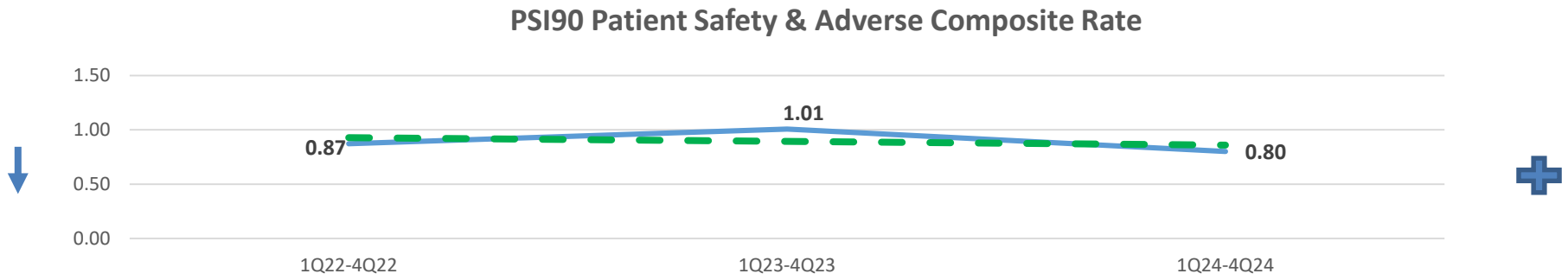
Quality Performance Objectives – FY25

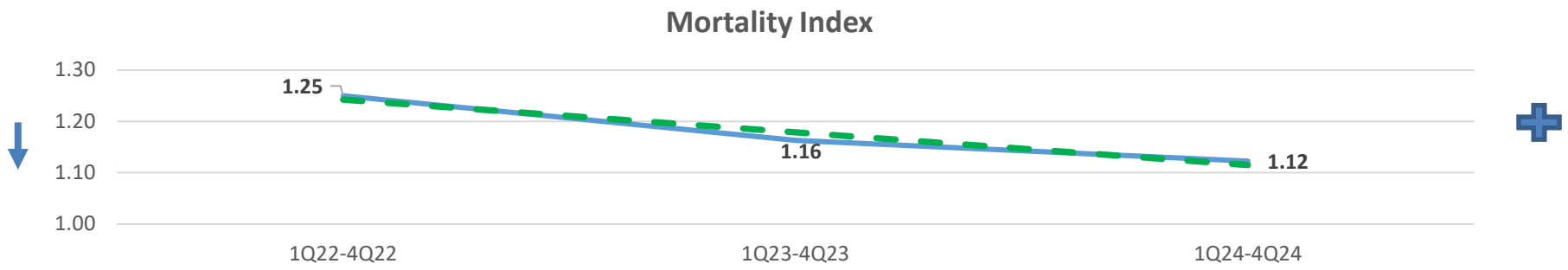
Approved by the Governing Board

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

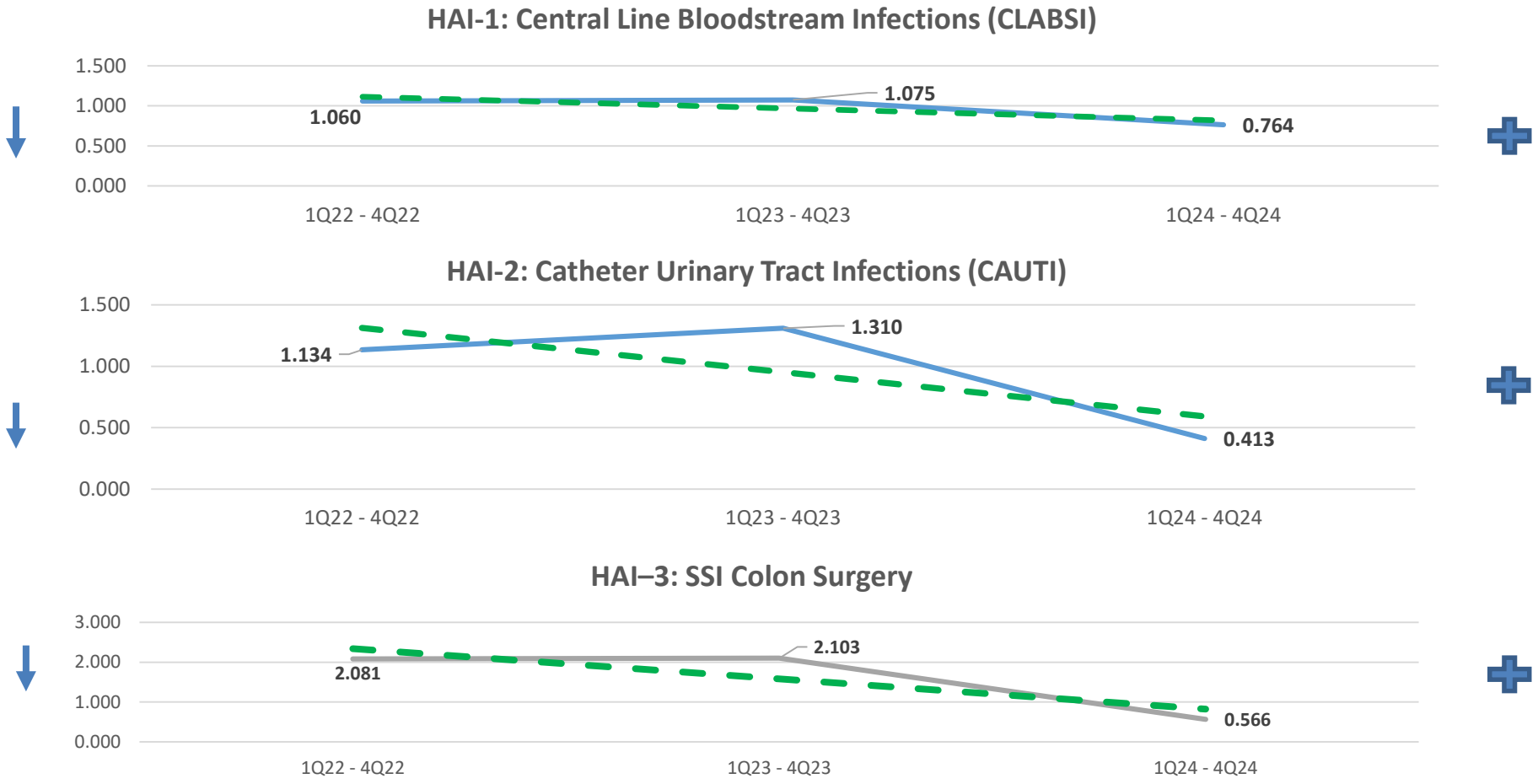
PSI 90 is a composite of the following 10, PSI indicators: pressure ulcers, iatrogenic pneumothorax, fall with hip fracture, peri-operative hemorrhage/hematoma, peri-operative metabolic complications, post-op respiratory failure, peri-op pulmonary embolism/deep vein thrombosis, post-op sepsis, post-op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



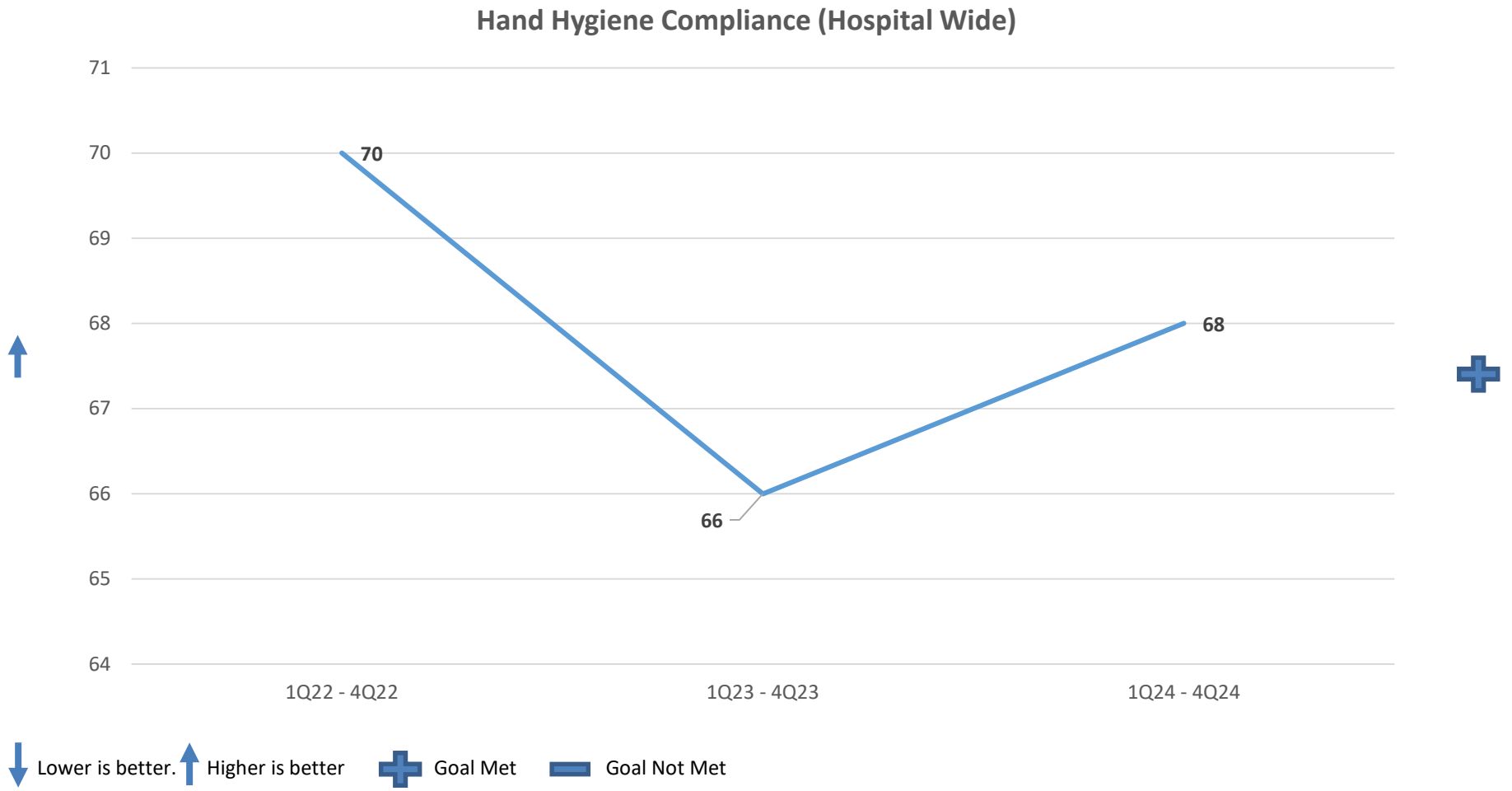
Data Source: UMC Infection Control Department – NHSN

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:

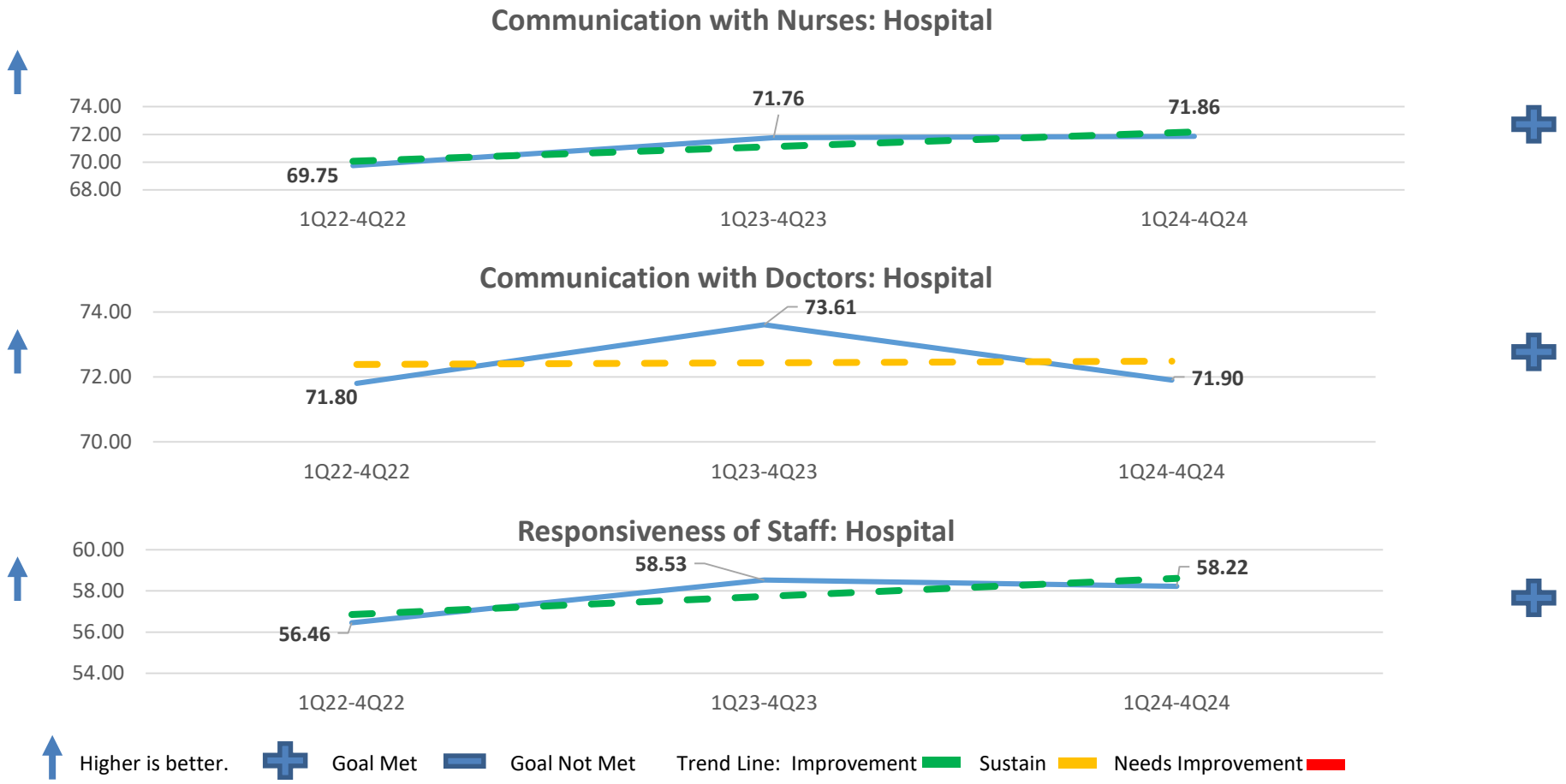


Data Source: UMC Infection Control Department - NHSN

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

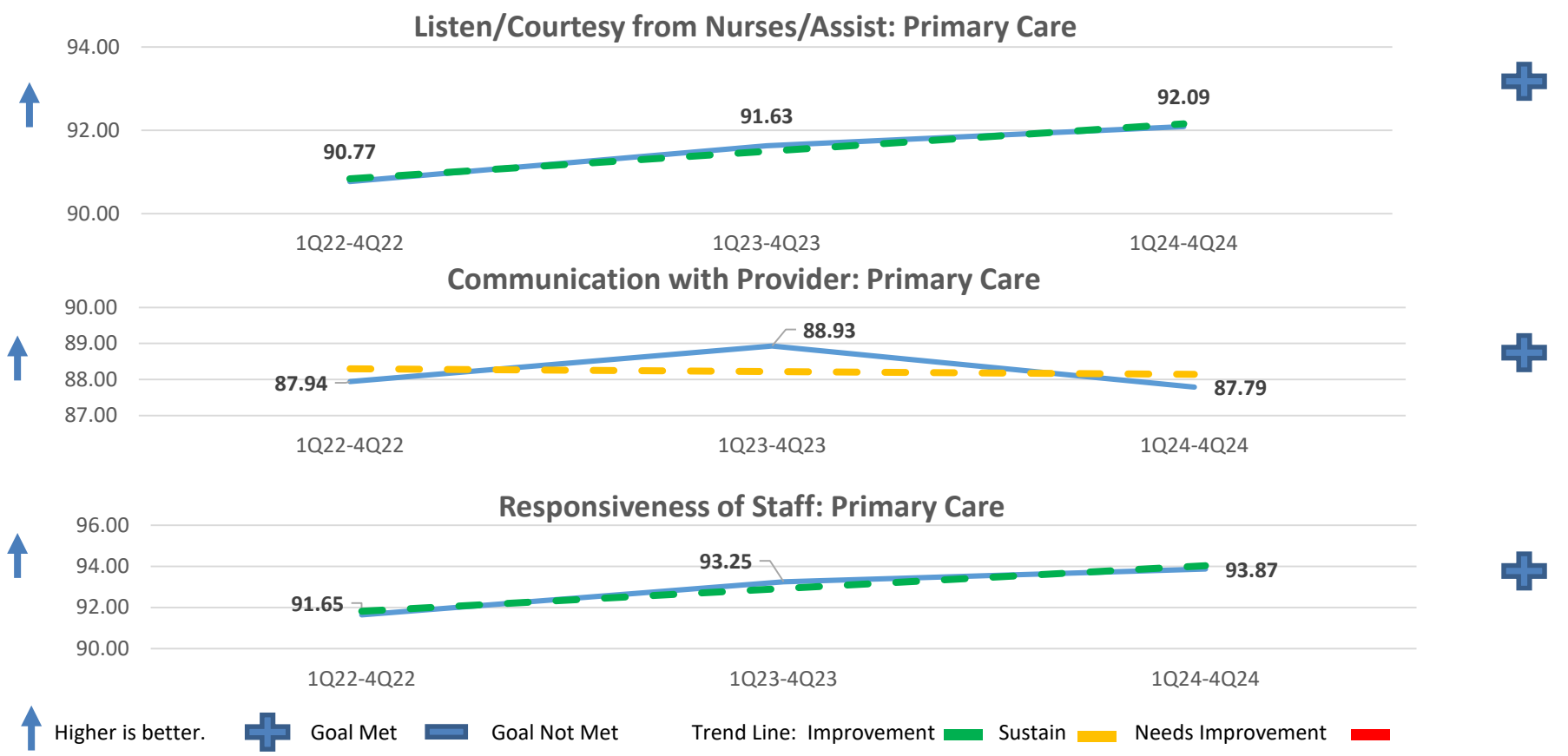


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

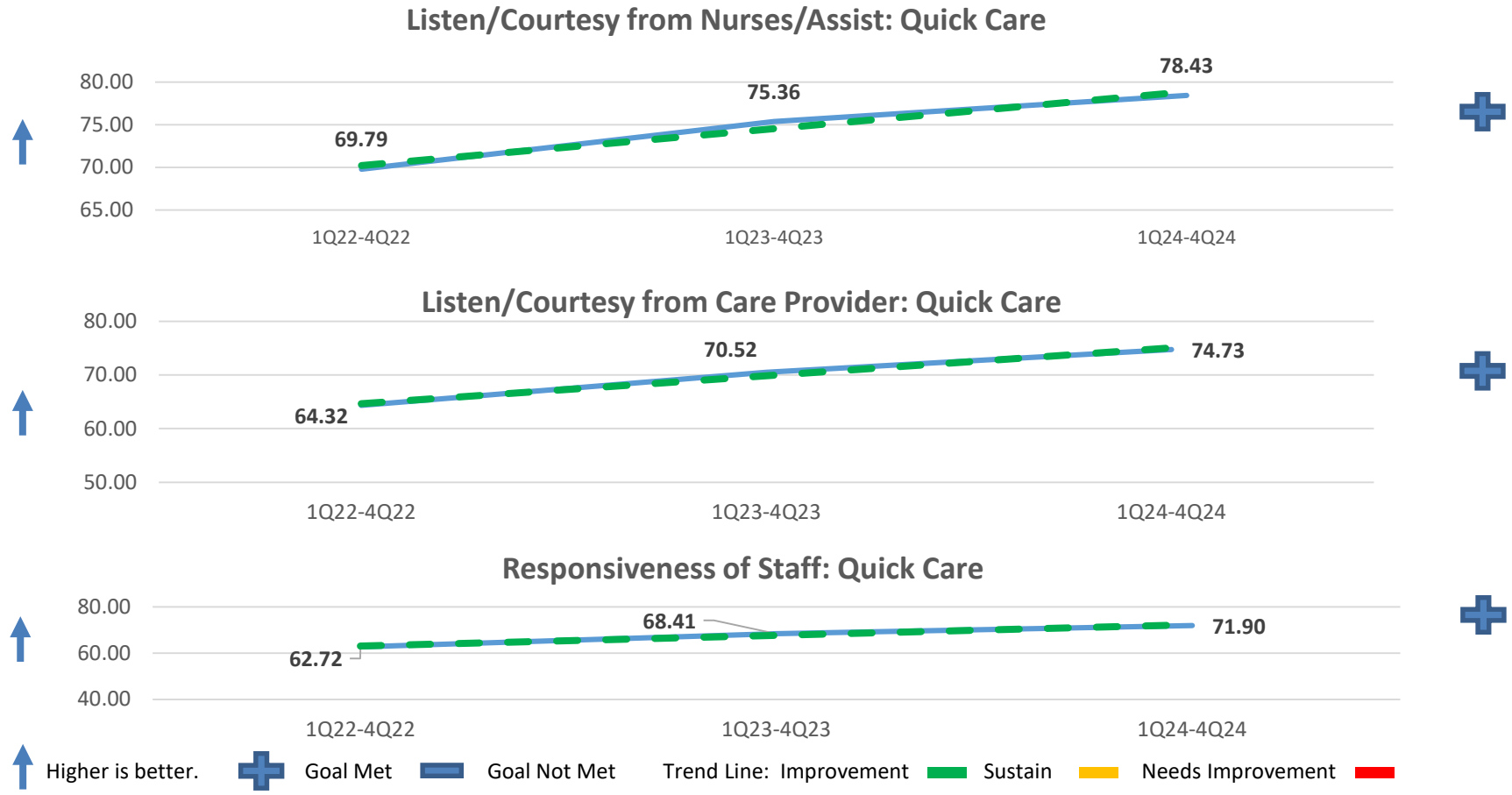


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs.
Press Ganey Top Box by Service Date

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

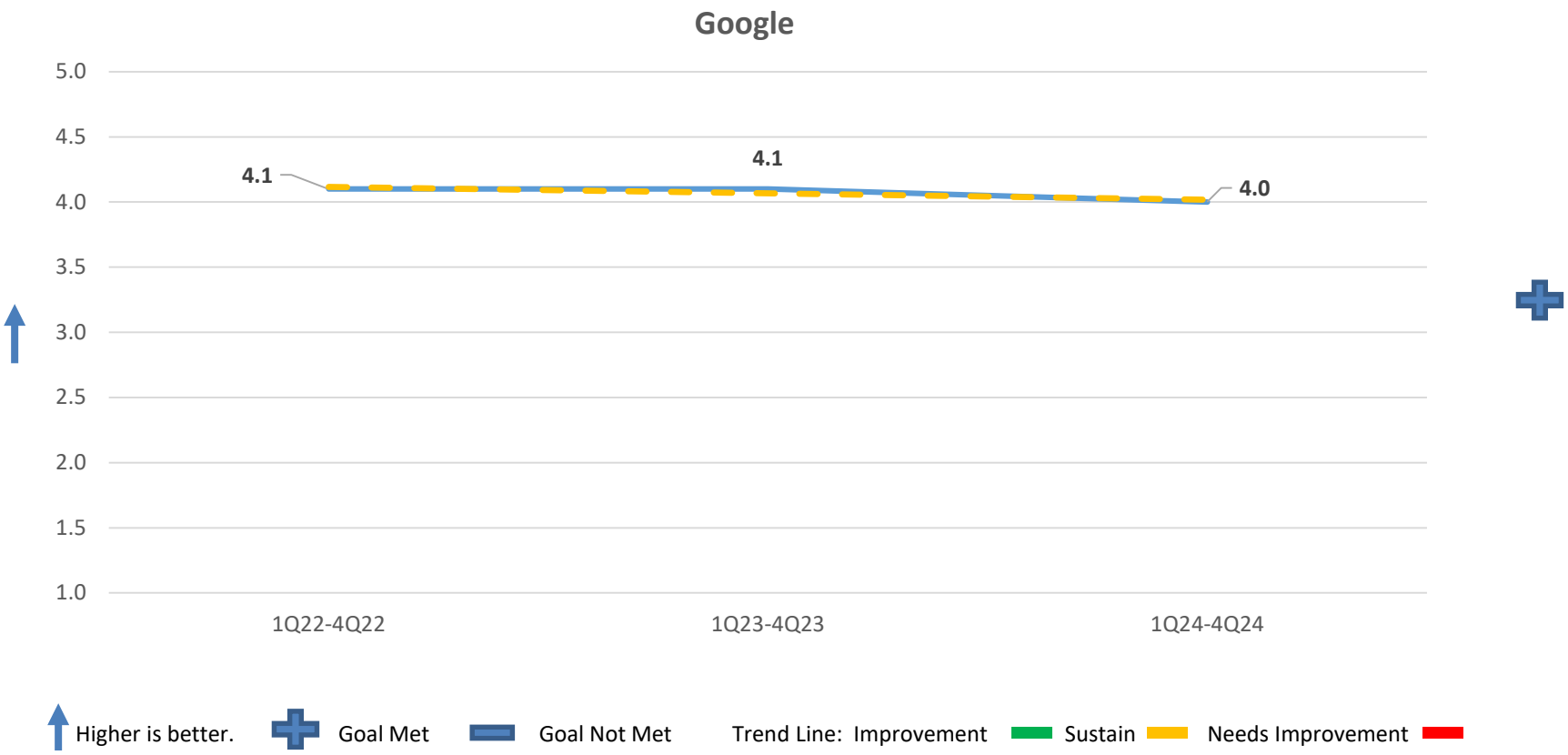


Data Source: HCAHPS Measures by Service Date - Press Ganey; Employee Recognition – Various UMC Recognition Programs. Press Ganey Top Box by Service Date.

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

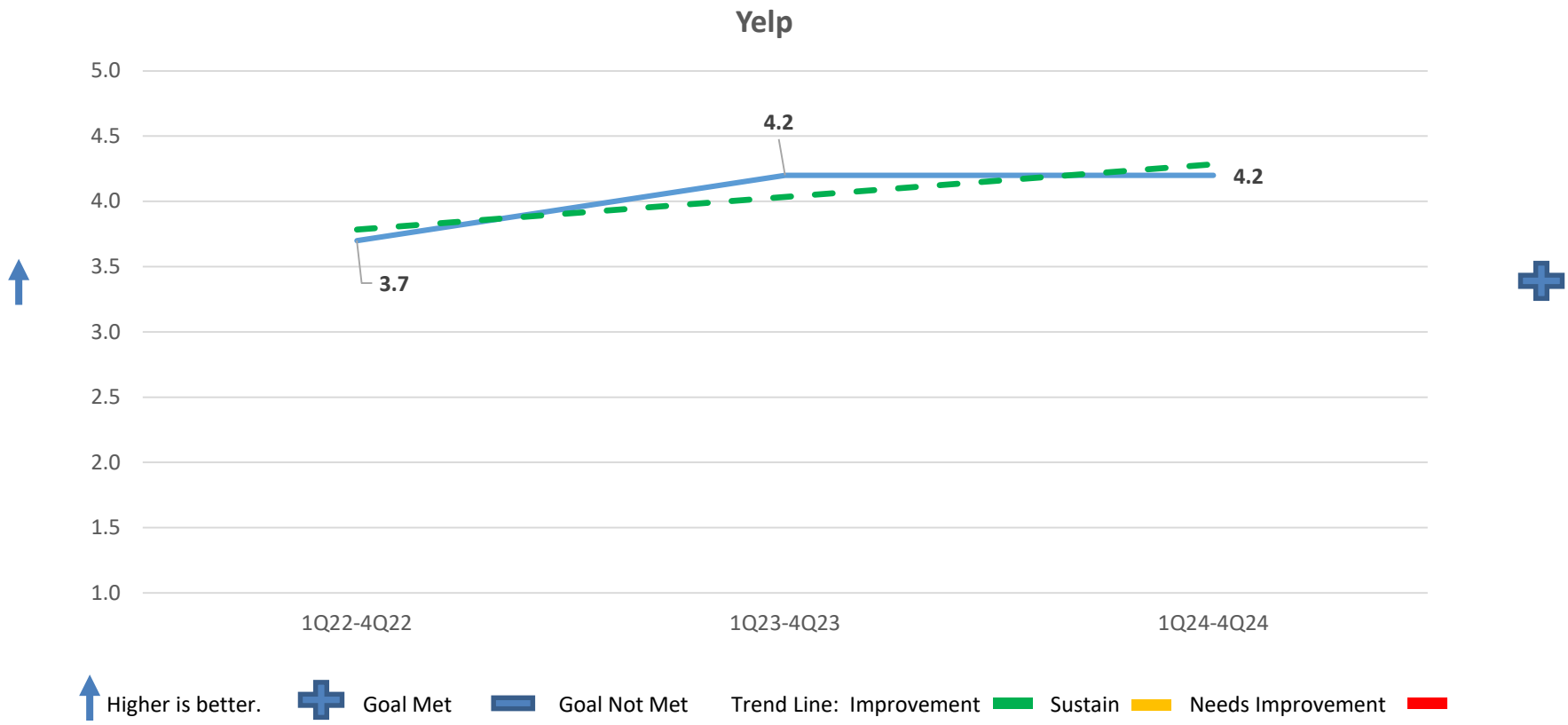


Date Source: UMC Experience Department, Yelp and Google websites. Average Star Score and Total Reviews during time period.
Score Range: 1-5 (5 Being the Highest)

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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



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

Quality Performance Objective

FY25 Clinical Quality & Professional Affairs Committee

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

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

Data provided by Patient Experience

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

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

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee review and recommend for approval by Governing Board, the UMC Policies and Procedures Committee's activities of 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)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 2, 2025

Agenda Item #
7

April 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 41 Approved, 0 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Code Sepsis – Adult Inpatient	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director, Quality, Performance Improvement & Regulatory Compliance.
Zolgensma Infusion	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Pediatric Clinical Manager, Maternal Child Director, ACNO and Peds Department.
Pediatric Anticoagulation Reversal	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Trauma Program Manager, Critical Care Director and ACNO
Interfacility Transfer of Trauma Patients	Revised	Approved as Submitted	Scheduled review. No changes. Vetted by Trauma Manager, Critical Care Director and ACNO.
Dialysis Solution Additives	Revised	Approved as Submitted	Scheduled review, changed to policy. Added in policy statement. Vetted by the Director of Pharmacy.
Controlled Substances: Pharmacy Controlled Substance Automated Dispensing Cabinet (Vault)	Revised	Approved as Submitted	Added receiving section. Added oral liquid controlled substance batching section. Updated returns section to include returns from ADC. Added cumulative volume loss definition and references. Vetted by Director of Pharmacy.
Controlled Substances: Pharmacy Specific Procedures	Revised	Approved as Submitted	Added in destruction process for unusable medications dispensed for patient use, clarified received requirements to ensure accuracy and accountability. Vetted b Director of Pharmacy.
Medical Equipment Emergency Response	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Clinical Engineering.
Cardiac Exercise Stress Test Inpatient and Outpatient	Revised	Approved as Submitted	Removed medication for emergency. Will follow MERT policy. Vetted by Cath Lab Clinical Manager and ACNO.
Cleaning, Disinfection, and Sterilization	Revised	Approved as Submitted	Updated HLD list. Vetted by Director of Infection Prevention.
Minimum Necessary	Revised	Approved as Submitted	Performed minor reformatting throughout the document. No content change was made. Vetted by Privacy Officer.
Limited Data Sets & Data Use Agreements	Revised	Approved as Submitted	Add a Standards section and Moved items from previous Procedure Section into the Standards section. Clarified allowable uses and disclosures

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			of a Limited set. Moved direction for execution of data use agreements to the new procedure section. Moved information concerning research data using a Limited Data Set and Data Use Agreement to the new procedure section. Reference to 45 CFR 164.512(e) was incorrect and correct to 45 CFR 164.514(e). Other minor formatting made for look and flow of the policy. Vetted by Privacy Officer.
Corporate Compliance Code of Conduct	Revised	Approved as Submitted	Scheduled review, minimal updates. Vetted by Privacy Officer.
Hypertensive Disorders of Pregnancy (Gestational/Hypertension/Preeclampsia /Eclampsia)	Revised	Approved as Submitted	Updated to reflect current Evidence-based practice. Created all algorithms (A - E). Vetted by Chairman of OBGYN Department, Director – Maternal/Child Division, Pharmacy.
Coding – Continuing Education (CE) Accumulation	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Assistant Director of Coding and CDI, HIM Director and CFO.
Midnight Reconciliation of Census	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by ACNO.
Forensic Personnel Information	Revised	Approved as Submitted	Removed: Public Safety Bullet #1 verbiage "Forensic Personnel UMC ID card." Removed: Law Enforcement verbiage bullet #2 regarding signing out UMC Forensic ID badge and returning badge. Added verbiage: Public Safety Bullet #9 9. For conditions of a single Law Enforcement officer supervising a high-risk prisoner/patient who needs to undergo diagnostic procedures such as x-rays or CT-Scans, staff should contact UMC Public Safety to assist with the escort. Added verbiage clarifying law enforcement restraints vs hospital restraints. Added verbiage for bullet 3 under "Important Information" Officers to remain alert. Deleted emergency code card photo. Vetted by Public Safety, EOC Committee and Quality.
Security Management Plan	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by EOC Committee.
Medical Student Resident and/or Fellow Supervision	Revised	Approved with Revisions	Revised policy to include Dental Anesthesia residents and CODA requirements. Clarifies resident supervision and consultation requirements consistent with the Medical and Dental Staff Bylaws. Requires graduated levels of responsibilities be updated every 6 months as

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
			required by affiliation agreements. Progress notes must be co-signed within 24 hours. Clarifies medical student documentation in the medical record. Vetted by Academic and External Affairs Administrator.
Hazard Communication Program	Revised	Approved as Submitted	Reviewed and updated content and added Appendix A. Vetted by Safety Program Manager.
Transition of Patients	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Case Management Director and CFO.
Utility Systems Plan	Revised	Approved as Submitted	Minor changes to reflect DNV standards and new goals/performance measures. Vetted by Director of Facilities.
Warming Blankets, Intravenous and Irrigation Fluids	Revised	Approved as Submitted	Pg. 2 Changed "Baxter" to "IFU". Pg. 4 Changed Baxter reference date from "2024" to "2025". Vetted by Director of Perioperative Services.
Radiation Safety Program	Revised	Approved as Submitted	Previously retired policy. Vetted by Director of Imaging Services.
Recruitment and Selection Program	Revised	Approved as Submitted	Revised Section K (2)(3) to provide clarity for initial and renewal certification/license and primary source verification. Vetted by Chief Human Resources Officer.
Position Classification and Compensation Plans	New	Approved as Submitted	Modified Section D & E to provide clarity related to overtime. Vetted by Human Resources Officer.
Respiratory – High Frequency Oscillatory Ventilation (HFOV)	Revised	Approved as Submitted	Changed from policy to practice guideline. No substantive changes to content. Cleaned up for verbiage and flow or content. Vetted by Director of Respiratory Services.
Respiratory – Humidifiers and Aerosol Nebulizers	Revised	Approved as Submitted	Reviewed. Changed to guideline from policy. No substantive changes to content. Cleaned up for verbiage and flow of content. Vetted by Director of Respiratory Services.
Initiation and Management of Mechanical Ventilation	New	Approved as Submitted	Reviewed. Modified verbiage and content to remove reference to a specific vendor or manufacturer. Removed reference to patients' weight and size, as it was specific to a particular ventilator circuit.
Early Closure of Offsite Clinics	Revised	Approved as Submitted	Addition of Guidelines for Closing Clinic Doors due to Imminent danger. Vetted by Ambulatory PAS Director.
Ambulatory Care Transfer from Urgent Care to Urgent Care	Revised	Approved as Submitted	Establish New Policy to maintain standardized process from transfer patients from QC to QC. Review/update registration current practices. Vetted by Ambulatory PAS Director.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Telehealth Video Visit in Primary Care	Revised	Approved as Submitted	Establish New Guideline based on current process stablished as adopting EPIC telehealth in our EHR. Updating/Reviewed Admit/Discharge Representative responsibilities. Vetted by Ambulatory PAS Director.
Extracorporeal Life Support (ECLS) Pump/Power Failure	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by ECLS Coordinator, Critical Care Services Clinical Director and ACNO.
Extracorporeal Life Support (ECLS) Equipment and Disposables	Revised	Approved with Revisions	Added the cardiohelp and the Nautilus SMART oxygenator. Vetted by ECLS Coordinator, Critical Care Services Clinical Director and ACNO.
Hazardous Materials and Waste Management Plan	Revised	Approved as Submitted	Revised to the new DNV standards and new 2025 performance indicator. Vetted by Safety Program Manager.
Safety Management Plan	Revised	Approved as Submitted	Updated to new DNV standards and added 2025 performance indicators. Vetted by Safety Program Manager.
Safety Management Plan Evaluation	New	Approved as Submitted	Minor changes. Reviewed and approved by the EOC Committee.
Medical Equipment Management Plan	New	Approved as Submitted	Updated to new DNV standards with performance indicators. Vetted by Safety Program Manager.
Post Anesthesia Care Unit (PACU) Discharge Criteria	Revised	Approved with Revisions	New protocol. Vetted by PACU Manager and Anesthesia Medical Director.
Risk Assessment for Safety & Security	New	Approved with Revisions	New policy. Updated Trauma Resus to 3 security risk. Vetted by Public Safety Director.
Code White Pathway for ED and Inpatients	Revised	Approved as Submitted	Updated to include hemorrhagic stroke pathway, clarify members of the stroke team, remove verbiage regarding a specific thrombolytic, and clarify stroke symptoms. Vetted by Director of Neurology & Stroke Program Coordinator.

May 7, 2024 Hospital Policy / Procedure Committee
As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.
Total of 66 Approved, 2 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Suicide Risk Screening, Assessment and Management – 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.
Zero Suicide Model – 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.
Behavioral Health Assessment - 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.
Trauma Informed Care - 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.
Neonatal Intensive Care Unit Nursing Standards of Care/Practice Guidelines	Revised	Approved with Revisions	Removed a few sentences because no longer relevant. Updated VS section, updated changing of suction canisters and IV tubing, updated wording. Vetted by NICU Clinical Manager and Pediatric Department.
Opioid Withdrawal in Infants	New	Approved with Revisions	New Guideline placed into template. Algorithm adjusted. Vetted by NICU Clinical Manager and Pediatric Department.
Burn Activation	Revised	Approved as Submitted	Added "Expected response time for Burn Attending is 30 minutes or less" to the PROCEDURE section. Updated REFERENCE. Removed Guideline for Trauma Centers. Added Burn Care Quality American Burn Association. Vetted by Burn Program Manager.
Inpatient Electronic Health Record (EHR) Downtime Process	Revised	Approved as Submitted	Removed references to Desert Radiology. Vetted by EHR Services Director and Information Security Officer.
2025 Emergency Preparedness Management Plan	Revised	Approved as Submitted	Updated plan to reflect 2024 DNV standards and removed Joint Commission standards.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Trauma Response Team – Laboratory Technician	Revised	Approved as Submitted	Updated policy to reflect current practice. Vetted by Trauma Program Manager and Director of Laboratory Services.
Human Immunodeficiency Virus Organ Recipient	Revised	Approved with Revisions	Updated to clarify post-transplant follow-up, NRS 449.101 section with hyperlink. Vetted by Transplant Team, Transplant QAPI Committee & Transplant Medical Director.
Renal Transplant Selection Criteria	Revised	Approved with Revisions	Removed cigarette report per self-report, specified "Morbid Obesity. Reviewed and vetted by Transplant Team, Transplant QAPI Committee & Transplant Medical Director.
ABO Verification	Revised	Approved with Revisions	Removed ABO Verification – Deceased Donor Recovery: TransNet portion - this function is performed by the OPO and not a function of the Transplant Team, removed attachments and updated references UNOS/OPTN 12/2024 & 2 person verification. Vetted by Transplant Team, Transplant QAPI Committee & Transplant Medical Director.
Organ Packaging and Labeling of Living Donor Kidney	Revised	Approved with Revisions	Policy statement added, Compared policy against Organ Procurement and Transplantation Network (OPTN) policy for, Organ & Extra Vessel Packaging, labeling, shipping and storage which was updated 12/11/2024. Reviewed and vetted by Transplant team, Transplant QAPI Committee & Transplant Medical Director.
Living Donor	Revised	Approved with Revisions	Process changes under roles (specified) for social work, caregiver for living donor updated, removed functions no longer performed by transplant coordinator(s), updated hyperlinks. Vetted by Living Donor Coordinator, Transplant Team, Transplant QAPI Committee & Transplant Medical Director.
Pain Assessment	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by ACNO.
Guidelines for In-line One-Way Speaking Valve Application for Tracheostomy on the Ventilator	Revised	Approved as Submitted	Guideline reviewed. Vetted by Respiratory therapy. Minor modifications for clarification. Vetted by Rehabilitation Services Director and ACNO.
Fall Assessment and Prevention	Revised	Approved as Submitted	Added/updated criteria for interventions for moderate risk, severe risk, and additions made to post fall assessment and process for adults/peds. Vetted by Falls Task Force.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Ambulatory Care Human Immunodeficiency Virus (HIV) Screening Guidelines	Revised	Approved as Submitted	Transferred to new template. Removed Express Care and prescreening at kiosk. Vetted by Ambulatory Clinical Director.
Ambulatory Care Social Identifiers of Health Process	New	Approved as Submitted	Establish a new guideline to standardize the process at UMC primary care and urgent care centers for documenting Social Identifiers of Health. Vetted by Ambulatory Care leadership.
Ambulatory Scanning Downtime Procedure	New	Approved as Submitted	Establish a new policy for the Onbase Downtime Procedure. Vetted by Ambulatory PAS Director and Ambulatory Leadership.
Ambulatory Admit/Discharge Supervisors On-Call	Revised	Approved as Submitted	Updated to include communication of on-call supervisors and added additional responsibilities. Vetted by Ambulatory PAS Director.
Video Remote Interpreting Equipment Cleaning (VRI)	Revised	Approved as Submitted	Updated disinfection instructions under 4a. Vetted by Cultural Experience Supervisor and Patient Experience Director.
Patient Identification and Labeling of Specimens	New	Approved as Submitted	Scheduled review, no changes. Vetted by General Lab Services Manager Pathology and Lab Services Director.
Cepheid GeneXpert Xpress SARS-CoV-2/Flu/RSV	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Lab Services Manager Pathology and Lab Services Director.
Histology Samples	Revised	Approved with Revisions	Removed only policy numbers and replaced with policy names. No additional changes. Vetted by General Lab Services Manager Pathology and Lab Services Director.
Kidney Biopsy to Cedars-Sinai Medical Center	Revised	Approved as Submitted	Updated policy to match current lab practice to include clarifying roles. Vetted by General Lab Services Manager Pathology and Lab Services Director.
STAT Tests - Turnaround Times	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Lab Services Manager Pathology and Lab Services Director.
SuperSTAT Procedure	Revised	Approved with Revisions	Scheduled review, no changes. Vetted by Pathology Lab Services Manager and Lab Services Director.
Surveillance Culture Protocol for Specific Pathogens	Revised	Approved as Submitted	Updated policy to reflect current lab practice. Referenced related Infection Control policy. Vetted by General Laboratory Services Manager Pathology and Laboratory Services Director.
Adult Minimum Specimen Requirements	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Laboratory Services Manager Pathology and Laboratory Services Director.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
24-Hour Urine Specimen Collection Instructions	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Laboratory Services Manager and Laboratory Services Director.
Blood Culture Collection	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Laboratory Services Manager and Laboratory Services Director.
hCG Cassette Rapid Test	Revised	Approved with Revisions	Scheduled review, no changes. Vetted by General Lab Services Manager and Lab Services Director.
Insti HIV-1/HIV-2 Antibody Test Kit	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Lab Services Manager and Lab Services Director.
Alere Determine HIV-1/2 Ag/Ab Combo Laboratory Procedure	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Lab Services Manager and Laboratory Services Director.
On Call Physician	Revised	Approved as Submitted	#15 Added 'outpatient" to make it clearer. Vetted by Director of Medical Staff and Executive Director of Medical Staff and Managed Care.
Emergency Release of Blood and Blood Products	New	Approved as Submitted	New policy. Vetted by Transfusion Services Supervisor.
Blood Transfusion Guidelines, Adult	Revised	Approved as Submitted	LTOWB eligibility has been added for Rh+ female patients aged 18 to 49. Item #5 under dosage for groups A, B, and AB patients has been removed to allow for DAT testing. Vetted by Transfusion Services Supervisor.
Administration of Blood and Blood Products	Revised	Approved as Submitted	The following statement has been added to the first page of the policy section: "Nursing staff must verify and confirm both donor unit and recipient information before hanging and spiking blood products". Vetted by Clinical Laboratory Supervisor, Blood Bank Manager and Laboratory Services Director.
Blood and Blood Product Transfusion Reaction	Revised	Approved as Submitted	Added a new Pulmonary category to include TRALI, TACO, and TAD according to AABB Standards 7.5.2.2. Vetted by Clinical Laboratory Supervisor, Blood Bank Manager and Laboratory Services Director.
Contingency Plan for Managing Blood Products during Nationwide Blood Shortage	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Blood Bank Manager and Lab Services Director.
Candidates for Receipt of CMV Seronegative Cellular Blood Products	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Blood Bank Manager and Laboratory Services Director.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Medicare Secondary Payer Billing	Revised	Approved as Submitted	Updated to the current template. Reviewed to ensure compliance with current regulations. Vetted by Patient Accounting, Billing Manager, Assistant Director, and Director.
Identity Theft/Red Flag	New	Approved as Submitted	The template was updated to the current version; there were no changes to the process. Vetted by Dion Mendoza, Manager, HIM, Patient Accounting Assistant Director, and Director.
Testing of Fire Safety Equipment and Building Features	Revised	Approved as Submitted	Revised policy to reflect two additional fire safety equipment-testing requirements. Vetted by EC Committee.
Research HIPAA Privacy	Revised	Approved as Submitted	Title changed from Use and Disclosure for Research to Research HIPAA Privacy Policy. Manual changed from Compliance to Privacy. Policy Owner changed from Compliance to Privacy Officer. Scope Changed from Hospital-Wide to Organization-Wide. Removed statement "The UMC Privacy Officer will serve as a member of the UMC IRB." Vetted by Privacy Officer.
Service Animals	Revised	Approved as Submitted	Added NRS 651.075 regarding miniature horses. Vetted by Director of Infection Control, Equal Opportunity Program Manager, and Medical Director of Infectious Disease Services.
Life Safety Management System Plan	Revised	Approved as Submitted	Changed title of management plan to Life Safety from Fire Safety for DNV compliance. Added new 2025 performance metric, DNV standards, and interpretive guidelines for regulatory compliance. Reviewed and approved by the EOC Committee.
ECMO Transport	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Director, ACNO and Pediatric Department.
ECMO Cannula Site Care	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Director, ACNO and Pediatric Department.
ECMO Patient Staff	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Director, ACNO and Pediatric Department.
ECMO General Patient Care	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Director, ACNO and Pediatric Department.
ECMO Electronic Documentation	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by PICU Clinical Manager, Maternal Child Director, ACNO and Pediatric Department.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Imaging Exam Completion and Radiation Protection	Revised	Approved as Submitted	Updated radiation safety – announcing the exposure, wearing lead, wearing a radiation badge, patient identification process. Added correct patient, correct side and correct procedure. Vetted by Director of Imaging Services.
Loss of Utilities Potable Water Supply	Revised	Approved as Submitted	Added contact information for potable water tanker trucks. Vetted by EC committee.
Loss of Utilities Natural Gas	Revised	Approved as Submitted	Added Southwest Gas contact information. Vetted by EC Committee.
Loss of Utilities-HVAC Systems	Revised	Approved as Submitted	Added Jones Sheet-metal/AC contact information. Vetted by EC committee.
Loss of Utilities Electrical Power and Security Systems	Revised	Approved as Submitted	Added contact information for Pilot Thomas. Vetted by EC Committee.
Patient's Personal Medications – Storage and Use	Revised	Approved as Submitted	Added the section on ordering a patient's home medication for use within the hospital. Updated the section on the returning of home medications, requiring patient identification or identification from the patient's representative for the release of home medications. Vetted by Pharmacy Services Supervisor.
Patient Screening for Delayed Stomach Emptying/GLP-1 Use	New	Approved as Submitted	New guideline. Vetted by Anesthesia Medical Director.
PAT Pre-Anesthesia High Risk Patient Screening	Revised	Approved as Submitted	Updated High Risk Anesthesia Consult Algorithm, Criteria. Vetted by Anesthesia Medical Director.
Assault & Abuse Response and Reporting for Adults and Children	Revised	Approved as Submitted	Scheduled review. Updated phone numbers on Attachment A. Vetted by CQPS.
UMCSN Organizational Plan for the Provision of Patient Care	Revised	Approved as Submitted	Updated to current structure. Vetted by all directors and administrators.
Patient Safety Event Reporting (Safety Intelligence)	Revised	Approved as Submitted	Clarified expectations of a comprehensive review of patient safety event reports; expanded timeframe for closures of events to 30 days to allow for investigation, corrective action plan development and closure of safety event report; removed TJC as reference.
Sentinel, Never, and Adverse Events; Serious Reportable Events (SRE)	Revised	Approved as Submitted	Added that the Director of Patient Safety is designated as the hospital Patient Safety Officer; removed the TJC sentinel event definitions; changed harm classification to align with NQF definitions.

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

Issue: **Emerging Issues**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly. (*For possible action)*

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
June 2, 2025

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