Clinical Quality and Professional Affairs Committee

Delta Point Building

Monday, August 3, 2026 2:00PM

Emerald Conference Room 1st Floor

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
August 3, 2026 2:00 p.m.
901 Rancho Lane, Las Vegas, Nevada
Delta Point Building, Emerald Conference Room (1st Floor)

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

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

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

SECTION 1. OPENING CEREMONIES

CALL TO ORDER

1. Public Comment

2. Approval of minutes of the regular meeting of the UMC Clinical Quality and Professional Affairs Committee meeting on June 1, 2026. *(For possible action)*

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

SECTION 2. BUSINESS ITEMS

4. Review, discuss, and score the outcomes of the FY26 Organizational Improvement Goals from Patty Scott, Quality/Safety/Regulatory Officer; and make a recommendation to the Human Resources and Executive Compensation Committee; and direct staff accordingly. *(For possible action)*

5. Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of June 3, 2026 and July 1, 2026 including the

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

6. Review and discuss the proposed FY27 Organizational Improvement Goals from Patty Scott, Quality/Safety/Regulatory Officer; and make a recommendation to the Human Resources and Executive Compensation Committee; and direct staff accordingly. *(For possible action)*

SECTION 3. EMERGING ISSUES

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

COMMENTS BY THE GENERAL PUBLIC

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

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

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

University Medical Center of Southern Nevada
UMC Governing Board Clinical Quality and Professional Affairs
June 1, 2026

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

The University Medical Center Governing Board Clinical Quality and Professional Affairs Committee met at the time and location listed above. The meeting was called to order at the hour of 2:00 p.m. by Chair 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
Dr. Don Mackay
Dr. John Fildes (via Teams)
Bobbette Bond (Ex-Officio) (via Teams)

Absent:
Laura Lopez-Hobbs (Excused)

Also Present:
Mason Van Houweling, Chief Executive Officer
Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Alma Angeles, Clinical Manager, Disease Specific Services
Carley Redmond, Stroke Program Coordinator
James Conway, Assistant General Counsel
Stephanie Ceccarelli, Board Secretary

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

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

Speaker(s): None

ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee meeting on April 20, 2026. *(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 an update on the Comprehensive Stroke Certification Program from Alma Angeles, Clinical Manager, Disease Specific Services; Carley Redmond, Stroke Program Coordinator; and direct staff accordingly. *(For possible action)*

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

DISCUSSION:

An update was provided by Alma Angeles, Clinical Manager, Disease Specific Services, and Carley Redmond, Stroke Program Coordinator on the Comprehensive Stroke Certification Program.

Ms. Redmond began the discussion by highlighting some of the outcomes of the stroke program and its future. Prevention, recognition, process, and protocol assist in shaping outcomes and refining care for patients during a stroke event.

A high prevalence of obesity, diabetes, hypertension, and smoking increases the risk of stroke in the community. The heart disease death rates exceed the national average, and these risk factors are compounded by unemployment and poverty rates. UMC provides community outreach and education to help reduce these occurrences.

UMC has earned certification from DNV for Advanced Chest Pain and the Heart Failure Advanced Certification, recognizing excellence in diagnosis and treatment in these service lines. Magnet designation was achieved in January 2026, highlighting leadership visibility and support, as well as initiatives to drive patient outcomes and quality metrics.

Ms. Redmond discussed collaboration with EMS, including educational events, and engagement with personnel. Staff participates in active drills, enhanced interdisciplinary communication and performance, and other educational projects, which helps improve staff readiness and response to code events.

UMC achieved Comprehensive Stroke Program Certification and the AHA Get With the Guidelines Stroke Gold Plus Award in 2025 and is projected to receive this recognition in 2026 with additional Honor Roll recognitions.

Lastly, Ms. Redmond reviewed future program initiatives and growth opportunities, including the CNA School Program, Diagnostic Radiology Residency Program.

Alma Angeles presented a stroke case study and highlighted the importance of the life-saving actions taken by community members, staff, and family members.

The presentation concluded with a reminder to B.E.F.A.S.T. to respond if someone is experiencing stroke symptoms. The important thing is to take care of

yourself and not ignore symptoms.

B – Balance – Difficulty walking, dizziness, loss of balance or coordination.
E – Eyes – Trouble seeing in one or both eyes.
F – Face – Ask the person to smile, look to see if it's uneven.
A – Arm – Ask the person to raise both arms, check if one arm is weak.
S – Speech – Ask the person to speak, listen for slurring.
T – Time – Call 911 at the first sign of stroke.

The Committee thanked staff for the educational and informative presentation. A discussion ensued regarding turning vs. repositioning to assist patients with functionality, the demographics of those who experience stroke, efforts to provide proper discharge instructions to patients, and efforts to provide education to EMS and the community on recognizing risk factors and increasing stroke awareness.

FINAL ACTION TAKEN:

None

ITEM NO. 5 Receive an update on the Survey and Regulatory Program from Patty Scott, Quality/Safety/Regulatory Officer; and direct staff accordingly. (For possible action).

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

DISCUSSION:

Patty Scott provided a review of the Survey and Regulatory Program.

UMC received a Leapfrog Safety Grade of C for spring 2026. This grade is consistent with prior periods. Ms. Scott noted improvement in 7 areas but also noted that some areas declined slightly. Hospital Compare documents were provided. There were 4 A-grades, 5 B-grades, 3 C-grades, and no D or F scores. She noted that UMC will focus on the actions needed to improve the targeted areas.

Chair Franklin stated that UMC is on the cusp of greatness, that it is not OK to remain just OK, and that a bit of a culture shift is needed to improve the Leapfrog ranking. A discussion continued on how the data is analyzed and reported to CMS to determine whether the scoring is accurate. Hospital Compare statistics were briefly reviewed.

There were 13 sentinel events reported in the 1st quarter. All cases were reported in a timely manner, and root cause analyses were completed with corrective actions. These events are being monitored by the Quality/Safety Committee to ensure sustainability.

There were 34 grievances in total. Ms. Scott noted opportunities to improve care team coordination, communication with patients and families, and service delivery and responsiveness. Overall, the rate was 0.28 per 1000 discharges or encounters. Ms. Scott also noted that more grievances were reported with the assistance of AI, along with an increase in EMTALA complaints.

Lastly, Ms. Scott commented on the Stroke presentation. UMC has transitioned from a Primary Stroke Center to a Comprehensive Stroke Center. She noted that this is a significant undertaking for the organization and a stellar job by the team. She added that the level of engagement by hospital staff during this process has been very impressive. The Committee echoed this sentiment. A brief discussion followed about the type of care, warmth, and attentiveness provided to patients and their families, which can shape perceptions of the care received.

FINAL ACTION TAKEN:

None

ITEM NO. 6 Receive an update on the FY26 Organizational Performance Goals from Patty Scott, Quality/Safety/Regulatory Officer; and take any action deemed appropriate. *(For possible action)*

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

DISCUSSION:

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

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

   - Hand hygiene compliance has demonstrated continued improvement over the last three years, increasing from 66% to 70% (1Q25–4Q25)
   - Ms. Scott noted some of the key actions that have aided in the improvement of hand hygiene.

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

   - This goal is not being met in total. CLABSIs are below national benchmark, but the metric related to ventilators has increased over the three-year period with an index of 2.434. This is an area requiring focused improvement.

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

   - This goal is not met. The overall Orthopedic SSI rate improved in the most recent period, decreasing from 1.14 to 0.973. Ms. Scott stated that this data only includes spinal fusion, laminectomy, hip & knee replacement.

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

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

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

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

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

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

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

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

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

   - Communication with physicians is at 100%, and the Unit of the Week Rounding is at 94%.

The goals will be reviewed and finalized at the next meeting. Ms. Scott would like to consider the goals for FY27 at the next meeting also.

FINAL ACTION TAKEN:

None

ITEM NO. 7 **Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of April 1, 2026 and May 6, 2026, including the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate.** ***(For possible action)***

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

DISCUSSION:

Policy and Procedures activities for April 1, and May 6, 2026 were reviewed.

There were a total of 71 approved 3 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 April 1, 2026 and May 6, 2026 and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

SECTION 3. EMERGING ISSUES

ITEM NO. 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

The Committee would like to review suggested ideas for the FY27 goals.

COMMENTS BY THE GENERAL PUBLIC:

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

SPEAKERS(S): None

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

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

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

Issue: **FY26 Organizational Improvement 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 FY26 Organizational Improvement Goals from Patty Scott, Quality/Safety/Regulatory Officer; 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 and score the FY26 Organizational Goals.

Cleared for Agenda
August 3, 2026

Agenda Item #

4

UNIVERSITY MEDICAL CENTER

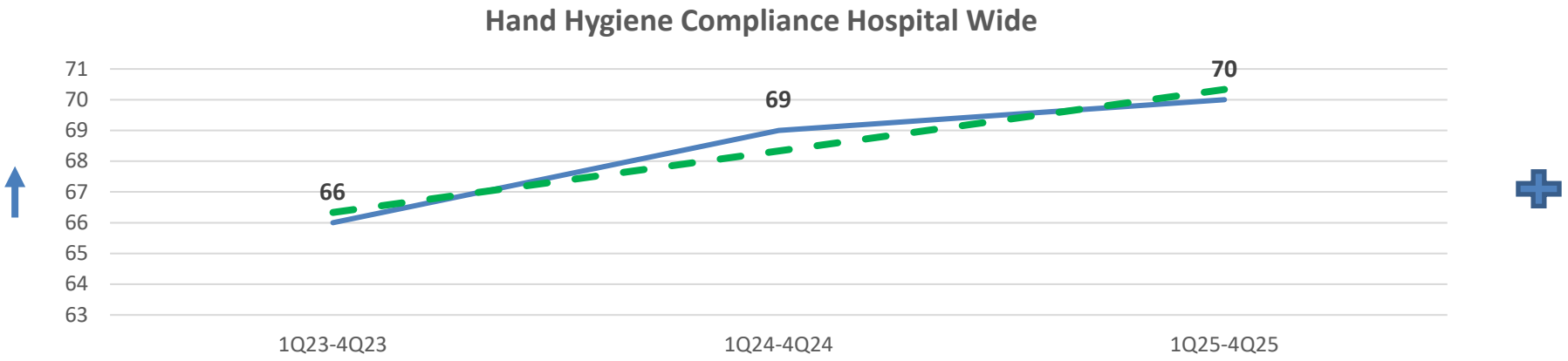
Quality/Safety Performance Objectives FY26

Approved by the Governing Board

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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



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

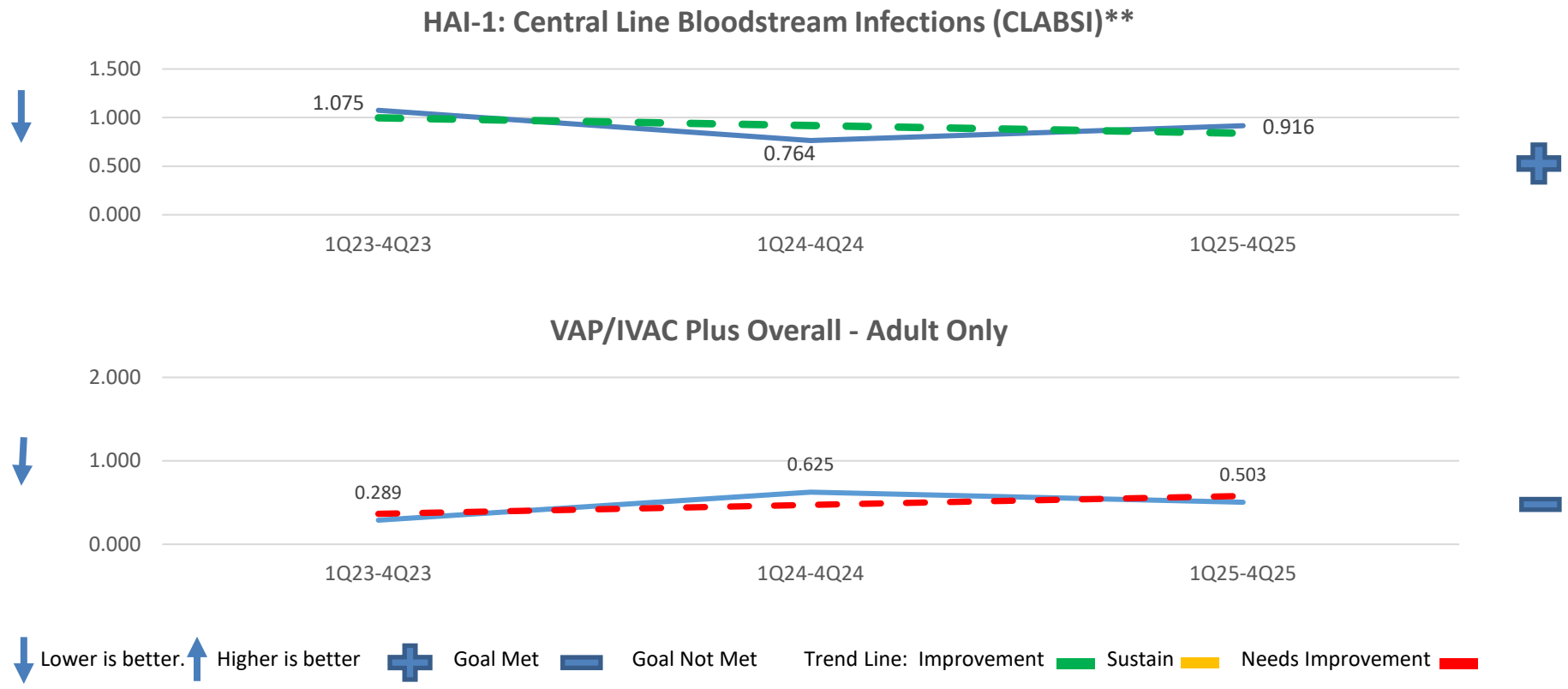
Lower is better. Higher is better Goal Met Goal Not Met Trend Line: Improvement Sustain Needs Improvement

Source: Infection Control Department, Hand Hygiene Observations.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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



Source: UMC Infection Control Department – NHSN

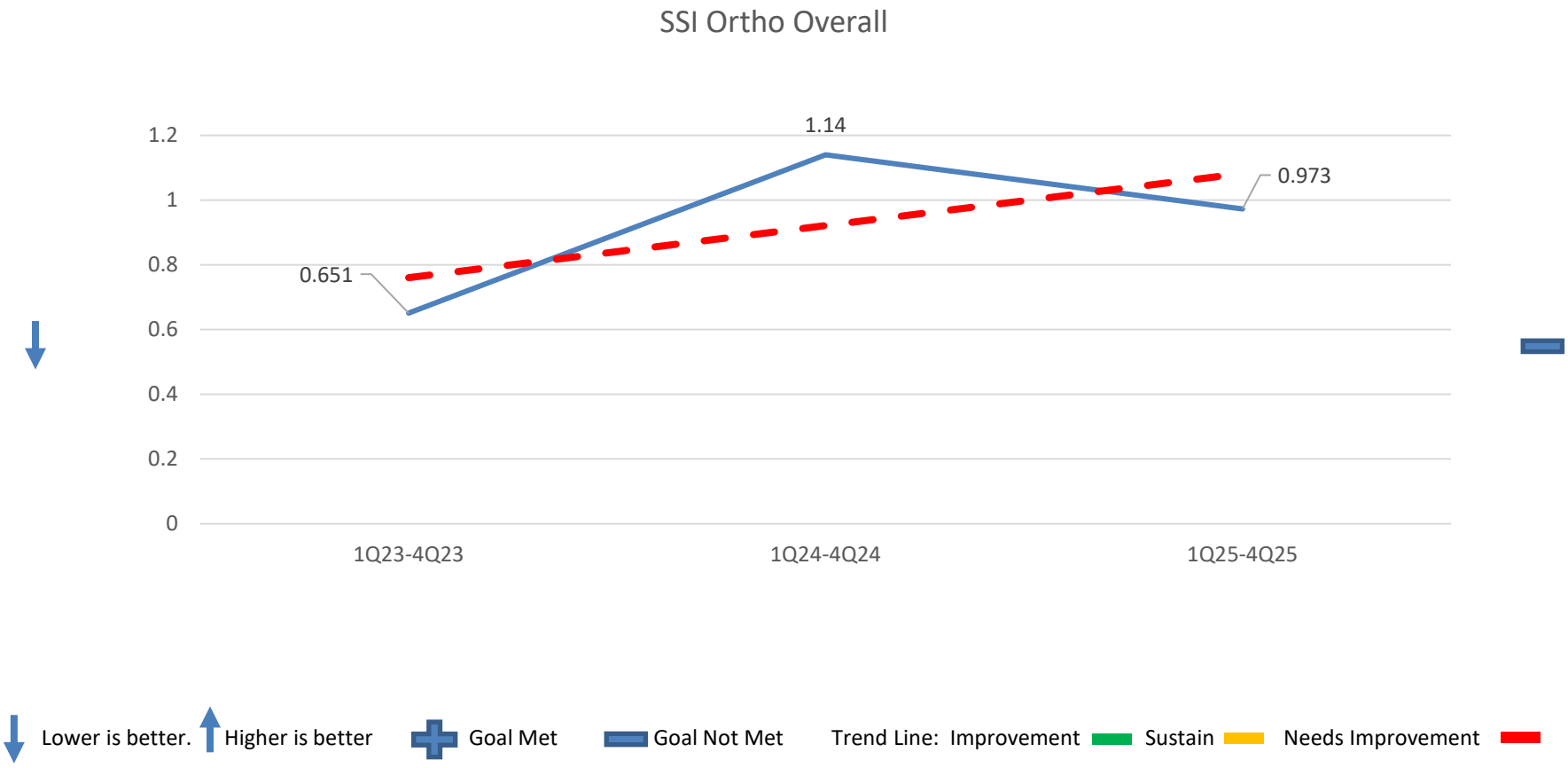
**CMS SIR Rebase for new 2022 Baseline Values, previously utilizing CMS 2015 Baseline Values.

VAP/IVAC Plus calculation: Total Events / Total Vent Days

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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

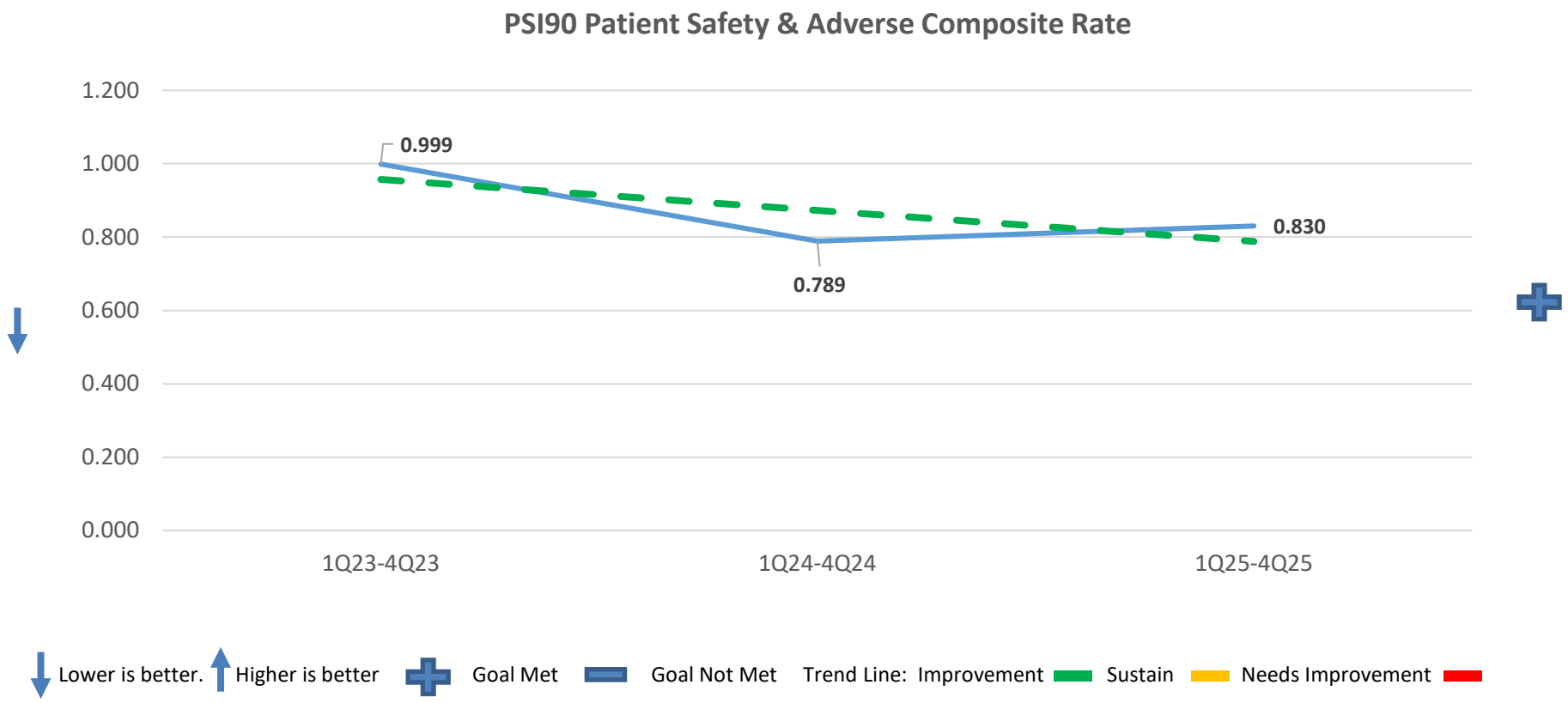


Source: UMC Infection Control Department - NHSN. SSI Ortho - NHSN reporting process, one quarter lag.
SSI Rate, percent of total procedures. Hip, Knee, Spinal Fusion and Laminectomy

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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



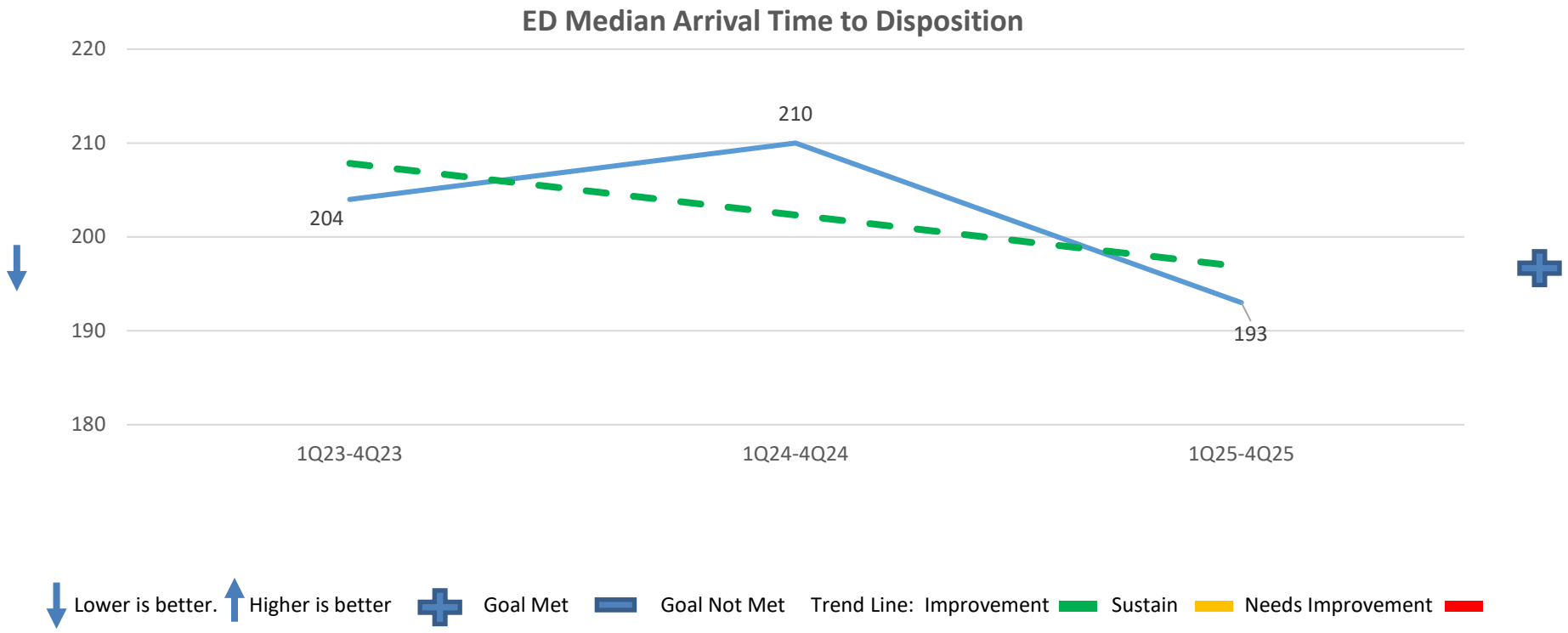
Source: Vizient Clinical Database

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

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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

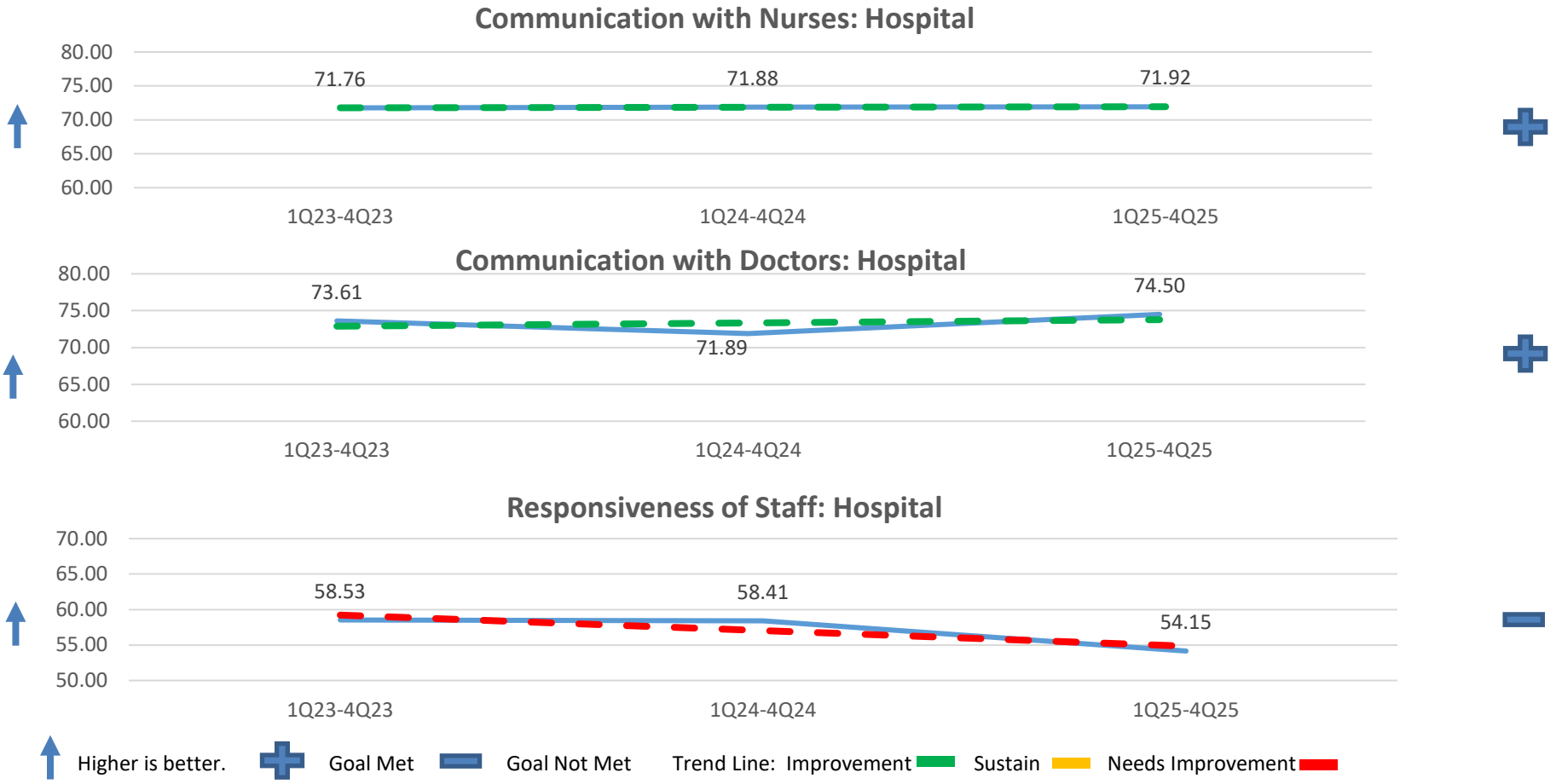


ED Median Arrival to Disposition: Epic Slicer Dicer. The median time (in minutes) from when the patient arrived until ED disposition was recorded. Adult, Peds, Trauma Resus.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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

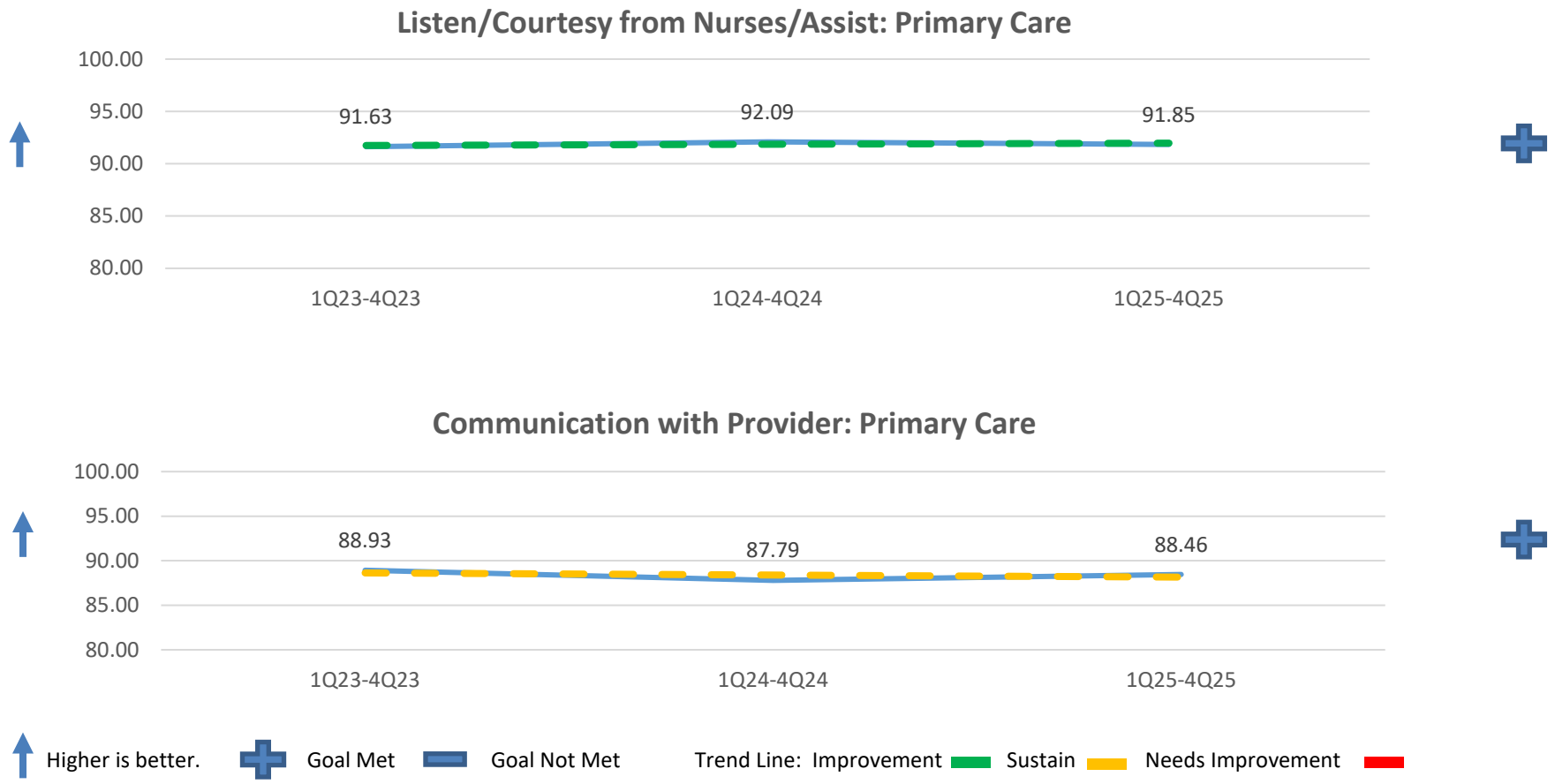


Source: HCAHPS Measures by Service Date - Press Ganey - Top Box by Service Date

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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

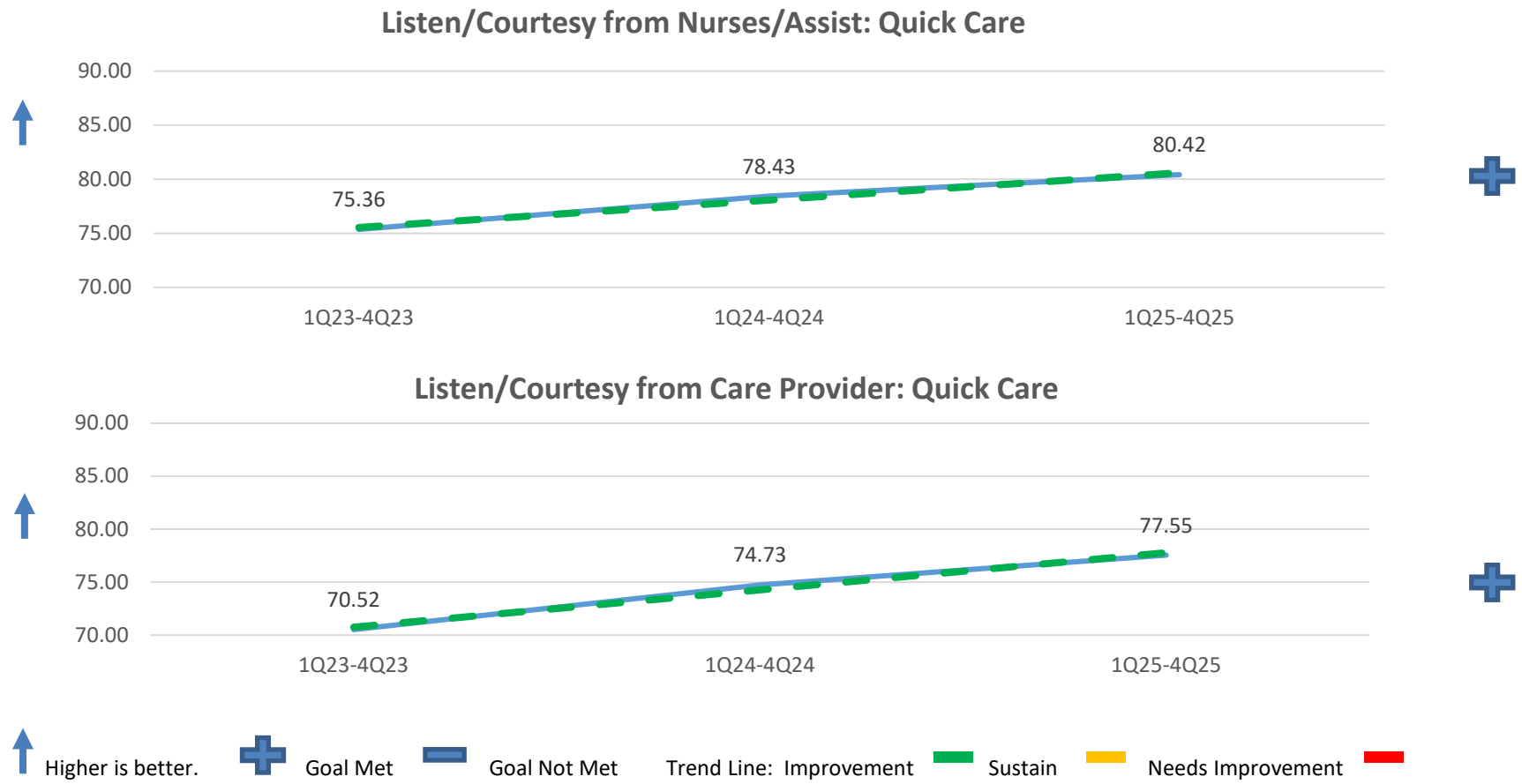


Source: HCAHPS Measures by Service Date - Press Ganey - Top Box by Service Date.

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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



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

Quality Performance Objective

FY26 Clinical Quality & Professional Affairs Committee

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

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

Source: Patient Experience

DISCUSSION / QUESTIONS?

Patricia Scott, MSNA, BSN, RN, RHIA, CPHQ, CCDS, CPHRM, CLSSBB
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UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM

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

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee review and recommend for approval by Governing Board, the UMC Policies and Procedures Committee's activities of June 3, 2026 and July 1, 2026, including, the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. ***(For possible action)***

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
August 3, 2026

Agenda Item #

5

June 3, 2026 Hospital Policy / Procedure Committee
As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.
Total of 32 Approved, 3 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Appropriate Mobile Device and Smart Phone Use	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Executive Director of Information Technology.
Payment Card Handling	Revised	Approved as Submitted	Updated owner to "IT Division Leader". Vetted by Executive Director of Information Technology.
Medication Orders: Range, PRN, Multiple Routes and Medications ordered for the Same Indication	Revised	Approved as Submitted	Reviewed. Minor wording clarifications. Vetted by Director of Pharmacy.
Protocol for Electrolyte Replacement in Adult Patients on Parenteral Nutrition	Revised	Approved as Submitted	Minor wording changes to enhance clarity. No changes to the protocol itself. Vetted by Director of Pharmacy.
Protocol for Thiamine Initiation Prior to the Start of Parenteral Nutrition in Adults at Risk for Refeeding Syndrome	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Pharmacy.
Stress Ulcer Prophylaxis Stewardship	Revised	Approved as Submitted	Minor editorial changes to enhance clarity. Additional exemptions added to the protocol (hypersecretory conditions, drug-induced gastropathy, refractory urticaria, scheduled NSAIDs, therapeutic anticoagulation). Vetted by Director of Pharmacy.
Therapeutic Interchange	Revised	Approved as Submitted	Replaced second-generation antihistamine therapeutic interchange with the current version that interchanges to cetirizine. Vetted by Director of Pharmacy.
Medication Management: Administration and Monitoring	Revised	Approved as Submitted	Clarified administration and documentation surrounding vomiting after medication administration; vetted by Practice Council and Director of Pharmacy.
Patient Choice	New	Approved as Submitted	New Policy. Vetted by Care Management Director.
Medicare Important Message	New	Approved as Submitted	New policy. Vetted by Care Management Director.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Respiratory Lab - Validation Protocol	Revised	Approved as Submitted	Reviewed. No updates required. Adheres to CAP standards. Vetted by Respiratory Lab Supervisor, Director of Cardiopulmonary Services and ACNO.
Respiratory Lab - Corrective Action for Failed Proficiency Testing	Revised	Approved as Submitted	Reviewed by Blood Gas Supervisor and Cardiopulmonary Director. No edits required. Adheres to CAP standards.
Transplant of HIV+ Donors to Recipients Living with HIV	New	Approved as Submitted	New policy in alignment with the Health Resources and Services Administration (HRSA) and the Organ Procurement and Transplantation Network (OPTN) approved policies to allow HIV-positive kidney transplant without requiring special IRB-approved research protocols. While the original 2013 HOPE Act required research, the December 30, 2024 final rule (effective early 2025) allows the Secretary of Health and Human Services (HHS) to lift these research restrictions based on accumulated evidence.
Waiting Time Modification for Kidney Candidates Affected by Race Inclusive eGRF Calculations	New	Approved as Submitted	New Policy: To correct inequity, as race-based formulas inaccurately showed higher kidney function for Black patients, often delaying their waitlist registration. Vetted by Transplant Coordinator, Transplant Director and ACNO.
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 Directors, Physicians and ACNO.
Child Passenger Safety Education/HLI	New	Approved as Submitted	New policy. Vetted by HLI leadership and Danita Cohen.
Staff Meetings and Huddles – Ambulatory Services	Revised	Approved as Submitted	Remove monthly meetings to perform meetings as needed. Add safety huddle agenda contents. Vetted by Ambulatory Services Director and Executive Director PAS & Ambulatory Care.
Telehealth Video Visit in Primary Care	Revised	Approved as Submitted	Reviewed guideline against current practice. Added Utilization of interpreter services, added pending order for electronic blood pressure device to take vital signs for patients without it. Vetted by Ambulatory Services Director.
Critical Tests/Critical Results Reporting	Revised	Approved as Submitted	Updated low glucose critical to <45 mg/dL for all ages. Vetted by General Lab Services Manager and Laboratory Services Director.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Blood Transfusion Adult - Guideline	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Laboratory Supervisor, Blood Bank Manager and Laboratory Director.
Interventional Radiology Suite: Use in the Trauma Center	Revised	Approved as Submitted	Updated to include language referencing process if Trauma IR is in use when need for trauma patient is identified. Clarified 60 minute response time. Added Anesthesia consult and completion of emergent/urgent procedures. Vetted by Trauma Manager, Critical Care Director and ACNO.
CT Scan – Use in the Trauma Center	Revised	Approved as Submitted	Updated to include patients in the pediatric ED and pediatric EM physician. Vetted by Trauma Program Manager, Critical Care Director and ACNO.
Trauma Field Triage Criteria (TFTC)	Revised	Approved as Submitted	Revised in order to be consistent with Southern Nevada Health District Trauma Field Triage Criteria. Vetted by Trauma Manager, Critical Care Director and ACNO.
Neurosurgery Contingency Plan	Revised	Approved as Submitted	Scheduled review. No changes. Vetted by Trauma Manager, Critical Care Director and ACNO.
Trauma Operating Room Staffing	Revised	Approved as Submitted	Scheduled review. No changes. Vetted by Trauma Manager, Critical Care Director and ACNO.
Resident Supervision	New	Approved as Submitted	New policy. Vetted by Academic Affiliation Analyst and Academic and External Affairs Officer.
GME Special Review Protocol	New	Approved as Submitted	New protocol. Vetted by Academic Affairs Analyst and Academic and External Affairs Officer.
Diagnostic Radiology Residency Clinical and Educational Work Hours	New	Approved as Submitted	New policy. Vetted by Academic Affiliation Analyst and Academic and External Affairs Officer.
Diagnostic Radiology Residency Supervision	New	Approved as Submitted	New policy. Vetted by Academic Affiliation Analyst and Academic and External Affairs Officer.
Diagnostic Radiology Residency Resident & Faculty Well-Being	New	Approved as Submitted	New policy. Vetted by Academic Affiliation Analyst and Academic and External Affairs Officer.
Diagnostic Radiology Residency Transition of Care	New	Approved as Submitted	New policy. Vetted by Academic Affiliation Analyst and Academic and External Affairs Officer.
Wound Care Treatment	Revised	Approved with Revisions	Added treatments reviewed and updated. Vetted by WOCN Manager and Dr. Nizamani.

July 1, 2026 Hospital Policy / Procedure Committee
As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.
Total of 32 Approved, 3 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Specimen Acceptability	Revised	Approved as Submitted	Removed tests that are no longer performed, AAT, TEG5, Lactic Acid Body Fluid, Ictotest. Added new testing to all departments. Vetted by Director and Assistant Director Lab Services.
Fern Test	Revised	Approved as Submitted	Clarified result recording, added interfering substances and certification sections. Vetted by Director and Assistant Director Lab Services.
Specimen Collection and Preparation Instructions	Revised	Approved as Submitted	Added downtime form names and numbers to #2. Clarified specimens that cannot be sent through the pneumatic tube system. Vetted by Director and Assistant Director Lab Services.
Glucose Tolerance Testing	Revised	Approved as Submitted	Corrected lab test order codes. Vetted by Director and Assistant Director Lab Services.
Deviation, Nonconformance's and Adverse Events	Revised	Approved with Revisions	Updated Vitalant form names/revisions in the Released Nonconforming Blood and Components section. Vetted by Director and Assistant Director Lab Services.
Histology Specimen Drop-off Instructions for After Hours	Revised	Approved as Submitted	Policy updated to reflect Quest process. Minor changes to normal hours of operations. Vetted by Director and Assistant Director Lab Services.
General Phlebotomy & Blood Collection Process	Revised	Approved as Submitted	Added Myco/F Lytic blood culture bottles for fungal cultures to images and Blood Collection Tube table. Vetted by Director and Assistant Director Lab Services.
Fecal Occult Blood: Hema-Screen Specific Gold Test	Revised	Approved as Submitted	Scheduled Review. No changes. Vetted by Director and Assistant Director Lab Services.
HemoCue Hb 201+	Revised	Approved as Submitted	Scheduled Review. No changes. Vetted by Director and Assistant Director Lab Services.
Nitrazine – Amniotic pH	Revised	Approved as Submitted	Referred to Lippincott Procedures for specimen collection. Vetted by Director and Assistant Director Lab Services.
Capital Expenditures	Revised	Approved as Submitted	Scheduled review – no changes. Vetted by Assistant Controller and CFO.
Accounts Payable (A/P)	New	Approved as Submitted	New policy. Vetted by Controller, Assistant Controller and Finance Manager.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Accounts Receivable (A/R)	New	Approved as Submitted	New policy. Vetted by Controller, Assistant Controller and Finance Manager.
Mobile Rover Device Use for Housekeeping in Healthcare (EPIC Integrated)	New	Approved as Submitted	New procedure. Vetted by EVS Director, Infection Prevention Director and Support Services Executive Director.
Disposable Linen Use & Management in Clinical Settings	New	Approved as Submitted	New procedure for disposable linen in Ambulatory setting. Vetted by EVS Director, Infection Prevention Director and Support Services Executive Director.
Procedure for Storage, Cleaning, and Transport of Beds and Gurneys	New	Approved as Submitted	New policy. Vetted by EVS Director, Infection Control Director and Support Services Executive Director.
Linen Resource Guideline	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by EVS Director, Infection Prevention Director and Executive Director, Support Services.
Mail Management and Handling	New	Approved with Revisions	New policy created to standardize mail handling, strengthen HIPAA compliance, financial controls, courier services, and chain of custody process across UMC. Vetted by Supply Chain Services Director, Compliance, Public Safety and CFO.
Record Retention and Destruction	Revised	Approved as Submitted	Described location on Intranet of Clark County Retention Schedule. Vetted by HIM Manager, HIM Director and CFO.
C-Collar Placement in Altered or Impaired Trauma Patients	New	Approved as Submitted	New policy. Vetted by Trauma Program Manager, Critical Care Director and ACNO.
Emergency Medicine Evaluation of Non-Activated Patients	Revised	Approved as Submitted	Language updated to be consistent with activation criteria, even if the criteria changes. Vetted by Trauma Program Manager, Critical Care Director and ACNO.
Neurosurgeon Response to Trauma Consult	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Trauma Manager, Critical Care Director and ACNO.
Vaccines For Children (VFC) Program and 317 Birth Dose Hepatitis B	Revised	Approved as Submitted	This is a new guideline, replacing the old "Vaccines" policy. The document was updated based on the requirements of the CDC and NSIP for the VFC/317 Birth Dose Hepatitis program. Vetted by Director of Pharmacy.
Pediatric Malignant Hyperthermia Crisis Guide	Revised	Approved as Submitted	Clarified language in the guideline to reflect how dantrolene is ordered in Epic. Vetted by Director of Pharmacy.
Pediatric Subcutaneous Rapid Short-Acting Insulin	Revised	Approved as Submitted	Scheduled review. No changes. Vetted by Pediatric Pharmacists.

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
Food, Drug, and Herbal Interactions	Revised	Approved as Submitted	Removed physician as policy owner since they are not part of the procedure. Vetted by ACNO and Clinical Nutrition Manager. Minor editorial changes to enhance clarity.
Controlled Substance: Non-ADC Storage (Control Box)	Revised	Approved as Submitted	Renamed form to Controlled Substance Perpetual Inventory Form. Vetted by Director of Pharmacy.
Financial Relief Program	Revised	Approved as Submitted	Removed Appendix D, E, F no longer needed. Updated Appendix G to D. Updated FPL from 400% to 300%. Updated Information Request deadline from 15 to 14 days. Updated copay amounts and added additional copay levels for specialty clinic visits. Vetted by Director of Patient Access and CFO.
Spiritual and Emotional Support	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Case Management and CFO.
Pharmacologic Treatment of Cyanide Toxicity Related to Smoke Exposure	New	Approved as Submitted	New guideline. Vetted by Francis Simon, PharmD, Dr. Tillett, Dr. Nizamani, and ED, Pharmacy Leadership, Burn and ACNO.
Face and Neck Burn	Revised	Approved as Submitted	Updated grammatical items to clarify processes. Formatting layout improved. Review and edits by Burn Medical Director, Burn Program Manager, Therapy Team Leads, Critical Care Director and ACNO.
Military Rotating Provider Program for Medical Readiness	New	Approved as Submitted	New policy. Vetted by Executive Director of Medical Staff.

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

Issue: **FY27 Organizational Improvement Goals**	**Back-up:**
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	

Recommendation:

That the Governing Board Clinical Quality and Professional Affairs Committee review and discuss the FY27 Organizational Improvement Goals from Patty Scott, Quality/Safety/Regulatory Officer; 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 UMC Organizational goals for FY27.

Cleared for Agenda
August 3, 2026

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DRAFT UMC FY27 ORGANIZATIONAL PERFORMANCE GOALS
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE OF THE GOVERNING BOARD

1. Improve **Hand Hygiene** compliance during FY27 in the following measure (utilize baseline data from CY2025 with current rate of compliance utilizing SwipeSense at FY27 end):

    - Hand Hygiene Compliance (Overall) (Data Source: Infection Prevention; SwipeSense)

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

    - CLABSI (Data Source: NHSN)
    - Ventilator-Associated Pneumonia (Data Source: NHSN)
    - SSI – Overall (Data Source: NHSN)
    - Hospital-Wide All-Cause Unplanned Readmission (HWR) measure for adult patients discharged from the acute care hospital who are readmitted for any reason within 30 days (Data Source: Vizient)

3. Improve or sustain improvement over the last (1) year trending period (FY26 / FY 27) for the following MIPS/HEDIS measures (Ambulatory – affecting State Directed Payment Program) – (Data Source: EPIC):

    - Increase weight assessment and counseling for nutrition and physical activity for children/adolescents
        - BMI percentile
        - Counseling for nutrition
        - Counseling for physical activity

    - Decrease rate of HbA1c poor control (>9%) for members with Diabetes
    - Increase rate of controlling high blood pressure

Patient Experience:

4. Identify and implement one creative or innovative resource to support and impact **patient experience** by the end of FY27 (Data Source: Patient Experience Department).

5. Create and implement an education and incentive program to increase **Responsiveness** scores year over year on HCAHPS by the end of FY27 (Data Source: Patient Experience Department; Press Ganey Survey).

6. Identify and propose **parking solutions** for implementation to mitigate parking issues and complaints from **patients and visitors** – (FY27) (Data Source: Patient Experience Department; Complaints/Grievances from patients/visitors relative to parking).

7. Share quarterly HCAHPS scores with physicians, along with ongoing training, on how to improve **physicians' communication and responsiveness** (FY26 / FY27) (Data Source: Patient Experience Department; Press Ganey Survey)**.**

8. Increase the **Wellhub membership** rate to 46% by the end of FY27 (utilize FY26 as baseline) to enhance employee well-being, support workforce resilience, and strengthen engagement (Data Source: Patient Experience Department through Wellhub application).

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
August 3, 2026

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