

University Medical Center of Southern Nevada
UMC Governing Board Clinical Quality and Professional Affairs
April 20, 2026

Emerald Conference Room
Delta Point Building, 1st Floor
901 S. Rancho Lane
Las Vegas, Clark County, Nevada
April 20, 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
Laura Lopez-Hobbs
Dr. Don Mackay
Dr. John Fildes

Absent:

Bobbette Bond (Ex-Officio)

Also Present:

Tony Marinello, Chief Operating Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Kathy Johnson, Director of Infection Prevention
Danita Cohen, Chief Experience Officer
Jeff Castillo, Director of Patient Experience
James Conway, Assistant General Counsel
Stephanie Ceccarelli, Board Secretary

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

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

Speaker(s): None

ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee meeting on February 2, 2026. (For possible action)

FINAL ACTION: A motion was made by Member Fildes 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 Annual Infection Prevention Program Evaluation and Plan from Kathy Johnson, Director of Infection Prevention; and direct staff accordingly. (For possible action)

DOCUMENT(S) SUBMITTED:

- PowerPoint Presentation

DISCUSSION:

Ms. Johnson presented the review of FY2025 Infection Prevention evaluation and the plan for FY2026. The purpose of the plan is to provide framework necessary to reduce the possibility of acquiring or transmitting infection that is specific to the organization's services and population.

Successes for 2025 included sustained performance in device-related infections, with CAUTIs and CLABSIs; a reduction in ventilator-associated events, with 13 fewer events than the prior year; and sustained device utilization SIR below 1.0 across all monitored devices. There was improvement or sustainment in LABID events with SIR at or below 1.000, C diff SIR 0.534, and MRSA SIR 1.026

For environmental cleanliness surveillance, blacklight audits increased from 109 to 207, and cleanliness improved to 81%. There was improvement in hand hygiene compliance to 70% and PPE utilization to 87%.

Multiple Infection Prevention performance improvement projects were discussed, including the development and refinement of a Candida auris screening tool, evaluation of hand hygiene monitoring with SwipeSense, and the implementation of in-house UV disinfection. Reduction strategies for CLABSIs, CAUTIs, IVAC, SSI, MRSA/C. diff., hand hygiene, and influenza were reviewed.

Ms. Johnson noted that hand hygiene has improved by 2%, and the SwipeSense monitoring system will be installed by June. A discussion followed on the implementation of SwipeSense and how the system will work.

Chair Franklin asked how to determine the cause of ventilator complications. Ms. Johnson responded that the team reviews each event to determine the root cause analysis of complications. The Committee would like to see a detailed breakdown of the root-cause statistical analysis, and a comparison with similar hospitals.

The 2026 Risks, Priorities, and Interventions were reviewed. Key priorities for the community, patient, environmental, and healthcare worker categories include public health pandemics and highly infectious diseases; emerging threats such as Candida auris; emergency preparedness; Ebola retraining; device-related and surgical site infections; multidrug-resistant organisms, with enhanced surveillance, rapid isolation, and Just-In-Time education; and multidisciplinary performance improvement charters.

There will be continued collaboration with SNHD, CDC, and regional healthcare partners

FINAL ACTION TAKEN:

None

ITEM NO. 5 Receive an update on the Hand Hygiene Campaign from Danita Cohen, Chief Experience Officer; and direct staff accordingly. (For possible action)

DOCUMENT(S) SUBMITTED:

- PowerPoint Presentation

DISCUSSION:

Danita Cohen reviewed the Hand Hygiene Campaign at UMC. The goal of the campaign is to improve hospital-wide hand hygiene compliance and achieve the hand hygiene performance target established by the Governing Board.

A hospital-wide, public-facing campaign was launched, featuring real UMC team members to promote visibility, accountability, and ownership of hand hygiene practices. Campaign materials are customized by unit and department, reinforcing that hand hygiene is a shared responsibility across all clinical and support areas.

The campaign is designed to empower patients and visitors to engage in safety by encouraging them to ask staff about hand hygiene.

Nearly 100 individual posters have been completed to date, reflecting broad participation and engagement across the organization.

The campaign supports broader Infection Prevention strategies and complements ongoing initiatives such as electronic hand hygiene monitoring and increased audit transparency.

Posters are being placed in public-facing areas across inpatient and outpatient units to maximize visibility.

Unit and department leaders identified Hand Hygiene Champions to represent their areas; selected staff participated in celebratory photo sessions for the campaign.

Chair Franklin suggested an opportunity to encourage hospital visitors, which will serve as a reminder to staff about hand hygiene.

FINAL ACTION TAKEN:

None

ITEM NO. 6 Receive an update on HCAHPS/CAHPS/Communication Boards from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. (For possible action)

DOCUMENT(S) SUBMITTED:

- PowerPoint

DISCUSSION:

Jeff Castillo provided an overview of HCAHPS, CCAHPS scores, and new UMC patient communication boards.

Overall Patient Experience Performance

UMC continues to demonstrate positive momentum in patient experience, with 8 of 10 adult HCAHPS measures are trending positively for 2025. The strongest improvements are seen in cleanliness and communication, both key drivers of overall patient satisfaction and safety perception. Adult inpatient performance shows steady quarter-over-quarter improvement across most domains, reinforcing the effectiveness of recent patient experience initiatives.

Responsiveness and quiet at night show opportunities for improvement.

Member Mackay asked whether environmental noise or shared patient rooms create issues with quietness. Mr. Castillo commented on the root causes of patient complaints and the mitigation measures that have been implemented.

Pediatric (Child HCAHPS) Performance

Pediatric HCAHPS results for 2025 show consistent improvement and stability. The majority of measures met or exceeded their prior-year 4th-quarter performance. Several domains are approaching or exceeding national peer group averages.

Strong pediatric communication scores were noted in nurse and physician communication with both children and families, discharge preparation and explanation, and staff efforts to help children feel comfortable and involved in care.

Key Pediatric Experience Interventions

Dedicated Patient Experience Coordinator assigned to pediatric areas
Experience rounding seven days a week
Expanded character visits, special events, and child-focused engagement
Increased availability of toys, activities, and resources
Introduction of gaming systems for pediatric patients
Unit of the Week rounding and enhanced Resident ICARE and customer service training
These targeted interventions are directly contributing to improved pediatric HCAHPS results.

EZ Communication Boards – Patient Safety & Experience Initiative

EZ Communication Boards were implemented to address barriers for:
Non-verbal patients
Stroke patients (short- and long-term)
Trauma patients
Intubated and speech-impaired patients

Prior communication methods were inconsistent, non-standardized, and often unavailable, increasing risk to patient safety and quality of care.

Impact and Benefits of EZ Boards Communications

Supports patient safety, quality of care, and emotional well-being
Reduces communication-related errors and patient anxiety
Improves patient participation in care decisions
Decreases over-reliance on caregivers for basic needs

Program Features

Single-patient use boards that remain with the patient throughout their stay
Available in English and Spanish
Combination of picture-based and word-based communication tools
Appropriate for all ages
Distributed to all ICUs and IMCs

The Committee commended staff on the implementation of the communication boards for non-verbal patients.

FINAL ACTION TAKEN:

- ITEM NO. 7 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:

- None

DISCUSSION:

Patty Scott provided a review of the Survey and Regulatory Program. Fifteen of the seventeen measures are meeting goal.

In January, the State on behalf of CMS surveyed the Adult, Trauma and Pediatric ED on EMTALA with a strong focus on behavioral health patients. Findings were addressed with a plan of correction. The team is expecting a re-survey within six weeks.

In February, DNV returned for the annual survey. There were 7 surveyors for a total of 21 survey days. There were 10 findings. A resurvey was done, and associated finding cleared.

In March, the State and CMS returned for EMTALA survey for 15 days. There were no findings. The State surveyors reviewed 32 complaints. There were two minimal non-clinical findings. The annual Comprehensive Stroke Certification survey is scheduled for May 14th and 15th.

There was continued discussion about the types of behavioral health patient cases that were surveyed. Ms. Scott responded that they come from varied backgrounds.

- ITEM NO. 8 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)

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. The metric related to ventilators has increased over the three-year period with an index of 2.434. The Committee acknowledged this as an area requiring focused improvement, with continued monitoring and prevention strategies in place.

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

- 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 remains in progress, and the Unit of the Week Rounding is at 94%.

The Committee would like staff to focus on and identify ways to improve and correct communication between physicians and patients.

FINAL ACTION TAKEN:

None

- ITEM NO. 9 Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of February 2, 2026 and March 4, 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 February 2, and March 4, 2026 were reviewed.

There were a total of 203 approved 11 were retired. All were approved through the hospital Policy and Procedures Committee, Hospital Quality and Safety Committee and the Medical Executive Committee.

A discussion ensued regarding the review process by the Policy and Procedures Committee.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to approve that the UMC Policies and Procedures Committee's activities of February 2, 2026 and March 4, 2026 and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

SECTION 3. EMERGING ISSUES

- ITEM NO. 10 Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly**

Member Hobbs shared a positive experience from a recent encounter with UMC staff and suggested a review of policy to award and thank staff members for above-and-beyond service. There was a brief discussion regarding the Employee of the Month program.

Mr. Marinello provided an update on Magnet Status and how it is being maintained. Health Links will be onsite in June prepping for data collection in September. An application will be submitted in January and the next survey will be in 2031.

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: June 1, 2026