University Medical Center of Southern Nevada
UMC Governing Board Clinical Quality and Professional Affairs
April 7, 2025

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
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: June 2, 2025