Oak Valley Hospital

Regular Board Packet

April 3, 2025

Board Packet

OUR MISSION

"We Focus on Personalized Quality Health Care and Wellness for Those We Serve"

OUR VISION

"Oak Valley Hospital District Will Continue as an Independent Locally Controlled and Governed Special District Hospital. To Accomplish This We Will Adhere to the Following Guidelines:
Being Fiscally Responsible in Our Decision Making Process
Maintain and Expand Services that Best Reflect Our Needs and Resources Available
Promote Positive Change in the Health Status of Employees and Area Residents."

OUR VALUES

"Accountability; Being Responsible for Actions Taken and Not Taken
Integrity; Doing the Right Thing for the Right Reason
Respect; Valuing All People at All Times"

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REGULAR MEETING OF THE BOARD OF DIRECTORS OF OAK VALLEY HOSPITAL DISTRICT

April 3, 2025, 5:30p.m.,
1425 West H Street, Oakdale, CA 95361
Royal and Charter Oak Conference Rooms

Time	*Action*	*Item*
5:30 p.m.	Action	**MEETING CALLED TO ORDER** Dan Cummins, Chair Person

PUBLIC COMMENT

In compliance with the California Brown Act the District Board of Directors welcomes comments from the public.

This is the opportunity for members of the public to directly address the District Board of Directors on any item of interest to the public under the jurisdiction of the District including items on this agenda.

Persons wishing to make a presentation to the Board of Directors shall observe the following procedure:

1. A written request to the Board on the form provided at the meeting (optional)
2. Oral presentations are limited to three (3) minutes.
3. Members of the public will be afforded the opportunity to speak at the beginning of the public meeting during the general Public Comment section of the agenda on any item under the jurisdiction of the District as well as during the consideration of an individual item on the agenda for that public meeting, however the three-minute limit described in item 2, above, will be applied to an individual's cumulative comments during the meeting.

The proceedings of the Board are recorded and are part of the public record.
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Materials related to an item on this Agenda, submitted to the Oak Valley Hospital District after distribution of the agenda packet, are available for public inspection in the Secretary's Office at 1425 West H Street, Suite 270, Oakdale, CA during normal business hours.

Action **ADMINISTRATION OF OATH OF OFFICE**
– Dan Cummins, Chair Person

- Danielle Sanders

Information/Action **CONSENT CALENDAR ITEMS**
Items 1-3 comprise the consent agenda, unless there is discussion by a member of the audience or Board Members, they may be approved in one motion.

1. **Oakdale Nursing and Rehabilitation Center Report**
   Will Pringle, V.P., Oakdale Nursing and Rehabilitation Center

2. **Approval of Administrative Forms and Policies**
   - Form0693 – Safety Monitoring
   - Form3425 – OVHD HIE Opt-Out Form
   - Ethics Committee
   - Sitter Guidelines

3. **Approval of Minutes** –
   - March 6, 2025– Regular Meeting
   - March 24, 2025 – Special Meeting

Action **MEDICAL STAFF REPORT –** Gretchen Webb-Kummer, M.D., Chief of Staff

The Medical Executive Committee requests the District Board's approval of the following items forwarded from the March 18, 2025 meeting.

A. The Department of Medicine Committee Report – (03/11/2025)
   Lee Horwitz, MD, Chairperson

   i. **FORMS & POLICIES**
   FORMS **Approval**

   - Form 0418 ED-Admission Orders (Retire)
   - Form 3002 Emergency Department Bridge Orders
   - Form1112 Stroke Clinical Pathway
   - Form 3000 Bariatric Post Op Orders
   - Form 3001 Bariatric Pre-Operative Order Instructions

POLICIES **Approval**

Administrative Manual

- Performance Improvement Plan FY 2025

Clinical Manual

- Critical Value/Test Results Read-Back
- Pediatric Admissions

Community Health Centers Manual

- Injections
-

Infection Control Manual

- Hand Hygiene
- Tetanus/Diphtheria/Acellular Pertussis Vaccine Screening and Administration

Nutritional Food Services Manual

- Access to Nutrition and Food Services Department (Retire)
  - Combined with Personnel Permitted in the Department
- Diets
- Diet Cardex (Retire)
- Floor Safety (Retire)
- Food From Outside Sources
- Food Ordering and Receiving
- Food Preparation and Service
- Food Storage
- Food Temperatures
- Meal Service to Residents
- Organization & Staff
- Personnel Management
- Procedures on the Sanitation of Water Pitchers
- Provision of Food or Nutrition Products for Altered Diets and Meal Schedules
- Re-Admission Nutritional Risk Note (Retire)
- Receiving and Storage Safety
- Safety in Food Preparation
- Safety Guidelines
- Safety Rules (Retire)
  - Combined with Safety Guidelines
- Sanitizing Dishwashing Area
- Standards of Care
- Texture Change Documentation (Retire)
- Tray Assembly (Retire)

- Trial Diets

Respiratory Therapy Manual

- Arrival of New Electrical Equipment
- Bi-Level Positive Airway Pressure (BiPAP)
- Blood Spill Procedure (Retire)
- Broken Equipment Procedure (Retire)
- Carboxy HgB Samples (Retire)
- Considerations in Oxygen Therapy for Infants (Retire)
- Continuous Pulse Oximetry (Retire)
- Cough Techniques and Respiratory Exercises (Retire)
- Crash Cart Supply List (Retire)
- Disposable Equipment Change Outs
- Downtime Procedure Record Keeping on the Ventilator Flow Sheet (Retire)
- EKG Interpretation Guideline
- Emergency Oxygen Process
- Evaluating Patient Test Results (Retire)
- General Safety Precautions with Oxygen Administration (Retire)
- General Statement of the Administration of Oxygen
- Nebulizer and Aerosol Therapy
- Handling of Gas Cylinders (Retire)
- Head Hood Oxygen or Free-Flow Oxygen (Retire)
- Humidifiers (Retire)
- Incentive Spirometry
- Indications and Precautions with Continuous Ventilation
- In-Service Education (Retire)
- Intubation

ii. **DEPARTEMNT SCOPE OF SERVICE**

- Medical/Surgical Telemetry Department **Approval**

iii. **Revised/New-Radiology Privilege Set** **Approval**

B. The Department of Surgery Committee Report – (Next Mtg 04/08/2025) **Standing**
Matthew Tilstra, MD, Chairperson

C. The Quality Council Report – (Next Sch Mtg 04/10/2025) **Standing**
Lee Horwitz, MD, Chairperson

FINANCE COMMITTEE – Edward Chock, M.D., Chairperson

- Matt Heyn, President and C.E.O. and Ann Croskrey, CFO

Action 1. Financial Reports for February 2025
Approval of February 2025 Financial Statements

CHAIR PERSON REPORT
- Dan Cummins Chair Person

Information 1. Chair Person Comments

CHIEF EXECUTIVE OFFICER REPORT
- Matt Heyn, President and Chief Executive Officer

Information 1. Chief Executive Officer Report

Information 2. Update on New Electronic Health Record System for Clinics
- David Rodrigues, Chief Operating Officer

Information 3. Overview of PR/Marketing Strategy
- David Rodrigues, Chief Operating Officer

ADJOURN TO CLOSED SESSION

Action 1. **Approval of Closed Session Minutes** –

- March 6, 2025 - Regular Meeting

(See attached Agenda for Closed Session)

RECONVENE TO OPEN SESSION

Information **REPORT OF CLOSED SESSION**

Action **ADJOURNMENT**

The next Regular meeting of the Board of Directors is scheduled on May 1, 2025 at 5:30p.m.

Posted on: March 31, 2025 By: Sheryl Perry, Clerk of the Board

OAK VALLEY HOSPITAL DISTRICT
BOARD OF DIRECTORS
AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

Regular Meeting of the Board of Directors of the Oak Valley Hospital District
April 3, 5:30p.m.,
1425 West H Street, Oakdale, CA 95361
Royal Oak Conference Room

CLOSED SESSION AGENDA ITEMS

HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, or report of quality assurance committee):

- Medical Staff Credentials Report – Gretchen Webb-Kummer M.D., Chief of Staff

- Chief Executive Officer – Matt Heyn, President and Chief Executive Officer

In observance of the Americans with Disabilities Act, please notify us at 209-848-4102 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

April 2025 ONRC Board Report

ONRC is pleased to report our 16th[th] consecutive month of operations with a patient census above budget. This February we closed with an Average Daily Census of 92. Our custodial census remains stable and averaged 81 patients per day. Both our average daily census along and custodial census remain in line with our performance, last year. Finally, the census in our Transitional Care Unit or 300 Wing has remained strong where we averaged 94% occupancy.

We are thrilled to announce the successful completion of our annual relicensing and recertification survey by CMS and the California Department of Public Health. The survey team consisted of 4 Health Facilities Evaluator Nurses, who spent roughly 225 labor hours surveying ONRC. They thoroughly reviewed a large sample of patients and requested nearly 1,500 pages of materials in the process. Interestingly, in 2024 the average California skilled nursing facility received 16 deficiencies. I am proud to announce that we completed our survey with only 11 deficiencies. Simply put, ONRC performed 37% better than our California skilled nursing facility peers.

Regarding staffing, we remain without the MDS nursing position. That said, we have an interview with a local candidate set for the first week of April.

Regarding the physical plant, Engineering is continuing to assess vendors for the replacement of the main fire panel within ONRC.

This concludes our April ONRC Board Report.
William Pringle II

REGULAR MEETING OF THE BOARD OF DIRECTORS
OF OAK VALLEY HOSPITAL DISTRICT
OPEN SESSION
March 6, 2025 5:30p.m.
1425 West H Street, Oakdale, CA 95361
Royal Oak Conference Room

Board	**Staff**
Dan Cummins, Chair Person	Matt Heyn, President and C.E.O.
Frances Krieger, Vice Chair Person	Gretchen Webb-Kummer, M.D., Chief of Staff
Edward Chock, M.D., Secretary	David Rodrigues, V.P., C.O.O.
Sara Shipman, Director	David Neal, V.P., Nursing Services
	Will Pringle, V.P., Oakdale Nursing & Rehab.
	Excused: Ann Croskrey, CFO

CALLED TO ORDER
The District Board of Directors Meeting was called to order by Dan Cummins, Board Chair Person at 5:32 p.m.

PUBLIC COMMENT
Public comment read. Public in attendance.

Nancy Podolsky expressed her enthusiasm about the hospital's recent additions of orthopedic and bariatric surgery services. She noted that it feels like the hospital is "coming back to life" with much-needed services for the community.

CONSENT CALENDAR
The following items, 1-2, will be acted on by one action, with discussion, unless a director or other person requests that an item be considered separately. In the event of such a request, the item will be addressed, considered, and acted upon separately.

1. **Oakdale Nursing and Rehabilitation Center Report**
   Will Pringle, V.P., Oakdale Nursing and Rehabilitation Center

2. **Approval of Administrative Forms and Policies**
   - Disaster Welfare Inquiry

3. **Approval of Minutes**
   - February 6, 2025 – Regular Meeting

Edward Chock, M.D., made the motion to approve the Consent Calendar Items. Sara Shipman made the second. No public input.
Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

MEDICAL STAFF REPORT – Gretchen Webb-Kummer, M.D., Chief of Staff

The Medical Executive Committee requests the District Board's approval of the following items forwarded from the February 18, 2025 meeting.

Forms/Policies

A. FORMS & POLICIES

Administrative Manual

- Patient Safety Plan Anesthesia Services
- Anesthesia Rules and Regulations Employee Health Manual
- Employee Communicable Disease Work Restrictions

Edward Chock, M.D., made the motion to approve the Medical Staff Report. Frances Krieger made the second. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye

MOTION CARRIED

Financial Report for January 2025

Highlights from the Finance Committee report noted strong financial performance for January. Gross revenue was strong across the organization. Inpatient revenue met budget for the first time, despite the ICU remaining closed, and outpatient revenue exceeded budget by 11%.

The hospital closed the month with an operational profit of approximately $1.1 million. After accounting for new hospital expenses, the net profit was $708,000. Year-to-date EBITDA stood at 17%, a strong indicator of cash flow, particularly notable for a rural, independent community hospital.

Days cash on hand increased from 58 to 92, boosted by additional IGT funds. Gross accounts receivable days rose slightly from 64 to 65. The hospital continues to see growth in outpatient services and has been actively engaging with local primary care practices to support this trend.

Sara Shipman made the motion to approve the Financial Report for January 2025. Fran Krieger made the second. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye

MOTION CARRIED

CHAIR PERSON REPORT – Dan Cummins, Chair Person

It was acknowledged that while the hospital will face a challenging financial year due to upcoming intergovernmental transfer paybacks, increased outpatient revenue and strategic initiatives are expected to help the organization navigate through the difficulty. Leadership remains confident the hospital will weather the storm.

An action item was presented regarding the resignation of Director Shirrelle O. Moore, who has accepted a position as the hospital's Human Resources Manager. Her resignation creates a vacancy on the Board of Directors, which must now be filled.

There are two options for filling the vacancy: (1) calling a costly special election, or (2) having the Board appoint a new member following a public application process. The Board will proceed with the appointment process, which includes posting a public notice in at least three locations and accepting applications for a minimum of 15 days.

A special board meeting has been scheduled for March 24 at 5:30 PM at the regular meeting location, with the sole agenda item being the appointment of a fifth board member. The appointed individual will serve until the next general election, which is scheduled for less than two years from now.

Director Shipman expressed disappointment that the Board must go through this process so early in the term, particularly considering the cost and impact to the hospital.

PUBLIC COMMENT

Danielle Sanders addressed the Board to express her interest in filling the current board vacancy. She noted her recent candidacy and affirmed her continued commitment to both the hospital and the community. Ms. Sanders emphasized the importance of reconnecting the hospital with the community and acknowledged the Board's role in providing oversight rather than managing day-to-day operations. She stated that being attuned to the needs of the community can help bridge existing gaps. Ms. Sanders submitted a formal letter of intent and thanked the Board for their consideration.

Frances Krieger made the motion to accept Shirrelle O. Moore's resignation. Sara Shipman made the second. made the second. No public input.

Cummins - Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

Edward Chock, M.D., made the motion to hold the Special Board meeting to appoint a new Board Member on March 24, 2025 at 5:30pm. Fran Krieger made the second. No public input.

Cummins - Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

Chief Executive Officer Report - Matt Heyn

Emergency and Hospitalist Coverage Transition
The hospital has officially announced a transition to a single provider group—Sound Physicians—for both Emergency Medicine and Hospitalist services. This change is designed to improve patient experience, streamline care delivery, and enhance operational efficiency. The agreement includes performance-based incentives tied to quality, cost, and other key objectives. While not all permanent providers will be in place by the transition date, temporary local coverage will support operations during the onboarding period.

Revenue Cycle Audit
A full revenue cycle audit is underway in partnership with consulting firm Forvis. The audit includes evaluation of billing practices, workflow, charge capture, documentation integrity, denial management, and vendor performance. The final report will be presented to the Finance Committee and Board and will outline findings and improvement plans.

AllCare Insurance Clarification
Clarification was provided regarding AllCare health insurance. Oak Valley does accept AllCare HMO and IPAs, with the exception of the Alignment plan, which restricts certain services to other hospital systems. A public education effort, including flyers and social media outreach, will be launched to ensure community awareness of accepted insurance plans.

Employee Survey Results
Results from the 2025 baseline employee survey were shared. A majority of respondents indicated they enjoy working at OVHD and would recommend it as a place of employment. Fewer respondents expressed confidence in the quality of care offered. Leadership plans to review the feedback in more detail and engage staff further to address concerns.

Cash Flow and Financial Forecast
A conservative cash flow analysis through fiscal year 2026 was presented. While the current fiscal year remains financially stable, projections for the following year indicate a potential decrease in cash on hand due to delayed reimbursements and increased expenses. Leadership emphasized transparency in presenting this outlook and highlighted opportunities for revenue growth and expense management to offset the projected gap.

Orthopedic Program Expansion
The hospital has launched elective orthopedic procedures, building on recent success with emergent cases. A strong partnership with Dr. Scott Calhoun and vendor Smith & Nephew supports this expansion. Additionally, a no-cost robotic-assisted surgery agreement has been signed, with performance benchmarks in place. This program is expected to significantly enhance both patient care and hospital revenue.

Radiology Services Contract Recommendation
Mr. Heyn presented an information/action item regarding the hospital's current radiology services. Ongoing quality concerns with the existing provider, Radiologica—including delays in report turnaround—have impacted patient care and frustrated emergency physicians. Given recent investments in Emergency Medicine, alignment across the continuum of care is essential.

Mr. Heyn recommended terminating the current contract with Radiologica and entering into a new agreement with SOL Radiology. While the new agreement would result in an estimated $90,000 increase in annual costs, it includes one full day per month of interventional radiology procedures. This added service is expected to offset the additional cost over time.

Edward Chock, M.D., made a motion to approve entering into a contract with a new radiology group. Sara Shipman seconded the motion. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

Ultrasound Equipment Purchase
Mr. Heyn reported on a recent meeting with Dr. Matt Tilster of the HERA group, a continued partner in providing prenatal care through the hospital's rural health clinic. Discussions are underway to expand the partnership to include GYN surgical coverage.

To support this effort and improve operational efficiency, the Board was asked to consider the purchase of a new ultrasound machine. The existing hospital unit will be relocated to the clinic, eliminating the need to move a shared unit between locations. A favorable purchase agreement was negotiated, and the cost will not exceed $110,000.

Sara Shipman made a motion to approve the purchase of a new Ultrasound Machine not to exceed $110,000. Fran Krieger seconded the motion. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

Disposal of Obsolete IT Equipment
The Board reviewed a list of obsolete IT equipment recommended for decommissioning, as included in the board packet. Annual disposal of such equipment requires formal Board approval.

Edward Chock, M.D., made the motion to dispose of obsolete IT Equipment. Fran Krieger made the second. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

Approval of United Steel Workers (USW) Negotiated Wage Increases – ONRC
The Board reviewed the negotiated and ratified wage increases for Oakdale Nursing and Rehabilitation Center (ONRC) employees under the United Steel Workers (USW) agreement. The total estimated cost of the increase is $154,026.44, based on a 2024 base wage of $5.5 million.

The adjustment represents an average increase of 2.77% across all ONRC employees. Specific increases include:

- Registered Nurses (RNs): $1.20 per hour
- Certified Nursing Assistants (CNAs): $0.60 per hour
- All other classifications: 2.25% increase

These increases were included in the organization's FY2026 cash flow analysis. The Board was asked to consider approval of the wage adjustments.

Fran Krieger made the motion to approve the ONRC Wage Increase. Sara Shipman made the second. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

Approval of United Steel Workers (USW) and Non-Union Wage Increases – Acute Care and Other Departments
The Board reviewed proposed wage increases for hospital-based employees under the United Steel Workers (USW) agreement, as well as planned raises for non-union and management staff.

For the acute care (hospital) side, the negotiated wage increases will result in an estimated additional annual cost of $608,636.25. Key adjustments include:

- Med/Surg Registered Nurses: $10.00 per hour increase
- Laboratory Personnel: $5.00 per hour increase
- All other covered employees: 2.25% increase or a minimum of $0.65 per hour

In addition to USW-covered staff, wage increases are also planned for other areas of the organization:

- Clinic Staff (non-union): 2.25% across-the-board increase, totaling $113,895
- Non-union and Management (excluding clinics): 2.00% across-the-board increase, totaling $119,709

These adjustments were included in the financial forecast and presented to the Board for review and approval.

Sara Shipman made the motion to approve the USW and Non-Union Wage Increases. Edward Chock, M.D., made the second. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

Approval of NAGE Wage Increases – EMS Personnel
The Board reviewed a proposed wage adjustment for NAGE-represented ambulance personnel (EMS staff). Although the formal vote by the union has not yet occurred, all negotiation points have been agreed upon, and final contract language is under review.

The proposed wage increase includes a 2% across-the-board raise, resulting in an estimated additional annual cost of $48,526 to the organization.

When combined with the previously approved wage increases for ONRC, acute care, clinics, and management staff, the total annual wage expense increase is approximately $1,044,000. With an estimated 32% benefit load (excluding medical insurance), the total projected annual impact to the organization is $1,379,000.

Sara Shipman made the motion to approve the NAGE Wage Increases. Fran Krieger made the second. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye **MOTION CARRIED**

ADJOURNMENT

Edward Chock, M.D., made the motion to adjourn to Closed session. Fran Krieger made the second. No public input.

Krieger – Aye
Chock – Aye
Moore – Aye
Shipman – Aye **MOTION CARRIED**

The Oak Valley Hospital District meeting was adjourned to Closed session at 6:20 p.m.

RECONVENE TO OPEN SESSION
ANNOUNCEMENT OF CLOSED SESSION

Approval of Board Meeting Minutes:

- February 6, 2025 – Regular Meeting *(Approved)*

Reports & Updates:

- Medical Staff Report – Gretchen Webb-Kummer, M.D., Chief of Staff *(Approved)*
- CEO Report – *None*

ADJOURNMENT

Edward Chock, M.D., made the motion to adjourn the Board of Directors meeting. Sara Shipman made the second. No public input.

Cummins – Aye
Krieger – Aye
Chock – Aye
Shipman – Aye

MOTION CARRIED

The Board of Directors meeting was adjourned at 6:37 p.m.

Recorder: Sheryl Perry, Clerk of the Board.

APPROVED: _____ DATE: _____
Edward Chock, M.D., Secretary

SPECIAL MEETING OF THE BOARD OF DIRECTORS
OF OAK VALLEY HOSPITAL DISTRICT
OPEN SESSION
March 24, 2025, 5:30p.m.
1425 West H Street, Oakdale, CA 95361
Royal Oak Conference Room

Board	**Staff**
Dan Cummins, Chair Person	Matt Heyn, President & CEO
Frances Krieger, Vice Chair Person	David Rodrigues, COO
Edward Chock, M.D., Secretary	David Neal, V.P., Nursing Services
Sara Shipman, Director	

CALLED TO ORDER
The District Board of Directors Meeting was called to order by Chair Person, Dan Cummins at 5:32p.m.

PUBLIC COMMENT
Public Comment read. No public input.

Dan Cummins, Chair Person

Appointment of New Board Member

The Board convened for a brief meeting with a single agenda item: the appointment of a new board member to fill the vacancy created by the departure of Shirrelle O. Moore, in accordance with Section 1780 of the California Government Code.

Two letters of interest were received, one from Danielle Sanders and one from Theodore R. Whidby. Danielle Sanders was present at the meeting; Mr. Whidby was not in attendance.

Fran Krieger made the motion to appoint Danielle Sanders to the vacant board seat. Edward Chock, M.D. made the second. No public input.

AYES: Cummins, Krieger, Chock, Shipman
NOES:

MOTION CARRIED

No Closed Session

ADJOURNMENT

Sara Shipman made the motion to adjourn the Special Board of Directors meeting. Edward Chock, M.D. made the second. No public input.

AYES: Cummins, Krieger, Chock, Shipman
NOES:

MOTION CARRIED

The Oak Valley Hospital District meeting was adjourned to closed session at 5:35p.m.

Recorder: Sheryl Perry, Clerk of the Board

APPROVED: _____ DATE: _____
Edward Chock, M.D., Board Secretary

MEMO: **April 3, 2025**
TO: **Members of the District Board**
FROM: **Medical Executive Committee**
RE: **Approval items to be reviewed in open session**

The Medical Executive Committee requests the District Board's approval of the following items forwarded from the March 18, 2025, meeting.

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Lee Horwitz, MD, Chairperson

i. **FORMS & POLICIES**

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POLICIES **Approval**

Administrative Manual

- Performance Improvement Plan FY 2025

Clinical Manual

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- Pediatric Admissions

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- Injections

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- Hand Hygiene
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- In-Service Education (Retire)
- Intubation

ii. **DEPARTEMNT SCOPE OF SERVICE**

- Medical/Surgical Telemetry Department **Approval**

iii. **Revised/New-Radiology Privilege Set** **Approval**

B. The Department of Surgery Committee Report – (Next Mtg 04/08/2025) **Standing**
Matthew Tilstra, MD, Chairperson

C. The Quality Council Report – (Next Sch Mtg 04/10/2025) **Standing**
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TO: **Members of the District Board**
FROM: **Medical Executive Committee**
RE: **Approval items to be reviewed in open session**

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- Safety Guidelines
- Safety Rules (Retire)
  - Combined with Safety Guidelines
- Sanitizing Dishwashing Area
- Standards of Care
- Texture Change Documentation (Retire)
- Tray Assembly (Retire)
- Trial Diets

Respiratory Therapy Manual

- Arrival of New Electrical Equipment
- Bi-Level Positive Airway Pressure (BiPAP)
- Blood Spill Procedure (Retire)
- Broken Equipment Procedure (Retire)
- Carboxy HgB Samples (Retire)
- Considerations in Oxygen Therapy for Infants (Retire)
- Continuous Pulse Oximetry (Retire)
- Cough Techniques and Respiratory Exercises (Retire)
- Crash Cart Supply List (Retire)
- Disposable Equipment Change Outs
- Downtime Procedure Record Keeping on the Ventilator Flow Sheet (Retire)
- EKG Interpretation Guideline
- Emergency Oxygen Process
- Evaluating Patient Test Results (Retire)
- General Safety Precautions with Oxygen Administration (Retire)
- General Statement of the Administration of Oxygen
- Nebulizer and Aerosol Therapy
- Handling of Gas Cylinders (Retire)
- Head Hood Oxygen or Free-Flow Oxygen (Retire)
- Humidifiers (Retire)
- Incentive Spirometry
- Indications and Precautions with Continuous Ventilation
- In-Service Education (Retire)
- Intubation

ii. **DEPARTEMNT SCOPE OF SERVICE** — **Approval**

- Medical/Surgical Telemetry Department

iii. **Revised/New-Radiology Privilege Set** — **Approval**

B. The Department of Surgery Committee Report (Next Mtg 04/08/2025) — **Standing**
Matthew Tilstra, MD, Chairperson

C. The Quality Council Report (Next Sch Mtg 04/10/2025) — **Standing**
Lee Horwitz, MD, Chairperson

Emergency Department Physician's Orders.

Patient Status ❒ Admit to the services of ______________ M.D.
❒ Admit to inpatient. A 2 midnight stay is expected based on diagnosis, signs and symptoms and comorbidities
❒ Observation status. A less than 2 midnight stay is expected based on diagnosis, signs and symptoms and comorbidities.

Location. ❒ ICU ❒ Med/Surg ❒ Tele ❒ Outpatient Services

Code Status: ❒ Full Code ❒ DNR

☑ Call primary physician for further admission orders

Diagnosis: ______________

Allergies: ______________

Date: ________ Time: ________ Physician's Signature ______________

Admitting Physician's Orders:

VITAL SIGNS
❒ Vital signs & pulse ox every 30 minutes x2 hours, then every 2 hours. Rhythm strips and temperature every 4 hours or as condition warrants.
❒ Vital signs & pulse ox every 4 hours, rhythm strips per Telemetry protocol. Call physician for: HR ______, BP ______.
Other ______
❒ Neuro checks every 4 hours

ACTIVITY: ❒ Bed Rest ❒ Use Commode ❒ Stand at Bedside ❒ Ambulate

NURSING:
❒ Intake and Output
❒ Follow Dysrhythmia management (ACLS) protocol for cardiac emergencies
❒ Sequential compression device and knee high Ted hose for all mechanically ventilated patients
❒ Continuous Pulse oximetry
❒ Insert foley catheter. Indication: ______________

DIET:
❒ NPO ❒ Regular ❒ 2 gram sodium low cholesterol, no caffeine
❒ Soft ❒ Fluid restriction of ______
❒ No concentrated sweets(ADA) ❒ Clear liquids ❒ Other ______

LAB/X-RAY/ECG: On admission
❒ Troponin I
❒ Repeat in 6 hours
❒ Repeat in 12 hours
❒ Myoglobin
❒ Repeat in 3 hours
❒ Magnesium (Mg)
❒ Completed blood count (CBC) (Daily 3x)
❒ Comprehensive Metabolic Panel
❒ Total Creatine Phoskinase (CPK)- On ALL elevated troponin
❒ Electrocardiogram on admission (if not already done) and ______
❒ Electrocardiogram stat x 1 for new episode of chest pain
☑ MRSA swabbing upon admission if meets criteria.

MEDICATIONS:
❒ Oxygen ______ L/M via ______ Keep O_2 Saturation greater than ______ R.T. to wean per oximetry every shift
❒ Ventilator Settings ______________
❒ Nitroglycerine 0.4-mg sublingual every 5 minutes x 3, as needed for chest pain
❒ Acetaminophen (Tylenol) 650 mg orally or per rectum every 4 hours as needed for mild pain or for temperature greater than 38° Celsius
❒ Hydrocodone/APAP 5/325mg 2 tabs PO every ______ hours PRN moderate pain
❒ Morphine Sulfate ______ mg IV prn every ______ for severe pain
❒ Anti-anxiety: ______ mg PO/IV *(circle one)* prn anxiety/agitation q ______ hrs
❒ Aspirin ______ mg PO every day; start upon admission
❒ Antiemetic: ______ mg PO/IV *(circle one)* prn nausea/vomiting q ______ hrs
❒ Beta Blocker: ______________
❒ Pantoprazole (Protonix) 40mg IV daily
❒ Enoxaparin (Lovenox) 40 mg subcutaneously daily
❒ Ceftriaxone (Rocephin) 2g IVPB every 24 hours
❒ Azithromycin 500mg PO daily x 1 day, then 250 mg PO daily days 2-5
❒ Levofloxacin (Levaquin) 750mg IV every 24 hours, pharmacy to adjust for abnormal renal function
❒ Zosyn3.375 mg IV every 6 hours.
Patients with MRSA Colonization or Infection, or allergy to all Beta-Lactams
❒ Vancomycin 1g IV now if not given in ED. For subsequent doses pharmacy to adjust for abnormal renal function and Therapeutic drug levels.

❒ R.T. Meds: Albuterol 2.5mg via hand held nebulizer every 4 hours prn wheezing ❒ Peak Flow before and after Bronchodilator
❒ Incentive Spirometer

IV:
❒ Saline Lock Flush with 2 mls 0.9% Sodium Chloride flush every 12 hours and as needed (unless otherwise ordered)
❒ Continuous IV Solution ______ Rate ______
❒ Titrate Nitroglycerin 50 mg/D5W 250ml IV drip for chest pain. Hold for BP less than or equal to ______

❒ These orders will expire in 24 hours unless renewed by admitting Physician

Date: ________ Time: ________ Physician Signature ______________

❒ I have reviewed the above orders and am renewing/re-ordering under my service

Date ________ Time: ________ Physician Signature ______________

Oak Valley Hospital

Emergency Department Bridge Orders:

Admission Diagnosis: .....

Date: .....

Time: .....

Admit to (hospitalist name): Dr. .....

Admission Status (circle one)

Observation:

Inpatient

Admission location

Med-Surg

VITAL SIGNS ❒ Vital signs

❒ A. Neuro Checks Q4 Hours or Q ___ Hours
❒ B. VS and Pulse OX Q4 Hours
❒ C. VS and Pulse Ox Q4 Hours and Rhythm Strips Per Telemetry Protocol

Report Abnormal Vital Signs to Admitting Hospitalist
a. HR less than 60 or greater than 100
b. Respiratory Rate Less than 12 or greater than 20
c. Temperature Less than 36.6C or greater than 37.8C
d. Blood Pressure Systolic less than 100 or greater than 150 and/or diastolic less than 60 or greater than 120

TELEMETRY
A. Yes
B. No

Condition (circle one) FAIR GOOD STABLE OTHER: .....

DIET: (circle one)
❒ NPO
❒ Regular Diet
❒ Clear Liquids
❒OTHER .....

IV Fluids (circle one)
A. Normal Saline at 100 ml/hour x 1 liter, then discontinue
B. D5 ½ normal saline at 100ml/hour x 1 liter then discontinue
C. Saline Lock IV
D. Other: .....

LABS:
AM LABS (One TIME)
A. CBC X1
B. BMPX1
C. .....

MEDICATIONS (check mark) ❒ Oxygen ___ L/M via ___ Keep O_2 Saturation greater than ___ R.T. to wean per oximetry q shift

❒ NG 0.4-mg sl q5 minutes x 3 prn chest pain
❒ Acetaminophen (Tylenol) 650 mg orally or per rectum every 4 hours as needed for mild pain or for temperature greater than 38° Celsius
❒ Tylenol 650mg po or per rectum q4 hours prn pain 1-3 or fever greater than 100F
❒ Hydrocodone/APAP 5/325 mg 1 tab po q 4 hrs prn mild (1-3) pain
❒ Hydrocodone/APAP 5/325 mg 2 tabs po q 4 hrs prn moderate (4-6) Pain
❒ Morphine Sulfate 4mg IV q 6 hours prn severe pain (7-10) OR Toradol (CHOOSE ONE)
❒ Toradol 15mg iv q 6 hours prn severe pain (7-10)
❒ Duonebs q 6 prn sob/wheezing

ANTI-EMETICS
❒ Zofran 4mg iv q 4 prn n/v
❒ Phenergan 12.5mg IM 6 prn n v unrelieved by Zofran

ANTIBIOTICS
❒ Vancomycin 1gm iv x 1 time dose
❒ Levaquin 750mg iv x 1 time dose
❒ Ceftriaxone 2 GM x 1 time dose
❒ Zosyn 3.375 mg iv x 1 time dose
❒ Other antibiotic ___ x 1 (one time dose)

Call the hospitalist for any additional orders, or for questions on the patient's condition
Bridge orders to be implemented for all admissions starting at midnight and last for 8 hours. All bridge orders to auto expire at 8am

Date: ___ Time: ___ Physician Signature: ___

DATE_____ **STROKE CLINICAL PATHWAY**

ARRIVAL TIME: ____:____ LAST KNOWN WELL: ____:____

TIME STROKE ALERT Called: ____:____

(Arrival time is when the patient presents to the ED, this is when the clock starts!)

0-10 minutes of arrival	***Time***	***N/A or incomplete, please note reason.***
√ CT Scan head w/o contrast • *Do not delay CT for labs, x-ray or ekg. Take BG on the way to CT whenever possible* • *Send straight to CT from EMS if possible*	**Time to CT** **___:___**	N/A Incomplete
√ MD at bedside • *CT ordered if not already done,* ***LKW, NIHSS, order lab work*** *(CBC, APTT, INR, electrolytes, creatinine, troponin)*	**Labs collected** **___:___**	N/A Incomplete
Within 20 minutes of arrival		
√ CT scan completed, RAD send to teleneuro if possible **√ Labs collected (if not already done)** **√ Teleneuro contact, video at bedside**	**CT sent to teleneuro** **___:___** **Teleneuro contact** **___:___**	N/A Incomplete
Within 45 minutes of arrival		
√ CT resulted **√ Labs resulted (specifically INR)** **√ IV tPA decision by teleneuro** **√ Decision- admit or transfer?** **√ tPA order**	**CT resulted** **___:___** **INR resulted** **___:___** **tPA decision** **___:___**	N/A Incomplete
Within 60 minutes of arrival		
√ IV tPA initiated **√ Keep SBP <180 & DBP< 105** **√ Swallow screen prior to anything PO**	**tPA given** **___:___** **Swallow screen** **___:___**	N/A Incomplete

Optional: Comments for Quality Review (use back if needed)	***Patient Sticker*** Please attach to back of form if displayed in public area.

NOT PART OF MEDICAL RECORD (PSWP).

PLEASE RETURN COMPLETED FORM TO QUALITY DEPARTMENT.

If patient is admitted from ED, please send Clinical Pathway form with chart.
At time of discharge (from ED or inpatient), please submit form to Quality Inbox.

P:\Medical Staff\Policy Manuals\Forms\Form1112 Stroke Clinical Pathway.docx

BARIATRIC – POST OPERATIVE ORDERS DRAFT

ALLERGIES: _____

DIAGNOSIS: _____

PROCEDURE: ☐ Laparoscopic / ☐ Open ☐ GBP ☐ Banding ☐ Sleeve Gastrectomy ☐ Duodenal Switch

ADMISSION (Select status & department): ☐ Inpatient ☐ Outpatient ☐ Observation
☐ Med Surg ☐ Telemetry ☐ Apnea monitoring

CODE STATUS: ☐ Full Code ☐ DNR

**Items without a place to check the order will be carried out unless the physician lines through the item.

1. **ASSESSMENTS:**
   - Vital signs per Nursing Assessment policy.
   - Notify physician if HR greater than 120, Temperature greater than 101.5, Respirations greater than 26, SpO_2 consistently less than 92% or systolic BP less than 90. Notify physician also if you notice HR trending upward or BP trending downward.

2. **MONITOR/ INTERVENTIONS:**
   - Strict I & O
     - Measure and record urine output Q 2 Hours first 24Hours post-op.
     - Measure and record J-P drainage if applicable.
   - Weight on admission and weekly.
   - Incentive spirometer Q 1 Hours while awake, Q 4 Hours at night.
   - If the patient is a known diabetic or A-1C greater than 6, follow Low Dose Insulin Sliding Scale.
   - **No NG tube insertion, reinsertion or advancement per R.N. No deep tracheal suctioning per R.N. unless patient is intubated.**

   ☐ Foley: Discontinue in AM or POD #1 only if urine output is greater than 30 ml/hr X 2. Monitor for bladder distention.
   ☐ Straight cath in 8 Hours if unable to void. If unable to void within the following 8 Hours, insert foley catheter.
   ☐ O_2 _____ L/min. Maintain SpO_2 of 92% or higher.
   ☐ Discontinue O_2 on POD #1. Resume O_2 PRN to maintain O_2 sats of 92% or higher.
   ☐ May use own BIPAP / CPAP machine with settings used prior to admission.
   ☐ BIPAP/ CPAP settings _____ FIO2/ O_2 _____
   ☐ Respiratory Treatments _____
   ☐ Sequential Compression Device continuously to bilateral legs. Remove only while ambulating.
   ☐ Evacuate JP drainage bulb Q 6 Hours and PRN if applicable.

3. **DIAGNOSTIC TESTS:**
   ☐ Gastrografin UGI (water-soluble) early AM POD #1.
   - S/P_____. Check for leaks, obstruction or band slippage.
   - Patient to be NPO after midnight.
   - Radiology to call patient care unit with wet read.

   ☐ CBC, CMP in AM POD #1. Also obtain an A1-C if patient is a known diabetic and not done pre-operatively (have results by 0600).

MD Initial: _____

BARIATRIC – POST OPERATIVE ORDERS DRAFT

4. MEDICATIONS:

- IV Therapy:
  - ☐ 0.9% NS 1000 ml infuse at _____ ml/Hour.
  - ☐ 0.9% NS with 20 mEq KCL per liter infuse IV at _____ ml/Hour (0.9% NS without KCL if pre-op serum creatinine greater than 1.5 or serum K+ greater than 5).
  - ☐ Bolus 500 ml 0.9% NS IV if urine output is less than 60 ml in a 2 Hour period (May repeat bolus x5 until urine output greater than 60 ml in a 2 Hour period).
  - ☐ Start POD #1, add 1 vial of Multivitamin to one liter of IV fluid daily x 3 days.
  - ☐ Discontinue IV fluids and saline lock line in afternoon of POD #2 if tolerating po fluids and if patient has taken a minimum of 750 ml/24 Hours orally.

- Antibiotic:
  - ☐ Cefazolin (Ancef) 2 GM IV 8 Hours post-operatively x 1 dose.
  - ☐ Other: _____
  - ☐ Other: _____

- IV Analgesic/Antipyretic: Discontinue POD #1 and start PO analgesics
  - ☐ Refer to specific PCA orders.
    - ❖ No other analgesics while on PCA.
    - ❖ Discontinue PCA order POD #1 and start PO narcotics
  - ☐ AcetaMINOphen 1 gram IV every 6 hours PRN mild pain (Level 1-3) or temperature greater than 38.5 degrees
  - ☐ Ketorolac (Toradol) _____mg IV every 6 Hours PRN moderate pain (Level 4-6) for 5 Days.
    - ❖ Hold Ketorolac if serum creatinine greater than 1.5, if hemoglobin less than 9 or patient is actively bleeding
    - ❖ Usual Ketorolac dose is 15 mg. Do not exceed 120mg in 24-Hour period and discontinue after 5 days).
  - ☐ Morphine 10 mg IV every 3 Hours PRN severe pain (Level 7-10)

    OR
  - ☐ HYDROmorphone 1 mg IV every 3 Hours PRN for severe pain (Level 7–10).

- PO Analgesic / Antipyretic – Beginning POD #1
  - ☐ AcetaMINOphen 325 mg 2 tablets PO every 4 Hours PRN mild pain (Level 1-3) or temperature greater than 38.5 degrees.
  - ☐ Hydrocodone/AcetaMINOhen 5 mg/325 mg 1 tablet PO every 4 Hours PRN for moderate pain (Level 4- 6)
  - ☐ Hydrocodone/AcetaMINOhen 10 mg/325 mg 1 tablet PO every 4 Hours PRN for Severe pain (Level 7-10)

  NOTE: Do not exceed greater than 4 grams acetaminophen in 24 Hour period.

- Reversal Agents
  - ☐ Naloxone 0.4 mg IV for respiratory rate less than 8
  - ☐ Flumazenil 0.2 mg IV for respiratory rate less than 8

MD Initial: _____

BARIATRIC – POST OPERATIVE ORDERS DRAFT

- Antiemetics: Administer in the order listed below if more than one drug is chosen
  - ☐ Ondansetron 4 mg IV push every 6 Hours PRN nausea / vomiting.

    OR
  - ☐ Ondansetron 8 mg IV push every 6 Hours PRN nausea / vomiting.
  - ☐ Prochlorperazine 25 mg suppository PR BID PRN nausea / vomiting.
  - ☐ Promethazine 25 mg suppository PR every 4 Hours PRN nausea / vomiting

    OR
  - ☐ Promethazine 25 mg IM every 4 Hours PRN nausea / vomiting.
  - ☐ Metoclopramide (Reglan) 10 mg IV every 6 Hours PRN nausea / vomiting.

- Anticoagulants (choose one):
  - ☐ Enoxaparin 30 mg subcutaneously once daily. Start 1st dose 12 Hours post op

    OR
  - ☐ Enoxaparin 40 mg subcutaneously once daily. Start 1st dose 12 Hours post op

    OR
  - ☐ Heparin 5000 units subcutaneously every 8 Hours. Start 1st dose 12 Hours post op

- Bedtime Medications May Have beginning POD #1 (choose one):
  - ☐ Temazepam 15 mg PO HS PRN sleep. May repeat in 4 Hours if needed

    OR
  - ☐ Zolpidem 10 mg PO HS PRN sleep.
  - ☐ No sleep meds to be given.

- Other Medications
  - ☐ DiphenhydrAMINE 50 mg IV or PO every 6 Hours PRN itching.
  - ☐ Hydralazine 10 mg IVP PRN SBP greater than 160 or DBP greater than 90

    OR
  - ☐ Labetalol 10 mg IVP PRN SBP greater than 160 or DBP greater than 90
  - ☐ Lorazepam 1 mg PO or IV every 6 Hour PRN anxiety.
  - ☐ Simethicone 80 mg 2 tablets PO every 4 Hours PRN gas.
  - ☐ Other: _____

5. **DIET:**
   - ☐ NPO except for ice chips and meds with sips of water.
   - ☐ Starting post-op day # _____. Encourage Bariatric Clear Liquids (Stage-1). (Unlimited Clear Liquids: Sugar free, caffeine free and non-carbonated).

6. **ACTIVITY:**
   - ☐ Ambulate within 4 Hours of admission to Med Surge with O_2 PRN to maintain O_2 Sats of 92% or higher.
   - ☐ Ambulate at least 4-6 times per day beginning POD #1. If the patient is awake enough and able to stand steadily enough.

MD Initial: _____

BARIATRIC – POST OPERATIVE ORDERS DRAFT

7. **OTHER:**

_____

_____

DAY OF DISCHARGE ORDERS:

1. After the surgeon makes rounds:
   - ☐ Remove all dressings and have the patient shower.
   - ☐ Remove all staples.
   - ☐ Apply a wide skin coating of tincture of Benzoin Spray , then apply full-length ½ inch x 4 inch steri strips over the Benzoin so that the strips do not come in contact with uncoated skin.

2. Teach Patient:
   - ☐ To change dressing using 4x4s and paper 2 inch tape
   - ☐ Activities with are allowable:
     - ❖ May shower. Pat incisions with towel to dry POD #2
     - ❖ Do not continue activities which are uncomfortable.
     - ❖ NO heavy lifting (Do not lift anything heavier than 15 pounds for 4 weeks).

3. Other:

_____

_____

Physician Signature: _____ **Date:** _____ **Time:** _____

AHP Signature: _____ ☐ NP / ☐ PA **Date:** _____ **Time:**

Oak Valley Hospital District

BARIATRIC PRE - OPERATIVE ORDER INSTRUCTIONS

PATIENT NAME: **DOB:** **SEX:** ☐ MALE ☐ FEMALE

ADMISSION (Select status & department): ☐ Inpatient ☐ Outpatient ☐ Observation ☐ Telemetry

SURGEON: **FIRST ASSISTANT:**

SURGERY DATE: **CASE #:** **BMI:** **HT:** **WT:**

ALLERGIES:

PROCEDURE: ☐ Laparoscopic / ☐ Open ☐ GBP ☐ Banding ☐ Sleeve Gastrectomy ☐ Duodenal Switch

☑ **ANESTHESIA SERVICES REQUIRED (I.e., General, MAC, Spinal, Regional Block, other):**

OBTAIN CONSENT FOR SURGICAL PROCEDURE:

PREOP DIAGNOSIS:
- ☑ Morbid Obesity (E66.01)
- ☐ Diabetes Mellitus (E11.69)
- ☐ GERD (K21.9)
- ☐ Other CPT Codes:

STUDIES TO BE COMPLETED:
- ☑ CBC
- ☑ CMP
- ☐ Covid 19 Swab
- ☐ UA
- ☐ HCG (QUAL.) Serum
- ☐ HCG (QUAL.) UA Day of Surgery
- ☐ PT/ PTT/ INR
- ☐ IRON
- ☐ A1C
- ☐ PRE-ALBUMIN
- ☐ TYPE & HOLD
- ☐ OTHER:

OTHER ORDERS:
- ☑ EKG
- ☑ AVI Boots
- ☑ Incentive Spirometry Instructions
- ☑ CHG 4% Solution
- ☐ MRSA Screen
- ☐ Patients on Beta Blockers

Other:

PRE-OP MEDICATIONS:
- ☐ Refusal of blood products
- ☑ Scopolamine patch Topical once
- ☐ Heparin 5000 units SQ once
- ☐ CeFAZolin (Ancef) 3 grams IV once
- ☐ CeFAZolin (Ancef) 2 grams IV once
- ☐ LevoFLOXacin (Levaquin) 500mg IV once
- ☐ Clindamycin 900mg IV once
- ☐ Clindamycin 600mg IV once
- ☐ CefTRIAXone ~~Ceftriaxone~~ 2grams IV once
- ☐ ~~Cefizox 2grams IV once~~
- ☐ CefOXitin~~Cefoxitin~~ 1gm IV once
- ☐ Gentamicin ~~1.7 mg/kg IV once LR~~160mg IV on
- ☐ 1000 ml TKO LR, IV once
- ☐ 1000 ml TKO NS, IV once
- ☐ Icy Green Dye, 2.5 mg IV once

ERAS
(MEDICATIONS TO BE GIVEN IN PRE-OP):
- ☐ Celecoxib (CeleBREX)~~Celebrex,~~ 400mg PO onc
- ☐ AcetaMINOphen~~Tylenol,~~ 1000mg PO once
- ☐ DexAMETHasone(Decadron), 4mg IV once (90 minutes prior to induction of anesthesia)
- ☐ Ondansetron 4mg PO once (may be given IV)
- ☐ Fosaprepitant (Emend) 150mg in 250mL NS Infused over 30 minutes once

OTHER:
- ☐ Tranexamic Acid 1000mg IV (Push on the table)

PATIENT INSTRUCTIONS:

****TAKE THIS ORDER SHEET** and all insurance information including your Medicare or MediCal cards to your pre-admission appointment at the hospital.

PHYSICIAN: **PHYSICIAN SIGNATURE:** _____ **DATE/ TIME:** _____

AHP SIGNATURE: _____ **DATE/ TIME:** _____

FORM 3001 Page 1 of 1	BARIATRIC PRE-ADMISSION ORDER INSTRUCTIONS	PATIENT LABEL HERE

OAK VALLEY HOSPITAL DISTRICT

Administrative Manual

QRM / Medical Staff

Policy/Procedure:		**Annual**
Performance Improvement Plan FY2025		
Also indexed as PI Plan		
Effective Date: 01/2001	*Page 1 of 11*	
Areas Affected: All Divisions and Departments of the Hospital District		
Composed by:		
☐ Reviewed ☒ Revised by: Performance Improvement Manager		

Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Quality & Risk Management	Performance Improvement Manager	10/07/2024	X
PPF	Medical Staff Coord	11/06/2024	X
Quality Council	Medical Staff Coord	02/13/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 12/2021, 7/2023, 10/24 **Reviewed**: 01/2013, 7/2023, 10/24 **Next Review Date**: ~~01/2025~~

PURPOSE

To establish a planned, systematic, and interdisciplinary approach to improving the care and services provided by the Oak Valley Hospital District (OVHD).

AUTHORITY AND RESPONSIBILITY

Board of Directors

The OVHD Board of Directors authorizes the establishment of this performance improvement plan. The Board is ultimately responsible for the quality of care provided by OVHD.

Medical Executive Committee & Quality Council

The Board delegates the development, implementation, and evaluation of this plan to the OVHD Medical Executive Committee (MEC). The MEC is responsible for monitoring, and taking actions to improve the quality of clinical care and service provided by OVHD and the medical staff. The MEC is charged with working in a collaborative fashion with the OVHD Administration in carrying out this responsibility. The Quality Council will be responsible for reporting quality improvement recommendations to the MEC for final approval.

Administration and Management

The Board also delegates the development, implementation, and evaluation of this plan to the OVHD Administration and Management team. Administration and Management are responsible for monitoring and taking actions to improve the operational quality of care and services provided by OVHD and its staff. Administration and Management are charged with working collaboratively with the Medical Staff in carrying out this responsibility.

Medical Staff and OVHD Staff

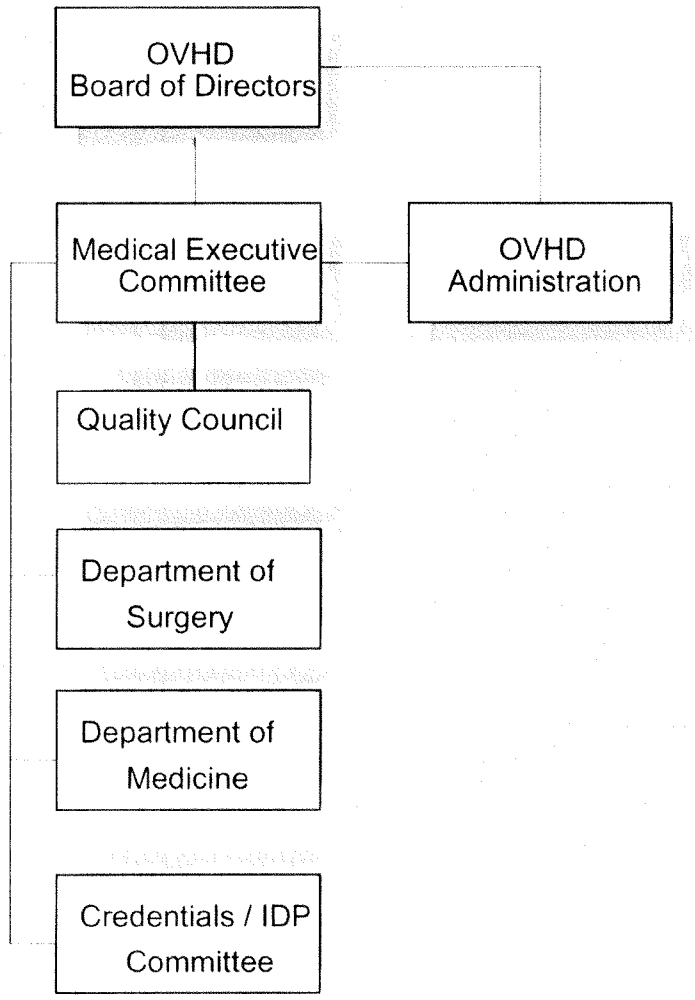
Staff are charged with participating in this performance improvement plan to the degree necessary and appropriate to achieve the plan's purpose.

Further Delegation of Authority and Responsibility

The MEC, Quality Council and/or OVHD Administration may further delegate aspects of this plan as necessary to discharge their responsibilities. As such, either body may delegate to existing committees in their respective organizational structure(s) or may formulate committees/work teams to achieve specific goals.

An organizational chart of the major entities charged with aspects of this performance improvement plan is found under Figure 1. A detailed accounting of the specific duties and responsibilities of each entity can be found – as appropriate – in the Medical Staff bylaws or rules and regulations, OVHD policy, or other documents.

Figure 1 – Performance Improvement Organizational Chart



DESIGNING PROCESSES AND SERVICES

When designing a new or modifying an existing process or service, OVHD will strive to assure that it is designed well. The following criteria are utilized to determine the effectiveness of design:

- The design is consistent with the Mission, Vision, Values, and organizational objectives of OVHD.

- The design meets the needs of the individuals served, the organization and medical staff, and key stakeholders.
- When clinical processes are involved, the design is safe, sound, and consistent with accepted national and/or community standards of care.
- The design is consistent with sound business practice and reflects stewardship of resources.
- The design, as appropriate, incorporates information about new technology and/or the performance of similar design(s) in other organizations. (For example, using evidence-based literature and practice guidelines or parameters.)
- The design, as appropriate, incorporates information from other organizations about the occurrence of sentinel events[1]

ESTABLISHING ANNUAL PERFORMANCE MEASURES

On an annual basis, OVHD will establish measurements to monitor its existing level of performance in order to identify opportunities for improvement. The scope of measurement will take into consideration, and be consistent with, the care and services provided, and the critical functions of the organization.

Criteria

The following criteria may be used to determine the scope of performance measurement:

- Assure the safety of the environment of care.
- Assure the safety of the providers of care and the recipients of care.
- Further the Mission and strategic objectives of OVHD.
- Meet legal, regulatory, licensure, and accreditation requirements.
- Establish the effectiveness, timeliness, and stability of processes that are high-risk~~, high~~-low-volume or problem prone.
- Establish desirable outcomes of care for at-risk patient populations.

ESTABLISHING ANNUAL PERFORMANCE GOALS

Based on conclusions drawn from data collected, a multi-disciplinary team approach will be used to determine annual performance improvement (PI) goals for the organization. (See annual PI Plans for current FY, Appendix A)

[1] A sentinel event is defined as an unexpected occurrence involving death or serious physical injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which the recurrence would carry a significant chance of a serious adverse outcome. OVHD maintains a separate policy on the identification and management of sentinel events. The reader is referred to that document for further information.

Example Areas of Focus

Based upon an application of the above criteria, the following care, services, and functions may be measured and reported to Quality Council:

- Processes, particularly those that are high risk, low volume, or problem prone
- Perception of Patient Safety
- Clinical outcome
- Risk Management - Error Prevention
- Infection Control
- Utilization Management
- Quality Control
- Safety of the environment
- Staff Opinions & Needs
- Outcomes of Selected Processes or Services
- Autopsy Results
- Customer Satisfaction
- Staffing effectiveness
- Effectiveness of Pain Management
- Staff willingness to Report Errors
- Use of Medications
- Performance of Operative, Invasive, and Non-Invasive Procedures that Place Patients at Risk
- Use of Blood and Blood Components
- Use of Restraint
- Outcomes Related to Resuscitation
- Outcomes Related to the Use of Procedural Sedation
- Sentinel Events
- Performance measures from acceptable data bases
- Care or Services Provided too High-Risk Populations
- Patient Complaints

In collaboration with department leaders and other key stakeholders, and with oversight from the Medical Executive Committee (MEC) and Administration, the Quality Council will annually develop a written summary of specific, annual Performance Improvement Goals to prioritize the measurement of the above areas (Refer to attached document for annual goals, appendix A).

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments, and services, or focused on selected populations.

Measurement may be ongoing, time limiting, episodic, intensive, or recurring. The duration, intensity, and frequency of a particular performance measure are based on the needs of the organization, external requirements, and the result of data analysis.

Specific performance measures are established annually for each of the above areas and are submitted to the Board of Directors for approval on an annual basis.

DATA COLLECTION AND AGGREGATION

Data will be collected and aggregated on performance measures.

Purpose

The purpose of data collection is to:

- Establish a baseline level of performance.
- Determine the stability of process.
- Determine the effectiveness of a process or desirability of an outcome as compared to internal or external targets (benchmarks).
- Identify opportunities for improvement.
- Identify the need for more focused data collection.
- Determine whether improvement has been achieved and or sustained.

Construct

Performance measures will have a construct to assure that data is appropriately identified, collected, aggregated, displayed, and analyzed. In general, the construct should consist of:

- A definition of the measure – including the dimensions of performance being measured.
- The population to be measured (including, when appropriate, criteria for inclusion and/or exclusion);
- The type of measurement (i.e., rate based, or event based);
- If rate based, a calculation formula (i.e., defined numerator / denominator);
- The minimum sampling size (where appropriate) to assure statistical validity.
- The frequency of data collection / aggregation.
- The methodology by which data will be collected.
- The entity is primarily responsible for data collection.
- The manner in which aggregated data will be displayed. The entity(s) to which the aggregated data will be reported for analysis and action.

ASSESSMENT OF PERFORMANCE

Data on performance measures will be analyzed to identify opportunities for improvement. There are two basic approaches utilized by OVHD to assess performance.

Assessment of Aggregated Data

Data on rate-based performance measures are aggregated to determine patterns, trends, and variation (common or special cause). Data may be aggregated for a single point in time or over time, depending on the needs of the organization and the reason for monitoring performance. In general, measurement designed to establish the desired stability of a process, or a desired outcome will be measured over time until target levels of performance are met. Once a process is considered stable, and/or a desired level of performance has been achieved, then an assessment of performance measures may be conducted in a more episodic fashion.

Data that is event based is assessed in singular or aggregated form depending on the number of data elements in the performance measure. In general, event-based measurements are monitored on an ongoing basis.

Intensive Assessments

There are times when an intense analysis of performance data is indicated. Intense analysis will occur for the following reason:

- The level of a performance, pattern, or trend varies significantly and undesirably from the expected.
- Performance varies significantly and undesirably from that of other organizations.
- Performance varies significantly and undesirably from recognized standards.
- A sentinel event has occurred or there was a near miss (or a sentinel event alert has been published).
- Confirmed blood transfusion reactions.
- Significant adverse drug reactions or medication errors[2].
- Major discrepancies or patterns of discrepancies between preoperative and postoperative diagnosis including those identified during the pathologic review of specimens removed during surgical or invasive procedures.
- Significant adverse events during anesthesia.

[2] A significant adverse drug reaction or significant medication error is an unintended, undesirable, and unexpected effect of a prescribed medication or medication error that requires discontinuing a medication or modifying dose, requires initial or prolonged hospitalization, results in disability, requires treatment with a prescribed medication, results in cognitive deterioration or impairment, are life threatening, results in death, or result in congenital anomalies.

- Root Cause Analyses or Systematic Investigative Reviews are performed when deemed appropriate by the Vice President of Quality and Risk Management.

IMPROVING PERFORMANCE

When analysis of data shows an opportunity for improvement, OVHD will undertake a planned approach to effectuate such improvement. This is accomplished by adhering to an organization-wide performance improvement model.

Performance improvement is achieved when customer valid expectations are met or exceeded, and organizational and patient health outcomes improve. The success of performance improvement activities is reliant on four basic steps:

1. Determine what dimensions of performance will be most affected ~~effected~~.
2. Identify how you expect or want the process to perform by setting goals.
3. Define a performance measurement that will accurately evaluate the process and outcome.
4. Involve those closest to the process in the performance improvement activity.

Performance Improvement Model

OVHD has adopted the "Plan, Do, Check, Act" (PDCA) model of performance improvement. This model is described briefly below: (See Attachment A)

- PLAN – The organization selects an action or series of actions to improve its performance in the affected process or outcome.
- DO – The action(s) is implemented as planned.
- CHECK – The affected process or outcome is re-measured to determine if actions taken resulted in the desired level of improved performance.
  ACT – The organization acts upon the results of the re-measurement. Such actions may include repeating the PDCA process until a desired level of performance is achieved, continued measurement of ~~measuring~~ the performance level until stability of process is assured or discontinuing performance measurement.

Work teams have the choice of tools using the Quality Improvement Story (QI Story); Rapid Cycle Improvement Methods Model; Clinical Pathways, Clinical Algorithms, or redesign, to solve the problem and improve organizational performance.

- Clinical Pathways Guidelines – flowcharts, which coordinate and integrate the best practice for physicians and patient caregivers.
- Clinical Algorithms – flowcharts, which serve as medical decision trees.
- QI Story – problem solving process statistical tools that can be used in conjunction with the P-D-C-A model to assist teams with their work.
- Rapid Cycle Improvement Model – Rapid cycle improvement utilizes a series of small improvement cycles in a continuous P-D-C-A cycle.

Sustaining Improvement

Once a desired level of performance has been achieved and stability of process has been demonstrated, then ongoing measurement is usually not indicated. In these cases, performance will be measured on a periodic basis to assure that desired level(s) have been sustained. Should such a measurement show that improvement has not been sustained, the PDCA cycle will resume.

Performance of the Individual

OVHD recognizes that, on occasion, improving performance requires addressing the care and/or service provided by an individual. For members of the Medical Staff, this is accomplished through the peer review process, continuing medical education and the credentialing/privileging mechanism. For organization staff, this is accomplished through competency assessments, education and training, and performance evaluations. Refer to documents addressing these processes for further information (see Related Policies below).

COORDINATION OF INFORMATION

Performance improvement activities and outcomes will be communicated through the organization as appropriate. (See Attachment B) Reports will be submitted to the Medical Executive Committee and Board of Directors and will indicate results, analysis, and recommendations. Findings relevant to the performance of individuals will be forwarded to the appropriate departments.

EVALUATION OF THE PLAN

The performance improvement program requires an annual appraisal of the effectiveness of the plan and results of annual Performance Improvement Goals. The evaluation will consider the degree in which performance improvement has been achieved in the processes and outcomes selected for measurement, and the degree in which the organization believes that the plan itself meets the needs of the organization. It will contain information regarding significant problems and/or opportunities to improve the performance improvement process. Individuals involved in performance improvement activities shall participate in the annual appraisal.

The Quality Council shall issue an annual report to the Medical Executive Committee and Board of Directors, outlining the Committee's review of the performance improvement program.

CONFIDENTIALITY OF INFORMATION

All data collection, aggregation, analysis, and resultant activities related to the clinical and attendant operational care of the patient as part of this Performance Improvement plan are undertaken under the auspices of the Medical Staff as part of their quality assurance efforts and are protected from discovery pursuant to CA Evidence Code, Section 1157.

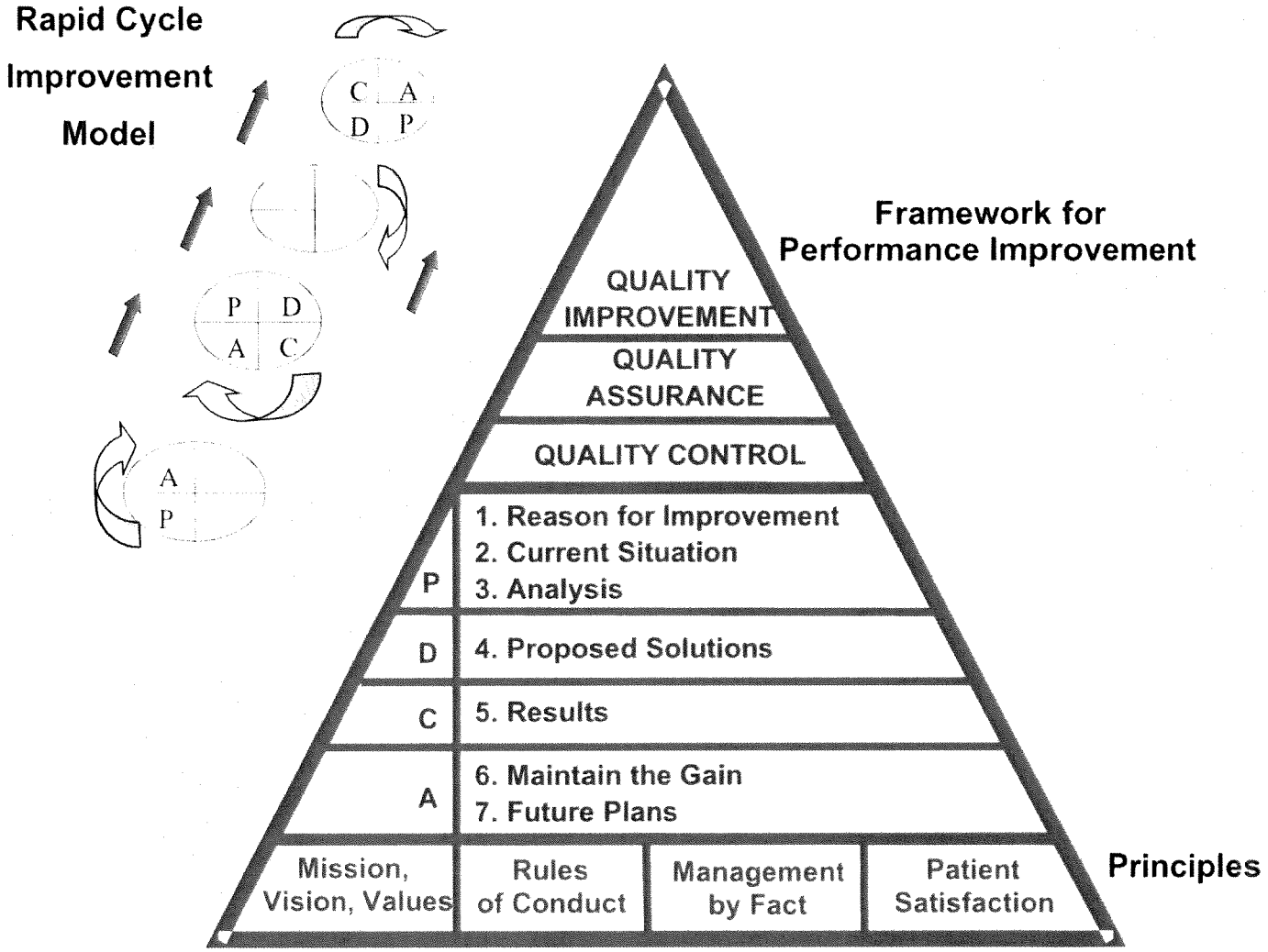
RELATED POLICIES

Medical Staff Peer Review
Orientation and Annual Education Update
Patient Safety Plan

REFERENCES

Joint Commission Standard Performance Improvement (PI) Chapter, PI.01.01.01 through PI.04.01.01
Centers for Medicare and Medicaid Services, Hospital Quality Initiative, last accessed on 7/21/23

Quality Improvement Process



Mission: Continuously improve the health and well being of our communities through partnerships with physicians, health care providers and residents.

Quality Control: Assessment of stability of existing processes. Includes customer satisfaction.

Quality Assurance: Peer review and staff competencies. Focuses on the individual.

Quality Improvement: Clinical pathways, clinical algorithms, operational improvements made by interdisciplinary teams using the PDCA (Plan-Do-Check-Act) problem-solving process. Focuses on process and outcomes, which are linked with strategic initiatives.

ATTACHMENT B

Oak Valley Hospital District
(Communication Flowchart for Quality)

ORGANIZATIONAL PRIORITIES
1. **Clinical quality (core measures)**
2. **Patient Satisfaction**
3. **Culture of Safety**

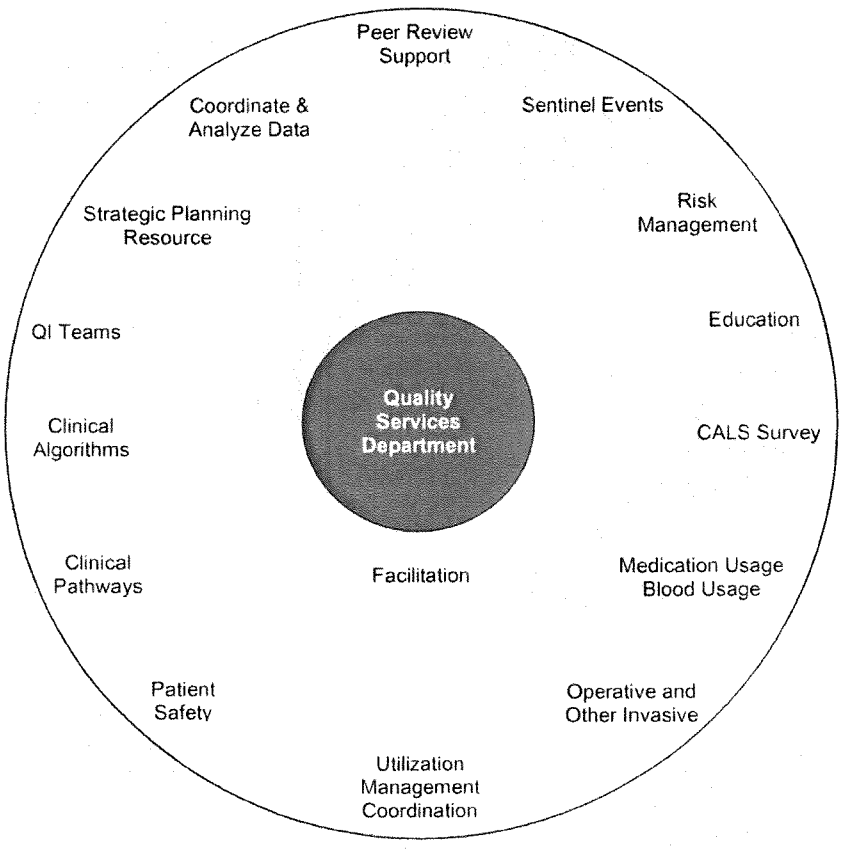
Board of Directors

Medical Executive Committee

Quality Council

Medical Staff
- Credentialing
- Privileging
- Peer Review
- Due Process
- Impaired Physician Activity

PI Nomination based on:
- Community need
- High volume
- High risk
- High cost
- Customer satisfaction
- Patient safety



Oak Valley Hospital District

Appendix A: OVHD FY 2025 Annual Performance Improvement Goals

FY 2025 Performance Improvement Plan

MISSION: We focus on personalized, equitable and quality health care and wellness for those we serve.

VISION

Oak Valley Hospital District will continue as an independent locally controlled and governed special district hospital. To accomplish this, we will adhere to the following guidelines:

- Being fiscally responsible in our decision-making process
- Maintain and expand services that best reflect the community's needs and resources
- Promote positive change in the health status of employees and area residents
- Promote diversity, equity, and inclusion in all facets of the operation.

VALUES

Accountability
Being responsible for actions taken and not taken
Integrity
Doing the right thing for the right reason
Respect
Valuing all people equally, and at all times

ORGANIZATIONAL PERFORMANCE GOALS

- ✓ **DELIVER EXCELLENT PATIENT CARE**
  Continuously improve processes to advance the quality of care
- ✓ **ENHANCE PATIENT SAFETY**
  Reduce the risk of preventable harm to patients
- ✓ **SERVE THE COMMUNITY**
  Expand and maintain health services to meet the needs of area residents in all demographic groups
- ✓ **CREATE A POSITIVE WORK ENVIRONMENT**
  Promote engagement, satisfaction, diversity, inclusion and safety of all employees and medical staff
- ✓ **ENSURE FISCAL RESPONSIBILITY**
  Allocate resources efficiently and reduce waste

Objective	FY 2025 Goals	MEASURE(s) OF SUCCESS
DELIVER EXCELLENT PATIENT CARE *Continuously improve processes and enhance staff competency to advance the quality of care.*	• Improve outcomes for patients suffering from stroke. • Recognize and treat patients with sepsis per evidence-based guidelines. • Evaluate and treat emergency patients more efficiently, using evidence-based guidelines. • Enhance cardiopulmonary resuscitation performance	• Stratify stroke patient data by demographic info and utilize this data for effective community education and outreach regarding stroke symptoms and treatment. • Sustain the percentage of patients with severe sepsis and septic shock who receive all elements of appropriate care at or better than 70%. • Establish baseline and reasonable target for arrival to triage. Decrease the average door to triage # of minutes by 10%. • Establish mock code education program and perform at least one mock code per shift per quarter.
ENHANCE PATIENT SAFETY *Reduce the risk of preventable harm to patients.* **See also:** *NPSG 2023* *OVHD Annual Patient Safety Plan*	• Reduce the risk of injury related to falls District-wide. • Reduce the risk of harm related to restraints. • Reduce the risk of significant adverse drug reactions. • Reduce the risk of transmission of communicable disease. • Reduce the risk of death related to self –harm.	• Establish baseline number of falls in both Acute Care and Long-term care and reduce the number of falls by 10%. • Establish baseline and increase the frequency of CPOE restraint orders by 10%. • Reduce the incidence of medication errors that may cause harm. • Achieve and sustain 80% district-wide hand hygiene compliance. • Achieve and sustain 100% compliance with screening of ED patients for suicidal thoughts or plans for self-harm, using an evidence-based screening tool.
SERVE THE COMMUNITY *Expand and maintain health services to meet the needs of area residents.* **See also:** *OVHD 2021 Community Health Needs Assessment* *OVHD 2023-2024 Strategic Plan for Health Equity*	• Use community, facility, and public health data to identify at-risk populations within our community and to provide equitable care to those populations to reduce healthcare disparities. • Work with community partners to provide needed services and resources to our patient population.	• Collect and analyzing data related to Social Drivers of Health on at least 70% of the adult inpatient population (housing insecurities, food insecurities, transportation access, utility difficulties and personal safety) to identify healthcare disparities in our community. • Maintain employee active engagement in Diversity, Equity and Inclusion committee whose purpose is to address the identified SDOHs and create action plans designed to promote health equity. • Create action plan(s) using data collected to address at least one (1) health care disparity identified.
CREATE A POSITIVE WORK ENVIRONMENT *Promote engagement, satisfaction, diversity, inclusion and safety of all employees and medical staff.*	• Reduce the risk of preventable illness and injury to staff. • Improve the retention of staff. • Create an organizational culture that promotes diversity and inclusion	• Establish baseline and reduce the annual number of employee injuries and decrease the number of injuries by 10% • Increase overall staff compliance rate with at least one vaccination that protects against preventable illness. • Establish baseline and improve culture of safety via survey.
ENSURE FISCAL RESPONSIBILITY *Allocate resources efficiently and reduce waste.*	• Reduce unanticipated expenses related to all costs i.e., supplies, labor, maintenance, etc. • Reduce the risk of liability	• Meet Annual Budget • Seek outside funding (grants etc.) for Health Equity Committee activities.

OAK VALLEY HOSPITAL DISTRICT
Clinical Manual

Policy/Procedure: *****Bi-Annual Review***

CRITICAL VALUE/TEST RESULTS READ-BACK

Also indexed as: Test Results Read-Back; Read-Back; Critical tests

Effective Date: 03 2004 | ***Page 1 of 554***

Areas Affected: All Divisions and Departments of the Hospital District

Composed by: Unknown

☐ Reviewed ☒ Revised by: Lab Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Imaging Services	Manager	11/18/2024	X
Laboratory	Medical Director	11/18/2024	X
Policy, Procedures, Forms Comm.	VP of Nursing	01/15/2025	X
Department of Surgery	Medical Staff Coordinator	02/11/2025	X
Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 3/17;7/19;09/2021, 1/2024 **Reviewed**: 1/2024 **Next Review Date** ~~4/2026~~

POLICY
Oak Valley Hospital District (OVHD) reports critical values/test results to the Provider or an RN. Read back is required for all verbally reported critical value/test results.

PURPOSE
To provide a standard process at OVHD to ensure that effective and accurate verbal communication occurs between all appropriate healthcare staff regarding all critical value/test results.

SCOPE
This policy applies to Providers, allied health professionals, and hospital staff providing or receiving verbal critical value/test results. This applies to all clinical service departments of OVHD (i.e. Respiratory Therapy, Laboratory, Imaging, nursing units, Oak Valley Community Health Centers, and Oakdale Nursing and Rehabilitation Center (ONRC)).

DEFINITIONS

Critical Value/ Results defined as results/values which are so far from the reference range or are so significant that they indicate a potentially dangerous condition requiring immediate attention by the clinician. Critical value/tests are defined in Appendix A and B.

PROCEDURE

1. Value/Test results that fall outside of the approved critical value limits will be repeated as appropriate and reported to the nurse or Provider on the unit where the patient is located. All critical value test results reported verbally to the nurse or Provider will be read back to the individual reporting the results

to verify accuracy. The verbal critical value/test results will be documented by the nurse, and then "read back" to verify accuracy.

2. Critical value test results will be reported within 15 minutes by the department to the nurse caring for the patient or the Provider.

3. The nurse receiving the value test results will contact the ordering Provider or designee within one hour, to report the critical value test results. If the ordering Provider cannot be reached, the nurse will notify the attending Provider. If the attending is not available, the nurse will contact the Medical Director of the ordering Provider's service. (See "Chain of Command" policy and procedure in Administrative Manual - Chief of Staff)

4. Reports of critical value/test results provided to Providers will be requested to be read back to the individual providing the value/test result to the Provider.

5. The Provider may not need to be notified if the critical value/test is the desired result of medication administration or due to a chronic condition, and the Provider is aware of the previous critical value/test. The Provider also does not need to be notified if an improvement from a previous critical value test is noted, while still remaining above or below the desired range. The Laboratory will call all alert values.

6. Refer to policy procedure, "Alert Values-After Hours" and "Abnormal Results" in the Oak Valley Community Health Centers Manual.

DOCUMENTATION

1. The person reporting the result will document on the report the date, time and person the result was called to and that it was "read back".

2. The nurse or Provider who receives the critical value test will transcribe the results and perform a "read back" to the reporting person.

3. Communication or attempts to communicate with the ordering Provider shall be documented in the the patient's medical record.
    a. Documentation of Provider notification shall include:
        - Date and time contacted;
        - Name of the Provider notified and or the licensed designee;
        - Reason for the notification;
        - Provider's read-back of the information;
        - Orders received (documented on the Provider Order Form);
        - What the alert value was.

    b. Documentation of attempted Provider notification shall include:
        - Date and time of each attempted contact;
        - Name of Provider attempting to notify;
        - Reason for notification.
        - Utilize "Chain of Command Problem Resolution" policy if unable to contact Provider

REFERENCES

The Joint Commission National Patient Safety Goals, 2021

Appendix A- Laboratory Values

TEST	VALUE LESS THAN OR EQUAL TO	VALUE GREATER THAN OR EQUAL TO
Arterial Blood Gas (ABG) PCO2	20 mmHg	60 mmHG
ABG PH	7.25	7.55
ABG PO_2	50 mmHg	NA
ABG SaO_2	90%	NA
Acetaminophen	NA	50.0 mcg ml
Bilirubin (Newborn)	NA	18 mg dL
Blood cultures	Positive results	NA
Calcium	7.0 mg dL	13.0 mg dL
Creatinine	NA	3.0 mg dL
Cerebral Spinal Fluid (CSF)	Positive gram stain or culture	NA
Direct Antiglobulin Test (DAT)	Positive results	NA
d-Dimer	NA	~~230~~ 500 ng Ml (FEU)
Digoxin	NA	2.5 ng mL
Glucose	40 mg dL	400 mg dL
Hematocrit	NA	65%
Hemoglobin	7.0 g dL	NA
Lactic Acid		2.1 mmol L
Magnesium	1.5 mg dL	6.0 mg dL
Phenytoin	NA	40 mcg ml
Phosphorus	1.5 mg dL	NA
Platelets	50 k ul	800 k uL
Potassium	3.0 mmol L	6.0 mmol L
Protime INR (PT)	NA	INR greater than 4.0
Activated Partial Thromboplastin Time (PPT)		100 seconds
Salicylate	NA	30 mg dL
Sodium	125 mmol L	155 mmol L
Troponin	NA	0.30 ng ml
White Blood Count (WBC)	2.0 k ul	25.0 k uL
Absolute Neutrophil Count (ANC)	1.0 k uL	N A

* NA= Not applicable

Appendix B- Radiology Tests

~~HEAD/NECK~~
~~NECK~~
~~Epiglottitis~~
~~Intra-cranial hemorrhage (Intracerebral, Subdural, Epidural)~~
~~Orbital floor fracture~~
~~Ocular Abscess~~
~~Spinal Cord Compression~~
~~Unstable spinal fractures~~

~~CHEST~~
~~Foreign body aspiration~~
~~Great vessel dissection or injury~~
~~Pneumomediastinum~~
~~Pneumothorax~~
~~Hemothorax~~
~~Pulmonary embolus~~
~~Tuberculosis~~

~~ABDOMEN/PELVIS~~
~~Aborted gestation~~
~~Appendicitis~~
~~Ectopic gestation~~
~~Foreign body~~
~~Intra-abdominal-pelvic hemorrhage i.e. Vascular injury~~
~~Ovarian testicular torsion~~

Intra-cranial hemorrhage (Intracerebral, Subdural, Epidural)
Ocular Abscess
Acute cord compression
Unstable spinal fractures
Pneumomediastinum
Pneumothorax
Pneumocephalus
Pneumoperitoneum
Pulmonary embolus
Deep vein thrombosis (DVT)
Acute ischemic infarction
Pediatric non-accidental trauma
Positive visceral trauma
Support tube/line malposition
Ectopic pregnancy
Active GI bleed hemoperitoneum
Ovarian testicular torsion

OAK VALLEY HOSPITAL DISTRICT
Clinical Manual

Policy/Procedure:

PEDIATRIC ADMISSION

Also indexed as: Head Circumference, Pediatric Basic Fluid Requirements, Weighing the Pediatric Patient

Effective Date: 6 2000 | **Page 1 of 3**

Areas Affected: Emergency Department, ICU, Med Surg, Surgery Department

Composed by: Manager

☐ Reviewed ☒ Revised by: VP of Nursing; Medical; Med. Exec

Dept / Committee Approval:	Dept/Title:	Date	Approved
Medical Surgical Unit	Med Surg Manager	01 14 2025	X
Social Services	Manager of Case Mgt & Social Svcs	01 14 2025	X
Policy, Procedures, Forms Comm.	VP of Nursing	01 15 2025	X
Department of Surgery	Medical Staff Coordinator	02 11 2025	X
Department of Medicine	Medical Staff Coordinator	03 11 2025	X
Medical Executive Committee	Medical Staff Coordinator	03 18 2025	X
District Board	Board Liaison	04 03 2025	

Revised: 3 12; 8 17; 10 18, 5 23, 01 25 | **Reviewed**: 5 23, 01 25 | **Next Review Date**: ~~7 2026~~

POLICY

Admission of a pediatric patient for emergency or elective surgery ~~7~~ 3 years of age or older ~~or 70 pounds or more~~ to Oak Valley Hospital District .

SUPPORTIVE DATA

1. Children aged ~~7~~ 3 years or older ~~or 70 pounds or more~~ presenting with non-critical types of illnesses may be admitted to the Medical Surgical Department (MSD) ~~and as a Med/Surg overflow to ICU~~. Examples of non-critical illnesses might include asthma, viral illness, infections without sepsis, and pneumonia without respiratory failure.

2. The decision to admit medically ill surgical pediatric patients less than ~~7~~ 3 years or older ~~or 70 pounds or more~~ will be at the discretion of surgery, anesthesia and the primary care physician.

3. Age specific information will be obtained from the "Guidelines" fingertip guide.

PROCEDURE

1. Patient Placement
   a. One room, #201, is designated as the pediatric room with pediatric décor, and is located in close proximity and easy visualization of the nursing staff.

b. All pediatric patients are admitted to Room 201 unless high census leaves Room 201 unavailable. Pediatric patients may be placed in semi-private rooms and grouped together appropriately.

c. Patients from the same family, if different sex may be in the same room if under the age of 10.

2. Room Preparation
   a. When notified of the admission place bed in room as appropriate for the age being admitted.

   b. Appropriate activities of daily living for the age and development of the child will be provided.

   c. A parent adult family member will be required to stay with the child if 17 years old or younger.
      1) A parent may stay with the child of any age.

   d. Check that the equipment needed is available:
      - Admission kit
      - Gown or pajamas
      - Blood pressure cuff of the appropriate size
      - Scale
      - Tape measure
      - Pediatric Nursing Admission History and Assessment form

3. Patient Identification
   a. Matching ID bands will be placed on the child and on the parents or authorized caregivers.

4. Assessment of the Patient
   a. Physical assessment must be completed within 12 hours of admission; patient should be reassessed every 24 hours.

   b. Vital signs:
      1) Weigh the patient on admission in a gown or underwear. Weigh in kilograms.
      2) Measure height or length of child; use tape measure if necessary.
      3) Document height and weight in EMR (Electronic Medical Record).
      4) Use appropriately sized blood pressure cuff
      5) Temperature to be taken axillary, orally if age appropriate
      6) Assess pain needs as evidenced by verbal and non-verbal behavior

5. Initiate care plan. Involve the family, caregiver and child, explaining what is to be done as well as what is expected, at the appropriate level of understanding. Assess their level of understanding.

6. Any suspicion of Child Abuse must be reported to law enforcement and or Child Protective Services. (See Child Abuse Criteria and Reporting Policy in the Administrative Manual)
7. Orientation to the Unit
   a. Orient the child and family to the room; call system, TV, phone, bathroom, emergency bathroom light, closet and patient safety.

   b. Demonstrate bed function as appropriate.

   c. Discuss ways of meeting the child's developmental needs with toys, videos, music, etc.

d. Inform the parents/guardians of the availability of complementary meals for one.

8. Documentation
   a. Complete the initial nursing admission history and assessment in the EMR..
   b. Chart pertinent data obtained in the assessment and family interview.
   c. Complete the Medication Reconciliation
   d. Acknowledge all orders via status board and verify accuracy.
   e. Initiate the care plan.

9. Patient Personal Items – document on the Patient Valuables Checklist
   a. Valuables are to return home with the family; the hospital safe is available in the business office.

   b. Prescriptions brought by the family are to be stored in Pyxis or sent back home with the family.

   c. Any personal electrical items brought to the hospital by the patient or family must be checked and tagged by the Engineering Department before use.

10. Coordination of Services for Pediatric Patients
   a. The family is to be involved throughout the patient's hospitalization.

   b. The family's ability to cope with the illness is to be assessed and the effect, if any, of the family on the patient's condition. The assessment is to focus on the duration, the severity or the effect on the patient's physical or psychosocial development and the coping mechanisms of the family members. The admitting nurse will make a referral to Social Services if needed.

   c. Ongoing communication with the families/guardians is to be maintained throughout the hospitalization. Such communication should at least address the family's perception of the patient's needs:
      1) The patient's condition.
      2) Treatment and prognosis
      3) Discharge planning

   d. For the school-aged child, the continuation of school is to be arranged by the parents with the school. Nursing staff will make accommodations with the tutor to maintain the child's schedule.

   e. Referrals to Medical Social Worker (MSW) as needed.

   f. Students temporarily disabled by accident or illness are eligible to receive school instruction while in the hospital, if physically able. This is the responsibility of the school district in which the child resides to provide ongoing education. The Nursing Staff or Case Management will notify the District Curriculum Director or Principal of the child's school if it is anticipated that the child will be out of school for more than 2 weeks and a request for independent study will be made. In most cases instruction will begin no later than after two weeks of absence.

11. Security
   a. At the time of admission, the child and two (2) guardians/parents will be given armbands that match the child's. These are to be worn at all times while child is a patient.

12. Referral Services
   a. The Discharge Planner will determine if referrals to community agencies are appropriate, such as Women, Children and Infants; Regional Services; Valley Mountain, etc.

OAK VALLEY HOSPITAL DISTRICT
Oak Valley Community Health Centers Manual

Policy/Procedure:

INJECTIONS

Effective Date: 2 10 | **Page 1 of 2 (+Attachments)**

Areas Affected: Oak Valley Community Health Centers
Composed by: Clinic Manager
☒ Reviewed ☐ Revised by: Clinic Manager

Dept. / Committee Approval:	Dept./Title:	Date	Approved
Clinics	Manager	02 04 2025	X
Medical Directors	VP Admin Services	02 04 2025	X
Policy, Procedures, Forms Comm.	Clinic Manager	02 05 2025	X
Department of Medicine	Medical Staff Coordinator	03 11 2025	X
Medical Executive Committee	Medical Staff Coordinator	03 18 2025	X
District Board	Board Liaison	04 03 2025	

Revised: 6 14, 2 24 | **Reviewed**: 7 15 ; 2 16; 4 18, 2/24 | **Next Review Date**: 2 2025

PURPOSE

To provide a consistent and accurate method of administering injections of all types to patients of all ages. This includes:

IM- intramuscular-
- Given at 90 degree angle
- 23-25 gauge needle
- 1 inch in length.
- Site- Vastus Lateral is in an infant/toddler or Deltoid for child/adult

SQ- subcutaneous-
- Given at 45 degree angle
- 25 gauge needle
- 5/8 inch in length
- Site- Outer aspect back of arm for infant/ toddler/child- adult

ID- Intra-dermal-
- Given at 5-15 degree angle
- 25 gauge needle
- 5/8 TB syringe
- Site- Left forearm

Oak Valley Community Health Centers will provide and document immunizations consistent with the Centers for Disease Control and Prevention (CDC) recommended schedule. Medications and immunizations will only be administered upon the order of a licensed provider.

PROCEDURE

1. Verify orders with licensed provider.

2. Verify patient identity using 2 patient identifiers (name and date of birth).

3. Obtains VIS sheets for immunizations child requires and provides them to parents.

4. Explain vaccines, sites to be given, side effects, fever control, follow up visits and answers any questions parent or child may have.

5. Perform hand hygiene (wash hands or use hand sanitizer)

6. Prepare the ordered vaccines for administration following Vaccines for Children (VFC) guidelines. Medications and immunizations will only be prepared and or drawn immediately prior to administration (when ready to give the medication or immunization).

7. Reassure patient as they position or restrain child with parent's assistance to give injections.

8. If TB test is required, it is best to do this first. Children who are scared or have had several injections before the TB test are less likely to remain still for the slow insertion of the Tb needle for the wheal formation. Please circle the wheal. Instruct parent to return 48-72 hours for reading of TB test.

9. Administer injections promptly and apply band aids, with exception of the TB test. Do not put band-aid on TB site.

10. Allow parent to console child immediately after

11. Nurse will dispose of any needles that were used immediately to avoid accidental needle stick.

12. Reassure child for job well done, offer sticker. Repeat instructions to parent on side effects, follow up care and fever control and any further questions to call Health Center for assistance.

13. Document injections on patient's medical record.

RELATED FORMS

1. Form0115 Tuberculosis Screening, Annual_Periodic TB Documentation

ATTACHMENTS

1. Anatomic Sites for Immunizations
2. Administering Inject able vaccines
3. Inject able vaccines by Route
4. Administering Vaccines: Dose, Route, Site and Needle Site
5. Recommended Immunization Schedules for Persons Aged 0 through 18 Years

REFERENCES

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OAK VALLEY HOSPITAL DISTRICT

Infection Control Manual

Policy/Procedure:

Hand Hygiene

Also indexed as Hand Washing

Effective Date: ~~05~~ 05 2000 | **Page 1 of 4**

Areas Affected: ~~All;~~ All Divisions and Departments of the Hospital District

Composed by: Unknown

❒ Reviewed X Revised by: Infection Preventionist

Dept / Committee Approval:	Dept/Title:	Date	Approved
Infection Control	Infection Preventionist	10 28 2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	11/06/2024	X
P&T Infection Control Committee	Medical Staff Coord	02/12/2025	X
Quality	Medical Staff Coord	02/13/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: ~~4/1~~ 19;6 21, 10/24 **Reviewed:** ~~4/1~~ 04, 10 24 **Next Review Date:** ~~6/6/2024~~

PURPOSE

To provide guidelines for hand hygiene to control and prevent the spread of microorganisms.

SUPPORTIVE DATA

1. Thorough hand hygiene is the ~~most important factor~~key factor in infection control; it must be faithfully practiced without exception. Hand hygiene can be done with either plain soaps or antimicrobial products. Hand hygiene with plain soaps suspends microorganisms and allows them to be mechanically removed by rinsing. Hand hygiene with antimicrobial products kills or inhibits the growth of microorganisms; this process is referred to as antisepsis.

2. The skin of patients and personnel can function as a reservoir of infectious agents and as a vehicle for transfer of infectious agents to susceptible persons. The microbial flora of the skin consists of resident and transient microorganisms. Resident microorganisms persist and multiply on the skin. Transient microorganisms are contaminants that can survive for only a limited period of time. Most resident microorganisms are found in superficial skin layers, but about 10% - 20% inhabit deep epidermal layers.

DEFINITIONS

Alcohol-Based Hand Rub (ABHR): An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. In the United States, such preparations usually contain 60-95% ethanol or isopropanol.

Antimicrobial Soap: Soap (i.e., detergent) containing an antiseptic agent.

Antiseptic Hand Wash: Washing hands with water and soap or other detergents containing an antiseptic agent.

Antiseptic Hand Rub: Applying an antiseptic hand-rub product to all surfaces of the hands to reduce the number of microorganisms present.

Decontaminate Hands: To reduce bacterial counts on hands by performing antiseptic hand rub or antiseptic hand wash.

Hand Hygiene: A general term that applies to handwashing, antiseptic handwash, antiseptic hand rub or surgical hand antisepsis.

Hand Washing: Washing hands with plain (i.e., non-antimicrobial) soap and water.

Visibly Soiled Hands: Hands showing visible dirt or visibly contaminated with proteinaceous material, ~~blood~~blood, or other body fluids (e.g., fecal material or urine).

Waterless Antiseptic Agent: An antiseptic agent that does not require use of exogenous water. After applying such an agent, the hands are rubbed together until the agent has dried.

PROCEDURE

To prevent and control the spread of microorganisms, personnel must always perform hand hygiene.

A. Wash hands with soap and water:
- When hands are visibly dirty.
- When caring for a patient with diarrheal disease such as clostridium difficile or Noro Virus.
- Before eating.
- After using ~~a restroom~~the restroom.

B. Alcohol-based ~~sanitizer~~ hand rub or ~~soap~~soap and water may be used in the following situations:
- Before and after any patient contact, including between patients.
- Before performing invasive procedures.
- After a procedure or body fluid exposure risk
- Before and after touching wounds, whether surgical, traumatic, or associated with an invasive device.
- After touching a patient's surroundings
- ~~After removal of gloves.~~ Before donning and after doffing gloves.
- Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.
- If moving from a contaminated-body site to a clean-body site during patient care.

C. Hand Hygiene Techniques

1. Hand Hygiene with Hand Rub
   a. Apply product to ~~palm~~the palm of one hand and rub hands together, covering all surfaces of hands and fingers until hands are dry.
   b. Duration of the entire procedure should take 20 - 30 seconds. (Hand sanitize for 20

seconds)

2. Washing Hands with Soap and Water:
   a. Stand close to the ~~sink~~sink.
      i. Hand control sink:
         1. Turn on water and adjust temperature. (Lukewarm water makes better suds and removes ~~less~~fewer protective oils.)
         2. Run water continuously.
      ii. Foot Control Sink:
         1. Turn on water and adjust temperature.
         2. There is no need to run water continuously.
   b. Wet hands with water, keeping hands lower than the elbow. Do not touch the sink.
   c. Apply enough soap to lather thoroughly.
   d. Wash hands using strong rubbing movements and circular motions to create friction. Wash both sides of hands, forearms, under nails and between fingers thoroughly. (Singing either "ABC" or "Happy Birthday" song ensures you have washed hands for a sufficient amount of time.)
   e. Duration of the entire procedure should take 40-60 seconds. (Hand wash for at least 20 seconds)
   f. Rinse well so water flows from wrist to fingers.
   g. Dry hands thoroughly with paper towels. If using hand-control sink, use paper towels to turn off the water.
   h. Discard towel in waste container.

D. Gloves

a. Are not a substitute for hand hygiene.
b. Always perform hand hygiene before donning and after doffing gloves.
c. Remove gloves carefully to prevent hand contamination as dirty gloves can soil hands.
d. Assure gloves fit appropriately.

E. Fingernails (refer to Nails in Healthcare Policy)

a. It is the responsibility of all healthcare workers to keep nails clean and short, less than ¼ inch long.
b. Artificial nails, nail jewelry, nail tips, and gel nails are prohibited.
c. Only clear nail polish, free of cracks and chip, is allowed.

F. Hand Lotions (refer to Lotions, Hospital Approved)

a. Only hospital approved hand lotions are to be used.

G. Skin Irritation

a. For any skin dryness or irritation, **contact** ***Occupational Health Center to be assessed and recommended alternative measures.***

H. Enforcement

a. The Management Team is responsible for keeping staff compliant with the Hand Hygiene policy.
b. Healthcare workers are responsible for demonstrating consistent high standards of compliance with hand hygiene.

Special Notes:

1. Patients will be given the opportunity to wash their hands before eating and after using toilet/urinal bedpan and as needed.

2. Alternative agents such as detergent-containing towelettes and alcohol-based hand rubs shall be available in the event of interruption of waterthe water supply.

3. For scrub, see Scrub Surgical Hand Scrub Policy

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OAK VALLEY HOSPITAL DISTRICT

Infection Control Manual

Policy/Procedure:

Tetanus/Diphtheria/Acellular Pertussis (Tdap) Vaccine Screening and Administration For Postpartum Women

Also indexed as TDAP Vaccine

Effective Date: 09 2010 | **Page 1 of 3**

Areas Affected: All Divisions and Departments of the Hospital District

Composed by: Unknown

X Reviewed X Revised by: ~~Infection Preventionist, Occupational Health Supervisor, V. P. Quality & Risk Management~~ Infection Preventionist, Clinic Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Infection Control	Infection Preventionist	10/24/2024	X
Clinics	Clinic Manager	10/24/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	11/06/2024	X
P&T Infection Control Committee	Medical Staff Coord	02/12/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 4/18; 7/21, 11/2024 **Reviewed**: 11/2024 **Next Review Date**: ~~7/2024~~

POLICY

Oak Valley Hospital District (OVHD) complies with California Department of Public Health (CDPH) recommendations to decrease pertussis in California.

SUPPORTIVE DATA

1. **Women of childbearing age:** CDPH recommends that all women of childbearing age be vaccinated with Tdap, preferably before pregnancy, but otherwise during or after pregnancy – pregnancy is not a contraindication to vaccination (1,4). The American Academy of Pediatrics (AAP) recommends that unvaccinated pregnant adolescents be given the same consideration for Tdap vaccination as non-pregnant adolescents (1). The Advisory Committee on Immunization the American College of Obstetricians and Gynecologists (ACOG) recommend that, when given during pregnancy, it is preferable to administer Tdap during the second or third trimester to minimize the coincidental association of Tdap vaccination with adverse outcomes, which occur most often during the first trimesters (1,2,4,6).
2. **Other close contacts of infants:** CDPH recommends that birth hospitals and other immunizers provide Tdap to all close contacts of infants without documentation of Tdap vaccination, especially parent and childcare providers. Contacts should be immunized before mother and baby are discharged after birth, regardless of when the contacts received any prior doses of Tetanus and Diphtheria (Td).

PROCEDURE

1. In the Oak Valley Community Health Center, Physician Assistant or other licensed health care professional (PLHCP), licensed Vocational Nurse (LVN), or a Registered Nurse (RN) will screen pregnant women in their second or third trimester and administer a single booster dose when screen indicates the patient is eligible.

2. Staff will refer siblings and other family members to their primary care provider (PCP) for vaccination.

CRITERIA FOR Tetanus/Diphtheria/Acellular Pertussis (Tdap) VACCINE:

1. Indications for administering Tdap Vaccine : **(must meet all criteria)**

    - Pregnant women in 3rd trimester, every pregnancy
    - Optimally recommended vaccinations as early as possible in the 27-36 weeks of gestation window. At least two weeks are needed for the development of sufficient maternal antibodies to be transplacental transferred to the infant. It is preferred to administer the immunization at the beginning of the third trimester.

2. Indications for Withholding Tdap Vaccine: (one indication is reason to withhold vaccine)

    - Patient family/legal representative unable to provide consent (confusion, disorientation, unconsciousness, unreachable etc.)
    - Patient refuses vaccination
    - A history of a serious reaction (e.g., anaphylaxis) after a previous dose of Td or to a Td or Tdap component.
    - For Tdap only, a history of encephalopathy within 7 days following DTaP given before age 7 years.
    - A history of Guillain-Barré syndrome within 6 weeks of previous dose of tetanus toxoid containing vaccine.
    - A history of an Arthus reaction following a previous dose of tetanus-containing and/or diphtheria containing vaccine, including meningococcal conjugate vaccine.
    - An unstable neurologic condition.
    - Moderate or severe acute illness with or without fever.
    - Attending physician writes order Do Not Vaccinate.

If vaccination is withheld, refer to primary care provider for additional guidance on the risks and benefits of immunization.

TDAP VACCINATION SCREENING AND ADMINISTRATION

1. All 3rd trimester pregnant women and all postpartum women are to be screened for potential vaccination.

2. If the patient meets criteria for vaccination, the nurse will review (VIS) Vaccination Information Sheet with the patient prior to administering the vaccination and give sheet to patient.

3. Administer 0.5 ~~ml~~ ml Tdap vaccine intramuscularly in the deltoid muscle.

4. Documentation.

    a. Enter order into medical chart: "Administer 0.5ml Tdap vaccine IM per standardized procedure".

b. In the medical record, record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).
c. Record the date of vaccination and the name location of hospital on the personal immunization record card.

5. Be prepared for management of a medical emergency related to the administration of vaccine and utilize Rapid Response Team, Code Blue or Code White activation as necessary. In Oak Valley Community Health Centers dial 911.

6. Document education in the patient's medical record. Ensure patient/family understanding of importance of providing their primary care physician with vaccination information via copy of personal immunization record.

7. Report all adverse reactions to Tdap vaccines via incident report and to Vaccine Adverse Event Reporting System (~~vAERS~~ VAERS).

SPECIAL CIRCUMSTANCES UNDER WHICH PLHCP, LVN OR RN MUST COMMUNICATE IMMEDIATELY TO PATIENTS ATTENDING PHYSICIAN:

1. Severe allergic reactions (hives, difficulty breathing, shock)

SUPERVISION REQUIRED TO PERFORM PROCEDURE

1. None

SETTINGS OR DEPARTMENTS WHERE PROCEDURE MAY BE PERFORMED

1. Medical Surgical Department
2. Oakdale Community Health Center (includes, Oak Valley Occupational Health Care and Oak Valley Women's Health and Prenatal Clinic)
3. Riverbank Community Health Clinic
4. Escalon Community Health Clinic
5. Waterford Community Health Clinic

REFERENCES

1. MMWR:RecommRep.2018,April 27, 67(2):1-44.doi: 10.15585/mmwr.r670201
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3. AAFP. Pertussis Vaccine: Receiving Tdap During Pregnancy. 2024
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5. CDC. ~~Pertrussis~~Pertussis United States, 2001-2003
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9. CDPH. Implement Prenatal Tdap Program to Prevent Infant Pertussis in California. (2016, December 30)

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OAK VALLEY HOSPITAL DISTRICT

Nutrition and Food Services Manual

Policy/Procedure:

ACCESS TO NUTRITION AND FOOD SERVICES DEPARTMENT (RETIRE, COMBINE WITH PERSONNEL PERMITTED IN DEPARTMENT)

Effective Date: 01/81	**Page 1 of 1**

Areas Affected: Nutrition and Food Services
Composed by: Director of Nutritional Services
☒ Reviewed ☐ Revised by: Director of Nutritional Services

Dept / Committee Approval:	Dept/Title:	Date	Approved
Director of Nutritional Services	Director of Nutritional Services	11/15/2024	X
Policy, Procedures, Forms Comm.	Director of Nutritional Services	02/05/2025	X
Quality Council	Medical Staff Coord	02/13/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 1/93, 01/04, 01/06, 11/24	**Reviewed**: 1/94, 1/95, 1/96, 1/97, 1/98, 1/99, 1/01, 01/07, 01/10, 01/13, 01/16, 01/19, 01/20, 01/21, 11/24	**Next Review Date**: 12/2023

PROCEDURE

Access to the department is limited for infection control and food safety reasons.

1. Staff of the department in performance of duties.

2. Maintenance and Environmental Services staff, Repair Services and Deliveries in the performance of required duties or services.

3.1. Hospital Staff are not allowed in the department unless required to do so in the performance of their duties.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure:

Personnel Permitted in Nutritional Services Department

Effective Date:10 1999 | **Page 1 of 1**

Areas Affected: Oakdale Nursing & Rehab Center

Composed by:

☑ Reviewed ❑ Revised by: Nutritional Services Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Quality	Medical Staff Coord	02/13/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised:11/24 **Reviewed**: 01/21, 11/24 **Next Review Date**: ~~1/22~~

POLICY

In order to provide a sanitary environment, ideal for food preparation, no one is allowed in the Nutritional Services Department without the expressed authorization of the Administrator or the Dietary Supervisor~~Nutritional Service Manager~~, except the kitchen employees and the Administrator.

PROCEDURE

1. Nutritional Services employees only signs shall be posted on all entrances to the department.

2. All unauthorized persons are to be discouraged from entering the Nutritional Services Department and remain behind the red lines on the floor when making requests. Staff needing to perform required services are allowed within the scope of their job requirement duties.

3. ~~The Nutritional Services Manager or designee~~ All Nutrition and Food Service staff will be responsible for enforcing this requirement.

3.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehab Center
Nutrition and Food Services Manual

Policy/Procedure:			
Diets			
Effective Date: 01/2000		**Page 1 of 1**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ☐ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised:11/24	**Reviewed**: 01/21, 11/24	**Next Review Date**: ~~1/22~~	

POLICY

The menus in this facility are written to include the most common and most appropriate diets for long-term care. They reflect the philosophy of offering our residents a ~~life style~~ lifestyle as close as possible to what they are accustomed.

PROCEDURE

1. Diet orders ~~of~~ for new admissions or diet changes will be ordered and evaluated by the doctor, Registered Dietitian, and/or the Speech Therapist. ~~and when possible will be written as reflected on the menu extensions.~~

2. Any diet order not on the menus will require a written reference on the tray card or on a sheet of paper posted at the tray line. The Registered Dietitian will be consulted if necessary to determine the proper diet modifications. Any changes to the resident's diet (e.g. diet texture, portion size, etc.) shall be documented as Progress notes.

3. Textures provided are aligned with the Nutrition Care Manual as follows:
   a. Regular
   ~~b. Mechanical Soft~~
   ~~c. Puree~~
   ~~d. Liquefied Puree~~
   b. Easy to Chew
   c. Soft and Bite Sized
   d. Minced and Moist
   e. Pureed
   f. Liquidized

4. Thickened liquids are provided for those residents with swallowing difficulties and are ordered by either the M.D or Speech Therapist. ~~Three~~ Five different liquid consistencies aligned with the Nutrition Care Manual are available:
   ~~a. Nectar thick~~
   ~~b. Honey thick~~
   ~~c. Pudding thick~~

a. Thin
b. Slightly Thick
c. Mildly Thick
d. Moderately Thick
e. Extremely Thick

i. ~~Nectar thick liquids along with Honey think liquids are purchase pre-thickened to provide standardized consistency of product~~

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Diet Cardex (RETIRE)

Effective Date: | **Page 1 of 2**

Areas Affected: Oakdale Nursing & Rehab Center

Composed by:

☑ Reviewed ☐ Revised by: Nutritional Services Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 11/24 **Reviewed:** 01/21, 1/24, 11/24 **Next Review Date:** 1/22

POLICY

The Diet Cardex is the center for communication about the residents diet and needs for the Nutritional Services Department. It is the responsibility of the Nutritional Services manager to maintain the Cardex and train Diet Aides in the use of the system. The resident is visited with in 72 hours for food preference information, which is recorded on the Cardex card.

:

PURPOSE

1. The Cardex should contain the following information for each resident:
   a. Name
   b. Room number and bed location
   c. Current diet order
   d. Diagnosis
   e. Resident diet pattern if different from the diet manual or therapeutic diet extension sheet.
   f. The prescribed supplemental feeding or extra nourishment provided to the resident beyond those listed on the therapeutic diet extension sheet.
   g. Admission date
   h. Physician
   i. Allergies
   j. Resident food preferences
   k. Residents birth date
   l. Pertinent physical data such as height, weight, etc.
   m. Assistance needed.

2. If a resident has a diet pattern different from the patternedpattern outlined in the diet manual or on the therapeutic extension sheet, the pattern must be on the Cardex card and posted on the tray card.

~~3. The Dietitian will also use the Cardex to record necessary diet information~~

~~4. Nutritional Services personnel must be trained in the purpose and function of the Cardex. This should be the first place to look for answers concerning individual resident's food preferences and diets. Nutritional personnel can use the Cardex to replace lost tray cards, check on resident food preference, and determine proper quantities of food for the resident tray.~~

~~5.~~1. ~~Emphasis must be placed on the privacy of the information contained on the Cardex.~~

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Floor Safety

Effective Date: | **Page 1 of 1**

Areas Affected: Oakdale Nursing & Rehab Center

Composed by:

☑ Reviewed ☐ Revised by: Nutritional Services Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 11/24 **Reviewed:** 01/21, 11/24 **Next Review Date:** ~~1/22~~

POLICY

Floors shall be maintained in a safe manner to ensure staff safety.

PROCEDURE

1. Floors should be kept clean and dry.
2. When floors are cleaned, one area should be mopped at a time. Keep mops and cleaning equipment out of the line of traffic.
3. Employees should walk across floors, never run, and always look carefully where they are going.
4. Clear traffic lanes shall be maintained. Objects should be kept off the floor and out of the aisles and doorways.
5. Floors are to be rinsed well to prevent slipping.
6. When operating electrical equipment, do not stand on a wet floor.
7. Any spills occurring should be cleaned immediately.
8. Placing rubber mats beside the dishwasher is an excellent practice, however, mats must be removed after each meal in order to mop and clean the floor in that area.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure:			
Food from Outside Sources			
Effective Date: 04/2019	**Page 1 of 1**		
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
❑ Reviewed ❑ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised:11/24	**Reviewed**: 01/21, 11/24	**Next Review Date**: ~~1/22~~	

POLICY

Food brought in by visitors for residents is discouraged due to problems of infection control.

PROCEDURE

1. Food brought in for residents will not be served by the Nutrition Services Department. Resident and their family members are also not allowed to ask Nutrition Services staff to cut up or prepare food from outside.
2. If food is brought in, the charge nurse must approve it before it is given to the resident.
3. Visitors are discouraged from bringing in potentially hazardous foods, i.e., meat, fish, eggs, custards, etc. If such foods are brought to the resident, they should be consumed immediately, but not stored in the facility and not shared with other residents within the facility.
4. Food left in the ~~residents~~resident's refrigerator shall be labeled with the ~~residents~~resident's name and date. Food still sealed by the manufacturer may be kept till the expiration date. All other food items will be discarded after three (3) days.
5. Non-perishable foods left in resident's room should be tightly sealed to prevent infestation of vermin and rodents.
6. The night shift licensed staff member assigned to check the refrigerator shall discard all ~~out of date~~out-of-date foods.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:			
Food Ordering and Receiving			
Effective Date: 06 2001		**Page 1 of 2**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ❑ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised:	**Reviewed**: 01 21, 11 24	**Next Review Date**: ~~1.22~~	

POLICY

~~Designation of companies or vendors through which facilities may, under normal conditions, order food supplies is the responsibility of the division Director of Dietary Services.~~

The Dietary Service Manager under the supervision of the Administrator, is responsible for ordering all food supplies necessary to adequately maintain Dietary Services and to meet local, state, and federal requirements regarding supplies on hand at all times.

PROCEDURE

1. ~~The Director of Nutrition and Food Services~~The menu as approved by a Registered Dietitian establishes specifications and guidelines for ordering all food supplies used in the Nutritional and Food Service Department.
2. All deliveries are received by the Nutritional and Food Service Department.
3. Orders are inspected when received to ensure quality, quantity, and condition. Meats, poultry, and fish are examined, and temperatures taken. If spoiled, defrosted food, or below acceptable temperature meat is received, it is refused and returned at the time of delivery.
4. Under normal operating conditions, the following minimum inventory is available on the

premises for both regular and therapeutic diets, based on state and federal requirement.

a. Staples seven (7) days
b. Perishable three (3) days
c. Disposables three (3) days
d.

5. Food is procured from sources that have been approved or are considered satisfactory by the health authorities. Food is clean, wholesome, and unspoiled. Meat and meat-products are purchased from suppliers who comply with local, state and federal laws and regulations.
6. It is advisable that deliveries be received at least seven (7) days prior to scheduled menu~~r~~ usage. This excludes perishables.
7. The Administrator (or designee) is responsible for:
    a. Supervising all food orders
    b. Doing periodic inspections of food materials received. Particular emphasis is placed on meats to ensure quality, condition and weight.
    c. Checking with the Nutrition and Food Service Manager to ~~insure~~ ensure that orders are received as initially ordered.
    d. Processing invoices and submitting for payment.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure:			
Food Preparation and Service			
Effective Date: 01 1992		**Page 1 of 2**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ❑ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised:11/24	**Reviewed**: 01 21, 11/24	Next Review Date:	

POLICY

Foods shall be prepared and served by methods that conserve nutritive value, enhance flavor and present an attractive and appetizing appearance to meet all resident's needs. Foods prepared shall be from a menu approved by a Registered Dietitian.

~~Food is prepared according to tested recipes in sufficient quality and by utilizing correct methods to conserve nutritive value and retain quality, appearance, and flavor. It is served attractively at proper temperatures in order to meet all residents' needs.~~

PROCEDURE

1. If the Dietary ~~Service Manager~~Supervisor is not available, the manager's designee assumes the responsibility for dietary activities, to include but not be limited to:
    a. Preparation of menu items
    b. Following the written menus
    c. Checking of resident trays
2. Standardized recipes from the approved menus are used. Recipes are adjusted to appropriate yield according to facility census. ~~A copy of the following is available in the facility's Nutrition and Food Service Department: (a) Registered Dieticians recipe manual and/or (b) Food for Fifty~~. It is the responsibility of the ~~Nutrition and Food Service Manager~~Dietary Supervisor to ensure that standardized recipes are used at all times. The recipe manual is an excellent tool to train new cooks.
3. Always wash raw fresh fruits and vegetables thoroughly before cooking or serving. This helps remove residue ~~form~~ from pesticides and other forms of contamination.

4. Frozen foods are properly thawed. Meat, fish, and poultry are thawed in the refrigerator below cooked food or produce. No meat is thawed at room temperature. Frozen fruits and vegetables need not be thawed before cooking. Allow extra time for preparation of the frozen products.
5. Food is chopped, ground or pureed to meet individual diet texture needs.
6. Each meal must be presented in an attractive and appetizing manner.
    a. Each serving should be clearly defined on the plate, ~~no~~ not running together. Side dishes are used when appropriate.
    b. There should be a good color balance on the plate to show variety.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Food Storage

Effective Date: 06 2001	**Page 1 of 2**

Areas Affected: Oakdale Nursing & Rehab Center
Composed by:
☑ Reviewed ❑ Revised by: Nutritional Services Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 11 24 **Reviewed**: 01 21, 11 24 **Next Review Date**: ~~1-22~~

POLICY

Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination.

PROCEDURE

The Nutrition and Food Service supply storeroom is the center of control in maintaining the quality of product and the cost control of the Nutrition and Food Service Department.

1. Dry storage rooms must be well ventilated.
2. Storage rooms must have only ~~one~~one access door. If the storeroom has more than one door, only one door will be used. All other doors must be locked and their use prohibited. Secure locks must be installed on all other doors and windows. The Nutrition and Food Service Manager shall control keys to storage rooms.
3. Contents of broken cases will be stored on shelves.
4. Metal or plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. These containers can be mounted on casters or dollies. All containers must be legibly and accurately labeled.
5. Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area always from food.
5. ~~5.~~

6. Scoops must be provided for flour, sugar, cereals, dried vegetables, and spices. Scoops are not to be stored in the food ~~containers, but~~containers but are kept covered in a protected area near the containers.
7. Scales, if available, must be conveniently located for weighing order.
8. Hands must be washed after unloading supplies and prior to handling any food items.
9. A cart with shelves is necessary for handling supplies. Facility size will determine necessary type and size.

10. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods.
    a. Place new items behind supply in stock of the same item; in this way oldest stock is always used first.
    b. Supervision is necessary to make sure that the person designated to put stock away is rotating it properly.
11. Food is purchased in quantities that can be stored properly.
12. Food is arranged in storage areas in food groups to make it easier to store, locate, and inventory.
13. Food is stored a minimum of six (6) inches above the floor on clean racks, dollies, or other clean surfaces, and is protected from splash, overhead pipes, or other contamination.
14. Perishable food such as meat, poultry, fish, dairy products, fruits, vegetables, and frozen products must be refrigerated immediately to ensure nutritive value and quality. Refrigeration temperatures should be thermostatically controlled.
15. ~~Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within thirty-six (36) hours or discarded.~~

16.15. **Refrigerator Temperatures:**
    a. Temperatures for refrigerators should be between 35-40 degrees Fahrenheit and must be recorded daily.
    b. Every refrigerator must be equipped with an internal thermometer, even if equipped with an external thermometer.
    c. Cooked foods must be stored above raw foods to prevent contamination.

17.16. **Freezer Temperature**:
    a. Temperatures for freezer should be zero (0) degrees Fahrenheit or below and must be recorded daily.
    b. Frozen foods must be received frozen. DO NOT accept frozen foods that have begun to thaw.
    c. Holding temperature for frozen foods is zero (0) degrees Fahrenheit or below. Frozen meats must be defrosted in a refrigerator. Defrosting time will depend on the size of the product being defrosted. Foods defrosting are placed on a tray.
    d. Every freezer must be equipped with an internal thermometer, even if equipped with an external thermometer.

e. Rewrap packages of frozen foods which have been opened. This prevents freezer burn and spoilage.

f. Do not refreeze frozen foods that have been thawed.

g. ~~To freeze leftover food, package in small untis for quick freezing. Wrap product so it is airtight, label and date it.~~

h.g. DO NOT crowd food. Proper air circulation ensures a more uniform temperature and prevents spoilage.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure:

Food Temperatures

Effective Date: 01 1992 | **Page 1 of 1**

Areas Affected: Oakdale Nursing & Rehab Center

Composed by:

☑ Reviewed ❑ Revised by: Nutritional Services Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 11 24 **Reviewed**: 01 21, 11/24 **Next Review Date**: ~~1-22~~

POLICY

Food will be maintained at proper temperature to ~~insure~~ ensure food safety.

PURPOSE

1. The temperature of hot foods during tray assembly will be 150 degrees F or above and hot food served to the resident will be no less than 140 degrees F.
2. The temperature of the potentially hazardous cold foods will be no greater than 40 degrees F when served to residents.
3. The cook is responsible to see that all foods are at the proper temperature.
4. The temperatures will be taken and recorded for all items at meal times. Record temperatures on temperature log sheets.
5. Test trays will be made up periodically and the temperatures, as served to the resident will be recorded by the Cook/Nutrition and Food Service Manager.
6. The following range of temperatures is recommended for the food at point of tray assembly:
    a. Broth, soup, hot beverages: 180-190 degrees F
    b. Meat, portioned for service: 165-180 degrees F
    c. Casserole dishes, creamed items, cream soup: 160-180 degrees F
    d. Chilled food and beverages: 40 degrees F or below
7. Heating food in the steam table is prohibited. Heating food to the proper temperature is accomplished by direct heat (stove, oven, steamer, etc.) and food is then transferred to the steam table not more than 30 minutes before meal services.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure:			
Meal Service to Residents			
Effective Date: 06 1994		**Page 1 of 1**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ❑ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised:11/24	**Reviewed**: 01 21, 11/24	**Next Review Date**: ~~1/22~~	

PURPOSE

1. Three (3) meals are served daily. Serving times are as follows:
   a. Breakfast: ~~7:30 a.m~~ 7:00 AM
   b. Lunch: ~~11:45 a.m~~11:30 AM
   c. Dinner: ~~4:45 p.m~~ 5:00 PM

2. All Dietary personnel are responsible for ensuring that all trays assembled meet dietary requirements, consistency/textures, and personal preferences for each resident. They are also responsible for timely delivery of tray carts to nursing staff who are in charge of passing trays to residents.
   ~~e.~~

~~2.~~3. Not more than fourteen (14) hours may elapse between the evening meal and breakfast the next morning.

~~3.~~4. Bedtime nourishments are offered to residents. Food ~~is of a~~ should be nourishing quality and consists of fruit juices, milk, crackers, cookies, gelatin, sandwiches, sliced cheese, pudding, etc. All food is served should be in accordance with the resident's diet.

~~4.~~5. The ~~Dieatary~~Dietary personnel is responsible for preparing and delivering the H.S. nourishments to the nurse's station. The ~~nourishment's~~nourishment will be offered to all residents at approximately 7:00-8:00 p.m. Nursing is responsible for offering all residents with H.S nourishments.

~~5.~~6. ~~Resident's~~ Residents' preferences will be adhered to as much as possible, unless medically contraindicated, and substitutes will be offered for all foods refused. Food is modified in the texture to meet resident needs. Food is cut, chopped, ground, or pureed, depending on the needs of the resident.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Service

Policy/Procedure:

Organization & Staffing

Effective Date:06 1994	**Page 1 of 2**
Areas Affected: Oakdale Nursing & Rehab Center	
Composed by:	
☑Reviewed ❑ Revised by: Nutritional Services Manager	

Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised:11 24 **Reviewed**: 01 21, 11 24 **Next Review Date**: ~~1~~22

POLICY

It is the policy of OVHD that the Nutrition and Food Service Department is organized, directed, staffed and integrated with other departments, services and units of the hospital to meet the nutritional needs of the clients served and maintain a quality food service operation.

PROCEDURE

1. Oak Valley Hospital ~~Director of~~ Nutrition and Food Services Department is directed full time by the ~~Director~~ Nutrition Service Manager who is a Registered Dietitian (RD).
2. ~~Oak Valley Care Center~~ Oakdale Nursing and Rehabilitation Center is directed by a full time ~~Nutritional Services Manager.~~Dietary Supervisor
3. ~~The Director and Nutritional Services Manager~~ The Nutrition Service Manager and Dietary Supervisor are responsible to the Administrator of ~~Oak Valley Care Center~~ Oakdale Nursing and Rehabilitation Center, as spelled out in the organization chart of the hospital district.
4. The ~~Director~~ Nutrition Service Manager at Oak Valley Hospital and the ~~Nutritional Services Manager~~ Dietary Supervisor at ~~OVCC~~ ONRC, assures the following:
    a. Implementation of established policies
    b. Maintenance of clinical and administrative aspects of the services provided by the department.
    c. Monitoring and evaluation of services provided by the department and initiating corrective ~~actions~~ actions based on finding.

d. The Nutrition and Food Services Department is staffed in the following manner:

i. Oak Valley Care Center

1. 5:00 am- 130 pm Cook AM
2. 10:00 am- 6:30 pm Cook PM
3. 5:00 ~~15~~ am- 1:30 ~~15~~ pm Aide AM
4. 5:030 am- 1:30 pm Aide AM
5. 11:30 ~~45~~ am- 8:00 ~~7:45~~ pm Aide PM
6. 11:30 ~~45~~ am- 8:00 ~~7:45~~ pm Aide PM

5. ~~Nutrition and Food Services Manager~~ The Dietary Supervisor is on duty 40 hours per week with variable schedule due to facility needs and staffing. ~~Director/~~The Nutrition Manager/RD is on 40 hours per week.
6. The ~~Director~~Nutrition Service Manager RD supervises the nutrition component of patient care to assure quality nutrition care is provided.
   a. The RD Nutritional Services Manager participates in committees related to nutritional care; for example Inter-Disciplinary Care Conference Committee, IDT Weight Variance and any nutrition related task force.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Service

Policy/Procedure:

Personnel Management

Effective Date:06 1994	**Page 1 of 1**

Areas Affected: Oakdale Nursing & Rehab Center
Composed by:
☑Reviewed ☐ Revised by: Nutritional Services Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised:11 15 **Reviewed**: 01 21, 11 15 **Next Review Date**: ~~1-22~~

POLICY

Sufficient staff should be employed, orientated, trained and their working hours scheduled to provide for nutritional needs of the residents and to maintain the Nutritional Services Department.

PROCEDURE

1. Job descriptions, work schedules, cleaning schedules and operating procedures are developed and written by the ~~Nutritional Services Manager~~ Dietary Supervisor with the assistance of the Dietitian as needed.
2. The Administrator, ~~Nutritional Services Manager~~Dietary Supervisor, and the Dietitian review personnel policies.
3. The ~~Nutritional Services Manager~~ Dietary Supervisor in consultation with the Administrator carries out employee interviews, hiring, evaluation reviews, and termination.
4. Staffing schedules are maintained by the ~~Nutritional Services Manager~~Dietary Supervisor within the budgeted hours allotted by the Administrator.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Procedures on the Sanitation of Water Pitchers

Effective Date:		**Page 1 of 1**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ❑ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised: 11/24	**Reviewed**: 01 21, 11/24	**Next Review Date**: ~~1/22~~	

POLICY

The Nutritional Service Staff shall provide clean and sanitized water pitchers for residents daily..

PROCEDURE

1. Empty dish machine, refill with clean water.
2. Run pitchers through machine.
3. Put on drying cart with cover and store in ~~Environmental Services office~~ designated area to air dry.

OAK VALLEY HOSPITAL DISTRICT
Nutrition and Food Services Manual

Policy/Procedure:

Provision of Food or Nutrition Products for Altered Diets or Meal Schedules

Effective Date: 01 92 | **Page 1 of 2**

Areas Affected: Nutrition and Food Services, Nursing Services
Composed by: Director of Nutritional Services
· Reviewed ❒ Revised by: Director of Nutritional Services

Dept / Committee Approval:	Dept/Title:	Date	Approved
Director of Nutritional Services	Director of Nutritional Services	11/15/2024	X
Policy, Procedures, Forms Comm.	Director of Nutritional Services	02/05/2025	X
Quality Council	Medical Staff Coord	02/13/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 1/95, 5/96, 01/04, 04/06, 11/24

Reviewed: 1/96, 1/97, 1/98, 1/99, 1/01, 01/07, 01/10, 01/13, 01/16, 01/190, 1/20, 01/21, 11/24

Next Review Date: ~~12/2023~~

PROCEDURE

Maximum efforts will be made to accommodate the patient's food and beverage preferences. At the request of the patient, alterations in the diet or diet schedule will be accommodated within the guidelines of any therapeutic diet (if applicable). For requests outside the therapeutic guidelines, the patient will be advised of the relationship between the therapeutic diet and their illness as part of the education process. Patients will be reminded of their rights and responsibilities in the health care process.

The responsible practitioner will be informed if the patient is non-compliant.

All information, steps ~~taken~~ taken, and education provided to the patient will be documented in the medical record.

Substitution will be offered for foods refused. Foods are modified to meet patient needs. Food can be cut, chopped or pureed depending upon the needs of the patient.

Patients who decline the regularly scheduled meal service ~~will~~ can be offered food at nourishment times if requested (10 AM, 3 PM, 7:30 PM). Patients requesting items during other times ~~will also~~ may be accommodated based on availability of items and the ~~patient~~patient's diet order. Food is available in the nurse's station refrigerator to meet patients' needs during the hours Food Service Staff is off duty. Items are labeled for patients.

There is a cut-off for requesting Meal Alternatives. All requests must be given before these times:

- 10:00 am for lunch
- 2:00 pm for dinner

Supplemental Food/Nutrition Products –

Products used as nutrition supplements (i.e. House Supplements, etc.) are stored in the Food Services storeroom until ready for use. These products are prepared in accordance with the Physician's orders, nursing request of patient preference. Products are prepared by Food Service Personnel, placed in the appropriate serving container and labeled. Products are stored and served at proper temperatures. These products are delivered to the nursing care unit for distribution to the patients by the nursing staff.

The use of food and nutritional products from outside sources (home, store, restaurants, etc.) is discouraged due to the concern for food safety and compliance with any therapeutic diet. If food is brought into the facility and consumed by the patient, this patient should be reminded of patient rights and responsibility and the consequences of such action.

If the patient requests an item be stored for later use, the following guidelines are to be used:

a. Item is to be placed in a separate receptacle or container, if appropriate, covered and labeled with patient name, room number and the date. The item is to be stored under proper conditions.
b. Item will be served at requested time and in requested manner.
c. Every attempt will be made to assure food safety of this item and to avoid cross contamination of the items.
d. If products are stored and found without the necessary cover, label and date, they will be discarded.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Re-Admission Nutritional Risk Note (RETIRE)

Effective Date:		**Page 1 of 1**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ☐ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11 15 2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02 05 2025	X
Department of Medicine	Medical Staff Coord	03 11 2025	X
Medical Executive Committee	Medical Staff Coord	03 18 2025	X
District Board	Board Liaison	04 03 2025	
Revised:11 24	**Reviewed**: 01 21, 11 24	**Next Review Date**: 1 22	

POLICY

Residents discharged for more the seven (7) days require a new Nutrition Risk note.

PURPOSE

1. New Risk notes are completed by the Nutritional Service Manager and are reviewed and assessed by the Dietitian.
2. The original Risk note needs to be reviewed and updated on all readmission's less than 7 days. This update is the placed in resident's current chart in the IDT Progress note.
3. If resident's condition dramatically changes, a new note is required.
4. If a resident transfers to a higher level of care, a note is required.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure:

Receiving and Storage Safety

Effective Date:	**Page 1 of 1**
Areas Affected: Oakdale Nursing & Rehab Center	
Composed by:	
☑Reviewed ❑ Revised by: Nutritional Services Manager	

Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised:11 24 **Reviewed**: 01 21, 11 24 **Next Review Date**: ~~1-22~~

POLICY

Safety precautions should be followed when delivery ~~container~~containers, crates, or boxes are opened, and when food and supply items are stored.

.

PROCEDURE

~~1. When opening boxes, cartons, barrels, crates, etc. remove nails.~~

~~2.~~1. In storing materials on shelves, always locate the heavier and bulkier materials on lower shelves. Avoid storage on top shelves or other high storage units.

~~3.~~2. All containers shall be clearly labeled.

~~4.~~3. All supplies shall be stored on well-constructed shelves and floor racks.

~~5.~~4. Arrange heavy supplies on racks or on lower shelves.

~~6.~~5. Odd shaped, sharp-edged objects shall be placed where they are readily visible, and never on top shelves.

-OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure:

Safety in Food Preparation

Effective Date:		**Page 1 of 2**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ❑ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised: 11/24	**Reviewed**: 01 21, 11/24	**Next Review Date**: ~~1/22~~	

POLICY

Food shall be prepared in a safe manner ~~so as to~~ to prevent employee injury.

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PROCEDURE

1. Only ~~dry towels,~~ mitts, or potholders shall be used when handling hot utensils (wet cloths conduct heat more readily.
2. Food should be cooked in minimum amounts of water to avoid boiling over. When the food reaches the boiling point, reduce heat to prevent boiling over.
3. Pot and pan covers should be removed slowly and by lifting sideways to ~~insure~~ ensure that steam might escape without scalding hands or face.
4. The handles of cooking utensils, pots, and pans should be turned away from the edge of the stove so that the utensils will not be accidentally brushed off, however, care should be taken so that handles are not positioned over an open flame.
5. When removing heavy containers from the stove, employees should have adequate assistance and know prior to removing it where the container is to be placed. Make certain that fellow employees are not present in the work area prior to moving hot containers, etc.
6. When hot water or coffee is drawn from an urn, the spigot should be turned slowly to avoid splashing. Check carefully to ~~insure~~ensure that all valves and spigots are in proper position before filling the urn.
7. ~~In order to~~ To avoid burns, each Nutrition Services employee should regard all pots, pans and the stove as hot.
8. Avoid splashing grease on top of the range (grease will ignite quickly, causing a dangerous fire).
9. Towels for handling hot containers shall not be placed on the range (the end of the towel may be dangled into or across the flame).
10. Avoid over-filling food containers.
11. ~~Do not turn the handle of any pot or pan toward the fire.~~

~~12.~~11. When employees are placing food ~~it~~ in hot grease, they are to let the ~~time~~ food item slide away from themselves to prevent grease from splashing. Do ~~N~~not leave greasy pans in the oven or let grease accumulate in drip pans.

~~13.~~12. Do not place glass near any hot cooking surface or equipment ~~food~~. It may break or chip.

~~14.~~13. The work area should be clean and orderly. Allow nothing to extend over the edge of a shelf, table or range.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Safety Guidelines

Effective Date: 06 1994	**Page 1 of 2**
Areas Affected: Oakdale Nursing & Rehab Center	
Composed by:	
☑ Reviewed ☐ Revised by: Nutritional Services Manager	

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Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised:11/24 **Reviewed**: 01/21, 11/24 **Next Review Date**: ~~1/22~~

POLICY

The Nutrition Services Department is ~~to~~ must be equipped with safe equipment and safe procedures are to be followed in equipment operation and daily work routines.

PROCEDURE

1. Equipment purchased shall meet the standards set by the National Sanitation Board, or NSF approved.
2. Instructions for operating equipment are kept readily available. All safety precautions shall be noted for each piece of equipment. All staff should be trained prior to operating any equipment and reviewed annually.
3. The ~~Nutrition Services Manager~~Dietary Supervisor shall stress safe techniques during the orientation of new employees and during daily employee work performance.
4. Every accident, no matter how minor, ~~occurring~~ must be reported, any injured employee must receive medical attention immediately and an incident form completed.
5. Equipment is kept in proper working order. Malfunctions ~~are~~ should be reported immediately.
6. ~~Directions are posted and followed for use of equipment such as mixers, slicer, dishwashers, ranges, and ovens.~~
7. ~~6.~~ Safety devices are used as provided on the equipment.
8. ~~7.~~ Precaution is exercised in handling hot equipment to guard against burns. Dry flameproof potholders are used to handle hot pots and pans. Handles of pans are turned away from the edge of the stove to prevent accidental spilling.
9. ~~8.~~ Glassware and dishes are handled with care. Chipped or cracked pieces are should be discarded.

~~10.~~9. ~~Spilled material~~ Any spillage ~~is~~ should be wiped up immediately to help prevent falls. Use wet floor signs to notify other staff to be careful.

~~11.~~ Heavy boxes are lifted properly to prevent injury. ~~Tow~~ Two or more employees lift heavy articles when necessary.

~~Injured employees receive immediate medical attention. A written incident report is made for each accident.~~

10. Employees shall report to the manager/supervisor respiratory and gastrointestinal infections.

11. Any lights that will not burn, broken chairs, frayed electrical cords, defective equipment, leaky faucets, broken China or glass, or additional unsafe items should be reported to the Dietary Supervisor.

12. Extreme caution should be utilized with swinging doors.

13. No one should engage in horseplay or practical jokes.

14. All personnel should observe warning signs, i.e. wet floor.

15. Personnel should walk, not run, in the Nutritional Service Department halls.

16. Employees shall familiarize themselves with their work procedures and safe practices.

~~12.~~

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Safety Rules (RETIRE, COMBINE WITH SAFETY GUIDELINES)

Effective Date: 10/1999	**Page** 1 of 1

Areas Affected: Oakdale Nursing & Rehab Center

Composed by:

☑ Reviewed ☐ Revised by: Nutritional Services Manager

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	x
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	02/18/2025	X
Medical Executive Committee	Medical Staff Coord	02/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 11/24 **Reviewed**: 01/21 11 24 **Next Review Date**: 1 22

POLICY

All employees should be aware of safety rules.

PROCEDURE

1. Employees should immediately report any unsafe conditions to Nutritional Service Manager.
2. Employees should report to the manager supervisor any accident, injury, or burn, no matter how minor. Secure immediate first aid if necessary.
3. Employees shall report to the manager supervisor respiratory and gastrointestinal infections.
4. Any lights that will not burn, broken chairs, frayed electrical cords, defective equipment, leaky faucets, broken china or glassware additional unsafe items should be reported to the Nutritional Service Manager.
5. Extreme caution should be utilized with swinging doors.
6. No one should engage in horseplay or practical jokes.
7. All personnel should observe warning signs, i.e. wet floor.
8. Personnel should walk, not run, in the Nutritional Service Department, halls or stairways.
9. Employees shall familiarize themselves with their work procedures and the safe practices to be followed.

P: Nutritional Services Manual 2021 Safety Rules (2024_1115_RI) RETIRE.docx

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Sanitizing Dishwashing Area

Effective Date: 1999	**Page 1 of 3**
Areas Affected: Oakdale Nursing & Rehab Center	
Composed by:	
☑ Reviewed ❑ Revised by: Nutritional Services Manager	

Dept / Committee Approval:	Dept/Title:	Date	Approved
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Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised:11/24 **Reviewed**: 01 21, 11/24 **Next Review Date**: ~~1/22~~

POLICY

To insure effective dishwashing, all equipment must be functioning.

PROCEDURE

1. Mechanical Dishwashing
    a. Ready the machine by ~~filling~~ filling it with water and turning on heaters according to the manufacturer's instructions.
    b. Charge the machine with detergent as recommended by the detergent supplier.
    c. Scraping, pre-rinsing, and pre-washing preparations:
        1. Sort and separate flatware, glasses, and dishes
        2. Presoak flatware in a detergent solution
        3. Presoak dishes, when necessary
        4. Stack trays.
    d. Rack dishes (without overlapping) in appropriate rack. DO NOT overload
    e. Rack cups, bowls and glasses upside down.
    f. Flatware should be placed loosely in flat racks for the first wash (no more than 100 pieces per rack) ~~Hatewarel~~ latware should be sorted and placed loosely in cylinders and washed a second time, handles down
        1. NOTE: after washing and allowing to air dry, place a clean ,empty cylinder over the mouthpieces and insert the cylinder so that the handles point up. Do not handle the mouthpiece.
    g. Wash Temperature: The wash temperature must be maintained at a minimum of ~~140 to 160~~ 120-145

degrees F during a minimum wash cycle time of 30-60 seconds.

h. Rinse Temperature: The rinse temperature must be maintained at a minimum of 180 degrees during a minimum wash cycle of 30 seconds

1. NOTE: To ensure proper sterilization of all dishes, this procedure must be followed exactly.

2. Dish Machine Temperature Log

a. To ensure that the wash and rinse temperatures are properly monitored and controlled, a long must be completed by those who are directly involved in the dishwashing process. Entries must be made for each meal..

b. Post the log in the rinse temperature must be observed and logged during the dishwashing period.

c. Wash and rinse temperature must be observed and logged during the dishwashing period..

d. The dish machine operator must enter actual temperature in the log three times daily.

e. Report temperatures that are below the required levels to the Nutrition Services Manager.

3. General Dish Area Sanitation

a. Food ~~waster~~waste material, heat, and moisture are the primary contributors to unsanitary conditions in the Nutrition Services Department and all are evident in the dish room.

1. Dish racks must be handled and stored off the floor. Both full and empty dish racks are to be stored on a dish rack dolly, cart, or an under shelf in the dish room at all times. Generally, the floor has a high bacterial contamination and is not considered to be a clean area.

2. Dish room work surfaces must be maintained in a clean and sanitary condition.

1. Wash the soiled dish table and rinse.

2. Wipe down the exterior of the dish machine; give particular attention to the top of the machine.

3. Wipe down all other work surfaces in the dish room.

3. Chips and cracks in dishware provided a home for bacteria and a potential contamination source. They can also be a safety hazard to residents and employees.

1. The dish machine operators should sort out chipped or cracked dishware, including trays and plate covers.

2. The ~~Nutrition Service Manager~~ Dietary Supervisor examines the sorted items to determine ~~whether or not~~ whether they meet acceptable standards. If not, damaged wares shall be discarded and replaced.

b. Non-disposable plastic ware is to be stain free and able to be sanitized. (Plastic ware cannot be properly sanitized when finish is worn off)

1. Consult your dish machine detergent supplier fro for recommendations on a plastic ~~destainer~~detainer.

2. Establish routine schedules for destaining plastic. Be sure to define how, by whom, and when the procedure will be ~~carried~~. Out. carried out.

3. Daily examination of plastic ware by random sample will ensure acceptability.

4. Dish Machine Maintenance Problems:

a. Proper dish machine maintenance is preventive maintenance that prolongs the life of the dish machine

and reduces operational costs.

1. Clean the dish tables with a detergent solution. Rinse with fresh water. Keep strainer trays in dish machine during this operation.
2. Turn off the heat switch on the wash and rinse tanks.
3. Drain the water from the tanks and pumps.
4. Remove the wash arms or end cups where arms are not removable and clean with a brush.
5. Check the final rinse spray nozzles and clean out any collected debris.
6. Remove the strainer and trays and clean thoroughly.
7. Close the tank, drain, and hose and scrub the entire interior of the machine thoroughly. Refill the tank, flush out the pump and pump lines by operating the machine for at least one minute, then drain the tank.
8. Scrub and wash down the curtains.
9. Replace the strainer trays and the wash and rinse arms.
10. Check the machine for the next operation; leave all inspection doors open.
11. Check the filler opening, final rinse, and pump packaging for any leakage.
12. The authorized detergent manufacturer representative should ~~make an inspection~~ inspect at least every month.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Service

Policy/Procedure:

Standards of Care
Definition of Services

Effective Date: 02 1994	**Page 1 of 1**
Areas Affected: Oakdale Nursing & Rehab Center	
Composed by:	
☑ Reviewed ❑ Revised by: Nutritional Services Manager	

Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 11/24 **Reviewed**: 01 21, 11/24 **Next Review Date**: ~~1/22~~

POLICY

It is the policy of ~~OVHD~~ Oakdale Nursing and Rehabilitation Center that the Nutrition and Food Service Department is committed to providing quality food service and optimum nutritional care to our patients and residents.

PROCEDURE

Food Service is provided to patients based upon the physician's order and nutritional needs. The following patient population is served: ~~infants taking solid foods, pediatrics,~~ adults and geriatrics. Menus are planned in advance with the goal to ~~provide~~of providing optimum nutrition, taste, eye appeal and patient acceptance. Enteral feedings, with physician's order, are provided ~~if oral intake is inadequate~~.

Patient satisfaction acceptance of meals is surveyed and evaluated. Changes are planned and instituted based on survey results, with the goal to provide optimum satisfaction acceptance of the meal

~~Nutritional~~ The nutritional needs of the residents are assessed and documented in the residents medical record by the Registered Dietitian (RD). The ~~Nutrition Services~~Dietary Supervisor or Registered Dietitian provides initial nutrition screening and prioritizing of residents ~~at Oak Valley Care Center~~ Oakdale Nursing and Rehabilitation Center. See Nutrition Services policy on "Nutrition Screening and Prioritizing" for specifics. Plans and goals are developed and documented based upon the assessment.

Resident and or family nutrition counseling education is provided by the Registered Dietitian (RD) as indicated by physician's order, resident request or identified need. Guidelines are planned and written with the goal ~~to provide~~ of providing optimum understanding and ease of compliance.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Texture Change Documentation (RETIRE)

Effective Date: 01/2001		**Page 1 of 1**	
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ☐ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised 11/24	**Reviewed:** 01/2111/24	**Next Review Date:** 1/22	

POLICY

Texture changes in diet orders will be documented in the progress notes indicating the reason for change. All texture change orders will be reassessed at all Care Plan meetings..

PROCEDURE

1. The Nutritional Service Manager will add the reason for the texture change to the Nutritional Service Progress notes. The Dietitian will assess the appropriateness of the texture change when needed.

2. 1. Texture changes will be addressed at all future Care Plan meetings and will be stated in the physician update orders.

OAK VALLEY HOSPITAL DISTRICT

Oakdale Nursing & Rehabilitation Center

Nutrition and Food Services Manual

Policy/Procedure:

Tray Assembly (RETIRE)

Effective Date: 10/1997	**Page** 1 of 1
Areas Affected: Oakdale Nursing & Rehab Center	
Composed by:	
☑ Reviewed ☐ Revised by: Nutritional Services Manager	

Dept / Committee Approval:	Dept/Title:	Date	Approved
Continuous Quality Improvement	ONRC	11/15/2024	X
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Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised:11/24	**Reviewed**: 01/21, 11/24	**Next Review Date**: 1/22

POLICY

Trays will be assembled at a given time in a given location with all the foods needed for regular and therapeutic diets on hand.

PROCEDURE

1. The Food and Nutrition Service Manager, head cook or relief cook is responsible for seeing that all foods needed for tray assembly are present at the designated time.

2.1 A person designated by the Food and Nutrition Services Manager is responsible for seeing that all tray assembled meet therapeutic requirements of the diets, consistency, and personal preferences noted on the tray card.

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehabilitation Center
Nutrition and Food Services Manual

Policy/Procedure: **Trial Diets**			
Effective Date: 01 2001	**Page 1 of 2**		
Areas Affected: Oakdale Nursing & Rehab Center			
Composed by:			
☑ Reviewed ❑ Revised by: Nutritional Services Manager			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	11/15/2024	X
Policy, Procedures, Forms Comm.	Medical Staff Coord	02/05/2025	X
Department of Medicine	Medical Staff Coord	03/11/2025	X
Medical Executive Committee	Medical Staff Coord	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised: 11/24	**Reviewed**: 01/21, 11/24	**Next Review Date**: ~~1/22~~	

PURPOSE/GOAL

To provide appropriate diet texture to all residents to promote and achieve optimum intake of meals.

PROCEDURE

When nursing staff notices a resident presenting symptoms of difficulty chewing/swallowing (see list of symptoms on the next page) they will notify the Registered Dietitian and the Speech Therapist. The Speech therapist~~y~~ will then evaluate/screen resident for swallowing/chewing difficulties ~~on trialed texture~~ and make recommendations for a trial diet.

~~At the discretion of the nursing staff and/or the Nutritional Services Manager~~ The Registered Dietitian, Nursing staff, and/or the Speech Therapist, ~~a residents~~ may change a resident's diet texture ~~may be changed~~ for a maximum of three days. The purpose of the change may be to trial a different texture than ordered to either advance diet or downgrade diet, as necessary.

The ~~nursing staff and the Nutritional Service Manager~~ nursing staff, Registered Dietitian, and/or Speech Therapist will evaluate the trial diet for effectiveness using ~~.P~~percentage intake and acceptance by resident ~~will~~ to determine appropriateness.

Once trial diet is completed, ~~nursing or Nutritional Service manager~~ the above-mentioned staff, will contact the doctor with recommendation for diet change.

~~Speech therapy will be notified of diet trial when diagnosis reflects swallowing difficulties and/or resident~~

~~presents symptoms of difficulty with chewing/swallowing. Speech therapy will then evaluate/screen resident for swallowing/chewing difficulties on trialed texture and make recommendations.~~

References: Dysphagia. Mayo Clinic. July 31, 2024. https://www.mayoclinic.org/diseases-conditions/dysphagia/symptoms-causes/syc-20372028.

Symptoms of Chewing/Swallowing difficulty:

- Pain while swallowing.
- Not being able to swallow.
- Feeling as if food is stuck in the throat or chest or behind the breastbone.
- Drooling.
- Hoarseness.
- Food coming back up, called regurgitation.
- Frequent heartburn.
- Food or stomach acid backing up into the throat.
- Weight loss.
- Coughing or gagging when swallowing.

References:

Dysphagia. Mayo Clinic. July 31, 2024. https://www.mayoclinic.org/diseases-conditions/dysphagia/symptoms-causes/syc-20372028.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

ARRIVAL OF NEW ELECTRICAL EQUIPMENT

Effective Date:	**Page 1 of 1**

Areas Affected: Respiratory Therapy Department
Composed by:
☒ Reviewed ☐ Revised by: RT Supervisor

Dept. / Committee Approval:	**Dept./Title:**	**Date**	**Approved**
Respiratory Therapy	RT Supervisor	11/17/2024	X
Policy, Procedures, Forms Comm.	VP of Nursing	02/05/2025	X
Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 8/21 **Reviewed**: 9/15; 10/18, 11/24 **Next Review Date**: 8/2024

POLICY

All new electrical equipment (patient or non-patient care) will be inspected for electrical safety and physical condition upon arrival at the hospital by the Engineering Department.

PROCEDURE

1. Upon receiving new equipment the on duty Respiratory Care Practitioner (RCP) will be responsible for notifying the Engineering Department for the initial inspection.

2. If possible the equipment should be taken to the Engineering Department for inspection.

3. If the equipment is too large, a phone call is to be made to Engineering as well as a requisition slip filled out.

OAK VALLEY HOSPITAL DISTRICT

Respiratory Therapy Manual

Policy/Procedure:

BI-LEVEL POSITIVE AIRWAY PRESSURE (BiPAP)

Also indexed as: BiPAP

Effective Date: 5 1993	**Page** 1 **of** 5		
Areas Affected: Respiratory Therapy Department			
Composed by: RT Manager			
☐ Reviewed ☒ Revised by: VP of Nursing			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Respiratory Therapy	Supervisor	11/17/2024	X
Policy, Procedures, Forms Comm.	VP of Nursing	02/05/2025	X
Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised: 9 15; 4 17; 8 21	**Reviewed**: 10 00; 4 04; 5 06; 11 09, 11 24	**Next Review Date**:	

~~PURPOSE~~SUPPORTIVE

Bi-Level Positive Airway Pressure (BiPAP) is a low pressure, electrically driven unit with electronic pressure control. It provides air at suitable pressures and flow rates for patient ventilation assistance. BiPAP is derived from Bi-level Positive Airway Pressure.

It is intended to augment patient ventilation by supplying pressurized air through a mask. It senses the patient's breathing efforts by monitoring airflow in the patient circuit and adjusts its output to assist in inhalation or exhalation.

BiPAP is able to provide leak tolerance and is leak compensated. It is able to maintain breath-to-breath sensitivity and pressure stability in the presence of leaks.

BiPAP is a non-continuous ventilator and is intended to augment patient breathing. It must not be used as a life support ventilator. It is not intended to provide the total ventilatory requirements of the patient.

INDICATIONS FOR USE

1. Unacceptable or worsening alveolar hypoventilation (an elevated or rising $PaCO_2$).

2. Chronic ventilatory muscle dysfunction, muscle fatigue, and/or those with an underlying medical problem and pathophysiology that makes ventilatory muscle fatigue or dysfunction likely.

   Clinical signs include:
   a. tachypnea
   b. use of accessory muscles of ventilation

c. reduced tidal volume
d. Subjective complaints of fatigue often accompanied by a rising $PaCO_2$.

3. Unacceptable hypoxemia despite administration of supplemental oxygen.

4. Patients who develop post-extubation difficulty in whom you wish to avoid re-intubation.

5. Patients with upper airway obstruction due to such conditions as laryngeal/supra or subglottic edema in post-extubation period or after inhalation injury.

CONTRAINDICATIONS FOR USE

1. Patients incapable of maintaining life-sustaining ventilation in the event of malposition of the mask.

2. Hypoventilation induced by positive pressure ventilation.

3. Patients with or susceptible to pneumothorax or pneumomediastinum should be monitored closely when applying positive pressure. Pre-existing bullous lung disease may represent a relative contraindication to PPV therapy.

4. A history of allergy or hypersensitivity to the mask material where the allergic reaction outweighs the benefit of ventilatory assistance.

***NOTE:**
CAUTION SHOULD BE EXERCISED IN APPLYING A SNUG OR TIGHT FITTING FULL FACE MASK (NASAL/ORAL) TO PATIENTS BECAUSE OF THE INCREASED POSSIBILITY OF ASPIRATING GASTRIC CONTENTS. THIS IS PARTICULARLY TRUE IN PATIENTS WHO ARE AT RISK FOR, OR WHO HAVE BEEN VOMITING. IN THESE PATIENTS PERHAPS THE PLACEMENT OF AN NG TUBE PRIOR TO APPLICATION OF A FULL-FACE MASK SHOULD BE CONSIDERED.

PROCEDURE

1. Confirm physician orders.
2. Physician must prescribe mode.
3. Evaluate patient oxygenation to determine his/her supplemental requirements.
4. An arterial blood gas should be done prior to BiPAP, whenever possible.
5. Leak FIO_2, tidal volume, minute ventilation and respiratory rate should be gathered and documented in the physician progress notes and on the BiPAP flowsheet.
6. Pulse and respiratory rate. Place patient on Telemetry and continuous Pulse Oximetry (pulse ox) while on bi-pap.
7. Skin color, temperature, and perfusion.
8. Use of accessory muscles of ventilation.
6. Paradoxical movement of the chest wall, which may reflect impending, or an actual ventilatory muscle fatigue.
7. Auscultation.
8. Explain BiPAP to the patient and to the medical team that will be taking care of the patient.

Laboratory data, including but not limited to:

1. ABG's
2. Chest x-ray
3. Baseline O_2 Sat.

WARNING

PERFORMANCE VERIFICATION SHOULD BE PERFORMED PRIOR TO EACH PATIENT USE OF THE BiPAP VENTILATORY SUPPORT SYSTEM. PLEASE SEE SECTION 9 PAGES 31-33 OF THE OWNERS MANUAL BEFORE YOU PROCEED ANY FURTHER.

FITTING THE MASK, NASAL, FACIAL

Proper mask sizing has been shown to be one of the most crucial components to the success of non-invasive ventilation. Mask comfort is often the limiting factor to continuous use of mask ventilatory support.

For complete fitting instructions refer to our owners manual or the attachments that are within this procedure.

1. Select the smallest size mask to comfortably fit the patient. The mask-sizing gauge may be used to assist in selection of the initial size mask.

2. The mask should fit from the end of the nasal bone to just below the nares for nasal mask. Be careful to ensure that the mask rests above the upper lip. The facial mask should fit from nasal bone to between lower lip and chin.

3. Place the mask over the patient's nose and select proper spacer size. Attach spacer to mask.

4. Attach head strap to mask. Apply mask and head strap to patient. Adjust straps until all significant leaks are eliminated. Avoid over tightening. This will cause leaks and patient discomfort.

5. Be careful not to over stress an anxious patient with attempts to place the mask. If not initially tolerated and the patient is continuing to fail, another mode of support should be considered.

6. Monitor for redness or breakdown to bridge of nose and cheeks, alternate masks (full-face or nasal masks) should be used to prevent breakdown to skin/tissues.

***NOTE:**

OPERATION OF THE RESPIRONICS BiPAP S/T-D VENTILATORY SUPPORT SYSTEM REQUIRES CLOSE CLINICAL AND PHYSIOLOGICAL MONITORING. CONTINUOUS MONITORING SHOULD BE CONDUCTED THROUGHOUT THE INITIAL APPLICATION IN ORDER TO DETERMINE THE OPTIMAL BiPAP SYSTEM SETTINGS, AND WHEN NECESSARY, THE APPROPRIATE LEVEL OF SUPPLEMENTAL OXYGEN. THE PATIENT'S CLINICAL AND PHYSIOLOGICAL STATUS SHOULD ALSO BE CAREFULLY MONITORED THROUGHOUT THE ENTIRE PERIOD OF TREATMENT DURING WAKEFULNESS AND SLEEP.

~~INDICATIONS FOR USE~~

~~6. Unacceptable or worsening alveolar hypoventilation (an elevated or rising $PaCO_2$).~~

~~7. Chronic ventilatory muscle dysfunction, muscle fatigue, and/or those with an underlying medical problem and pathophysiology that makes ventilatory muscle fatigue or dysfunction likely.~~

~~Clinical signs include:~~
~~e. tachypnea~~
~~f. use of accessory muscles of ventilation~~
~~g. reduced tidal volume~~
~~h. Subjective complaints of fatigue often accompanied by a rising $PaCO_2$.~~

~~8. Unacceptable hypoxemia despite administration of supplemental oxygen.~~

~~9. Patients who develop post-extubation difficulty in whom you wish to avoid re-intubation.~~

~~10. Patients with upper airway obstruction due to such conditions as laryngeal/supra or subglottic edema in post-extubation period or after inhalation injury.~~

~~CONTRAINDICATIONS FOR USE~~

~~5. Patients incapable of maintaining life-sustaining ventilation in the event of malposition of the mask.~~

~~6. Hypoventilation induced by positive pressure ventilation.~~

~~7. Patients with or susceptible to pneumothorax or pneumomediastinum should be monitored closely when applying positive pressure. Pre-existing bullous lung disease may represent a relative contraindication to PPV therapy.~~

~~8. A history of allergy or hypersensitivity to the mask material where the allergic reaction outweighs the benefit of ventilatory assistance.~~

~~*NOTE:~~
~~**CAUTION SHOULD BE EXERCISED IN APPLYING A SNUG OR TIGHT FITTING FULL FACE MASK (NASAL/ORAL) TO PATIENTS BECAUSE OF THE INCREASED POSSIBILITY OF ASPIRATING GASTRIC CONTENTS. THIS IS PARTICULARLY TRUE IN PATIENTS WHO ARE AT RISK FOR, OR WHO HAVE BEEN VOMITING. IN THESE PATIENTS PERHAPS THE PLACEMENT OF AN NG TUBE PRIOR TO APPLICATION OF A FULL FACE MASK SHOULD BE CONSIDERED.**~~

PATIENT CAUTIONS

1. Advise the patient to immediately report any unusual chest discomfort, shortness of breath or severe headache upon awakening or when using the machine.

2. If using a full-face mask, the patient should be advised not to eat or drink two to three hours prior to bedtime.

3. If skin irritation or breakdown develops due to the mask refer to the patient accessory guide for the appropriate action (the owner's manual).

4. Other potential side effects of CPAP/BiPAP system use:
   a. Ear discomfort
   b. Conjunctivitis
   c. Skin abrasions

HELPFUL HINTS

1. Turn on APM (airway pressure monitor) first, then the vent. The APM measures the high and low-pressure alarms plus the delay function.

2. To augment tidal volume by improving alveolar ventilation or reducing accessory muscle use, increase the IPAP in 2cm increments.

3. To increase FRC increase EPAP in 2cm increments.

4. EPAP cannot and should not be raised higher than IPAP. In some patients they may be equal.

5. The slotted openings should always be positioned away from the patient during operation. The openings allow the patients exhaled gas to escape. The slots should never be blocked or sealed.

6. The O_2 flow should be started at the same liter flow that the patient was using (nasal cannula or mask) or 2-5 liters. Be sure to monitor the patient for adequate O_2 flow.

7. Don't adjust the FIO_2 using an analyzer. It may not reflect the correct delivered FIO_2 due to:
   a. Analyzer response time.
   b. Gas mixing in the circuit.

SETTINGS

IPAP-BiPAP DELIVERS CPAP. INDICATED BY IPAP KNOB. ABOUT 4-20cm's H_2O.
(IPAP IS LIKE PRESSURE SUPPORT).
Suggested initial setting 8.0 cm H_2O
Physician settings ordered.

EPAP-BiPAP DELIVERS CPAP. INDICATED BY EPAP KNOB. ABOUT 4-20cm's H_2O).
(EPAP IS LIKE PEEP). THIS IS THE PREFERRED SETTING FOR DELIVERY OF CPAP.
Suggested initial setting 3.0 cm H_2O.
Physician settings ordered.

BiPAP Mode as clinically indicated:
Spontaneous
Set IPAP and BiPAP as above.

Spontaneous/Timed
Set IPAP and EPAP per above.
Set BPM as clinically indicated.
Consider 2-5 BPM less than the patient's spontaneous rate.

Timed
Set IPAP and EPAP as per above.
Set BPM as clinically indicated.
Consider setting slightly higher than the patient's spontaneous rate.
Set % IPAP as clinically indicated.
Consider setting 33% - 50% to deliver a 1.2 to 1.1 I:E ratio.

ADJUSTMENT OF THE BiPAP SYSTEM

IPAP -
Increase IPAP in increments of 2.0 cm H_2O to increase "pressure boost."
Increase pressure boost to reduce or stabilize $PaCO_2$ with augmentation of alveolar ventilation, relieve the sense of dyspnea, reduce the use of accessory muscles of ventilation and eliminate stridor if present.

EPAP –
Increase EPAP by 2.0 cm H_2O increments to increase FRC and improve oxygenation in those patients with low pulmonary compliance and shunting, or to manage upper airway obstruction. It in not possible or desirable to raise the EPAP levels higher than IPAP.

RE-ADJUSTMENT OF SETTING WHEN INDICATED

1. Adjust control settings as necessary.
2. Supplemental oxygen. Maintain a liter flow that allows clinically acceptable PaO_2.
3. Mask-leak; skin condition, patient assessment, and mask appearance.
4. Note patient discomfort on BiPAP, re-evaluate. Be sure to include notes in progress notes and on flow sheet.
5. Check IPAP and EPAP settings and BPM and % IPAP settings as indicated.

REFERENCES

1. BiPAP clinical manual.
2. Respironics Inc. suggested protocol for initiation of the BiPAP system.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:			
BLOOD SPILL PROCEDURE			
Effective Date: 9 92		**Page 1 of 1**	
Areas Affected: Respiratory Therapy Department Composed by: ☒ Reviewed ☐ Revised by: RT Supervisor			
Dept. / Committee Approval:	**Dept./Title:**	**Date**	**Approved**
Respiratory Therapy	RT Supervisor	11/17/2024	X
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Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised:	**Reviewed**: 10 18; 8 21, 11/24	**Next Review Date**: 8 2024	

PROCEDURE

In the event of a blood or other bodily fluid spill, the Respiratory Therapy staff is to do the following:

1. Put on gloves, goggles with face mask (a gown should be worn if the spill is large).

2. Paper towels are to be placed over the spill and then spray or pour Quatsyl (R) 256. Wait 15 minutes and clean spill with the paper towels and dispose of them in a red biohazard bag. If there are no red bags available in the Respiratory Therapy department, call Environmental Services and ask for red Biohazard bags.

3. When the spill is cleaned up, Environmental Services is to be called to properly dispose of the Biohazard bag.

If the spill is large do not attempt to clean it up. Secure the area and call for Environmental Services to clean the spill.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

BROKEN EQUIPMENT PROCEDURE

Effective Date: 7 94		**Page 1 of 1**	
Areas Affected: Respiratory Therapy Department			
Composed by:			
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District Board	Board Liaison	04/03/2025	
Revised: 9 96	**Reviewed**: 10 18; 8 21, 11 24	**Next Review Date**: ~~8-2024~~	

PROCEDURE

1. If broken equipment results in altered patient care, the Department Manager should be notified and an incident report prepared.

2. All broken non-disposable respiratory care equipment must be repaired in a timely manner. When a piece of equipment is broken and requires repair, the following procedure must be followed:

   a. Provide patient with alternative equipment
   b. Take the equipment out of circulation
   c. Fill out a Maintenance request report. Be certain to report:

      i. Name of therapist finding broken equipment
      ii. Date
      iii. Serial number if the broken equipment is a ventilator
      iv. The problem found with the equipment. Be specific.

3. A copy of this ticket should be left with the broken equipment.

4. Notify the Department Manager of this action so that the proper steps can be taken to repair the equipment.

5. Equipment must be checked by the Bio Med Engineering when it is returned from an outside repair service prior to being placed back in service.

6. Engineering is to receive a copy of all repairs to equipment including contract repairs.

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Respiratory Therapy Manual

POLICY/PROCEDURE:			
CARBOXY HgB SAMPLES			
Effective Date:		**Page 1 of 1**	
Areas Affected: Respiratory Therapy Department			
Composed by:			
☒ Reviewed ☐ Revised by: RT Supervisor			
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Respiratory Therapy	RT Supervisor	11/17/2024	X
Policy, Procedures, Forms Comm.	VP of Nursing	02/05/2025	X
Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
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Oak Valley Hospital does not perform Carboxy HgB analysis. All samples will be collected and handled by the Laboratory. If you are called for a carboxy HgB instruct them to call the Laboratory.

OAK VALLEY HOSPITAL DISTRICT

Respiratory Therapy Manual

POLICY/PROCEDURE:

CONSIDERATIONS IN OXYGEN THERAPY FOR INFANTS

Also indexed as : Oxygen Therapy for Infants

Effective Date: 3/86 | **Page 1 of 2**

Areas Affected: Respiratory Therapy Department

Composed by:

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POLICY

When an increased inspired oxygen concentration is judged to be required for any newborn infant, it must be administered with great care since there is a causal relationship between a higher than normal oxygen tension in retinal arterial blood and retrolental fibroplasia. (Normal is 80 to 100mg. Hg. when infants are breathing room air). Susceptibility to retrolent fibroplasia increase with increasing prematurity. Current information suggests that the most susceptible infants can develop this disease when the oxygen tension of arterial blood is above 150 mm. Hg. for as short a period as 4 hours. Even concentrations of inspired oxygen of 30% to 40% may raise the oxygen tension of retinal arterial blood to these dangerous levels in such infants.

On the other hand, for infants with cardio respiratory disease, an inspired oxygen concentration of 40% may be insufficient to raise the oxygen tension of arterial blood to a normal level. In such cases, in inspired oxygen of 60, 80, or 100% may be needed. These infants are not in a steady state and arterial oxygen tensions may vary greatly minute to minute. In some infants, such as those recovering from asphyxia, arterial oxygen tension may change dramatically up or down, in 5 to 10 minutes. With these infants, it is difficult to judge by clinical signs the concentration of inspired oxygen necessary to maintain the arterial oxygen in the normal range. An infant may have peripheral cyanosis and have normal oxygenation of arterial blood. Therefore, when an infant's clinical condition suggests that an oxygen-enriched environment is necessary, pulse oximeter or blood gas measurements are required for regulation of the inspired oxygen concentration.

GUIDELINES

1. Oxygen tension of arterial blood should not exceed 150 mg. Hg. and should be maintained between 50-70 mm Hg. When cardiac output and the distribution of the cardiac output are normal, oxygen tensions of 40-50 mm. Hg. probably provide adequate oxygenation of arterial blood.

2. Inspired oxygen concentrations above 40% may be used if necessary to maintain the arterial oxygen tension between 50-70 mm. Hg. When concentrations above 40% are used in infants weighing less than 1500 grams, arterial oxygen tension must be measured at least every 6 hours when the condition of the infant is stable. When his condition is changing rapidly, measurements must be made more frequently (see below).

3. It is essential that when an infant is placed in an oxygen-enriched environment, the concentration of oxygen delivered to the infant's airway be measured with an oxygen analyzer at least every hour, preferably every 2 hours. The performance of the oxygen analyzer must be checked daily and calibrated with room air and 100% oxygen.

4. Mixtures of oxygen and room air must be delivered to an infant by means of endotracheal tubes, masks, hoods, or incubators. Regardless of the method used, the mixture must be warmed and humidified.

5. As newborn infants with the idiopathic respiratory distress syndrome improve, the concentration of oxygen should be lowered by no more than 10% decrements and at intervals of no less than 10 to 20 minutes. In infants recovering from birth asphyxia, it may be necessary to lower the oxygen concentration more rapidly. In infants with chronic lung disease (requiring oxygen for more than 5 or 6 days) the concentration of oxygen will have to be lowered much more slowly. With these infants, lowering the inspired oxygen concentration from 30 to 21% may take more than a week and the concentration should not be lowered in greater than 2% decrements.

REFERENCES

1. American Association of Respiratory Care. Clinical Practice Guidelines. "Selection of an Oxygen Delivery Device for Neonatal and Pediatric Patients". 2002

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

CONTINUOUS PULSE OXIMETRY

Also indexed as: Oximetry – Continuous; Pulse Oxymetry Continuous

Effective Date: 3 94	**Page 1 of 1**
Areas Affected: Respiratory Therapy Department	
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PURPOSE

Pulse oximetry is a non-invasive procedure to monitor the oxygen saturation in the blood.

PROCEDURE

1. Check physician order.
2. Obtain room air SaO_2 or ABG if possible (ABG must have a written physician order).
3. Identify any risk factors for respiratory depression (history of obstructive sleep apnea, administration of opioids or other anesthetic agents).
4. Place patient on ordered FIO_2 utilizing the ordered mode of oxygen delivery.
5. Wait 20 minutes and document SaO_2 on the set FIO_2.
6. If order is written to adjust FIO_2 to keep SaO_2 within parameters or above a certain percent, adjust FIO_2 to reach the desired SaO_2.
7. The site of the oximetry probe should be changed every 24 hours.
8. Report any significant changes in FIO_2 needed to meet the set parameters to the RN and Physician.
9. Document FIO_2 and SaO_2 at least every 4 hours while on continued pulse oximetry as well as any other pertinent information or episodes of apnea or bradycardia.(Can be documented as part of nursing vital signs)

REFERENCES

1. San Diego Patient Safety Council, "Respiratory Monitoring of Patients outside of the ICU", 2014.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

COUGH TECHNIQUES AND RESPIRATORY EXERCISES

Also indexed as: Respiratory Exercises and Cough Techniques

Effective Date: 4 86 | **Page 1 of 3**

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Revised: 10 00, 11/24 | **Reviewed**: 10/18; 8 21, 11/24 | **Next Review Date**: 8/2024

PURPOSE

1. Many patients require continued therapy following an acute respiratory disorder to return their respiratory status to normal. Chronic lung disease patients require continued therapy both on an in-patient and out-patient basis to prevent recurrent severe episodes of respiratory infection.

2. Maintaining clear airways is a crucial aspect of retarding the development of recurrent infection. Previously described techniques, including aerosol therapy, IPPB, and Postural Drainage and Percussion are frequently employed modalities in maintaining clear airways. In conjunction with these therapeutics, clean equipment must be continually stressed to the home patient to prevent pulmonary ~~contaminating~~contamination from improperly cleaned equipment.

3. Other techniques found to be useful in rehabilitation will be discussed in this section. These therapeutics will be designed to improve ventilation and/or improve ambulation and activities of daily living. These exercises can also be helpful during acute episodes of shortness of breath to allay panic and anxiety.

POLICY

I. RESPIRATORY EXERCISES AND COUGH TECHNIQUES

A. ***Purpose:*** Cough Control (quad cough) Effective coughing can change inadequate air exchange to adequate ventilation. This can be the prime method of maintaining airway patency.

B. Conditions requiring effecting cough control include:

1. Pulmonary restriction
2. Post-ventilator weakness
3. Air trapping, mucous plugging and airway collapse

C. Patients with pain-inflected restriction can be aided in coughing by the clinician supporting the thorax bilaterally with the hands. If treatment is after surgery, support the surgical wound.

1. As the patient inhales as deeply as possible, the therapist applies modest resistance to the sides against which the patient must work.

2. Upon peak inspiration, the clinician must push inward on the sides, initiating the cough's pressure development. The clinician can use the same technique by compressing on the upper abdomen on long, slow exhalation rather than the sides of the thorax.

3. The clinician's continued inward force during the cough provides increased effectiveness of the patient's own cough maneuver.

4. This procedure should be repeated several times to expectorate as many secretions as possible and should be performed as often as necessary.

5. Pursed lip exhalation should be incorporated in most coughing and breathing techniques, and may be all that is needed to achieve desired results. Pursed lip breathing can be used for asthmatics and emphysematics to decrease air turbulence, airway collapse, and wheezing.

a. The patient should initiate the cough in mid-inspiratory position.

b. Then the patient is to exhale in a rapid series of short, sharp, burst coughs.

c. This maneuver should be repeated several times to remove as many secretions as possible.

II. PURSED LIP BREATHING

A. ***Purpose:*** Pursed lip breathing -- quite beneficial for patients who trap air due to flaccid airways. Slowing of respiratory rate and emotional support are important.

1. Instruct the patient to purse his lips during expiration similar to whistling.

2. Utilizing pursed lips, he should slow the velocity of his expired air to the slowest possible flow that he can tolerate.

3. The patient should be encouraged to breathe out as completely as possible.

4. The compressing maneuver at the sides or upper abdomen as in diaphragmatic breathing by clinician, as described earlier in this section, can be quite helpful. This maneuver can be performed in a sitting or supine position, depending upon which provides improved affects.

III. ABDOMINAL BREATHING EXERCISES

A. ***Purpose:*** Abdominal Breathing Exercises -- aimed toward improving ventilatory mechanics by aiding the diaphragmatic excursion with increased abdominal pressure. The patient's present exercises pattern must be assessed first, the breathing exercises may be quite helpful. This maneuver can be performed in a sitting or supine position, depending upon which provides improved effects.

1. During inspiration, the abdomen is to move flaccidly outward to allow improved ability for the diaphragm to move downward.

2. Then, during expiration, the abdominal muscles are tightened which forces the abdominal contents up against the diaphragm, helping raise it and expel air against pursed lips.

3. Initially, it may be helpful for the patient to lie on his back with his hand on his stomach to learn the procedure. He would force his hand downward on expiration. Utilizing his hands in the erect position may also aid in learning the procedure. The hand is pulled inward upon expiration. This procedure should not be done for more than three to five minutes at one time, two to four times a day.

4. The training initially is to teach control of the patient's abdominal muscles.

REFERENCES

1. American Association for Respiratory Care. Clinical Practice Guideline. "Directed Cough". 1993

OAK VALLEY HOSPITAL DISTRICT
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POLICY/PROCEDURE:			
CRASH CART SUPPLY LIST			
Effective Date: 10 92		**Page 1 of 1**	
Areas Affected: Respiratory Therapy Department			
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Revised: 3 94	**Reviewed**: 10/18; 8/21; 11/24	**Next Review Date**: 8 2024	

CRASH CART SUPPLY LIST

1. Adult Airway Kit (tray in drawer #4 labeled "Respiratory Tray") for contents see Adult Airway Kit list.
2. Pediatric Airway Kit (tray in drawer labeled "Respiratory Tray) for contents see Pediatric Airway Kit list.
3. Arterial Blood Gas Kits – Two in drawer
4. Disposable Adult Bag – Mask unit with supply tubing (hanging on hook on side of cart).
5. Disposable Pediatric Bag – Mask unit with supply tubing (Pediatric Cart, hanging on hook on side).
6. Disposable Infant CPAP bag with mask, supply tube, O_2 tube, and manometer (Pediatric Cart only).
7. Adult Nasal Cannula x2 (Drawer #5)
8. Adult Nebulizer (Drawer #5)
9. Adult Aerosol Mask (Drawer #5)

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

DISPOSABLE EQUIPMENT CHANGE OUTS

Effective Date: 7 93	**Page 1 of 1**

Areas Affected: Respiratory Therapy Department
Composed by:
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Revised: 6 6; 8 21, 11/24 **Reviewed**: 10 18, 11 24 **Next Review Date**: ~~8/2024~~

PURPOSE

To define the frequency that disposable equipment is to be changed out, to comply with infection rules and be cost effective.

PROCEDURE

The following disposable items will be changed ~~out~~ as stated regardless of the patient's date of admission. The following are guidelines, always follow manufacturer's recommendations for cleaning and disposal of disposable equipment.

1. Ventilator circuits will be changed out on Fridays, or more frequently if visibly soiled.
2. Artificial Nose (HME) will be changed out every 24 hours or sooner if soiled.
3. Ballard In-Line Suction catheters will be changed out every 72 hours or earlier if soiled.
4. Handheld Nebulizers will be changed out every Friday.
5. Oxygen humidifiers will be changed ~~out~~ when the water level is low. (Humidifiers will only be used on patients with more than 3 liters per minute, unless requested by patient or physician).
6. Heated or non-heated aerosols, via mask, trach or T-Piece will be changed out every 72 hours.
7. Nasal Cannulas and oxygen masks will be wiped off with alcohol if soiled but will not be changed out unless deemed necessary by the Respiratory Care Practitioner (RCP).
8. All equipment should be changed as needed when soiled and deemed necessary by the RCP.

REFERENCE

i. American Association for Respiratory Care (2003). AARC Clinical Practice Guideline: Care of the Ventilator Associated Pneumonia. Respiratory Care, 48(9), 869-879

ii. Centers for Disease Control and Prevention "Disinfection and Sterilization in Healthcare settings" CDC, 2022, www.cdc.gov/infectioncontrol/guidelines disinfection Accessed 22 January 2025

iii. Centers for Disease Control and Prevention "Environmental Cleaning and Disinfection in Healthcare Settings" CDC, 2021, www.cdc.gov/infectioncontrol/guidelines/environmental Accessed 22 January 2025

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

DOWNTIME PROCEDURE
RECORD KEEPING ON THE VENTILATOR FLOW SHEET

Also indexed as: Record Keeping on the Ventilator Flow Sheet in the Event of E-Charting Downtime

Effective Date: 6 93 | **Page 1 of 6**

Areas Affected: Respiratory Therapy Department
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POLICY

All respiratory therapy treatments and procedures, including the patent's response to care, will be documented in accordance with all applicable laws, rules, regulations and standards.

PURPOSE

To define the method used to document respiratory therapy provided when E-documentation is not available.

PROCEDURE

A. The Ventilator Patient Flow Sheet consists of a 12-hour monitoring and every shift assessment. The front side of the form is for documentation of the ventilator checks and treatments. It also includes some assessment information. The back of the form is narrative charting of occurrences or change of condition during the shift, and a patient assessment including weaning assessment.

1. One form is used each shift. The completed sheets are to be placed in the patient's chart in the Respiratory Therapy section.

2. The form is to be stickered with the patient's information on each page of the form. It is the responsibility of the therapist doing the initial set up (and initiating a new flow sheet) to complete this.

3. The date and time is to be written with each ventilator check and each entry on the therapy

progress notes on the backside of the form. Numerical dating to be used (i.e. 01/15/89).

4. Time – use the 24-hour clock (i.e. 0000:0100, Etc.)

5. Physicians – list all attending physicians.

6. Mode – List mode with each ventilator check, in the box titled set rate, using the list provided from the label on the left side of the flow sheet (i.e. AC/12 = Assist Control of 12).

7. Set Rate – List the rate in the box provided that is ordered by the physician. The acceptable rate for 10 occurs when 10-11 breaths is delivered between 58-60 seconds.

8. Patient Rate – List the patient's combined Respiratory rate (both spontaneous, assisted breaths and ventilator breaths).

9. Set Volume – List in the box provided, the physician ordered total volume to be delivered. Acceptable volumes are plus or minus (+/-) 5% of ordered tidal volume. If the volumes are not equal, document as follows: 600-620w (w = Wrights).

10. Volume Delivered – Using the box provided list the patient's exhaled volume.

11. Spont VT – Spontaneous tidal volume, fill this box in if the patient has spontaneous breaths.

12. VE – List the combined volume: patient and ventilator.

13. Peak Pressure – List the patient's peak pressure attained on the Ventilator. If CPAP is used list also the peak pressure obtained over the CPAP.

14. Pressure Limit – List the pressure limit that is set on the ventilator. Generally 10-15cm water above the patient's peak pressure. (Both high and low limits should be documented if applicable).

15. Peak Flow – List the peak flow that is dialed on the ventilator.

16. IE – List the Inspiratory/Expiratory ratio as appears on ventilator screen.

17. Static Compliance:

    a. If a patient is not on bronchodilator therapy static compliance should be done every 2-4 hours. If a patient is precipitating ARDS, every hour. Should be performed before and after bronchodilator to determine effectiveness 1-2 times per shift.

       Example:

VT	500	Normal	40-60ml
Plateau-PEEP	17-5		ccH$_2$O

       i. VT is used because it most closely reflects the volume of gas in the airway at end inspiration.

ii. PLATEAU is used because it reflects the airway pressure under the most static conditions attainable in the patient/ventilator system. Reference: The Essentials of Respiratory Therapy.

iii. Document plateau pressure in the static compliance section (static compliance = 10 plateau pressure = 20). Example 10/20

b. Determination of plateau pressure for Bird 8400:

i. Drain water from tubing if applicable.

ii. If possible and tolerable to patient, flow should be constant (square wave flow pattern).

iii. Just before peak inspiration, press inspiratory hold button.

iv. Manometer will rise to its peak.

v. Manometer needle will then decrease to equilibrate. This becomes the plateau pressure.

c. Determination of static and dynamic compliance on the Bear 5.

i. Add .5 of pause to ventilator. (If patient is on SIMV with a rate less than 10, change over to AC of 10 for this procedure).

ii. Access the "Mechanics" section by pressing the corresponding button.

iii. Press button corresponding with "update Mechanics."

iv. A reading of Dynamic and Static compliance and Resistance will appear.

v. Resistance – should be performed before and after bronchodilator to determine effectiveness. If a patient is not on bronchodilator therapy resistance should be done, every 2-4 hours. If a patient is precipitating ARDS, every 1-2 hours.

$$R = \frac{\text{PEAK-PLATEAU}}{\text{Flow (1/second or 1 minute)}} \qquad \text{Normal } \frac{.5\text{-}1.5 \text{cm } H_2O}{\text{L sec}}$$

- Peak is the maximum pressure developed in the system. Plateau is the static system pressure.

18. PEEP – List the PEEP ordered by the physician. If PEEP is not ordered, simply leave blank or 0. If inadvertent PEEP shows on the manometer and PEEP is shut off.

a. List accordingly, i.e. + 2 of inadvertent PEEP. (Physician should be notified of intrinsic or "Auto" PEEP).

b. Put on a test lung, if problem persists, see C.

c. Call department manager.

d. Change ventilator (anything greater than 3cm).

e. Specify problem and flag for repair.

19. Pressure support – List the pressure support ordered by the physician. If not ordered leave blank or 0.

20. Sigh Vol. – List to sigh volume and rate ordered.

21. FIO_2 – List the FIO_2 ordered by the physician.

22. Temperature – List the temperature of the inspired gas or circuit. If a heat moisture exchanger is used in may be abbreviated "HME" or "NOSE." Remember for each 5" of large bore corrugated tubing the temperature decreases 1 degree Fahrenheit.

23. Tx Mode – List the treatment mode the patient is receiving from the label on the left side of the flow sheet, i.e. patient order reads every 4-hour in line – write Q4IN.

24. Meds – List the medication and dosage ordered from the left side of the flow sheet, i.e. 0.5cc of Proventil = .5 p. Example: if Unit Dose Proventil is used, U.D.P. may be substituted. If a medication not listed is used it must be written out completely, i.e. 1mg/ml Terbutaline Sulfate.

25. ABG's – List ABG result.

26. Breath Sounds – Indicate breath sounds observed. Should be documented 2-3 times per shift and before and after each treatment.

27. Suction – Indicate with a check mark if the patient was suctioned. If not leave blank. Indicate amount: large, moderate, small.

28. Color – Indicate color of secretions. You may also want to indicate consistency and if they have an odor.

29. HR – If the patient is on an EKG monitor, record the HR during each ventilator check as well as prior to and after treatments. (When recording HR before and after treatments: 8/5/88). Rhythm pattern may also be documented here. If the patient is not on an EKG monitor the patient's heart rate should be checked at least 1-2 times per shift as well as when the patient receives any kind of treatments. Other monitoring measurements are needed only on critical patients. The table on the left side of the flow sheet lists the monitors along with their normal measurements. The above are to be documented in the HR box. There is only one box and the reference list of monitoring measurements lists eight, therefore, not all of the monitors can be recorded with every ventilator check. Use the monitors that are most important and applicable to each individual patient. You may also use the vent. Change box for these monitors if you clearly document them so that they are not confused with a ventilator change.

30. Ventilator Changes – document changes that are increased or decrease. Use the triangle sign (Δ)

if mode, medication or treatments are changed. If a change in any of the above occurs after a ventilator check, indicate the time of the change in this section.

31. SaO_2 Indicates SaO_2 at least every 2 hours.

32. $ETCO_2$ Indicate $ETCO_2$ if End Tidal CO_2 monitor is in use.

33. Therapist Use first initial and full last name, must be legible.

34. Physician Orders Indicate current orders.

B. ASSESSMENT

Each shift is responsible for assessing patient and ventilator functions.

1. ET Tube Size/Placement – Indicate exactly what size ET tube is in place. If the tube has been cut, tape the cut portion to an easily accessible sight on the ventilator and indicate in this section where it can be found. Indicate numerically, approximately where the ET tube is located either at the nares or teeth/gum. If the tube was cut in O.R. or some other location state that in this section. Indicate if tube was moved to the opposite side of the mouth.

2. Trach size Indicate what kind and size.

3. Spare at Bedside Indicate with a check mark if there is an exact duplicate taped to the head of the bed. If non-available call Purchasing.

4. Cuff Pressure If cuff pressure is measured with a Cuff Pressure Manometer refer to the procedure on Measuring Cuff Pressures. List pressures obtained in cm's of H_2O. If the Minimal Occluding Volume (MOV) method is used indicate that here. (Or minimal leak technique).

5. Wave Form If applicable, indicate waveform, sine, square, or decelerating.

6. Equipment Changes – Indicate with a check mark and time when equipment was changed.

7. Check Ventilator Orders – Indicate with a check mark that the orders on the ventilator patient flow sheets coincide with the recent physician orders.

8. Ventilator Type – Indicate what type of ventilator is in use.

9. Serial Number – Indicate the serial number or hospital ID number of the ventilator in use.

10. Alarms set and checked – Indicate where the ventilator alarms are set.

    a. Patient system leak or disconnect alarm could be either:
        i. Low exhaled tidal volume 100-200cc
        ii. Low inspiratory pressure 10cm H_2O (below machine peak pressure).

    b. High inspiratory pressure limit:
        i. Set around 10 to 15cm H_2O (above machine peak pressure)

ii. Should be audible and visible

c. Other alarms/monitors:
   i. Temperature
   ii. FIO_2
   iii. Low PEEP
   iv. System oxygen/air pressure
   v. Electrical failure

d. If an alarm has been shut off indicate specifically which one and why.

11. Sensitivity – Indicate where sensitivity is set by documenting the digital read out.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

OVHD EKG INTERPRETATION GUIDELINES

Effective Date: 3/92	**Page 1 of 2**

Areas Affected: Respiratory Therapy Department, Medical Staff, ED, Med Surg, ATC, Anesthesiology
Composed by:
☒ Reviewed ☐ Revised by: RT Supervisor

Dept. / Committee Approval:	Dept./Title:	Date	Approved
Respiratory Therapy	RT Supervisor	11/17/2024	X
Policy, Procedures, Forms Comm.	VP of Nursing	02/05/2025	X
Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 3/13	**Reviewed**: 4/17; 10/18; 8/21, 11/24	**Next Review Date**: ~~8/2024~~

PURPOSE

To give guidance to staff in the interpretation of EKG's

POLICY

1. Emergency Room EKG's:

   a. All EKG's done in the Emergency Room will be read by the Emergency Room physician. The original EKG will be placed with the Emergency Room Record at the time of the procedure. No copies will be made.

2. Inpatient EKG's:

   a. The original EKG is to be placed on the patient's chart. Physicians involved with the care of the patient and who have EKG interpretation privileges will sign the original computerized EKG report on the chart.

   ~~b. A copy will be faxed to the ordering physician (with a second copy to be faxed to the attending physician if different). This will be an unsigned machine interpreted copy. If the physician wishes, a copy of the original physician signed copy they may contact medical records to obtain one.~~

3. Outpatient EKG's:

   a. The original will be stamped "Original." The order is to be attached to the back of the EKG or stapled to it. A copy of the admitting sheet is to be attached. The EKG will then be forwarded to Medical Records without a signature.

   b. A copy will be faxed to the ordering physician (with a second copy to be faxed to the attending physician if different). This will be an unsigned machine interpreted copy. If the physician wishes, a copy of the original physician signed copy they may contact medical records to obtain one.

4. Pre-Operative EKG'S:

   a. All Pre-Operative EKG's will be reviewed and signed by an ~~Anesthesiologist.~~anesthesia provider.

REQUESTED INTERPRETATIONS

If a physician desires another opinion about the EKG interpretation, he/she ~~will~~ may write an order requesting the second opinion, stating who he/she wants to interpret the EKG. Respiratory Therapy will then facilitate the second opinion.

1. Physician writes order for EKG to be read by another physician. (Who is to read the EKG is to be written in the order).

2. A call will also be placed to the physician's office to notify them that there has been a request by the ordering physician for them to interpret an EKG. RT will work with the physician to determine where the EKG in need of interpretation will be left for them to review.

3. If an EKG is not read within 1 week, a courtesy reminder call will be made to the interpreting physician. After two weeks, the ordering physician will be notified, and the EKG will be filled as uninterpreted.

4. When the EKG is signed it will be placed in the patients chart.

OAK VALLEY HOSPITAL DISTRICT

Respiratory Therapy Manual

POLICY/PROCEDURE:

EMERGENCY OXYGEN ~~PLAN~~PROCESS

Effective Date: 7 93 | **Page 1 of 2 (+Attachment)**

Areas Affected: Respiratory Therapy Department, Engineering, House Wide

Composed by:

☒ Reviewed ☐ Revised by: RT Supervisor

Dept. / Committee Approval:	Dept./Title:	Date	Approved
Respiratory Therapy	RT Supervisor	11/17/2024	X
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Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	

Revised: 9 15 | **Reviewed**: 10 18; 8 21, 11 24 | **Next Review Date**: ~~8/2024~~

PURPOSE

To give the Respiratory Therapy and Engineering departments guidance in what to do in the incident of total loss of piped in oxygen, including the reserve system.

SCOPE

All Respiratory Therapy and Engineering staff

PROCEDURE

Upon discovering or receiving the message that we have lost all piped in oxygen, including the reserve system:

A. When RT is notified, they are to ask that Engineering be notified also, and visa versa. At this point RT should ask for the Supervisor to be called. If the Supervisor is not available, the Chief Engineer, Vice President of Administration or other designated personnel shall call in other staff as required to assist the technician on duty. This person will first alert ER and OR to use their back up "E" cylinders until the problem is resolved. They will also notify the cylinder supplier that additional oxygen "H" & "E" tanks will be needed.

B. RT staff should report immediately to the ICU. All ventilator patients should be ventilated with an "Ambu" bag connected to an "E" cylinder of oxygen. Once all ventilator patients are being manually ventilated, install the "H" cylinders of oxygen, located ICU bed 5. These "H" cylinders of oxygen are equipped with a regulator, hose, and Ohio Quick Connect.

C. To install these units:

1. Turn off the main oxygen valve to the ICU. This is located in the hall outside ICU (by door 1).

2. Plug the hoses into the oxygen out lets on each side of the bed and turn the tanks on. This will supply oxygen to all five ICU beds.

3. Check to assure that all ICU patients are receiving oxygen.

4. You must return often to check the tank pressure until the bulk system is functioning.

D. After the ICU is taken care of, the RT staff shall go to the Med/Surg floor and the TCU and place all oxygen patients on "E" cylinders of oxygen. They shall then check with the Emergency Room to see that they have an adequate number of "E" cylinders of oxygen to meet their patient needs. (In the event of loss of piped in oxygen, the ER staff are to change their patients over from wall oxygen to the "E" cylinder, located in the Trauma room and on some gurneys.)

1. Surgery will also be using their back up "E" cylinders.

E. At this point all patients should be on alternate oxygen sources.

F. If help has arrived they may initiate this step sooner. "H" cylinders of oxygen with regulators and hoses shall be taken to the following and set up as in ICU (see B-14).
1. Recovery Room/Surgery
2. Emergency Room
3. Med Surg
4. Transitional Care Unit (TCU)

G. All available "H" and "E" oxygen cylinders in carts are to be brought in to the door across from the bulk oxygen cage. This may require the assistance of the Engineering department if the road between the cage and the hospital has been damaged. These tanks shall be placed just inside the door by the employee entrance to the Lab. If additional tanks will most likely be needed, call the cylinder supplier whose number is located in the RT department on the phone if they were not already notified.

H. The RT department is then responsible for making oxygen rounds hourly to each department to assure that all tanks are functioning and patients are receiving oxygen.

I. When notified Engineering should respond to the bulk oxygen system and work on repairing the system. If the bulk and reserve systems are not repairable, or will take some time, the Engineering department will call the Oxygen supply company "Liquid Air" at 415-471-6282. They will request that a portable bulk oxygen system to be delivered STAT to Oak Valley Hospital. When this unit arrives Engineering will assist Liquid Air in hooking up the system. The hook up is located behind the fence on the main building next to the boiler room on the south side of the hospital. This hook up will provide oxygen throughout the hospital.

J. Engineering manager should notify RT Supervisor (or technician on duty) of estimated time of repair of the oxygen system.

If alarm is resolved, document on the alarms sheet.

If the side of the bank that is operating is empty, switch the lever to the full side.

Document on the alarm sheet and fill out a Maintenance Request form telling them that the lever has been moved over and that the (Rt. or Lt.) side of the nitrous oxide bank needs to be changed out.

If the alarm condition is not resolved:

Go to the Nitrous bank outside:

Call Engineering to correct pressure. If engineering is not in house, call the operator and ask them to call in the on call Engineering Staff member.

Change out Nitrous bank when notified by RT.

A MEDICAL GAS ALARM REPORT FORM MUST BE FILLED OUT AFTER THE PROBLEM HAS BEEN RESOLVED.

Vacuum alarms may sound. Notify Engineering if alarm sounds.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

EVALUATING PATIENT TEST RESULTS

Effective Date:		**Page 1 of 2 (+Attachments)**	
Areas Affected: Respiratory Therapy Department			
Composed by:			
☒ Reviewed ☐ Revised by: RT Supervisor			
Dept. / Committee Approval:	**Dept./Title:**	**Date**	**Approved**
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District Board	Board Liaison	04/03/2025	
Revised: 11/24	**Reviewed:** 10/18; 8/21, 11/24	**Next Review Date:** 8/2024	

POLICY

The Respiratory Therapy Department identifies and evaluates patient test results that appear inconsistent with clinically relevant criteria such as:

1. Patient's age
2. Sex
3. Diagnosis or pertinent clinical data
4. Distribution of patient test results
5. Relationship with other test parameters

SUPPORTIV DATA

Normal Arterial Blood Gases (ABG's) for a term infant, child, and adult will be listed. A venous sample will be listed. General guidelines will be listed for estimating pH, pCo_2 and pO_2.

PROCEDURE

In the event that the ABG is questionable, based on age, sex, Disease State, FiO_2 past results, trends, and how the patient is actually doing, the ABG should:

1. Re-analyze ABG (review policy "Questionable Contaminated Samples" in the ABG section of the manual for variations.)

2. Confirm patient data and settings

3. Review "Typical Blood Gas Contaminants" policy in the manual.

4. Redraw sample re-analyze

5. Notify ordering attending physician if results are still questionable of problems arise.

REFERENCES

1. American Association for Respiratory Care. Clinical Practice Guidelines. "Blood Gas Analysis and Hemoximetry". 2013

2. American Association for Respiratory Care. Clinical Practice Guidelines. "Oxygen Therapy for Adults in the Acute Care Facility". ~~2013~~2022

NORMAL ABG's

	Term Infant	Child	Adult
pH	7.26 7.41	7.35 – 7.45	7.35 – 7.45
$PaCo_2$	34 – 54 mmHg	35 – 45 mmHg	35 – 45 mmHg
PaO_2	60 – 80 mmHg	75 – 100 mmHg	80 – 100 mmHg
SaO_2	40 – 95 %	95 – 98 %	> 95%
BE	-7 to -1 mEq/l	-4 to +mEq/l	-2 to +2 mEq/l
Hb	14 – 24g %	12.5 – 15g %	> 12 – 16g %
HCO_3			22 – 27 mEq/l
COHB			0.5 – 1.5 %
MetHb			0.5 – 1.5 %
HHb			< 4.5 %
tHb			Female 12 – 16 g/dl Male 13 – 18 g/dl

NEONATE

**Note: Blood gas values of neonates at birth usually show Metabolic and Respiratory Acidosis along with severe hypoxemia.

pH	7.20 – 7.25
$PaCO_2$	53 –53 mmHg
PaO_2	20 – 25 mmHg
HCO_3	18 – 19 mEq/l
After 1 hour PaO_2	• Term infant 60mmHg • Premature infant 40 – 60 mmHg

NORMAL ADULT VENOUS SAMPLES

pH	7.35
PCO_2	46 mmHg
PO_2	40 mmHg
HCO_3	27 mEq/l
SaO_2	75%

GUIDELINES

If starting at a pH of 7.40 and a PCO_2 of 40, for every 10mm PCO_2 decrease there is an approximate 0.10 pH unit increase.

PCO_2	pH	HCO_3
40	7.40	-24
35	7.45	-23
30	7.50	-22
25	7.55	-21
20	7.60	-20

If starting at a pH of 7.40 and a PCO_2 of 40, for every 10mmHg PCO_2 increase there is an approximate 0.05 pH unit decrease.

PCO_2	pH	HCO_3
40	7.40	-24
50	7.35	-25
60	7.30	-26
70	7.25	-27
80	7.20	-28

Expected minute volume to arterial CO_2 tension relationship in the normal non-exercising man.

	MV (L)	$PaCO_2$ mmHg	RANGE mmHg
NORMAL	5.0	40	35 – 45
	10.0	30	25 – 35
	20.0	20	15 - 25

Acceptable arterial oxygen tension at sea level breathing room air.

AGE (yrs)	ACCEPTABLE RANGE (mmHg)
60	> 80
70	> 70
80	> 60
90	> 50

Generalized inspired oxygen – Arterial tension relationship

FiO_2	PREDICTED MINIMAL PaO_2 (mmHg)
30%	150
40%	200
50%	250
80%	400
100%	500

**NOTE: If PaO_2 is less than FiO_2 x 5, the patient can be assumed to be hypoxemic at room air.

DISEASED STATES CLASSIC TEXTBOOK OF BLOOD GAS INTERPRETATIONS

Respiratory Acidosis (Ventilatory Failure)				**Disease / Cause**
pH	PCO_2	HCO_3	BE	1. COPD 2. Cardiopulmonary **Other Causes:** 1. CNS depression by drugs, trauma, or lesion. 2. Neurologic or neuromuscular disease resulting in profound weakness of ventilatory muscle. 3. Failure following any acute pulmonary disease.
< 7.35 (uncompensated)	> 45	Normal	Normal	
< 7.35 (partially uncompensated)	> 45	> 27	> +2	
7.35 – 7.45 (compensated)	> 45	> 27	> +2	

Respiratory Alkalosis (Aveolar Hypervention)				**Disease / Cause**
pH	PCO_2	HCO_3	BE	1. Acute alveolar hyperventilation with hypoxemia. a. Pneumonia & atelectasis b. ARDS c. Acute asthma 2. Acute myocardial disease a. Acute MI b. Pulmonary Edema (interstitial & gross) c. Acute heart failure (R&L) d. Effects of cardiopulmonary bypass 3. Chronic alveolar hyperventilation with hypoxemia a. Post-op conditions b. Chronic heart failure c. Adult cystic fibrosis d. Third trimester pregnancy e. Non-cardiopulmonary disease 4. Alveolar hyperventilation with hypoxemia a. Anemia b. Carbonmonoxide poisoning **Other Causes:** 1. Compensation for primary metabolic acidosis 2. CNS stimulation by drugs, trauma or lesion. 3. Emotional disorders (i.e. pain, anxiety, or fear)
< 7.45 (uncompensated)	< 35	Normal	Normal	
< 7.45 (partially uncompensated)	< 35	< 22	< -2	
7.40 – 7.45 (compensated)	< 35	< 22	< -2	

Metabolic Acidosis				Disease / Cause
pH	PCO_2	HCO_3	BE	1. Lactic acidosis 2. Ketoacidosis a. Uncontrolled diabetes mellitis b. Starvation 3. Renal failure 4. Ingestion of base depleting drugs or acids a. Aspirin b. Alcohol c. Ethylene glycol d. Paraldehyde **Other Causes:** 1. Increase in anaerobic metabolism 2. High fat content in the diet 3. Patient needs glucose & insulin
< 7.35 (uncompensated)	Normal	< 7.22	< -2	
< 7.35 (partially uncompensated)	< 35	< 22	< -2	
7.35 – 7.45 (compensated)	< 35	< 22	< -2	

Metabolic Alkalosis				Disease / Cause
pH	PCO_2	HCO_3	BE	1. Hypokalemia 2. Hypochloremia 3. Gastric suction 4. Massive dose of steroids 5. Diuretics 6. Ingestion of acid-depleting drugs or bases **Other Causes:** 1. Steroids increase absorption of NA+ and accelerate 2. Diuretics cause an increase in the amount of K+ excreted
< 7.45 (uncompensated)	Normal	> 27	> +2	
< 7.45 (partially uncompensated)	> 45	> 27	> +2	
7.40 – 7.45 (compensated)	> 45	> 27	> +2	

CLINICAL METHOD OF BLOOD GAS INTERPRETATION

Status	pH	PCO2	HCO3	B3
Respiratory Acidosis (Ventilatory failure)				
Acute	< 7.30	> 50	Normal	Normal
Chronic	7.30 – 7.50	> 50	> 27	> +2
Respiratory Alkalosis (Alveolar Hyperventilation)				
Acute	> 7.50	< 30	Normal	Normal
Chronic	7.40 – 7.50	< 30	< 22	< -2
Metabolic Acidosis				
Uncompensated	< 7.30	Normal	< 22	< -2
Partially Compensated	< 7.30	< 30	< 22	< -2
Compensated	7.30 – 7.40	< 30	< 22	< -2
Metabolic Alkalosis				
Uncompensated	> 7.50	Normal	> 27	> +2
Partially Compensated *	> 7.50	> 50	> 27	> +2
Compensated *	7.40 – 7.50	> 50	> 27	> +2
Combined Ventilatory Failure and Metabolic Alkalosis				
	< 7.30	> 50	< 22	< -2
Combined Alveolar Hyperventilation and Metabolic Alkalosis				
	> 7.50	< 30	> 27	> +2

* In general, partially compensated or compensated metabolic alkalosis is rarely seen clinically because of the body's mechanism to prevent hypoventilation.

OAK VALLEY HOSPITAL DISTRICT

Respiratory Therapy Manual

POLICY/PROCEDURE:

GENERAL SAFETY PRECAUTIONS WITH OXYGEN ADMINISTRATION

Also indexed as: Oxygen Administration and General Safety Precautions

Effective Date: 2/89 | **Page 1 of 5**

Areas Affected: Respiratory Therapy Department

Composed by:

☒ Reviewed ☐ Revised by: RT Supervisor

Dept. / Committee Approval:	Dept./Title:	Date	Approved
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District Board	Board Liaison	04/03/2025	

Revised: 7/16, 11/24 | **Reviewed**: 10/18; 8/21, 11/24 | **Next Review Date**: 8/2024

PURPOSE

To provide instruction for the safe use of oxygen in the clinical setting.

PROCEDURE

A. No smoking is allowed within hospital district buildings.

B. Do not use oil or grease on any connections in the oxygen system or appliance. A special lubricant is available for use with oxygen apparatus.

C. Do not allow any electrical devices, such as radios, heating pads, telephones, hearing aids, electrical shavers, battery operated toys or spark-generating toys in or near an oxygen tent or when oxygen is being administered. Battery operated shavers should not be used when oxygen is on.

D. Be sure that cylinders are firmly secured in an upright position away from radiators and electrical panels.

E. Do not use glass connectors or adhesive tape for oxygen tubing connectors.

F. Never permit oil, grease or highly flammable material to come in contact with oxygen cylinders, valves, regulators or fittings.

G. Never lubricate flow meters, regulators or gauges with oil, or any other flammable substance.

H. Never handle medical gases with oily hands, greasy gloves or rags.

I. Always clear the particles of dust and dirt from cylinder valves by slightly opening and closing the cylinder valve before applying and fitting the regulator. This should be done before bringing it to the patient's room.

J. Open the valve slowly with the face of the gauge on the regulator pointed away from any person.

K. Never drape anything over the gas cylinder.

L. Please contact Respiratory Therapy if you have any doubts about safety hazards when administering oxygen.

M. Follow the oxygen safety precautions when administering compressed air.

N. When transporting cylinders always use a cart or other device which ensures control of the cylinder at all times.

SAFETY PROCEDURES FOR THERAPEUTIC GAS EQUIPMENT

A. Storage

1. Cylinders should not be stored in an area where the temperature exceeds 125° F.
2. No flames should have the potential of coming in contact with the cylinders.
3. The storage area must be permanently posted.
4. Cylinders must be grouped by content.
5. Full and empty cylinders must be segregated in storage area.
6. Storage rooms must be dry, cool and well ventilated.
7. The storage facility should be fire resistant where practical.
8. Belowground storage should be avoided.
9. Cylinders must not be stored near flammable substances.
10. Those gases supporting combustion must be stored in a separate location from those that are combustible.
11. Cylinders should never be stored in the operating room.
12. Large cylinders must be stored in an upright position.
13. Cylinders must be protected from being cut or abased.

14. Cylinders must be stored to protect them from extreme weather to prevent rusting, excessive temperatures and accumulations of snow and ice.

15. Cylinders should not be exposed to continuous dampness or corrosive substances to prevent rusting of the cylinder and its valve.

16. Cylinders must not be stored where readily combustible materials, such as oil and grease, may come in contact with them.

17. Cylinders should be protected from tampering.

18. Valve should be kept closed on empty cylinders at all times.

19. Cylinders must be stored with protective caps in place.

20. Cylinders must be separated when not in use into either "empty" (0-49%) or "full" (100%) storage areas must be clearly marked with the appropriate signage.

B. Transporting

1. When protective valve caps are supplied, they should be utilized whenever cylinders are in transport and until they are ready for use.

2. Appropriate hand trucks that secure cylinders on the truck should be used to transport cylinders. The cylinder truck must be pushed ahead of you to maintain control at all times.

C. Use

1. Prior to connecting equipment to a cylinder, be certain that connections are free of foreign materials.

2. Turn valve outlet away from personnel and "crack" cylinder valve to remove any dust or debris from cylinder valve outlet.

3. Cylinder valve-outlet connections must be American Standard or C.G.A.; pin-indexed, and low-pressure connections must be C.G.A diameter indexed.

4. Cylinders must be secured at the administration site and not to any moveable objects or head radiators.

5. Outlets and connections must be tightened with only appropriate wrenches and must never be forced on.

6. Equipment designed for one gas should not be utilized on another.

7. Never use medical cylinder gases where contaminated by back flow of other gases may occur.

8. Regulators should be "off" as the cylinder is turned on, and the cylinder valve should be opened

slowly.

9. Before equipment is disconnected from a cylinder, the cylinder valve should be closed and the pressure released from the device.

10. Cylinder valves should be closed at all times, except when they are in use.

11. "Transfilling" of cylinders is hazardous and must not be done.

12. Hospital personnel cannot refill cylinders.

13. Cylinders must not be lifted by the cap.

14. NEVER LUBRICATE valve outlets or connecting equipment (oxygen and oil under pressure cause an explosive, oxidation reaction).

15. "Flame-testing" for leaks must not be done (usually a soap solution is utilized).

16. When in use, open valve fully and then turn it back ½ to ¼ turn.

17. Replace cap on empty cylinders.

18. Position the cylinder so that the label is clearly visible.

19. Check label PRIOR to use; it should always match the color code.

20. Inform all occupants of the area of the hazards of smoking and of the regulations.

21. No sources of open flame shall be permitted in the area of administration.

22. Equipment connected to cylinders of oxygen should be labeled: "OXYGEN USE NO OIL."

23. Equipment designated for use with a specific gas must be clearly and permanently labeled accordingly.

24. Enclosures intended to contain patients must be posted regarding "No Smoking."

25. Cylinder carts must be of a self-supporting design with the appropriate casters and wheels, and those intended for use in surgery must be grounded.

26. High-pressure oxygen equipment must not be sterilized with flammable agents, i.e., alcohol and ethylene oxide, and the agents must be oil-free and non-damaging.

27. Polyethylene bags cannot be used to wrap sterilized high-pressure oxygen equipment because polyethylene, when flexed, releases pure hydrocarbons that are severely flammable.

28. Oxygen equipment expose to pressures of less than 60 psi may be sterilized with either non-flammable mixtures of ethylene oxide and carbon dioxide or with fluorocarbons.

29. Very cold cylinders must be handled with care to avoid hand injury due to tissue freezing caused by rapid gas expansion.

30. Cylinders must not be handled with oily or greasy hands, gloves, or clothing.

31. Cylinders contents must be identified prior to use by reading the label, which should not be defaced, altered, or removed.

32. Safety-relief mechanisms, non-interchangeable connections, and other safety features shall not be removed or altered.

33. Control valves on equipment must be closed both prior to connection and when not in use.

D. Wall Outlets

1. Each station outlet for oxygen and nitrous oxide must provide either a manually operated or an automatic shutoff valve.

2. The station outlet must be legibly labeled with the name of the gas contained.

3. Manually operated valves must be equipped with a non-interchangeable connection complying with the Diameter Index Safety System (CGA Pamphlet V-5).

4. Threaded outlets of this type must either be provided with a cap on a chain or be installed in a recessed box equipped with a door to protect the outlet when not in use. Station outlets in patients' rooms shall be either located approximately five feet above the floor or recessed to avoid physical damage to the valve or control equipment.

5. Each oxygen delivery line which services an anesthetic device through a yolk must have a back-flow check valve installed in the line immediately adjacent to the yolk insert Each check valve must be designed to hold a minimum of 2400 psig.

6. Quick-connect outlets are subject to the same regulations as D.I.S.S. outlets. The hollowing additions apply, as well:

   a. Each station outlet that is equipped with a female member of an approved quick-connect, non-interchangeable system for gas service must be so identified and provided with an automatic shutoff valve incorporated in such a manner that when quick-connect is removed from the pipe line, the flow of gas must be automatically shut off until the male member is reattached.

   b. Female members of the quick connect couplers may be attached to manually operated shutoff valves.

REFERENCE

American Lung Association, Oxygen Therapy; "Using Oxygen Safely" 2023
American Associations for Respiratory Care, Clinical Practice Guidelines, Oxygen Therapy in the Home or Alternate site health Care Facility, 2007

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

GENERAL STATEMENT ON THE ADMINISTRATION OF OXYGEN

Also indexed as: Oxygen Administration General Statement

Effective Date: 2 89	**Page 1 of 6**

Areas Affected: Respiratory Therapy Department
Composed by:
☒ Reviewed ☐ Revised by: RT Supervisor

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POLICY

It is the responsibility of the Respiratory Therapy Department to survey, replace and maintain all oxygen therapy equipment with the hospital. The Respiratory Therapist and or nursing personnel will initiate all oxygen therapy. If nursing initiates the oxygen they will notify the Respiratory Therapy department so that appropriate record keeping can be done. (Recovery room and Emergency Room personnel will initiate and monitor all oxygen therapy delivered in their departments. They will follow the set procedures as follows).

I. THERAPEUTIC OBJECTIVES OF OXYGEN THERAPY

A. To relieve hypoxemia
B. To prevent hypoxemia
C. To produce a higher than normal arterial oxygen pressure

PROCEDURE

I. ORDERING

1. The initiation and continued use of oxygen is only on the order of a physician.

2. The order must include:
   a. Desired inspired oxygen fraction where appropriate.
   b. Oxygen flow rate where appropriate.

3. The therapeutic objective(s) must be concurrently recorded by the physician on the Respiratory Therapy Order form or in their progress note.

II. INDICATIONS FOR INITIATING OXYGEN THERPAY

A. Hypoxemia documented by invasive or non-invasive analysis of oxygen partial pressure or hemoglobin saturation of arterial blood.
   1. PaO_2 decrease 60 torr or lower on room air.
   2. Oxyhemaglobin saturation of 90% or lower on room air.

-OR-

B. Any of the following diagnoses:
   1. Myocardial infarction
   2. Carbon monoxide poisoning
   3. Methemoglobinemia
   4. Acute anemia

-OR-

C. Any one of the following clinical circumstances:
   1. Post anesthesia
   2. Post cardiopulmonary arrest
   3. Reduced cardiac output, demonstrated by:
      a. Cardiac index less than 1.5 L/min/M2
      b. Venous oxygen saturation less than 75% or oxygen partial pressure less than 40 torr.
   4. Hypotension
   5. Tachycardia
   6. Cyanosis
   7. Chest pain
   8. Dyspnea
   9. Acute neurological dysfunction

III. OUTCOME

A. Arterial oxygen tension or saturation normal or acceptable (PaO_2 greater than 60 torr or oxyhemoglobin saturation greater than 90 per cent).

B. Arterial oxygen tension above normal.

C. Symptoms or signs of reduced oxygen delivery relieved.

IV. CONTRAINDICATIONS

A. None identified

V. HAZARDS

A. Oxygen induced hypoventilation. This usually occurs in patients who retain carbon dioxide and the respiratory drive is due to hypoxemia. When the hypoxemia is alleviated, ventilation stops or is decreased.

B. Atelectasis. This can occur when high concentrations of oxygen are given, thereby replacing the nitrogen within the alveoli. An alveolar duct may become blocked leading to a collapsing respiratory unit (acinus).

C. Retrolental Fibroplasias. This disease is only present when high concentrations of oxygen are delivered to premature infants and the PaO_2 is greater than 100 to 150 mmHg. It is a fibrotic lesion behind the lens leading to permanent blindness and occurs after repeated or prolonged exposure to high oxygen concentrations that yield high PaO_2's.

D. Oxygen Toxicity. This is the toxic effect upon the lung that occurs when lung tissues are exposed to high concentrations of oxygen over long periods of time. Actual lung damage can occur with enzyme system disturbances yielding pleural effusions, pulmonary edema, emphysema and severe decreases in accomplished (pH 20 to 47 mmHg) oxygen concentrations are kept below 40%.

E. High concentrations of oxygen rapidly support and perpetuate combustion. The potential calamities demand strict adherence to the following safety regulations when using oxygen:

1. Absolutely no smoking is permitted within 15 feet of the site of oxygen administration, or in any room where oxygen is being administered or where there is an oxygen flow meter on the wall outlet.

2. Smoking materials must be removed from the patient or patient areas.

3. Oil, grease, alcohol or other flammable substances must not be permitted in any oxygen-enriched atmosphere.

VI. PATIENT EDUCATION

1. Patient informed of indication for the use of oxygen.
2. Patient instructed in appropriate use of equipment.
3. Patient informed of potential fire hazard.

VII. CONTINUED USE OF OXYGEN

1. The continued need for oxygen may be documented by one or more of the following:

a. Arterial blood gas analysis for oxygen and carbon dioxide as ordered by the physician.

b. O_2 saturation by non-invasive oximetry.

c. Clinical picture of patient (i.e. cyanosis, tachypnea, etc.)

2. Oxygen may be discontinued at therapist's discretion after 24 hours of non-use.

~~I. ORDERING PROCEDURE~~

~~1. The initiation and continued use of oxygen is only on the order of a physician.~~

~~2. The order must include:~~
~~a. Desired inspired oxygen fraction where appropriate.~~
~~b. Oxygen flow rate where appropriate.~~

~~3. The therapeutic objective(s) must be concurrently recorded by the physician on the Respiratory Therapy Order form or in their progress note.~~

VIII. TYPES OF THERAPY

A. The Administration of Oxygen via Nasal Cannula

This device should be used when oxygen concentrations in the low range (24% to 35%) is necessary to relieve hypoxemia. Abnormalities of the nasal passages such as polyps and septal deviation may impede oxygen insufflation. A patient with these abnormalities may be treated by an alternate method of oxygen administration.

B. The Administration of Oxygen via Masks

Oxygen masks are of many different types and styles and serve varied purposes. The masks used by this hospital are the disposable type, to minimize the risk of cross contamination. In almost all uses of the oxygen mask, humidity is supplied to prevent drying of the upper airways, and to help relieve the humidity deficit. Humidity should never be provided during the use of carbon dioxide-oxygen (carbogen) mixtures, probably the only exception. Some of the specific hazards or complications are:

1. An oxygen mask can be hazardous on a patient who is prone to vomit due to the danger of aspiration. This is a particular hazard and is not recommended for use in the unconscious patient.
2. By the nature of their construction, face masks add dead space to the patient's airway. In some types of masks, particularly the re-breathing styles, this must be considered.
3. Care must be exercised in not adjusting the head straps so securely as to risk the possibility or pressure necrosis of the skin.

C. The Administration of Oxygen via Simple Oxygen Mask

The simple oxygen mask may be used to administer oxygen concentration of 35% to 60%, at 6 to 12 liters per minute.

D. The Administration of Oxygen via Partial Re-breathing Mask

This mask may be used when an oxygen concentration of 60% to 85% is desired. Approximately the first third of the patient's expired air is directed into the reservoir bag for re-breathing. Since the air does not take part in gas exchange, it's still high in oxygen. The liter flow should be adjusted sufficiently to allow the reservoir bag to remain half inflated at the end of inspiration. This will help prevent the chance of carbon dioxide re-breathing.

E. The Administration of Oxygen via Non-Re-breather Mask

This mask is used when an oxygen concentration of up to 100% is desired. It is necessary that the mask be as tight fitting as possible. The mask is designed to give 100% oxygen from a reservoir bag to the patient. To prevent re-breathing, one way valves are directed away from the patient and the reservoir bag. Also to help prevent the patient from re-breathing carbon dioxide, the liter flow should be sufficient to keep the reservoir bag inflated at the beginning of each inspiration.

F. The Administration of Oxygen via Venturi Mask

This mask is designed to deliver a carefully controlled oxygen concentration, especially indicated in patients with COPD. Construction design maintains a constant air/oxygen ration, ensuring a fixed concentration of inspired oxygen. The venturi mask has variable concentrations of oxygen, starting at 24%, up to 50%. The oxygen flow is also variable for these concentrations, ranging from 3 to 15 liters per minute.

G. The Administration of Oxygen via Aerosol Mask

This mask is designed to give a nebulized aerosol with a variable oxygen concentration from 21% to 100%, with supersaturated humidity at body temperature.

H. The Administration of Oxygen via T-Piece or Tracheostomy Mask

This device is used to administer high humidity, preferably at body temperature, to the patient with an endotracheal tube or tracheostomy tube. Oxygen concentrations may be controlled by variable liter flows, and by dilution controls on nebulizers. This may be used with room air if oxygen is not indicated. The mask or T-Piece facilitates nursing care and does not restrict the patient's movement. This therapy is always heated unless otherwise specific.

I. The Administration of Oxygen via Mist Tent

The mist tent may be used to provide the patient with an environment in which the temperature, humidity, and oxygen concentration may be controlled. The oxygen tent is the most impressive method from this standpoint. Oxygen concentrations from room air up to 60% to 70% oxygen may be obtained, although it can be very difficult to maintain this environment. One of the disadvantages of the tent is the difficulty in administering nursing care. When using concentrations other than room air, the tent shall be checked at least every four hours with an oxygen analyzer.

J. The Administration of Oxygen via Isolette or Incubator

This unit is designed for use with the newborn infant. It consists of a transparent hood mounted on a main unit, which has a controlled heating unit, a heat circulating system, a humidity system, an air filtering unit and an infant bed. Oxygen may be used with this unit by way of humidification or aerosol units. These units, when used with oxygen shall be checked every two hours with an oxygen analyzer.

K. The Administration of Oxygen via Infant Head Hood

The head hood is a plastic device, which covers the head only, and is used to administer precise concentrations of oxygen and relative humidity to an infant. These units, when used with oxygen, shall be checked every two hours with an oxygen analyzer.

REFERENCES

1. American Association for Respiratory Care. Clinical Practice Guidelines. "Oxygen Therapy for Adults in the Acute Care Facility". ~~2002~~2022

~~1.~~2. ACLS Guidelines – Advanced Cardiovascular Life Suport (ACLS) Guidelines." American Heart Association, 2020. www.heart.org. Accessed 22 January 2025

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

HANDHELD NEBULIZER AND AEROSOL THERAPY

Effective Date: 8 5 21	**Page 1 of 5**
Areas Affected: Respiratory Therapy Department, ONRC, Nursing & Health Clinic	
Composed by:	
☒ Reviewed ☐ Revised by: RT Supervisor	

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Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
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PURPOSE

Hand Held Nebulizer (HHN) treatments are administered to deliver medications (bronchodilators, mucolytics or vasoconstricting medications) to the tracheobronchial tree and adjacent lung fields, assist in mobilization and clearing of secretions, and/or hyper-inflate lung fields and overcome atelectasis with deep breathing. Aerosol therapy is administered to add humidity to the airways/lung parenchyma, to thin and mobilize secretions, or to provide vasoconstriction in order to reduce local edema.

CLINICAL CRITERIA:

A. Hand Held Nebulizer (with medication)

1. Hand held nebulizer treatments are given only on the order of a physician. Physician order must include the frequency and the medication with the exact strength, dosage and route (HHN, metered dose inhalers, etc.).

2. Orders may also include duration or length of treatment, and specify whether the treatment will be administered via oxygen or medical air. (Treatment will be administered until the medication is gone unless otherwise stated).

3. Treatment will be given with oxygen unless otherwise ordered or indicated. (Exceptions: treatments delivered at Oakdale Nursing and Rehab Center (ONRC) and the Health Clinics will be given with air compressors with an occasional exception of treatments given off an oxygen cylinder.)

4. Indications for initiating HHN treatments include, but are not limited to:

   a. atelectasis (sub-segmental, segmental, lobar or lung)
   b. bronchiectasis
   c. cystic fibrosis
   d. pneumonia
   e. laryngotracheitis
   f. laryngeal edema
   g. stridor
   h. bronchospasm or history of reactive airway disease

5. Contraindications include, but are not limited to:
   a. Arrhythmia (including tachycardia)
   b. Hypertension
   c. Bronchospasm (only a contraindication for mucolytic medications)

6. Patients with confirmed or suspected aerosol transmissible disease (tuberculosis, SARS-CoV-2 etc.) will not be given hand held nebulizer treatments or aerosol therapy due to risk of transmission to staff and other patients. All efforts will be made to provide appropriate medications via metered dose inhalers (MDIs) instead.

B. Aerosol therapy
   1. The initiation of aerosol therapy is only on the written order of a physician. The order must specify the length and frequency of treatment, the FIO_2 and the type of aerosol modality (heated, cold or ultrasonic).
   2. Indications for initiating treatment include, but are not limited to:
      a. Atelectasis (sub-segmental, segmental, lobar or lung)
      b. Chronic obstructive lung disease (including asthma, emphysema, chronic bronchitis)
      c. Bronchiectasis
      d. Bronchitis
      e. Laryngotracheobronchitis
      f. Laryngeal edema
      g. Pneumonia
      h. Cystic fibrosis
      i. Sputum induction in order to collect specimen

PROCEDURE
For Hand Held Nebulizer Treatments:

A. Preparing for Therapy

1. Check the patient's chart for order, note the following:

a. Type of therapy

b. Specific medication and diluent, including the amount

c. Frequency of therapy

2. Enter the patient's room, introduce yourself and check the patient's identification band. Explain simply and clearly that the physician has ordered hand held nebulizer treatments. Complete patient education regarding ordered therapy, and provide written materials printed from hospital approved patient education website (links found on OVHD intranet page).

B. Setting up the Equipment

1. Perform hand hygiene.

2. Don appropriate personal protective equipment (PPE).

3. Attach the flow-meter to the wall outlet.

4. Attach the nipple adapter to the flow-meter.

5. Assemble nebulizer as indicated on the package.

6. Attach the connecting tubing in the nebulizer package to nipple adapter on the flow-meter. (If using a flow selector attach connecting tube to one of the side nipples).

(If using an air compressor delete step 2 and 3 and attach the connection tube to the air compressor nipple. Plug the compressor in).
(If using an oxygen cylinder skip step 2 and attach the tubing to the nipple on the flow-meter of the regulator).

C. Patient Application

1. Document medication administration in electronic medical record. Scan patient identification band and medication barcode.
2. Have the patient sit upright (as much as possible).
3. Document pulse, respiratory rate and auscultate breath sounds.

4. Place medication in nebulizer.

5. Turn the flow-meter to 6-8 lpm if utilizing wall oxygen or an oxygen cylinder. If utilizing an air compressor turn the compressor on.

6. Instruct the patient to breathe through his/her mouth and every tenth breath, take three slow deep breaths with inspiratory holds if possible.

7. Ensure the patient is performing diaphragmatic breathing so that maximal distribution and deposition of medications occur.

8. Monitor the patient during therapy for any adverse reactions (i.e. increased heart rate or respiratory rate, headache, nausea, anxiety or feeling unwell).

9. Instruct the patient in proper cough technique to help mobilize and expectorate sputum.

10. Document the pulse rate, respiratory rate and breath sounds at the end of the therapy.

11. Shake out the nebulizer cup and place in a clean dry bag for use in the next treatment.

12. Document the therapy and education in the patient's electronic medical record under the appropriate intervention.

13. If any adverse reactions occur during the treatment, discontinue therapy and notify physician. Record in the electronic medical record under "notes".

For Aerosol Therapy:

A. Preparing for Therapy

1. Check the patient's chart for order, note the following:
   a. Delivery device specified
   b. Duration of therapy

2. Enter the patient's room, introduce yourself and check the patient's identification band. Explain simply and clearly that the physician has ordered aerosol therapy. Complete patient education regarding ordered therapy, and provide written materials printed from hospital approved patient education website (links found on OVHD intranet page)

B. Setting up the equipment

1. Perform hand hygiene
2. Don appropriate PPE
3. Attach flow-meter to oxygen outlet
4. Attach aerosol delivery device to flow-meter

C. Patient Application:

1. Ensure adequate levels of sterile water or saline in device.
2. Place aerosol delivery device (mask, nebulizer, cannula etc.) on patient and ensure a good fit.
3. Set the gas flow as necessary to meet the patient's inspiratory flow demands (average peak inspiratory flow is about 25 L/M). Aerosol should be seen leaving the patient connection throughout inspiration to assure adequate flow. Oxygen percentages from a

blender or controller must have enough flow to exceed the patient's peak inspiratory flow demands or the oxygen percentage and humidity content will drop.

4. Monitor patient for any adverse reactions to therapy, notify physician of any reactions.
5. Document aerosol setup and any relevant events or reactions under "notes" in electronic medical record. Document the education in the appropriate intervention.
6. Aerosol particles can carry microorganisms and cause pulmonary contamination and infection. Strict aseptic technique must be adhered to and all disposable equipment should be changed every 7 days per "Disposable Equipment Change Outs" policy, or when visibly soiled.
7. The aerosol setup should be checked at least every 4 hours by respiratory therapy staff or nursing staff to ensure that proper function exists, the water/saline level is adequate, the temperature is correct (if heated) and that the patient continues to have no adverse reactions.

Aerosol particle size and deposition site:

PARTICLE SIZE (u)	DEPOSITION IN RESPIRATORY TRACT
100	Do not enter tract
100-5	Trapped in nose
5-2	Deposited somewhere proximal to alveoli
2-1	Can enter alveoli, with 95% to 100% retention of those down to 1 u.
1-0.25	Stable, with minimal settling
0.25	Increased alveolar deposition

REFERENCES

1. Dolovich, M. American College of Chest Physicians American College of Asthma, Allergy and Immunology. "Device Selection and Outcomes of Aerosol Therapy: Evidence-Based Guidelines" DOI:10.1378/Chest. 127.1.335. 2005
2. Ari, A., & Restrepo, R. D. (2012). Aerosol Delivery Device Selection for Spontaneously Breathing Patients: 2012. *Respiratory Care*. 57(4), 613-626. doi:10.4187/respcare.01756
3. Summary of Common Approaches to Pharmaceutical Aerosol Administration. (2003). *Pharmaceutical Inhalation Aerosol Technology*. 409-446. doi:10.1201/9780203912898-17

4. American Association for Respiratory Care Clinical Practice Guidelines; "A Guide to Aerosol Delivery Devices for Respiratory Therapist, 2017

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

HANDLING OF GAS CYLINDERS

Also indexed as: Oxygen Tanks: Handling of Gas Cylinders

Effective Date: 6 2006	**Page 1 of 2**

Areas Affected: Respiratory Therapy Department
Composed by:
☒ Reviewed ☐ Revised by: RT Supervisor

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District Board	Board Liaison	04/03/2025	

Revised: 11/24 **Reviewed**: 10/18; 8/21, 11/24 **Next Review Date**:

PURPOSE

Provide instruction for transporting, set-up, exchanging and handling large and small compressed gas cylinders in the clinical setting.

PROCEDURE

A. Cylinder Transport

1. Large cylinder (size F, G, H, K) transport.

2. Small cylinder (size A, B, C, D, E) transport.

   a. Secure the cylinder to the proper transporting cart with the valve protection cap attached.

      i. For large cylinders use a four-wheeled cart.
      ii. For small cylinders use a two or four-wheeled cart.

   b. Transport the cylinder to the appropriate area, making sure you are in complete control of the cylinder and cart at all times.

   c. Stabilize the cylinder in appropriate area by chaining it to a fixed structure or by mounting on cylinder ring stand.

d. When the cylinder is not in use, it should be labeled as either full or empty. If partially full, label cylinder contents in pounds per square inch (PSI).

e. Always check the cylinder for deep scratches that may indicate a defect.

f. Any cylinder transported from a patient in isolation should be wiped down with germicide.

B. Regulator Attachment

1. Small Cylinder

a. Secure the appropriate regulator that is pin-indexed to fit the ordered cylinder gas.

b. Remove any cylinder seal and crack the cylinder by quickly opening and closing the main valve. Pin-index cylinders are the exception to this.

c. Attach the regulator making sure appropriate gasket is in place.

d. Tighten the regulator securely and open cylinder valve with face of regulator pointing away from anyone.

e. Close the flow regulator to test for leaks.

f. Attach appropriate flow regulating device, if not part of the regulator.

g. Transport as indicated in the procedure entitled Small Cylinder Transport.

2. Large Cylinder

a. Secure the appropriate regulator that is threaded to fit the ordered cylindered gas.

b. Remove any cylinder seal facing it away from you and others and crack the cylinder by quickly opening and closing the main valve.

c. Tighten the regulator securely and open the cylinder valve with the regulator flow obstructed to test for leaks.

d. Attach appropriate flow regulating device, if not part of the regulator.

e. Open main valve with regulator face pointing away from anyone.

f. Transport as indicated in the procedure entitled Large Cylinder Transport.

REFERENCE

Occupational Safety and Health Administration(n.d.). Compressed Gas and Equipment US Department of Labor https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.101

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

HEAD HOOD OXYGEN OR FREE-FLOW OXYGEN

Effective Date: 3 86		**Page 1 of 2**	
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INDICATIONS

1. Cyanosis
2. Apnea, tachypnea, grunting, retractions
3. Tachycardia, bradycardia, arrhythmias
4. Hypovolemia
5. Hypothermia
6. Depression of capillary or arterial pO_2

EQUIPMENT

- Air compressor
- Oxygen blender
- Flowmeter
- Heated humidifier or Nebulizer
- Supply tubing or wide bore tubing
- Head hood with thermometer
- Oxygen analyzer

PROCEDURE

A. Head Hood

1. A Head Hood setup consists of the following:

   a. A Head Hood of appropriate size for the infant

   b. Two eight link sections of aerosol hose, connected by a drain bag.
   c. Temp probe
   d. Fisher & Paykel heated humidifier

2. Assemble all equipment so that a controlled flow of gas travels from the air compressor and or wall oxygen outlet to the blender, to the flowmeter, to the humidifier, to the head hood.

3. Set oxygen blender at % prescribed by the physician, or not over 40% if a physician is not present. The FIO_2 should be determined by arterial blood oxygen tensions. Optimal paO_2 is 50-70 mm. Hg.

4. Fill the humidifier to the fill line with sterile H_2O and hang the fill bag where it will auto feed the unit.

5. Set Flowmeter at 6 LPM. The flow of gas through the hood must be enough to prevent buildup of CO_2. The larger the hood, the greater the flow.

6. Place hood over baby's head.

7. Monitor oxygen concentration in hood with oxygen analyzer. This should be checked frequently at first and every one-hour after stabilization or whenever the environment of the hood is disturbed.

   a. Oxygen by head hood or freeflow should be withdrawn slowly. Decrease the FIO_2 in 1%-5% increments at a time depending on your patient's response. Monitor SaO_2 for at least 10 minutes before decreasing FIO_2 each time. (Exception: when blow by is given upon delivery of the infant O_2 is to be weaned off by pulling it gradually away from the patient. It is not necessary to wait 10 minutes before decreasing FIO_2 in this case).

8. Monitor the temperature in the hood. This should be maintained at 35-36°C. The control of temperature is achieved by increasing or decreasing the heater setting on the Fisher & Paykel humidifier.

9. Chart all procedures and observations on the infant's chart.

B. Free Flow

1. Hold oxygen tube steady at ½" from nares with oxygen set at 5 liters per minute. This provides approximately 80% oxygen if tube is not waved back and forth.

DOCUMENTATION

1. Chart all procedures and observations on the infant's chart.

REFERENCES

1. American Association for Respiratory Care. Clinical Practice Guidelines. "Selection of an Oxygen Delivery Device for Neonatal and Pediatric Patients." 2002

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:			
HUMIDIFIERS			
Effective Date: 3 92		**Page 1 of 1**	
Areas Affected: Respiratory Therapy Department, Nursing, PACU			
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PURPOSE

To provide instruction in the proper clinical use and appropriate placement of humidification bottles.

PROCEDURE

A. Humidifiers will not be used on any patient receiving oxygen at 3 liters per minute or less, and will not be used in the PACU at all, unless specifically ordered by a physician, at nursing or Respiratory Therapy (RT) discretion, or a patient complaint.

B. Humidifiers will be used when more than 3 liters of oxygen are used. Excluding PACU, and when Venti Masks are used.

C. Application of the humidifier to the oxygen source.

1. Connect the cap to the water bottle by screwing it on tightly.
2. Screw the cap of the humidifier to the male adapter on the flowmeter or timemeter.
3. Break the tip of the nipple off the humidifier water bottle.
4. Attach the oxygen tubing to the nipple.
5. Turn the oxygen to flush level and occlude the oxygen tubing. You should hear a whistle after a few seconds. This whistle is to alert you if back pressure is applied to the system (i.e. tubing pinched under wheel of bed, etc.)
6. Decrease flow to prescribed level and apply oxygen source to patient.

D. Humidifiers are to be changed when the water level is running low.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

INCENTIVE SPIROMETRY

Effective Date: 4 86	**Page 1 of 3**
Areas Affected: Respiratory Therapy Department	
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POLICY

The Incentive Spirometry Exercise can be utilized to prevent atelectasis as well as improve respiratory muscular tolerance. It is an aid in pre and post-operative prophylaxis of respiratory complications. Any device that measures inspiratory flow rates or volumes can be used as a guide to deep breathing by allowing the patient to measure his depth of breathing. The incentive is to gradually increase this inspiratory volume until inspiratory capacity is reached.

PURPOSE

1. To optimize lung inflation
2. To optimize the cough mechanism

SUPPORTIVE DATA

A. Therapeutic Objective of Incentive Spirometry

   1. To encourage maximal sustained spontaneous inhalations at frequent intervals:
      a. Re-inflate collapsed lung parenchyma
      b. Prevent collapsed of lung parenchyma
      c. Mobilize secretions

B. Indications for Initiating Incentive Spirometry

   1. Any of the following diagnoses or conditions:
      a. Atelectasis (sub-segmental, segmental, lobar, or lung)
      b. Pulmonary edema

c. Chronic obstructive lung disease (including asthma, emphysema, chronic bronchitis)
d. Pneumonia
e. Bronchiectasis
f. Conditions where 1.a. have an increased incidence:
   1) Obesity
   2) Chest wall deformity
   3) Prolonged immobilization
   4) Following upper abdominal or thoracic surgical procedures

AND

2. Reduced vital capacity

OR

3. Poor patient motivation to effect spontaneous deep breathing without a physical incentive

C. Outcome
1. Re-inflation of lung parenchyma
2. Lung collapse does not develop
3. Resolution of pneumonia

D. Contraindications
1. Comatose patient

E. Hazards
1. Hyperventilation
2. Transmission of infection

F. Special Exercises
1. Incentive Spirometry

PROCEDURE

1. Explain procedure to the patient and purpose of treatment.

2. Elevate patient as high as possible and the patient can tolerate.

3. Explain to patient how to breathe through the Incentive Spirometer beginning on a complete exhalation. Encourage a deeper breath with each trial until an average peak effort is attained. Ten to twenty breaths are adequate for each exercise. A sustained inhalation is helpful for airway expansion.

4. Finish each exercise with several controlled cough efforts to clear the airways.

5. Instruct patient how often they should use the device.

6. Record your observations on the Multi Disciplinary Education Record.

PRECAUTIONS

1. Patients commonly tend to hyperventilate in an effort to complete the exercise. This can be avoided by a brief pause between each trial.

2. Exercises performed after a meal may induce nausea or regurgitation.

3. Splinting of recent surgical sites will sometimes reduce pain and allow a deep lung inflation. This is especially true during the cough effect.

REFERENCES

1. American Association for Respiratory Care. Clinical Practice Guidelines. "Incentive Spirometry" 2011
2. Wilkins, R.L., Stroller, J.K., & Kacemarek, R.M. (2009). Lung Expansion Therapy, Egan's Fundamentals of Respiratory care (9th Ed., pp 903-920), Mosby

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:

INDICATIONS AND PRECAUTIONS WITH CONTINUOUS VENTILATION

Effective Date: 4 86	**Page 1 of 3**
Areas Affected: Respiratory Therapy Department	
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INDICATIONS FOR VENTILATION

Continuous ventilation is a commonly considered modality, effective as a measure for ventilatory failure. Ventilatory failure is defined by the following data:

PH less than 7.20; pCO_2 greater than 65mmHg; & pO_2 less than 40mmHg

The clinical situations, which could precipitate such values, are as follows:

1. Alveolar Hypoventilation (normal lungs) cervical spine trauma, neurological disease, drug overdose, neuromuscular disorder, skeletal deformities, surgery.

2. Alveolar Hypoventilation (associated with cardiopulmonary disorders) decreased compliance (asbestosis, scleroderma, beryllosis, sarcoidosis, pulmonary fibrosis), increase airway resistance (status asthmaticus, chronic airway obstruction, acute bronchitis), infections pulmonary disease, (pneumonia), emboli, (thrombus, fat, septic), ventilatory mechanics imbalance (chest trauma, pneumothorax), heart failure.

The control of a patient's ventilatory needs when they are incapable of doing so satisfactorily themselves is comprised of five major facets. First, the blood gases must be maintained within physiological limits. This requires the immediate considerations of rate, tidal volume, dead space (mechanical), and FIO_2.

Secondly, the pulmonary physiological status requires consideration in order that proper ventilation perfusion can be maintained or encouraged. Based upon other physiological data, this could require the use of inflation hold, pressure plateau, PEEP, expiratory retard, CPAP, I.M.V., etc.

Third, other aspects, such as neurological disorders or cardiac output, may require modification to the normal approach to reduce mean inspiratory thoracic pressures.

Fourth, ancillary functions, such as turning the patient and tracheal-bronchial aspiration, are vital to maintain proper pulmonary stability.

Fifth, psychosomatic support of the patient, even though they may appear totally unresponsive, cannot be over-stressed. The few extra moments it takes to treat all continuous ventilation patients as individuals you are attempting to help, is well worthwhile in relieving apprehension and encouraging achievement of improved physical status.

PRECAUTIONS WITH CONTINUOUS VENTILATION

1. Oxygen is a drug and should only be utilized in sufficient quantities to restore blood gas levels toward normal. Excessive levels of oxygen over a period of time may result in disorders associated with hyperoxygenation.

2. The effectiveness of oxygen administration should be periodically monitored by the physician order of all or part of the following:

   a. Arterial blood gases to assure adequate levels of oxygen are being administered.

   b. Oximetry

   c. Hemoglobin level so that oxygen content of the arterial blood can be calculated. (PaO_2 x 0.003) + (1.34 x HB. gm% x Sat.) = arterial O_2 content.

   d. Hemoglobin level so that oxygen content of the venous blood can be calculated. (PaO_2 x 0.003 + 1.34 x Hb.gm% x Sat.) = venous O_2content.

   e. Venous blood gas to be able to calculate the quantity of oxygen removed by the cells. (PaO_2 x 0.003) + 1.34 x Hb.gm% x Sat.) = venous O_2 content.

   f. Pulse and blood pressure should be within normal limits as indication that cardiac output is reasonable normal.

   g. Increase in lactic acid production above normal indicates the presence of anaerobic metabolism at elevated levels in the body where oxygen is not reaching the cells sufficiently.

      NORMALS:
      [H+]=35-45nM/1
      pH = 7.35-7.45

   ACID-BASE DISORDERS

   Clinical data (history and signs listed above)

   Blood valves

   Respiratory Acidosis Low pH, High $PaCO_2$*, Normal to high NaHCO3

REFERENCES

1. Branson, R., Godwin, ., Hargett, J., Papadakos, P., Rodrigues, D., Stampor, L., Stickland, S. "Safe initiation and Management of Mechanical Ventilation: A White Paper from the AARC. [White Paper]. Retrieved~~: 05/18/18~~10/14/2024 from http://www.aarc.org

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:			
IN-SERVICE EDUCATION			
Also indexed as : Education/In-service			
Effective Date: 4/86		**Page 1 of 1**	
Areas Affected: Respiratory Therapy Department			
Composed by:			
☒ Reviewed ☐ Revised by: RT Supervisor			
Dept. / Committee Approval:	**Dept./Title:**	**Date**	**Approved**
Respiratory Therapy	RT Supervisor	11/17/2024	X
Policy, Procedures, Forms Comm.	VP of Nursing	02/05/2025	X
Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised: 7/16	**Reviewed**: 4/17; 10/18; 8/21, 11/24	**Next Review Date**:	

POLICY

All Respiratory Care Practitioners are encouraged to attend as much In-service Education Programs as possible. Benefited employees may request to attend in-services to be paid for by the hospital. The Department Supervisor and Administration using the following guidelines will make approval:

1. The class must be relevant to this hospital, or to Respiratory Care to be approved. The approval may be for the class tuition, hours in class, or travel expenses or any combination of the above.

2. All Respiratory Care Practitioners must obtain the required number of CEU's to keep their Respiratory Care Practitioner license current. NRP, ACLS and PALS are required certifications. All benefited employees will be sent to these classes at the hospital's expense.

3. All per-diem staff is required to keep their card current at their primary employer. If this is not possible, Oak Valley Hospital will send them.

4. Occasionally, technicians will be asked to voluntarily attend seminars at the discretion of the Department Supervisor with the approval of the Administrator.

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

POLICY/PROCEDURE:			
INTUBATION			
Effective Date:		**Page 1 of 6**	
Areas Affected: Respiratory Therapy Department			
Composed by:			
☒ Reviewed ☐ Revised by: RT Supervisor			
Dept. / Committee Approval:	**Dept./Title:**	**Date**	**Approved**
Respiratory Therapy	RT Supervisor	11/17/2024	X
Policy, Procedures, Forms Comm.	VP of Nursing	02/05/2025	X
Department of Medicine	Medical Staff Coordinator	03/11/2025	X
Medical Executive Committee	Medical Staff Coordinator	03/18/2025	X
District Board	Board Liaison	04/03/2025	
Revised: 8/21, 11/24	**Reviewed**: 10/18, 11/24	**Next Review Date**: 8/2024	

POLICY

Respiratory care practitioners (RCP) shall participate in emergency airway management. This includes performing intubations, assisting the physicians with intubations, and inserting oral and nasal airways. Only respiratory care practitioners that have completed training with anesthesia and have competencies on file shall perform intubations.

PURPOSE

1. To provide for a patient airway in the presence of airway obstruction or in circumstances in which the patient cannot manage or maintain their own airway.
2. To provide a route for the administration of positive pressure ventilation.

EQUIPMENT

- Bag and mask
- Suction equipment
- Proper size and type endotracheal tube (include one size above and below)(see tables one and two)
- Surgical lubricant
- 10 cc syringe
- McGill forceps
- Stylette
- Oral airway
- Tape and or Tube Holder

- Tonsillar tip (Yankauer type) suction device
- "Glide Scope" video laryngoscope

PROCEDURE FOR ASSISTING THE PHYSICIAN WITH INTUBATION

1. Wash hands.
2. Don appropriate PPE (see page 5 for considerations regarding aerosol transmissible diseases).

3. Gather necessary equipment for intubation. Endotracheal tube size may be selected according to age (tables 1 and 2).
4. Assure that the suction apparatus is working properly. Set suction level -60 to -80 mmHg for neonates, -80 to -100 for pediatric patients, and -100 to -120mmHg for pediatric and adult patients.

5. Assure that the laryngoscope(either traditional or video) is working properly.

6. Assure that ventilation and oxygenation are acceptable during the intubation procedure. Place nasal cannula on patient at 3-5 lpm to ensure adequate oxygenation throughout procedure. If necessary, ventilate with a manual resuscitator and mask, connected to a 100% oxygen source.

7. Assist the physician with handling of equipment and patient position. For neonates, use the "sniffing position" for pediatric and adult patients extend the neck a little more but do not hyper extend.

8. When using cuffed endotracheal tubes, inflate cuff and check for a leak.

9. Ventilate with Ambu bag 100% oxygen between intubation attempts.

10. Monitor heart rate and oxygen saturation closely during attempts.

11. After the physician has inserted the endotracheal tube, watch for the "frosting" sign. The walls of the endotracheal tube will "frost" during exhalation. This is an excellent indication that the tube is not in the esophagus.

12. Place Easy Cap on tube and check for color change (refer to Easy Cap policy in the Clinical Manual). (Or use Ambu bag with built in CO_2 detector.)

13. Check for bilaterally equal breath sounds. Also check for "gurgling" sounds in the stomach during positive pressure breaths. This indicates esophageal intubation. Lung sounds should be bilaterally equal. If they are diminished on the left, this usually indicated right main-stem intubation. Slowly withdraw the endotracheal tube while listening to the breath sounds on the left. When the tip of the tube is pulled above the carina, the left sided breath sounds should improve.

14. After successful intubation, secure the endotracheal tube (see the procedure for re-taping endotracheal tubes).

15. Endotracheal tube position should be confirmed with an x-ray.

PROCEDURE FOR INTUBATION BY THE RCP

1. Wash hands.
2. Don appropriate PPE (see page 5 for considerations regarding aerosol transmissible diseases).

3. Gather necessary equipment for intubation.

4. Insert a stylet (if desired) into the tube such that the tip of the stylette do not protrude out the distal end of the tube.

5. Assure that the suction apparatus is working properly. Set suction level -80 to -100 mmHg for neonates and infants, and -100 to -120mmHg for pediatric and adult patients.

6. Assure that the laryngoscope is working properly.

7. Assure that ventilation and oxygenation are acceptable during the intubation procedure. If necessary, ventilate with a manual resuscitator and mask, connected to a 100% oxygen source.

8. When using cuffed endotracheal tubes, inflate cuff and check for a leak.

9. Position the patient and equipment needed. For neonates, use the "sniffing position," for pediatric and adults, extend the neck more but do not hyper extend.

10. Carefully monitor heart rate as oxygen saturation during the procedure.

11. Clear the oropharynx with gentle suctioning.

12. Hold laryngoscope handle in left hand.

13. Steady the head with the right hand. Avoid using the blade to open the mouth, and avoid resting the blade on the maxilla or using the maxilla as a fulcrum.

14. While visualizing, insert blade midline until the tip is between base of tongue and epiglottis within the vallecula.

15. Open mouth further by pulling up on the laryngoscope handle. Simultaneously tilt blade tip upward slightly to elevate epiglottis and visualize glottis. Use base of tongue as pivot point, not the maxilla. Avoid extreme tension or tilt on laryngoscope. Use an upward motion. **DO NOT ROCK** the blade.

16. If necessary (e.g. difficulty visualizing glottis) have an assistant palpate the suprasternal notch and apply gentle pressure.

17. Hold the tube with the concave curve anterior, and pass it down the right side of the mouth, outside the blade, while maintaining visualization of the epiglottis.

18. As the patient inspires, pass the tube through the vocal cords. Advance the tube until the assistant feels it pass under the suprasternal notch. Insertion depth may also be estimated using table 2.

19. Ventilate with Ambu bag100% oxygen between intubation attempts.

20. After insertion of the endotracheal tube, watch for the "frosting" sign. The walls of the endotracheal tube will "frost" during exhalation. This is an excellent indication that the tube is not in the esophagus.

21. Place Easy Cap to the tube and check for color change (refer to Easy Cap policy in the Clinical Manual) (or use Ambu bag with built in CO_2 detector).

22. Check for bilaterally equal breath sounds. Also check for "gurgling" sounds in the stomach during positive pressure breaths. This indicates esophageal intubation. Lung sounds should be bilaterally equal. If they are diminished on the left, this usually indicates right main-stem intubation. Slowly withdraw the endotracheal tube while listening to the breath sounds on the left. When the tip of the tube is pulled above the carina, the left sided breath sounds should improve.

23. After successful intubation, secure the endotracheal tube (see the procedure for re-taping endotracheal tubes).

23. Endotracheal tube position should be confirmed with an x-ray.

ASSESSMENT OF THERAPY

1. The rapid and continuing assessment of proper placement of an endotracheal tube is of extreme importance.

2. Tube position should be assessed immediately after placement by auscultation, visual notation of good chest excursion during positive pressure breaths and chest radiograph.

HAZARDS

1. Acute trauma
   a. tracheal or hypopharyngeal perforation
   b. hemorrhage
   c. laryngeal edema
   d. mucosal necrosis
   e. vocal cord injury
2. Chronic trauma
   a. palatal grooves
   b. cricoid ulceration and fibrosis
   c. stenosis of glottic or subglottic larynx or of trachea
   d. hoarseness
   e. tracheomegaly
3. Systemic side-effects
   a. infection
   b. hypoxemia
   c. apnea

TABLE 1

FORMULA FOR DETERMINING ENDOTRACHEAL TUBE SIZES:

$$\frac{16 + \text{patients age in years}}{4}$$

d. bradycardia and cardiac arrest

4. Misplacement into the esophagus or bronchus
   a. atelectasis
   b. pulmonary air leak
   c. loss of tube into esophagus
5. Accidental extubation
6. Obstruction
7. Kinking
8. Unrecognized disconnection from Ventilation

TABLE 2: GUIDE TO CHOICE OF ENDOTRACHEAL TUBES

AGE (cm)	INTERNAL DIAMETER (mm)	ORAL LENGTH (cm)	NASAL LENGTH
PREMATURE	2.5	8	11
NEWBORNS	3.0	9	12
6 MONTHS	3.5	10	14
1 YEAR	4.0-4.5	12	16
2 YEAR	5.0-5.5	14	17
2-4 YEAR	5.5-6.0	15	18
4-7 YEAR	6.0-6.5	16	19
7-10 YEAR	6.5-7.0	17	21
10-12 YEAR	7.0-7.5	20	23
12-16 YEAR	7.5-8.0	21	24
ADULT (FEMALE)	8.0-8.5	22	25
ADULT (MALE)	8.5-9.0	22	25

Endotracheal tube sizes will vary with body size and height. One size smaller and one size larger should be available during intubation for individual variations.

Consideration regarding aerosol transmissible diseases:

1. In the event that a patient with suspected or known aerosol transmissible disease such as tuberculosis or SARS-CoV-2, the most experiences practitioner available should perform intubation. In most instances this will be anesthesia, however, other practitioners such as emergency room physicians and hospitalists may perform intubation when necessary and/or appropriate.
2. Patients with suspected or known aerosol transmissible disease will be placed in a negative pressure room for intubation whenever possible.
3. Personnel present during intubation will be limited to the provider performing intubation, respiratory therapist, and primary RN. Other staff should be available outside negative pressure room in order to provide extra supplies and help if necessary.
4. Personnel present for intubation shall don appropriate PPE for aerosol transmissible diseases prior to entering the room per CDC recommendations.

5. Respiratory and ventilator equipment shall be set up prior to intubation and every effort should be made to prevent and/or decrease the number of times the ventilator circuit is disconnected. All filters, HME, inline suction catheters and sensors will be placed on circuit prior to intubation and RT staff will use appropriate style of endotracheal tube holder that does not require circuit disconnect to secure endotracheal tube.

REFERENCES

Kacenarek, R.M., Stoller, J.K. & Heuer, A.J.(Eds). (2001 Airway Management in Egan's Fundamentals of Respiratory Care (13th ed., pp 742-779). Elsivier

NRP Reference – American Academy of Pediatrics. (2021) Neonatal Resuscitation Program (NRP) textbook 8th ed. American Academy of Pediatrics

OAK VALLEY HOSPITAL DISTRICT
MEDICAL/SURGICAL TELEMETRY DEPARTMENT
DEPARTMENT SCOPE OF SERVICE

Overview of Service Provided

The Medical/Surgical unit is a 24 bed multidisciplinary unit, with Telemetry monitoring capability for up to 8 patients. It provides care for a variety of post – surgical and medical patients to include, but not limited to: general surgery, orthopedic, infectious disease, cardiac, pulmonary, gastrointestinal, renal, diabetic and pediatric patients with either acute or chronic disease process.

Types and Ages of Patients Served

The Medical/Surgical department provides service to patients from three ~~months~~ years of age and above with medical/surgical needs. The decision to admit patients less than 3 ~~months~~ years will be at the discretion of surgery, anesthesia and the pediatrician.

Hours of Operation

This unit provides care 24 hours a day for 7 days a week.

Staffing

- Minimum Requirements

The department follows the State mandated ratio of 1 Registered Nurse to 5 Medical/Surgical patients. The ratio is 1 RN to 4 patients for Telemetry and Pediatric patients. However, staffing is adjusted appropriately. Additionally, Ancillary Nursing personnel (CNAs, Techs and Clerks) may provide nursing support to the RN's to ensure quality patient care.

Integration of Services

The Medical Surgical Unit, in collaboration with the Medical Staff, works closely with various disciplines including respiratory therapy, pharmacy, radiology, laboratory, social services / case management, infection control, physical / occupational / speech therapy, and dietary to ensure complete diagnostic and treatment services are provided to achieve the goal of patient improvement and safe discharge.

Oak Valley Hospital
A Division of Oak Valley Hospital District

Medical Staff use only
Physician Name: _____ *Please Print*
Privilege Period: _____

RADIOLOGY PRIVILEGES REQUEST/ APPROVAL FORM

Physician Name: _____

Initial Appointment Requirements:
To be eligible to request radiology privileges, the minimum threshold criteria must be met:

1. The provider must be an M.D. or D.O.
2. Successful completion of an ACGME or AOA approved post-graduate Diagnostic Radiology residency training program with satisfactory proficiency from their program and/or having been granted these privileges/ procedures at other hospital affiliations.
3. Must hold a current California radiology x-ray supervisor and operator fluoroscopy certificate.
4. Must provide case logs/ activity with a minimum of 200 radiographs, 200 CT/ MRI, and 100 ultrasound cases, during the past 24 months.
5. The applicant will provide documentation of their current DEA license reflecting schedules 2, 2N, 3, 3N, 4, 5. If the applicant's DEA does not reflect full schedule, the physician will not be granted full drug ordering privileges.
6. They are qualified to act as consultants.

Proctoring Requirements: Ten (10) radiographic studies, two (2) Fluoroscopic procedures, five (5) CT, five (5) ultrasound cases will be proctored retrospectively.

Reappointment Requirements:

1. Maintain California Radiology X-Ray Supervisor and Operator Fluoroscopy Certificate
2. Must provide case logs/activity showing a combination of 500 radiologic exams reflective of the privileges requested in the past 24 months as defined by the Medical Staff and acceptable results from quality improvement activities.
3. In the case of an emergency, an individual who is a member of the medical staff or who has been granted delineated privileges is permitted to do everything possible, within the scope of his/her license, to save a patient's life or to save a patient from serious harm, regardless of the individual's staff status or privileges.

Medical Staff Category Requested:

☐ **Provisional** - Initial appointees expected to become Active, Adjunct, or Courtesy Staff. Duration: 09 to 24 months, and re-appointed physicians who have been absent from staff membership for more than six months. Not eligible for the medical staff leadership position.

☐ **Adjunct** - Regularly admits patients, but not necessarily 12 per reappointment, otherwise active in community and on Medical Staff, eligible for Medical Staff leadership position.

☐ **Courtesy** - Occasionally admit/treat patients, provides consultations on patients as an expert, or is a contracted physician not eligible for Medical Staff leadership position.

☐ **Telemedicine Affiliate** - Provide services via telemedicine modalities.

Oak Valley Hospital

A Division of Oak Valley Hospital District

Medical Staff use only

Physician Name: _____
Please Print

Privilege Period: _____

Core Privilege Requests

Request	Procedure	Renewal Criteria	Proctoring Requirement	Approval	Denied
☐	**Please ~~line through~~ privileges or procedures you wish to exclude **Your request for privileges in this department implies that you have and will maintain competency in these core privileges unless you specifically opt out of a core privilege by crossing out/initializing/dating such requests.** *Privileges included in the Core:* Privileges to consult through diagnostic workup planning and perform and interpret diagnostic procedures. **Included in the Core are:** • Computer Tomography (CT) • Magnetic Resonance (MRI) • Radiograph Studies (X-ray) • Ultrasonography (US) • Diagnostic Mammography/ Mammography *Mammography must be an MQSA interpreting physician. • Fluoroscopy procedures, CT/US Guided Percutaneous Aspiration, drainage and biopsy, diagnostic mammography [Must maintain Fluoroscopy permit].	The appropriate number of cases performed per year as based on category Reappointment Be prepared to provide a list of cases performed at facilities other than OVHD if requested Minimum of 40 cases required in the past two years *Mammography – minimum of 800 cases required in the past two years	Minimum 25 cases/ charts	☐	☐

Special Procedure – Privilege Request

Request	Procedure	Renewal Criteria	Proctoring Requirement	Approval	Denied
☐	Arthrography	_____ # of cases in 2 years Minimum of 5 cases required in the last two years	Two cases/chart reviews	☐	☐
☐	Injections • Epidural Spinal Injection • Steroid Joint Injection	_____ # of cases in 2 years Minimum of 5 cases required in the last two years	Two cases for each privilege/ chart reviews	☐	☐
☐	Image Guided Biopsy (US, Fluoroscopic or CT guided) • Aspiration, drainage and biopsy • Stereotactic breast biopsy	_____ # of cases in 2 years Minimum of 5 cases required in the last two years	Two cases for each privilege /chart reviews	☐	☐
☐	Lumbar Puncture/ Myelography	_____ # of cases in 2 years Minimum of 5 cases required in the last two years	Two cases for each privilege /chart reviews	☐	☐
☐	Thoracentesis and Paracentesis	_____ # of cases in 2 years Minimum of 5 cases required in the last two years	Two cases/chart reviews	☐	☐

Teleradiology Privilege Request

(** Initial criteria for teleradiology privileges: Successful completion of an ACGME or AOA-accredited residency/ fellowship in radiology or a subspeciality of radiology. Proctoring requirements: retrospective case review for a combination of teleradiology privileges listed below**).

Request	Procedure	Renewal Criteria	Proctoring Requirement	Approval	Denied
☐	Teleradiology Core Diagnostic Imaging **Please ~~line through~~ privileges or procedures you wish to exclude • Computer Tomography (CT) • Magnetic Resonance (MRI) • Radiograph Studies (X-ray) • Ultrasonography (US) • Diagnostic Mammography/ Mammography *Mammography must be an MQSA interpreting physician.		**As stated above**	☐	☐

Oak Valley Hospital
A Division of Oak Valley Hospital District

Medical Staff use only

Physician Name: _____
Please Print

Privilege Period: _____

Acknowledgement of Practitioner:

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and,

I understand that:

1. In exercising clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the situation.
2. Any restriction on the clinical privileges granted to me is waived in an individual who is a member of the medical staff or who has been granted delineated clinical privileges is permitted to do everything possible, within the scope of his license, to save a patient's life or to save a patient from serious harm, regardless of the individual's staff status or clinical privileges.an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature: _____ **Date:** _____
Practitioner

Department Chair Recommendation:
I have reviewed the requested clinical privileges and supporting documentation of the above-named applicant and make the following recommendation (s):

- ☐ **Recommend all requested privileges**
- ☐ **Recommend requested privileges with the following conditions/ modifications:**
- ☐ **Do not recommend the following requested privileges**

Approved: _____ **Date:** _____
Medical/ Service Director Signature

Approved: _____ **Date:** _____
Medicine Department Chair Signature