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

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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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- 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**

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Matthew Tilstra, MD, Chairperson

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

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- 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 to 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

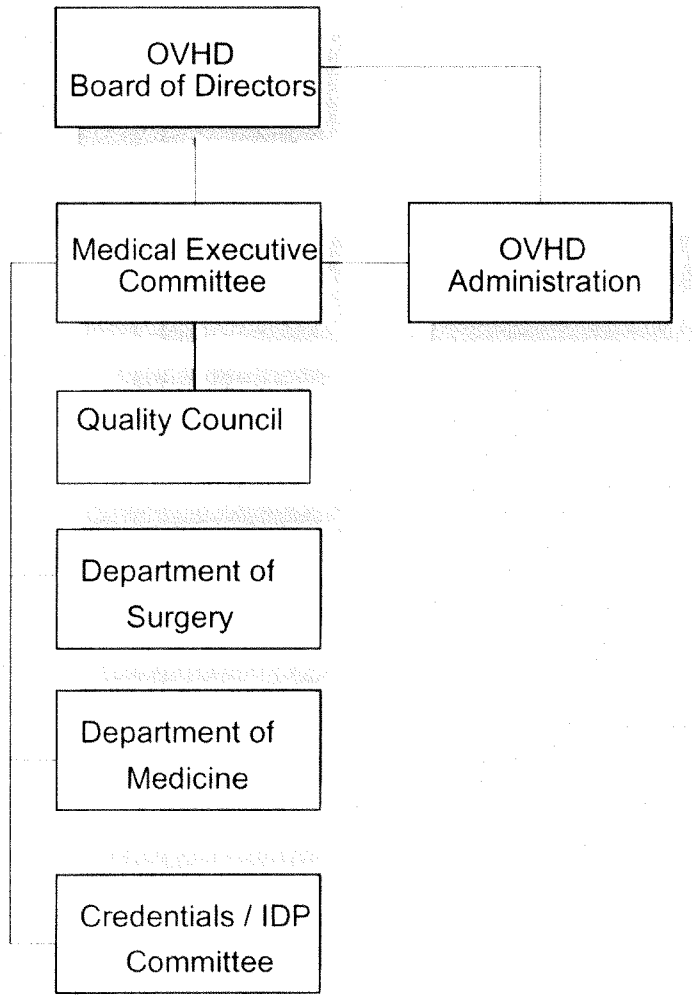
Staff are charged with participating in this performance improvement plan to the degree necessary and appropriate to achieve the plan's purpose.

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

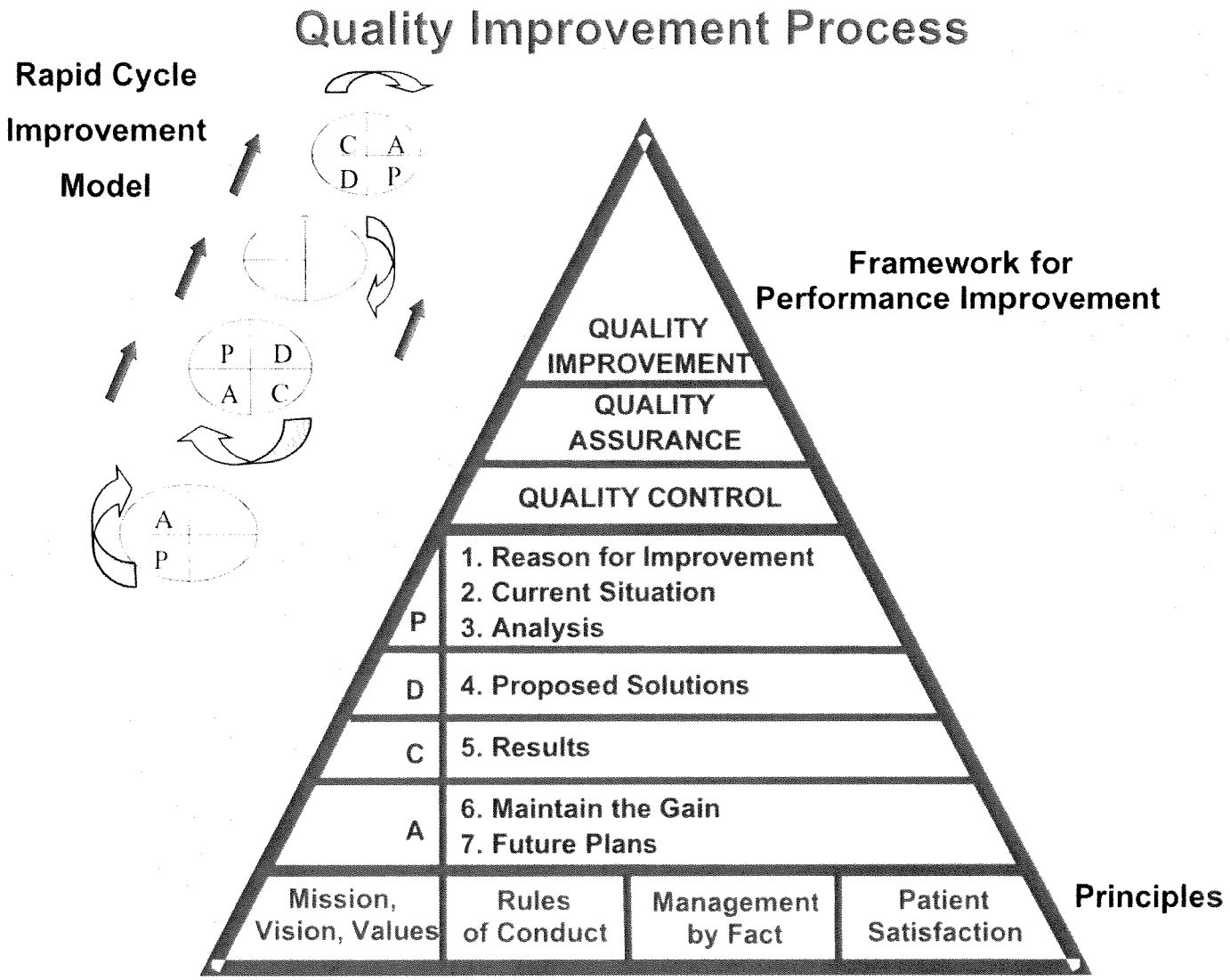
All data collection, aggregation, analysis, and resultant activities related to the clinical and attendant operational care of the patient as part of this Performance Improvement plan are undertaken under the auspices of the Medical Staff as part of their quality assurance efforts and are protected from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



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**

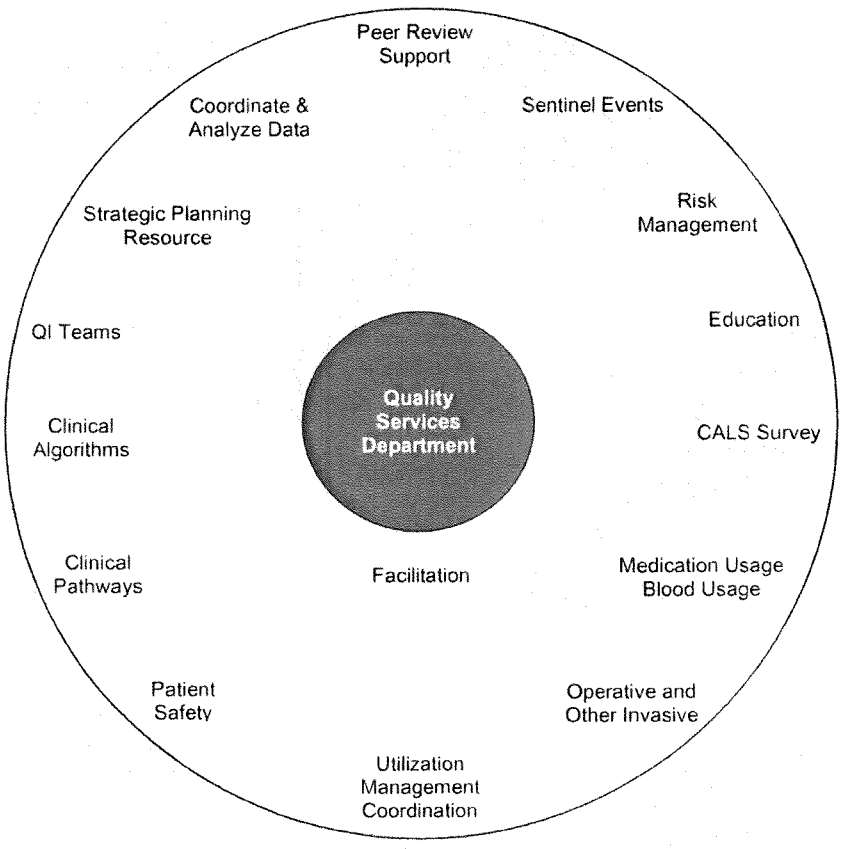
Board of Directors

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~~+~~ 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 ~~water~~the water supply.

3. For scrub, see ~~Scrub~~ Surgical Hand Scrub Policy

REFERENCES

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~~3.~~ Guidelines for Hand Hygiene in Health-Care Settings. Centers for Disease Control and Prevention, Vol. 51, No. RR-16, pgs. 1-44. October 25, 2002.

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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
2. ACOG: The American College of ~~Ostestricians~~Obstetricians and Gynecologist; update on Immunization and Pregnancy: ~~Tenays~~ Tetanus, ~~Diptheria~~Diphtheria and Pertussis Vaccinations: Number 718: September 2017
3. AAFP. Pertussis Vaccine: Receiving Tdap During Pregnancy. 2024
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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**
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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:	

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

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Continuous Quality Improvement	ONRC	11/15/2024	X
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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.
6. ~~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

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Continuous Quality Improvement	ONRC	11/15/2024	X
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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
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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**
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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
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Medical Executive Committee	Medical Staff Coord	03/18/2025	X
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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	
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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.