Oak Valley Hospital

Regular Board Packet

June 4, 2026

Board Packet

Oak Valley Hospital District

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

June 4, 2026, 11:00 a.m.
350 S. Oak Ave. Oakdale, CA 95361
REDWOOD ROOM

Time	*Action*	*Item*
11:00 a.m.	Action	**MEETING CALLED TO ORDER** Dan Cummins, Chairperson

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.

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 350 S. Oak Ave., Oakdale, CA during normal business hours.
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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 Minutes –
- May 7, 2026 – Regular Meeting
- May 13, 2026 – Special Meeting

3. Admin Policies
Emergency Operations Management Manual
- Hazardous Vulnerability Analysis

HR Manual
- Dress Code
- Employee Badge Buddy

Action **MEDICAL STAFF REPORT –**Matthew Tilstra, M.D., Chief of Staff

The Medical Executive Committee requests the District Board's approval of the following items forwarded from the May 22, 2026 meeting.

Committee Reports

A. Interdisciplinary Practice Committee Meeting (IDPC) – (05/05/2026) **Standing**
Chaitanya Mahida, MD, Chairperson
i. Summary Review
ii. Changes to Nurse Practitioner Hospital Privileges **Approval**

B. Credentials Committee Meeting – (05/05/2026) **Standing**
Chaitanya Mahida, MD, Chairperson

C. The Department of Medicine Committee Report – (05/12/2026) **Standing**
Lee Horwitz, MD, Chairperson
i. Summary Review **Standing**

D. The Department of Surgery Committee Report – (Next Sch Mtg 06/09/2026) **Standing**
Andrew Huber, MD, Chairperson

E. The Quality Council Report – (Next Sch Mtg 06/11/2026) **Standing**
Lee Horwitz, MD, Chairperson

F. Policy Agenda **Approval**
A. Community Health Centers Manual (Department of Medicine 05/12/2026)
i. Prior Authorization

B. Clinical Manual (Department of Medicine 05/12/2026)
   i. Code White – Medical Emergency (Pediatric)
   ii. Blood Recipient ID Bands
   iii. Rapid Response Team

C. ONRC Manual
   i. Pressure Injury-Skin Breakdown Prevention and Management

D. Radiology Manual (Department of Medicine 05/12/2026)
   i. Computed Tomography Reportable Events
   ii. Cone Removal
   iii. Radiation Safey and Protection Program
   iv. Radiation Safety and Protection – *RETIRE*

E. Respiratory Therapy Manual (Department of Medicine 05/12/2026)
   i. Peripherally Inserted Central Catheter (PICC) Insertion

G. Vice Chief of Staff Results **Informational**

FINANCE COMMITTEE – Sara Shipman, Chairperson
- Chang Ahn, Chief Financial Officer

Action 1. Approval of May 7, 2026 Minutes

Action 2. Financial Reports for April 2026 – Chang Ahn, Chief Financial Officer
- Approval of April 2026 Financial Statements

CHAIRPERSON REPORT
- Dan Cummins Chairperson

Information 1. Chairperson Comments

Information 2. Report on Board Member Vacancy
- Opportunity for Interested Candidates to Address the Board

Action 3. Consideration of Rescheduling or Cancelling the December 3, 2026, Finance Committee and Board of Directors Meetings.

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

Information 1. Chief Executive Officer Report

Action 2. Consideration of Resolution 2026-03 of the Board of Directors of Oak Valley Hospital District Calling 2026 General Election for Oak Valley Hospital District; Consolidation of Election with Statewide General Election; and Publication of Notice of Election by Secretary.
Resolution 2026-03

Action 3. Consideration to Approve the Purchase and Installation of Center for Health Improvement Signage, in an Amount Not to Exceed $145,000.00.
- David Rodrigues, Chief Operating Officer

Action 4. Consideration and Approval of Revisions to the Paid Time Off (PTO) Accrual policy.
- David Rodrigues, Chief Operating Officer

ADJOURN TO CLOSED SESSION

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

- May 7, 2026 - 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 July 2, 2026 at 5:30p.m.

Posted on: June 1, 2026 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
June 4, 2026 11:00 a.m.
350 S Oak Ave., Oakdale, CA 95361
Redwood Room

CLOSED SESSION AGENDA ITEMS

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

- **Medical Staff Credentialing Report – Matthew Tilstra, M.D.**
  (Government Code §37624.3 & Health and Safety Code §§1461, 32155

- **Chief Executive Officer Report – Matt Heyn, President & CEO**
  REPORT INVOLVING TRADE SECRET
  (Government Code §37606 & Health and Safety Code § 32106)

  Discussion will concern: Proposed New Services, Program, or Facility.
  Anticipated Date of Disclosure: Unknown.

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.

June 2026 ONRC Board Report

ONRC recorded an average daily census of 94 patients per day in our prior month of operations. We continue to maintain a strong daily census in both the TCU and LTC settings.

From a regulatory standpoint, ONRC experienced zero unannounced complaint surveys and submitted no new self-reports to CDPH during the past month. Finally, we remain in our annual survey window and are preparing daily for the inspection.

Regarding the physical plant, Engineering is actively working on the completion of two new showers within ONRC and progress is moving according to plan. Additionally, we continue to replace resident room furniture, a much needed and improvement to our community.

This concludes our ONRC monthly board report.

REGULAR MEETING OF THE BOARD OF DIRECTORS
OF OAK VALLEY HOSPITAL DISTRICT
OPEN SESSION
May 7, 2026 5:30 p.m.
350 S. Oak Ave, Oakdale, CA 95361
Redwood Room

Board	**Staff**
Dan Cummins, Chairperson	Matt Heyn, President and C.E.O.
Sara Shipman, Director	David Rodrigues, Sr. VP/COO
Danielle Sanders, Director	David Neal, Sr. VP/CNO
	Chang Ahn, VP/CFO
	Jennifer Cook, VP/Quality & Risk Management

CALLED TO ORDER

The District Board of Directors Meeting was called to order by Dan Cummins, Board Chairperson at 5:35 p.m.

PUBLIC COMMENT
Public in Attendance. Public comment read.

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 Minutes –
   - April 2, 2026 – Regular Meeting

Danielle Sanders made the motion to approve the Consent Calendar items. Sara Shipman made the second. No public input.

Cummins – Aye
Shipman – Aye
Sanders – Aye

MOTION CARRIED

MEDICAL STAFF REPORT – Matthew Tilstra, M.D., Chief of Staff
The Medical Executive Committee requests the District Board's approval of the following items forwarded from the April 21, 2026, meeting.

Committee Reports

A. The Department of Surgery Committee Report – (04/14/2026)
Andrew Huber, MD, Chairperson
i. Summary Review – Discussion

B. The Quality Council Report – (04/16/2026)
Lee Horwitz, MD, Chairperson
i. Summary Review – Discussion

C. Interdisciplinary Practice Committee Meeting (IDPC) – (Next Mtg 05/05/2026)
Chaitanya Mahida, MD, Chairperson

D. Credentials Committee Meeting – (Next Mtg 05/05/2026)
Chaitanya Mahida, MD, Chairperson

E. The Department of Medicine Committee Report – (Next Mtg 05/12/2026)
Lee Horwitz, MD, Chairperson

Other

A. Policy – Approval
i. Titration of Intravenous Medications policy reviewed. The committee discussed the policy and agreed to the changes.

B. Annual Radiation Safety Officer – Approval
i. The Radiation Safety Officer role was delegated to the Radiology Department Chair, Dr. Rahul Nayyar. He will fulfill all responsibilities of the position and oversee radiation safety practices, compliance, and protocols for the organization. The committee discussed and agreed to this change.

Sara Shipman made the motion to approve the Medical Staff Report. Danielle Sanders made the second.
No public input.

Cummins – Aye
Shipman – Aye
Sanders – Aye

MOTION CARRIED

Financial Report for March 2026

Mr. Ahn reported that, following the District's recent financial statement audit, Intergovernmental Transfer (IGT) payments are now being reported as operating expenses in accordance with GAAP. While the accounting change negatively impacts reported operating margins and Days Cash on Hand, it does not affect the District's underlying operational performance. Despite the reporting change, March financial results remained strong, with gross patient revenue reaching a historic high of $34.4 million, operating income before new hospital expenses totaling approximately $678,000, net income of approximately $603,000, and year-to-date EBIDA at 12.2%.

Sara Shipman made the motion to approve the March 2026 Financial Report. Danielle Sanders made the second. No public input.

Cummins – Aye
Shipman – Aye
Sanders – Aye

MOTION CARRIED

Chairperson Report – Dan Cummins

Mr. Cummins addressed community questions regarding the recent Board vacancies, explaining that the resignations of Fran Krieger and Dr. Edward Chock were solely the result of the District's transition to zone-based elections under the California Voter Rights Act and were not related to any conflict or other issue. He noted that the Board is actively seeking qualified candidates to represent the currently vacant zones and encouraged interested community members to apply.

Mr. Cummins also highlighted the District's strong financial performance, stating that Oak Valley Hospital District is experiencing the strongest financial results in its history. He expressed appreciation to the medical staff, leadership team, and employees for their contributions to the District's success.

Mr. Heyn reviewed the process for appointing Board members to fill the vacant positions and advised that a Special Board Meeting would be scheduled to consider appointments, administer oaths of office, and address Board officer assignments. Billie Scott expressed interest in serving as a Board member and provided information regarding her professional background and commitment to the community. The Board discussed scheduling a Special Board Meeting to consider Board appointments and agreed to hold the meeting on May 13, 2026, at 5:00 p.m.

Chief Executive Officer Report - Matt Heyn

Mr. Heyn announced plans to welcome two new family medicine physicians to the community with a meet-and-greet event at the Morning Market on May 30, 2026. A larger community event is planned later in the summer to introduce all three new physicians joining Oak Valley Hospital District.

He reminded the Board that the Strategic Planning Retreat is scheduled for June 4, 2026, from 11:00 a.m. to 3:00 p.m. Discussions will focus on the District's continued growth, future capital needs, potential funding opportunities, and strategic initiatives to enhance healthcare services throughout the region.

An update was provided on physician recruitment efforts, including the addition of a full-time cardiologist and ongoing negotiations for interventional radiology services. Both specialties are expected to support future expansion of advanced procedural services.

Mr. Heyn also announced the promotion of Jennifer Cook to Vice President of Quality & Risk Management, recognizing her leadership and contributions to quality improvement, patient satisfaction, accreditation, and medical staff services.

In closing, appreciation was expressed for the District's nurses and employees in recognition of National Nurses Week and National Hospital Week and for their continued dedication to serving the community.

ADJOURNMENT TO CLOSED SESSION
Danielle Sanders made the motion to adjourn to Closed Session. Sara Shipman made the second. No public input.

Cummins – Aye
Shipman – Aye
Sanders – Aye

MOTION CARRIED

The Oak Valley Hospital District meeting was adjourned to Closed Session at 6:10 p.m.

RECONVENE TO OPEN SESSION

ANNOUNCEMENT OF CLOSED SESSION
- Approval of Closed Session April 2, 2026 Regular Meeting Minutes
- Discussion regarding strategic planning related to potential expansion of services, programs, or facilities.

ADJOURNMENT

Danielle Sanders made the motion to adjourn the Board of Directors meeting. Sara Shipman made the second. No public input.

Cummins – Aye
Shipman – Aye
Sanders – Aye

MOTION CARRIED

The Board of Directors meeting was adjourned at 6:47 p.m.
Recorder: Sheryl Perry, Clerk of the Board.

APPROVED: _____ DATE: _____
Billie Scott, Secretary

SPECIAL MEETING OF THE BOARD OF DIRECTORS
OF OAK VALLEY HOSPITAL DISTRICT
OPEN SESSION
May 13, 2026 5:00 p.m.
350 S. Oak Ave, Oakdale, CA 95361
Redwood Room

Board	**Staff**
Dan Cummins, Chairperson	Matt Heyn, President & CEO
Sara Shipman, Director	David Rodrigues, Sr. VP/COO
Danielle Sanders, Director	David Neal, Sr. VP/CNO
	Chang Ahn, VP/CFO
	Will Pringle, VP/Chief Admin of LTC
	Jennifer Cook, VP/Quality & Risk Management

CALLED TO ORDER
The District Board of Directors Meeting was called to order by Dan Cummins, Board Chairperson at 5:00 p.m.

PUBLIC COMMENT
Public comment was opened. There was no public comment.

Chairperson Report – Dan Cummins
Board Chairperson Dan Cummins welcomed attendees and presided over the administration of the Oath of Office for newly appointed Board Member Billie Scott. Following the oath, Ms. Scott signed the required documentation and officially joined the Board of Directors. Mr. Cummins noted that the Board currently has four of its five seats filled and continues efforts to recruit a representative from the Waterford area.

Mr. Cummins then announced Board officer appointments in accordance with the District's Bylaws. Billie Scott was appointed Secretary, Danielle Sanders was appointed Vice Chairperson, and Sara Shipman was appointed Chair of the Finance Committee.

Mr. Cummins also announced that the next regular meeting of the Board of Directors would be held on June 4, 2026, from 11:00 a.m. to 3:00 p.m. and would include the Board Retreat.

NO CLOSED SESSION

ADJOURNMENT

Danielle Sanders made the motion to adjourn the Special Meeting of the Board of Directors. Sara Shipman made the second. No public input.

Cummins – Aye
Shipman – Aye
Sanders – Aye

MOTION CARRIED

The Board of Directors meeting was adjourned at 5:10 p.m.
Recorder: Sheryl Perry, Clerk of the Board.

APPROVED: _____ DATE: _____
Billie Scott, Secretary

RESOLUTION NO. 2026-03
OF THE BOARD OF DIRECTORS
OF
OAK VALLEY HOSPITAL DISTRICT

CALLING 2026 GENERAL ELECTION FOR
OAK VALLEY HOSPITAL DISTRICT;
CONSOLIDATION OF ELECTION WITH STATEWIDE GENERAL ELECTION; AND
PUBLICATION OF NOTICE OF ELECTION BY SECRETARY

ADOPTED JUNE 4, 2026

WHEREAS, Oak Valley Hospital District is a Local Health Care District duly organized and operating pursuant to Division 23 of the California Health and Safety Code ("Health Care District Law") with a five-member Board of Directors with staggered terms and elected by voters of the District;

WHEREAS, the term of one member of the Board of Directors of the Oak Valley Hospital District who assumed office on the first Friday of December, 2022, namely, Director DAN CUMMINS will expire at 12:00 p.m. on Friday, December 4, 2026;

WHEREAS, the term of one member of the Board of Directors of Oak Valley Hospital District, namely Director DANIELLE SANDERS who was appointed to fill the vacancy due to the resignation of SHIRRELLE O. MOORE effective on March 6, 2025, and because the vacancy occurred during the first half of the term of SHIRRELLE O. MOORE and more than 130 days before the next general election on November 3, 2026, pursuant to Government Code Section 1780(d)(3), said partial term will expire at 12:00 p.m. on Friday, December 4, 2026; and

WHEREAS, the term of one member of the Board of Directors of the Oak Valley Hospital District, namely Director BILLIE SCOTT who was appointed and assumed office in May 2026 due to the resignation of EDWARD CHOCK, M.D., also expires at 12:00 p.m. on Friday, December 4, 2026; and

WHEREAS, the term of a vacant seat of the Board of Directors of the Oak Valley Hospital District due to the resignation of FRANCIS KRIEGER, which has not been filled by the Board of Directors, will expire at 12:00 p.m. on Friday, December 4, 2026;

WHEREAS, for the purpose of filling said offices, it is necessary that a Local Health Care District election be held pursuant to the Health Care District Law, and other pertinent laws of the State of California; and

WHEREAS, on April 2, 2026, the Board of Directors adopted Resolution 2026-01, Approving the Establishment of Geographical Zones and Sequencing for Election of Members of the Board of Directors whereby they established five (5) separate electoral zones to permit residents of each of said zones to select a representative of their choosing, and selected the sequencing of zones for election in November, 2026 as Zones 1, 2 and 4. The Board also noted that Zone 3 would be eligible for election for the remaining two years of the initial four year term due to the resignation by SHIRRELLE O. MOORE; and

WHEREAS, the Stanislaus County Elections Department was provided the following

documents: Resolution 2026-01, before and after SHAPE files of the newly drawn geographical electoral zones of the District so that they may conduct the November 2026 election for Oak Valley Hospital District Zones 1, 2, 3 and 4 with the General Election in Stanislaus County;

WHEREAS, pursuant to Section 10002 of the California Elections Code, the Board of Directors of the OAK VALLEY HOSPITAL DISTRICT requests the Board of Supervisors of Stanislaus County to permit the County Registrar of Voters to render specified services to the District relating to the 2026 election.

NOW, THEREFORE, BE IT RESOLVED THAT:

1. An election of the Oak Valley Hospital District be held on November 3, 2026 pursuant to Section 32100.5 of the California Health and Safety Code.

2. The Oak Valley Hospital District consists of five (5) geographical zones – Zones 1, 2, 3, 4 and 5.

3. The seat vacated by Director DAN CUMMINS, whose term expires on December 4, 2026, will be filled by a qualified candidate to represent Zone 2.

4. The seat currently held by DANIELLE SANDERS due to the resignation during the first one-half of the term of the prior elected Director, SHIRRELLE O. MOORE, pursuant to Government Code Section 1780(d0(3) shall be filled for the remaining two (2) years of the term from a qualified candidate to represent Zone 4.

5. The seat for which BILLIE SCOTT was appointed to finish the term due to the resignation of EDWARD CHOCK, M.D. will be filled by a qualified candidate to represent Zone 3.

6. The vacant seat, resulting from the resignation of FRANCIS KRIEGER, will be filled by a qualified candidate to represent Zone 1.

7. In accordance with Section 13307 of the California Elections Code, the candidates are to pay for the publication of statements of qualifications; that candidates shall be allowed to submit a Candidate's Statement of Qualifications consisting of not more than 200 words; and that no additional mailing of candidates' materials will be authorized by this governing body pursuant to Section 13307 of the California Elections Code. This determination should not be interpreted to discourage any candidate from making any political mailings on his or her own that the candidate sees fit to make.

8. The Secretary of this Board of Directors be and is hereby authorized and directed, for and on behalf of said Board of Directors, pursuant to Section 10509 of the California Elections Code, to notify by a Notice, attached to this Resolution as Exhibit A, the Registrar of Voters of Stanislaus County on or before the 125th day prior to said election that there are three elective offices to be filled at the District election for the Oak Valley Hospital District's Board of Directors, and that each candidate will pay for publication of his/her Statement of Qualifications.

9. Pursuant to California Elections Code Section 10407, the period for filing of nomination documents by candidates in this District election, which is consolidated with the general election, shall commence on the 113th day prior to the election. The nomination

documents shall be filed not later than 5:00 p.m. on the 88th day prior to the election in the office of the appropriate officer during regular office hours.

10. Unless the publication of notice of election is otherwise provided by the Elections Department of Stanislaus County, the Secretary of this Board of Directors be and is hereby authorized and directed, for and on behalf of said Board of Directors, pursuant to Section 12112 of the California Elections Code, not less than 90 days but not more than 120 days prior to the day fixed for said election, to publish at least once in THE OAKDALE LEADER, the same being a newspaper of general circulation in the District, a Notice, attached to this Resolution as Exhibit B stating the date of the election and the number of offices to be filled at said election, namely, three members of the Board of Directors of Oak Valley Hospital District.

11. The Secretary of this Board of Directors shall designate the Registrar of Voters or her designee to act in her place and stead in issuing Official Filing Petitions and administering oaths or affirmations as required under Section 10512 of the California Elections Code and Article XX, Section 3 of the California Constitution.

12. The Secretary or any officer of this Board of Directors be, and hereby is, authorized and directed to take the above action for and on behalf of the Board of Directors and any and all action that may be necessary or appropriate, including procurement of necessary supplies and services to prepare for and conduct said general election in accordance with the Health Care District Law.

The above Resolution was passed by the following vote of the Board of Directors of the Oak Valley Hospital District, at a regular meeting of said Board held on June 4, 2026.

AYES:
NOES:
ABSENT:

OAK VALLEY HOSPITAL DISTRICT

By _____
Billie Scott, Secretary
Board of Directors

Certificate of Secretary

The undersigned hereby certifies that the foregoing is a true and correct copy of a Resolution of the Board of Directors of the Oak Valley Hospital District, duly adopted by said Board at a meeting held on June 4, 2026.

I have executed this Certificate of Secretary for Oak Valley Hospital District on June 4, 2026.

OAK VALLEY HOSPITAL DISTRICT

By: _____
Billie Scott
Secretary, Board of Directors

NOTICE TO REGISTRAR OF VOTERS OF GENERAL ELECTION OF
OAK VALLEY HOSPITAL DISTRICT

(California Elections Code Section 10509)

NOTICE IS HEREBY GIVEN:

1. At the next general election of the Oak Valley Hospital District, there will be filled four (4) elective offices the same being the offices of three members and one vacant seat of the Board of Directors of Oak Valley Hospital District. Said election shall be held on November 3, 2026.

2. Each candidate is to pay for the publication of any statement of his or her qualifications pursuant to Section 13307 of the California Elections Code.

3. Each candidate shall be allowed to submit a Candidate's Statement of Qualifications consisting of not more than two hundred (200) words.

4. No additional mailing of candidates' materials will be authorized by this governing body pursuant to Section 13307 of the California Elections Code.

Executed at Oakdale, California, on June 4, 2026.

OAK VALLEY HOSPITAL DISTRICT

By: _____
Billie Scott
Secretary, Board of Directors

EXHIBIT A

NOTICE OF GENERAL ELECTION OF
OAK VALLEY HOSPITAL DISTRICT

(California Elections Code Section 12112)

NOTICE IS HEREBY GIVEN that the General Election of the Oak Valley Hospital District will take place on Tuesday, November 3, 2026. The number of offices to be filled at said election is four (4), the same being the offices of three members and one vacant seat of the Board of Directors of Oak Valley Hospital District.

Declarations of Candidacy for eligible candidates desiring to file for any of the elective offices, may be obtained from the Office of the Registrar of Voters. An eligible candidate must be a registered voter and reside within the Local Health Care District.

Nominations for said offices may be filed no earlier than July 13, 2026 or later than 5:00 p.m., August 7, 2026, the same being 88 days prior to said election, with the Registrar of Voters or his designee, at the Office of the Registrar of Voters, 1021 "I" Street, Suite 101, Modesto, California, on forms procurable in the Registrar of Voters' Office between the hours of 8:00 a.m. and 4:00 p.m., Monday through Friday, beginning on July 13, 2026.

In the event that there are no nominees or an insufficient number of nominees for the office and a petition for an election is not filed with the Registrar of Voters on or before August 12, 2026, that being the 83rd day before the election, appointment to each elective office will be made as prescribed by Section 10515 of the California Elections Code.

Dated: June 4, 2026

OAK VALLEY HOSPITAL DISTRICT

By:_____
Billie Scott
Secretary, Board of Directors

EXHIBIT B

OAK VALLEY HOSPITAL DISTRICT
Emergency Operations Management Manual

Policy/Procedure: **Hazardous Vulnerability Analysis**			
Effective Date: 02/02/23		***Page 1 of 44***	
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: Emergency Management Coordinator			
❒ Reviewed ☒ Revised by: Emergency Management Coordinator			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP Nursing	05/06/2026	X
EOC	Chief Engineer	04/16/2026	X
Admin Council	CEO	05/13/2026	X
District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**: 2/23	**Next Review Date**:	

Purpose:
To provide comprehensive all hazards analysis of the health, property, and business-related impacts of hazards that can occur within our county or healthcare facility to accurately reflect our organization's ability, scope, actions, and communications. Results can be used to focus resources and to help prioritize planning efforts for those emergencies. In addition, to provide a mechanism for external partners to align efforts in emergency management and operational continuity.

Scope: Oak Valley Hospital District's HVA, EOP, and emergency inventory documents.

Definitions

Emergency Operations Plan (EOP) – An organization's written document that describes the process it would implement for managing the consequences of emergencies, including natural and human-made disasters, that could disrupt the organization's ability to provide care, treatment, and services.

Emergency inventory – A list of resources and assets needed during an emergency that are present at the hospital.

Hazard vulnerability analysis (HVA) – A process for identifying potential emergencies and the direct and indirect effects these emergencies may have on the organization's operations and the demand for its services.

Responsibilities

The Emergency Preparedness Committee (a subcommittee of the Environment of Care Committee) is responsible for:

1. Managing and maintaining this document
2. In collaboration with Facilities Management department, and other stakeholders, as applicable, collecting relevant data used to perform the reviews of the HVA, EOP, and emergency inventory.

The Emergency Management Team is responsible for reporting the results of the HVA, EOP, and emergency inventory reviews to senior hospital leadership.
Senior hospital leadership is responsible for reviewing the HVA, EOP, and emergency inventory reports and responding appropriately.

Procedures

The Emergency Management Team does the following:

1. Maintains a written HVA document.
2. Identifies one or more individual(s) who is responsible for performing the HVA review.
3. Provides designated individual(s) with appropriate training and education necessary to complete the review successfully and effectively.
4. Provides designated individual(s) with a standardized evaluation form to be used in documenting the results of the review.
5. Ensures the standardized review form addresses the following components of the HVA:
    - Risks, hazards, and potential emergencies that may affect the hospital
    - How each identified incident might affect the hospital's ability to provide care, treatment, or services.
    - Prioritization of identified incidents for attention, based on relative likelihood, severity, and scope.
6. Reports results of the review to appropriate leadership.

The Emergency Management Coordinator and or designee(s) who performs the review does the following:

1. Assembles and reviews relevant data from the following sources:
    - Hospital's existing HVA
    - Performance data and other applicable reports provided to the Emergency Preparedness Committee by department managers and others during the previous year.
    - Meeting minutes from the previous year
    - Relevant EOC Committee reports or minutes from the previous year
    - Applicable laws, regulations, standards, and evidence-based practice guidelines, especially those that have changed in the previous year.
    - Reports from outside organizations, state or federal agencies, local health departments, and other sources of information about the community
    - Results of all relevant risk assessments completed in the previous year

- Reports or evaluations on applicable drills or practice exercises from the previous year
- Reports from applicable training and educational programs from the previous year
- Reports from actual incidents, emergencies, or disasters that occurred over the previous year

2. Uses these data to determine whether the hospital's existing HVA remains relevant to its current exposure to risks, hazards, and potential emergencies.
3. Identifies potential areas for improvement to the HVA.
4. Documents the review using the standardized form provided by the Emergency Preparedness
5. Reports results of the review, including possible updates to the EOP, to the Emergency Preparedness Committee.

Emergency Inventory

The Emergency Management Coordinator does the following:

1. Maintains a written emergency inventory document.
2. Identifies one or more individual(s) who is responsible for performing the emergency inventory review.
3. Provides designated individual(s) with appropriate training and education necessary to successfully and effectively complete the review.
4. Provides designated individual(s) with a standardized evaluation form to be used in documenting the results of the review.
5. Ensures that the standardized review form addresses all applicable components of the emergency inventory, including but not limited to the following:
    - Medications and related supplies
    - Medical supplies, such as personal protective equipment
    - Nonmedical supplies, such as food, bedding, and other provisions
    - Transportation equipment and fuel
    - Backup utility systems
    - Location of resources
    - Identification of alternative sources of emergency resources
6. Reports results of the review to appropriate leadership.

The designated individual(s) who performs the equipment inventory review does the following:

1. Assembles and reviews relevant data from the following sources:
    - Hospital's existing emergency inventory
    - Hospital's current EOP and related documents (for example, Emergency Communications Plan)
    - Hospital's current HVA
    - Inventories, lists, and reports from the Facilities Management department
    - Documentation related to agreements with external organizations (for example, hospitals, government agencies, community groups, vendors) that share resources during an emergency.
    - Documentation related to agreements with external organizations (for example, hospitals, government agencies, community groups, vendors, and so on) that

provide alternate sources of supplies, equipment, materials, and resources
- Emergency Preparedness Committee meeting minutes from the previous year
- Relevant EOC Committee reports or minutes from the previous year
- Relevant reports or minutes from the meetings related to facilities management activities.
- Applicable laws, regulations, standards, and evidence-based practice guidelines, especially those that have changed in the previous year.
- Results of all relevant risk assessments completed in the previous year.
- Reports or evaluations on applicable drills or practice exercises from the previous year
- Reports from applicable training and educational programs from the previous year
- Relevant reports from actual incidents, emergencies, or disasters that occurred over the previous year.

2. Uses these data to determine whether the hospital's existing emergency inventory accurately reflects the existence and location of emergency equipment, supplies, materials, and other resources.
3. Updates the emergency inventory, as appropriate.
4. Documents the review using the standardized form provided by the Emergency Preparedness Committee.
5. Reports results of the review, including any updates made to the emergency inventory, to the Emergency Preparedness Committee.

References

Centers for Medicare and Medicaid Services. (2021, April 16). State Operations Manual

1. The Centers for Disease Control and Prevention. (n.d.) Hospital all-hazards self-assessment tool.
2. NFPA® 1600: Standard on Continuity, Emergency, and Crisis Management, 2019 edition.
3. NFPA® 99: Health Care Facilities Code, 2012 edition.
4. The Joint Commission Standards EM.11.01.01

OAK VALLEY HOSPITAL DISTRICT

Human Resources Manual

Policy/Procedure: **Dress Code**			
Effective Date: 09/2002		**Page 1 of 2** *(Attachments)*	
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: Unknown			
X Reviewed ❒ Revised by: V. P. Human Resources (04/05/16)			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	V. P. Nursing	05/06/2026	X
Administrative Council	CEO	02/18/2026	X
District Board	Board Liaison	06/04/2026	
Revised: 09/2011	**Reviewed**: 05/2016	**Next Review Date**:	

POLICY

Oak Valley Hospital District (OVHD) is committed to enhancing and maintaining a positive image and appearance of professionalism in the work place. This policy addresses the expected professional appearance of all staff members. Each department may have a more stringent policy. The District reserves the right to determine what is acceptable or not in terms of professional image and acceptable attire.

SUPPORTIVE DATA

All employees are important representatives of the District. The impression made upon the hospital's customers reflects on the entire organization. Good grooming is the responsibility of each employee. Employees must wear identification badges at all times.

PURPOSE

This policy will define appropriate attire for all District Hospital employees. To define standards for personal appearance in keeping with the District's needs to maintain professionalism, a therapeutic environment and adhere to the principles of safety and infection control.

SCOPE

All OVHD employees, including Contract/Agency employees must adhere to this policy and will demonstrate a professional, neat and clean appearance at all times when entering the facility.

REQUIREMENTS

ACCEPTABLE ATTIRE FOR ALL EMPLOYEES IS:

- Professional and business like appearance
- Personally neat and clean

UNACCEPTABLE ATTIRE IS:

- Dirty, torn, overly casual, revealing and/or detracting from the professional demeanor and image of OVHD.
- No sandals or open-toed shoes may be worn in patient care areas by any employee. Patient care areas include: any location in the Hospital, ~~Care Center~~Oakdale Nursing and Rehab Center (ONRC) or Clinics. Staff working in the Medical Office Building who wear sandals or open-toed shoes must change shoes before going to a patient care area.

WHEN IN DOUBT

- Employee should seek advance clarification from his/her Supervisor before wearing the apparel.

PROCEDURE

A. Monitoring

1. The Supervisor of each shift or department will be responsible for monitoring the dress code.

2. Specific infractions requiring disciplinary action will be handled by the Supervisor in accordance with standard District disciplinary procedures and must be consistently enforced throughout the District.

3. The Supervisor will give the employee a copy of the Dress Code with the violation highlighted and instructions for correction as a part of the disciplinary action.

4. The employee will be sent home if the violation is extreme or offensive.

5. Time taken away for the employee's work time to change attire is without pay.

6. Continued violation of this policy may lead to further disciplinary action up to and including termination.

B. Casual Friday

Each Friday of the week, employees who are not required to wear uniforms or scrubs are allowed to wear business casual dress for the day. If an employee chooses to dress casual, he/she must adhere to the following guidelines:

1. ~~Slacks and khaki pants~~Jeans may be worn on casual Friday and other approved casual days. Jeans worn on these days need to be free of holes and rips.

2. ~~Only~~ Oak Valley Hospital District apparel or business casual attire may be worn anyday. ~~and Life Savers T-shirts are allowed on Fridays only.~~

3. Shorts, ~~skorts~~, or similar apparel are not allowed.

4. ~~No~~ Jeans or denim material of any color may be worn on Fridays and approved casual days.

5. Must meet the general guidelines as outlined in the above policy.

Business Professional – To wear or not to wear…		
Clothing	**Wear**	**Not to Wear**
Pants	• Dress pants or dress Khakis • Comfortable fit • Dress capri's, cropped pants ~~or gaucho's~~ • Jeans without holes and tears on Fridays and approved casual days.	• ~~Jeans, Levi type, worn out, or denim (any color)~~ • Shorts, cutoffs ~~(No drawstring legs, cargo pants, unprofessional prints~~ • Extremely baggy or tight pants, ~~spandex leggings, stretch pants,~~ leather, overalls, yoga pants.
Skirts	• Skirts with slip if needed • No shorter than 2" above the knee	• Tight skirts, revealing split skirts, Jean, denim type, worn out or denim (any color) • Mini skirts, ~~Skorts~~
Shirts, Blouses (Note: Dresses follow the combined guidelines for skirts and blouses)	• Collared, v-neck, turtle-neck, crew • Rounded neck line • Full length (covered midriff) • Polo shirt with small insignia • Sweaters • Professional sleeveless (2" strap width). • Shirt tucked in (if appropriate) • ~~Suit jackets~~ • Some departments, such as Engineering, may wear appropriate outerwear for their specific work area.	• Halter tops, spaghetti straps, tank tops, camisole tops or denim material • Low neck line, exposed cleavage, strapless tops, tube tops, short length (exposed midriff) • T-shirts with pictures, slogans, logos • ~~Sweatshirts~~ • All dress attire should be appropriate when standing or stooping.
Shoes and Socks • ~~Sandals and open-toed shoes in the Medical Office Building only.~~	• Dress shoes • Loafers, pumps, ties • Heels under 3" • Oxfords or athletic-style shoes providing foot support, socks must be worn	• Platforms or heels higher than ~~3"~~ • Bare feet • Thongs, flip flops • No sandals or open-toed shoes in patient care areas.
Head	• Conservative barrettes, hairpieces, headbands • Scarves, caps, turbans for religious designation or medical necessity	• Hats, (other than surgery) caps, (may be worn in approved departments) bandanas, scarves except as a requirement for religious reasons or medical necessity
Jewelry and Adornment	• Small, moderate in size • Should not create distraction or job interference • Deodorant must be worn	• Multiple visible body-piercings (other than ears or other single small, discrete piercings.) • Face Tattoos~~Visible tattoos, other than one or two small, discrete tattoos, body paintings or body marks (must be covered band aids or make up)~~ • Overpowering cologne or sprays

Clothing	Wear	Not to Wear
Hair	• Clean and neat • Beards, sideburns, mustaches neatly trimmed • Employees who handle food must have hair covered and tied back	• Dirty, untidy, extreme colors or styles.
Fingernails	• Clean and neat • Professional polish and length	• Long, unprofessional, or extreme colors
Undergarments MUST WEAR and may not be visible through clothing	• Appropriate for attire • Supportive	• No undergarments • See through or thin material • Colored undergarments that can be seen through clothes
Uniforms	• Designated by department • Appropriate size	Tight, revealing or untidy

Professional Patient Care Attire – To wear or not to wear…		
Uniforms • Pateint Access need to wear black scrubs provided by the hospital. Pants	• ~~White~~, print or color coordinated tops • Scrub pants must be solid in color • Cargo style scrub pants (not denim or khaki material) • Scrubs (if hospital issued may not be worn outside of hospital) • Lab coats (required in some areas) No shorter than 2 inches above ankle	• Too tight, loose or revealing • Sleeveless garments • Capri type pants • Print scrub pants • Denim
Shirts, Tops	• Polo shirts with small insignia • Sweaters (hooded sweaters may be worn) • Scrub covers, snap or button • District approved T-shirts may be worn ~~at the Care Center~~. • OVHD sweatshirts •	• Sweatshirts, coats or other outer wear • T-shirts with pictures, slogans, logos • Low neck-line, exposed cleavage, tube tops, tank tops, exposed midriff, halter tops spaghetti straps, camisole tops
Shoes and Socks	• Leather shoes or athletic-style shoes with soft soles are required~~preferred~~ • Clogs may be worn with socks • Plain hosiery or socks	• Open-toed shoes • Canvas • Sandals • Flip-flops, thongs
Hair and Headwear	• Conservative barrettes, hairpieces and headbands • Long hair tied back • Beards, sideburns, mustaches neatly trimmed • Scarves, caps, turbans for religious designation	• Hats (other than surgery), caps, (may be worn in approved departments) bandanas, or scarves except as a requirement for religious reasons • Hair – Extreme colors or styles

Clothing	Wear	Not to Wear
Jewelry and Adornment	• Small, moderate in size • Should not create distraction or job interference, deodorant must be worn.	• Multiple visible body-piercing (other than ears or other single, small, discrete piercings) • Visible tattoos, other than one or two small discrete tattoos, body-paintings or body marks (must be covered – band aids, make-up)
Undergarments MUST WEAR and may not be visible through clothing	• Appropriate for attire • Supportive	• No undergarments • See through or thin material • Colored undergarments that can be seen through clothes
Fingernails	• Per hospital policy	Acrylic nails or other types of false fingernails

OAK VALLEY HOSPITAL DISTRICT
Human Resources Manual

Policy/Procedure: **Employee Badge Buddy**			
Effective Date: New		**Page 1 of 3**	
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by:			
☐ Reviewed ☐ Revised by:			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP of Nursing	05/06/2026	X
Admin Council	CEO	05/13/2026	X
District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**:	**Next Review Date**:	

PURPOSE

To ensure clear, consistent, and easily identifiable staff role recognition for patients, families, visitors, and staff by standardizing the use of **badge buddies** worn with official Oak Valley Hospital District identification badges. This policy supports patient safety, trust, communication, and regulatory readiness.

POLICY STATEMENT

Oak Valley Hospital District requires all designated clinical and patient-facing staff to wear an approved **badge buddy** at all times while on duty in patient care or patient-accessible areas. Badge buddies must accurately reflect the staff member's **role or licensure**, be clearly visible, and be worn in conjunction with the employee's official OVHD photo ID badge.
Failure to comply with this policy may result in corrective action in accordance with Human Resources and Administrative policies.

SCOPE
This policy applies to the following Oak Valley Hospital District staff when working for the District.

DEFINITIONS

Badge Buddy:
A color-coded or clearly labeled identifier worn behind the official OVHD ID badge that displays the staff member's role or licensure in large, readable text.

Official OVHD ID Badge:
The hospital-issued photo identification badge required for all employees, contractors, and authorized personnel.

POLICY REQUIREMENTS

- **Visibility**
  - Badge buddies must be worn **above the waist**, facing forward, and fully visible.
  - Badge buddies must not be obscured by clothing, jackets, lanyards, or other items.
- **Accuracy**
  - The badge buddy must accurately reflect the staff member's **current role or licensure**.
  - Staff may not wear badge buddies for roles they are not credentialed or assigned to perform.
- **Standardization**
  - Only **hospital-approved badge buddies** may be worn.
  - Personal, altered, handwritten, or non-approved badge buddies are not permitted.
- **Professional Appearance**
  - Badge buddies must be clean, legible, and in good condition.
  - Damaged or illegible badge buddies must be replaced promptly.

RESPONSIBILITIES

- **Employees**
  - Wear the correct badge buddy at all required times.
  - Report lost, damaged, or incorrect badge buddies to their supervisor.
- **Department Leadership**
  - Ensure staff compliance during shifts.
  - Address non-compliance in real time.
  - Request replacements as needed.
- **Human Resources / Administration**
  - Maintain standard badge buddy inventory and role assignments.
  - Ensure badge buddies align with job titles and credentials.

COMPLIANCE & ENFORCEMENT

Non-compliance with this policy may result in:

- Verbal reminder or coaching
- Progressive corrective action per OVHD Human Resources policy

Repeated or intentional non-compliance may escalate corrective action.

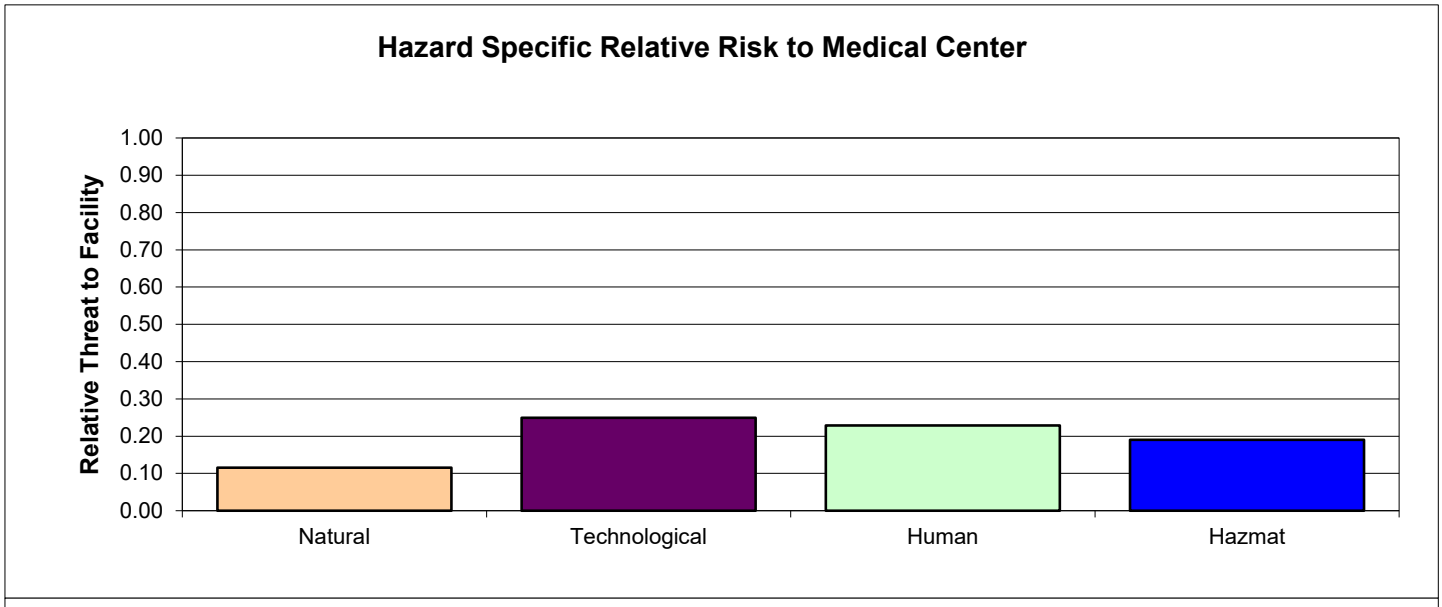
REFERENCES

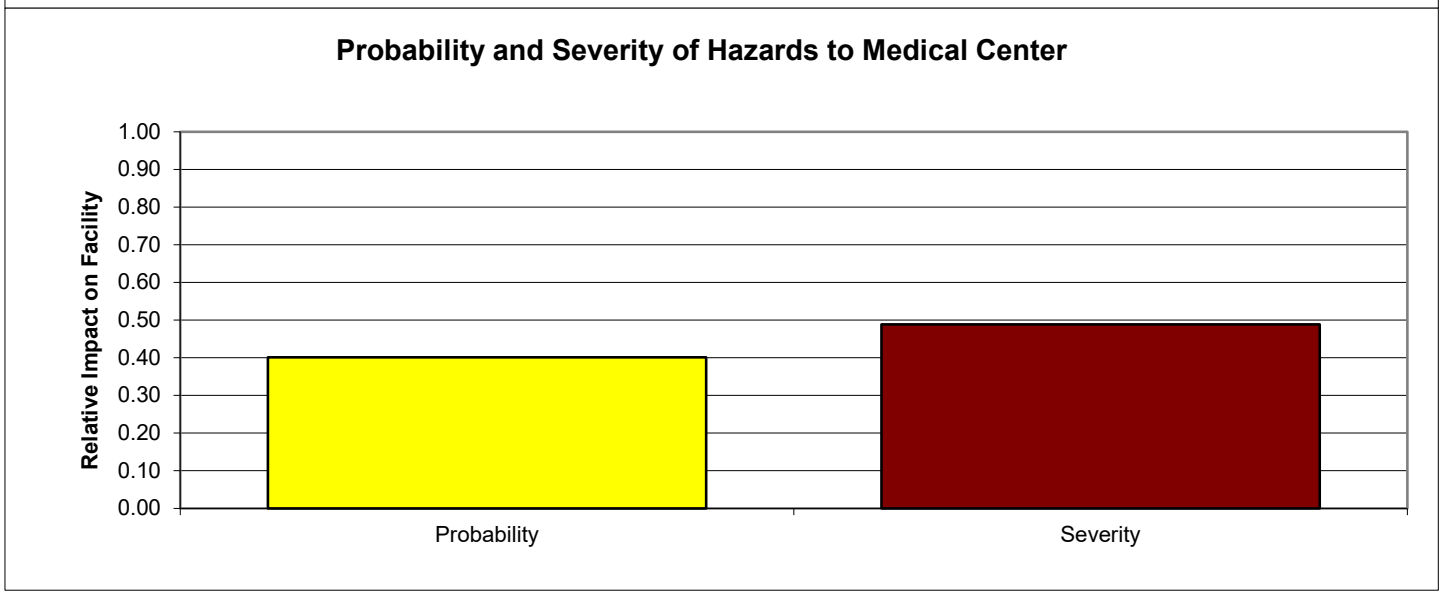
1. Oak Valley Hospital District Human Resources Policy and Procedure Manual
2. Joint Commission Patient Safety and Communication Standards
3. OVHD Employee Identification Requirements

SUMMARY OF HAZARDS ANALYSIS

TOP 10 HVA	RANK	RISK
Information Systems Failure	1	61%
Electrical Failure	2	56%
Generator Failure	3	41%
Temperature Extremes	4	33%
Terrorism, Radiologic	5	31%

	Natural	Technological	Human	Hazmat	Total for Facility
Probability	0.29	0.53	0.43	0.30	0.40
Severity	0.40	0.47	0.53	0.64	0.49
Hazard Specific Relative Risk:	0.12	0.25	0.23	0.19	0.20





OAK VALLEY HOSPITAL DISTRICT
Human Resources Manual

Policy/Procedure: **PTO/Holidays (Paid Time Off)** *Also indexed as Holidays/PTO; Paid Time Off*			
Effective Date: 09/1996	**Page 1 of 4**		
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: Unknown			
❒ Reviewed ❒ Revised by:			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Human Resources	VP Human Resources		
Policies, Procedures & Forms	Medical Staff Coord		
Administrative Council	VP Nursing Admin		
District Board	Board Liaison		
Revised:	**Reviewed**:	**Next Review Date**:	

POLICY

Accrual of Paid Time Off (PTO) hours for benefited employees to use for time off with pay.

PURPOSE

To define the accrual of PTO for benefited employees

PROCEDURE

Accrual of PTO Time

1. Eligibility
   a. Benefited employees who regularly work a minimum of 30 hours per week (60 hours per pay period) are eligible to earn PTO.
   b. PTO hours accrue from date of hire, and can be taken upon **completion of ninety (90) days of employment**. PTO may be utilized for recognized holidays that occur during the first ninety (90) days of employment.

2. Accrual
   a. PTO accrues on all paid hours, not exceeding 80 hours per pay period, with the exception of: Hospital requested (called off) absent day/hours, standby pay, SDI benefits, worker's compensation benefits, long term disability benefits, PTO or sick hours paid during a leave of absence, and PTO hours paid in lieu of time off.
   b. PTO the hours taken are deducted from the employee's accrued PTO hours. Employees **may not** have a negative balance of PTO except as provided in section 6(c) of this policy and are only paid for hours accrued and not taken.
   c. PTO benefits are accrued and paid at the employee's current base hourly regular rate of pay. It does not include shift differential, premium pay, temporary supervisor pay, etc.

   d. PTO hours are accrued in accordance with the following schedule:

Executive Scale	8WKS + 8 HOLIDAYS					
CEO	Previous			Proposed		
Years of Service	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year
1st 89 days	0.1847	14.776	384	0.1847	14.7760	384
Year 1 to 2	0.1847	14.776	384	0.1847	14.7760	384
Years 3 to 5	0.1847	14.776	384	0.1981	15.8480	412
Years 6 to 10	0.1847	14.776	384	0.2375	19.0000	494
Years 11 & Up	0.1847	14.776	384	0.2707	21.6560	563

Vice President**	6WKS + 8 HOLIDAYS					
	Previous			Proposed		
Years of Service	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year
1st 89 days	0.1077	8.6160	224	0.1462	11.6960	304
Year 1 to 2	0.1077	8.6160	224	0.1462	11.6960	304
Years 3 to 5	0.1154	9.2320	240	0.1568	12.5440	326
Years 6 to 10	0.1385	11.0800	288	0.1880	15.0400	391
Years 11 & Up	0.1577	12.6160	328	0.2140	17.1200	445
**COO/CNO/CFO/Chief Admin of LTC/VP of Quality & Risk Mgmt.						

Manager/Director	4WKS + 8 HOLIDAYS					
	Previous			Proposed		
Years of Service	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year
1st 89 days	0.1077	8.6160	224	0.1077	8.6160	224
Year 1 to 2	1.0770	8.6160	224	0.1077	8.6160	224
Years 3 to 5	0.1154	9.2320	240	0.1154	9.2320	240
Years 6 to 10	0.1385	11.0800	288	0.1385	11.0800	288
Years 11 to 15	0.1577	12.6160	328	0.1577	12.6160	328
Year 16				0.1621	12.9680	337
Year 17				0.1664	13.3120	346
Year 18				0.1707	13.6560	355
Year 19				0.1750	14.0000	364
Year 20				0.1794	14.3520	373

Regular: 80 Hrs	3WKS + 8 Holiday		
Years of Service	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year
1st 89 days	0.0885	7.0800	184
Year 1 to 2	0.0885	7.0800	184
Years 3 to 5	0.0962	7.6960	200
Years 6 to 10	0.1193	9.5440	248
Years 11 to 15	0.1395	11.1600	290
Year 16	0.1424	11.3920	296
Year 17	0.1462	11.6960	304
Year 18	0.1500	12.0000	312
Year 19	0.1539	12.3120	320
Year 20	0.1577	12.6160	328

12 Hr Positions	3WKS + 8 Holiday		
Years of Service	PTO Accrual Rate/Hour	Max PTO Hours Accrual/ PP	Max PTO Accrual/ Year
1st 89 days	0.0983	7.0776	184
Year 1 to 2	0.0983	7.0776	184
Years 3 to 5	0.1069	7.6968	200
Years 6 to 10	0.1326	9.5472	248
Years 11 to 15	0.1550	11.1600	290
Year 16	0.1582	11.3904	296
Year 17	0.1624	11.6928	304
Year 18	0.1667	12.0024	312
Year 19	0.1710	12.3120	320
Year 20	0.1753	12.6216	328

e. A 12-hour shift employee who works 72 hours per pay period will accrue PTO as a full time 80-hour employee.
f. There will be no accrual beyond 600 hours.

Use of Accrued PTO Hours

1. Use of Time

a. PTO will be used for SCHEDULED vacations, paid holiday time off, religious observations, dental or doctor visits, personal or family needs, causing absences from work, as secondary/integrated pay to supplement SDI or Workers' Compensation, or any other reasons deemed appropriate by the employee. In addition, PTO will be used on days a department is closed (i.e., day before or after Thanksgiving).
b. PTO may also be used for the diagnosis, care or treatment of an existing condition, or preventive care, for the employee or for a family member (PTO for family members include a child (biological, adopted, foster, step) legal ward, child to whom the employee stands in loco parentis; parent (biological, adoptive, step), legal guardian of the employee or employee's

spouse or registered domestic partner, person who stood in loco parentis when employee was a minor; spouse; registered domestic partner; grandparent; grandchild; and sibling ("PTO for Medical").

c. PTO may also be taken by the employee if the employee is a victim of domestic violence, sexual assault, or stalking (PTO for Domestic Violence and together with PTO for Medical, collectively referred to herein as "PTO for Sick Leave").
d. The employee should provide notice of the need to use accrued PTO for Sick Leave as soon as practicable, and in advance if foreseeable.
e. Two weeks' notice should be given to the employee's supervisor if PTO time will exceed more than 2 days. This requirement does not apply to the use of PTO for Sick Leave.
f. PTO does not count as hours worked for overtime purposes.

2. Family and Medical Leave

a. Employees on qualified Family and Medical Leave (for their own serious illness or illness of a family member) must use their PTO hours (after their accrued sick leave is exhausted). However, said employee may (if they so choose) maintain a balance of 80 hours in his/her PTO bank that he/she is not required to use for such leave.
b. An employee who requests and is granted a Personal Leave of Absence is required to use available PTO to cover their absence. In this situation, said employee may not maintain 80 hours, as allowed for disability leaves.
c. Requests to use PTO for vacations, paid holiday time off, and religious observations, must be provided to your Supervisor (and approved) in advance, as applicable to individual department policies.

3. PTO Pay Off Upon Termination or Change of Status

a. Accrued PTO will be paid to any terminating employee on their final check. Any employee changing from a benefited status to a non-benefited status will be paid accrued PTO hours during the pay period the status change takes effect. Such hours will be paid at the employee's rate of pay prior to the addition of 10% in lieu of benefits.

4. PTO Bonus Plan

a. Employees with sick leave balances in excess of 240 hours on the last payroll of the year will be rewarded with the option of converting the excess sick hours into PTO hours. The Human Resources Office will notify eligible employees of the amount of sick hours they may choose to convert to PTO. It is the employee's responsibility to return the notification form to the Human Resources office indicating his/her decision. The conversion of sick hours to PTO hours will take place during the third payroll of the New Year. The following table will be used for such a conversion.

If at the end of the last pay period of the year, an employee's sick balance (A) is at least (hours).	(A) – 240 hrs. = B	F = Factor	B*F = hours added to PTO balance
384	144	0.25	36
364	124	0.24	30
344	104	0.23	24
324	84	0.22	19
304	64	0.21	13
284	44	0.20	9
264	24	0.19	5
244	4	0.18	1

This benefit will be available to the current employees who have at least 240 hours of sick leave on the last payroll of the year. There will be a cap of 384 hours of sick leave, beyond which there will be no accrual.

5. Transfer of PTO Hours
   a. All employees who have a PTO balance greater than 40 hours are eligible to request a transfer of said PTO hours to another employee who has experienced an unanticipated family emergency or other catastrophic event.
   b. An employee requesting such a transfer of hours should complete the "Request to Transfer PTO Hours" form (available in Human Resources) and submit it to the Human Resources office for review and approval by Administration.
   c. If approved, the donated PTO hours will be deducted from the donor employee's PTO bank during the pay period in which the request is approved. The PTO hours will be converted to dollars based on the donor's current salary (excluding shift differential, or any other type of supplemental pay). These dollars will then be converted back to the appropriate number of PTO hours based on the recipient employee's current salary (excluding shift differential, or any other type of supplemental pay). The hours will be credited to the recipient's PTO balance on the same pay period.
   d. Approved donations will be processed as outlined below:
      1) Employee donating 10 hours of PTO earns $10.00 per hour = $100. Ten hours will be deducted from his/her balance.
      2) Employee receiving donation earns $8.00 per hour, $100 converted at $8.00 per hour equals 12.5 hours added to his/her PTO balance. The employee receiving the donation may use the PTO hours to cover an absence caused by an emergency.
      3) The employee donating PTO hours will not be taxed on said hours. However, the employee receiving the donated hours will be taxed accordingly when the hours are used or cashed in, as required by law.

6. Miscellaneous Issues
   a. Employees may elect to receive pay in lieu of time off, up to a maximum of eighty (80) hours per calendar year. This option is contingent upon completion of the PTO Sell-back or Transfer Request form before the beginning of the calendar year in which lieu pay will be received. Employees are required to maintain a balance of 80 PTO hours in order to provide for available for appropriate annual "rest and recuperation".
      1) Hours to be paid out are at regular base rate, excluding interim or acting pay.
      2) PTO cash in requests will be processed during normal payroll processing according to IRS guidelines. Requests must be approved and submitted with regular timesheets to be processed.
   b. Eligible employees from departments that are not staffed on the Oak Valley Hospital District recognized holidays will normally receive payment for these days, if indicated on their time sheet. Hours will be paid from their PTO bank. Payment will not be made if the employee has no PTO hours available.
   c. Newly hired employees eligible for PTO, assigned to departments that are not staffed on Oak Valley Hospital District recognized holidays, will be paid for the holiday if requested, and allowed to have a "negative" balance in their PTO bank for the first 90 days of employment.
   d. Employees assigned to departments that are staffed on Oak Valley Hospital District recognized holidays will receive payment of time and one-half their hourly rate for working those days. PTO may not be taken in addition to the holiday pay. Oak Valley Hospital District recognized holidays are listed below:
      - New Year's Day
      - President's Day
      - Martin Luther King Jr. Day

- Memorial Day
- 4th of July
- Labor Day
- Thanksgiving Day
- Christmas Day

e. PTO will be integrated with State Disability Insurance (SDI) or Workers' Compensation (WC) pay, but under no circumstances will this integrated compensation be in excess of the straight time earnings for an employee's scheduled hours. It is the employee's responsibility to ensure that the combined SDI/WC pay and PTO earnings do not exceed their regular weekly earnings.

f. The entire PTO program will be evaluated by Administration on an annual basis and any changes deemed appropriate or necessary will be made during this evaluation.

RELATED FORM(s)

PTO Sell-Back or Transfer Request, Form0365

DISTRICT BOARD REPORT
OPEN SESSION
06/04/2026

MEMO: **June 4, 2026**
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 May 22, 2026, meeting.

Committee Reports

A. Interdisciplinary Practice Committee Meeting (IDPC) – (05/05/2026)
Chaitanya Mahida, MD, Chairperson
   i. Summary Review **Standing**
   ii. Changes to Nurse Practitioner Hospital Privileges **Approval**

B. Credentials Committee Meeting – (05/05/2026) **Standing**
Chaitanya Mahida, MD, Chairperson

C. The Department of Medicine Committee Report – (05/12/2026) **Standing**
Lee Horwitz, MD, Chairperson
   i. Summary Review **Standing**

D. The Department of Surgery Committee Report – (Next Sch Mtg 06/09/2026) **Standing**
Andrew Huber, MD, Chairperson

E. The Quality Council Report – (Next Sch Mtg 06/11/2026) **Standing**
Lee Horwitz, MD, Chairperson

F. Policy Agenda **Approval**

A. Community Health Centers Manual (Department of Medicine 05/12/2026)
   i. Prior Authorization

B. Clinical Manual (Department of Medicine 05/12/2026)
   i. Code White – Medical Emergency (Pediatric)
   ii. Blood Recipient ID Bands
   iii. Rapid Response Team

C. ONRC Manual
   i. Pressure Injury-Skin Breakdown Prevention and Management

D. Radiology Manual (Department of Medicine 05/12/2026)
   i. Computed Tomography Reportable Events
   ii. Cone Removal
   iii. Radiation Safey and Protection Program
   iv. Radiation Safety and Protection – *RETIRE*

E. Respiratory Therapy Manual (Department of Medicine 05/12/2026)
   i. Peripherally Inserted Central Catheter (PICC) Insertion

G. Vice Chief of Staff Results **Informational**

Oak Valley Hospital
Oakdale Nursing & Rehabilitation Center
A Division of the Oak Valley Hospital District

ALLIED HEALTH PROFESSIONAL
QUALIFICATIONS/SCOPE OF PRACTICE/FUNCTIONS

NURSE PRACTITIONER PRACTICE PRIVILEGES
INPATIENT AND OAKDALE NURSING & REHABILITATION CENTER

Name_____ **Date**_____

BASIC PRIVILEGE CRITERIA-QUALIFICATIONS

1) Holds current California Registered Nursing license;
2) Nurse Practitioner Licensure with successful completion of a Nurse Practitioner education program from an approved accredited program. Documentation of all training
3) National Certification and CME relevant to specialty, i.e. Family Practice, Adult, Pediatrics, or OB/GYN to be forwarded at time of application. Those not meeting that requirement will be allowed to take next available course and must meet the requirement with 12-months of starting work.
4) Current DEA
5) Letters of reference (from peers and physicians) attesting to ethical and professional behavior and to current competence in relevant clinical skills;
6) Continuing demonstration of competency relevant to specialty;
7) Has BLS, certification(OVHD only accepts certification form the American Heart Association)
8) Minimum of one year experience as a Nurse Practitioner in specialty;
9) Speaks, reads, and writes English fluently. Is able to record information accurately in English;
10) Ability to function in a collegial relationship with medical staff and other disciplines in coordinating all aspects of ambulatory care or specific inpatient care within the scope of practice.

SCOPE OF PRACTICE: INDEPENDENT LICENSED PRACTITIONER

The Nurse Practitioner will ~~not~~ have admitting privileges. The Nurse Practitioner will have a designated ~~collaborative~~ Supervising physician. The Nurse Practitioner shall have accountability to the ~~Medicine Department Chair~~ Chief Medical Officer.

The primary responsibilities of the Nurse Practitioner will include, but not be limited to, engaging in the expanded practice of Nursing, which includes issuance of prescriptions within identified areas of practice (i.e. Family Practice, Pediatrics, OB/GYN, etc.) covered by protocols. Such protocols shall reflect accepted standards of Nursing and Medical practice and includes, but is not limited to, provisions for case management-including diagnosis, treatment, and appropriate record keeping by the Nurse Practitioner and collaborating physician to be appropriate. The Nurse Practitioner shall refer to the ~~collaborating~~ Supervising physician, and in his absence, the Attending Physician on call, any patient who does not meet protocol criteria. Protocols followed by the Nurse Practitioner will be submitted for approval at the time of initial application and at reappointment, if changes have been implemented. *All hospitalized patients shall require ~~collaborating~~ Supervising physician to follow, and co-sign legal documents.*

A Nurse Practitioner may see patients in the Medical/Surgical and Pediatrics Units, and in the Oakdale Nursing & Rehabilitation Center (ONRC), which includes the 300 Wing. ***ICU Excluded.***

QUALIFICATIONS/SCOPE OF PRACTICE/FUNCTIONS
NURSE PRACTITIONER
INPATIENT/ONRC PRACTICE PRIVILEGES Name _____

The Department of Medicine authorizes nurse practitioners to perform the following tasks/procedures/duties while under the supervision of the duly licensed member of the department:

1. Dictate/Write History and Physical
2. Dictate/Write Discharge Summaries
3. Write Progress Notes
4. Daily Hospital Care/Rounds in hospital setting
5. Monthly Patient Visits alternating with a Primary Care Physician in the *ONRC*
6. Perform procedures consistent with patient's condition and within scope of practice.
7. Initiates emergency procedures essential for the life of the patient.
8. Instructs and counsels patients and families regarding health and psychological problems.
9. Order Medications (within scope of furnishing license and approved protocols)
   Antibacterial/Antibiotics, Antifungals, Antipyretics, Analgesics/Sedatives, Antihistamines, Antipruritics, Laxatives, GI Motility, Dietary Supplements, Vitamins/Minerals, Dermatologicals
10. Order Writing
    IV Fluid and Electrolytes, Blood Products, Dressings/Wound Care, Order lab tests, routine X-Rays, Routine therapy (PT, OT, RT, DT)
11. Waived Testing; Hemoglobin, Occult Blood, Nitrazine, pH Paper

This privilege list is a guideline. Privileges not included, must be individually applied for below and submitted to, and approved by, the Interdisciplinary Practice Committee.

Other:	**Approved**	**Tabled**
_____	_____	_____
_____	_____	_____

_____ _____
NP Signature Date

_____
NP Printed Name

_____ _____
Sponsoring Physician Signature Date

_____
Sponsoring Physician Printed Name

APPROVED BY:

_____ _____
Department Chairman Date

Board Approved: 10/2002; 6/22/2016
Reformatted: 09/05
Revised: 10/2009; 12/2015; 5/2016

OAK VALLEY HOSPITAL DISTRICT
Oak Valley Community Health Centers Manual

Policy/Procedure: **Prior Authorization**			
Effective Date: NEW POLICY		**Page 1 of 2**	
Areas Affected: Oak Valley Community Health Centers			
Composed by: Clinic Manager			
☐ Reviewed ☐ Revised by:			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP Nursing	05/06/2026	X
Department of Medicine	Medical Staff Coordinator	05/12/2026	
Medical Executive Committee	Medical Staff Coordinator	05/19/2026	
District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**:	**Next Review Date**	

POLICY

The purpose of this policy is to ensure that prior authorizations (PAs) required by third-party payers (Medicare, Medi-Cal, private insurers, etc.) are identified and obtained in a timely manner. This supports medically necessary patient care, complies with payer contracts, prevents claim denials, and protects the financial viability of the clinic.

POLICY STATEMENT

It is the policy of the Rural Health Clinic that no non-emergent service, procedure, medication, diagnostic test, or referral that requires prior authorization will be scheduled or performed until the authorization has been obtained and documented, except in documented urgent or emergent situations as defined by the payer. The clinic will follow all applicable federal, state, and payer-specific rules regarding prior authorization.

SCOPE

This policy applies to all clinic staff, providers, and contracted personnel involved in patient scheduling, referrals, ordering, or billing for services.

DEFINITIONS

- **Prior Authorization (PA):** Written or electronic approval from a payer confirming that a specific service, medication, or supply is medically necessary and will be covered before the service is rendered.
- **Urgent/Emergent:** Situations in which a delay in care would jeopardize the patient's health, as defined by the payer's expedited review criteria.

RESPONSIBILTIES

- **Providers and Clinical Staff:** Determine medical necessity, provide complete and timely clinical documentation, and respond promptly to payer requests for additional information.
- **Referral Clerk / Designated Authorization Staff:** Verify insurance benefits, identify services that require PA, submit complete authorization requests, track status, and communicate outcomes to patients and providers.
- **Billing Staff:** Confirm that required PAs have been obtained and documented before submitting claims; flag any claims lacking authorization.
- **Clinic Administration:** Ensure staff training, maintain current payer guidelines, monitor compliance, and update this policy as regulations or payer rules change.

RESPONSIBILTIES

1. At the time of scheduling, referral, or order entry, insurance verification will include a check for prior-authorization requirements using the payer's current guidelines or portal.
2. If PA is required, the referral clerk will gather necessary documentation and submit the request using the payer's preferred method (portal, fax, phone, etc.).
3. All PA submissions, approvals, denials, and communications will be documented in the patient's electronic health record.
4. Patients and ordering providers will be notified of the authorization status in a timely manner.
5. Denials will trigger an appeal process according to the payer's timeline and requirements.
6. In urgent or emergent cases, care will proceed per medical necessity and payer expedited guidelines, with retrospective authorization pursued when allowed.

DOCUMENTATION AND COMPLIANCE

- All prior-authorization activity must be clearly documented in the patient chart.
- The clinic will retain copies of authorizations for the period required by law and payer contracts.
- Staff will receive training on this policy and payer-specific processes upon hire and annually.
- Non-compliance may result in claim denials, delayed payments, and disciplinary action up to and including termination.

OAK VALLEY HOSPITAL DISTRICT
Clinical Manual

Policy/Procedure:

CODE WHITE: MEDICAL EMERGENCY (PEDIATRIC)

Also indexed as: Medical Emergency (Pediatric); Pediatric Medical Emergency

Effective Date: 08/2013	**Page 1 of 4**
Areas Affected: All Divisions and Departments of the Hospital District	
Composed by: Unknown	
☒ Reviewed ☐ Revised by: Vice President Nursing Services	

Dept / Committee Approval:	Dept/Title:	Date	Approved
Policy, Procedures, Forms Comm.	VP of Nursing	05/06/2026	X
Department of Medicine	Medical Staff Coordinator	05/12/2026	
Medical Executive Committee	Medical Staff Coordinator	05/19/2026	
District Board	Board Liaison	06/04/2026	
Revised: 10/16, 06/23	**Reviewed**: 06/23	**Next Review Date**:	

POLICY

Oak Valley Hospital District (OVHD) will provide an appropriate response to a suspected or imminent cardiopulmonary arrest or a medical emergency for a pediatric patient.

PURPOSE

Code White is called for patients who do not have an advance healthcare directive indicating otherwise.

A. **Code White** is to be initiated immediately whenever an individual under eight years of age is found in cardiac or respiratory arrest (per facility protocol). In areas where pediatric patients are routinely admitted there will be a pediatric crash cart (Broselow) available. If a Code White is called in an area without a Broselow crash cart, the designated response team will bring a Broselow cart with pediatric equipment.

B. If the patient's weight does not meet the expected developmental growth, consider a response based on the appropriate protocol (e.g., ACLS/PALS).

SUPPORTIVE DATA

A. At the beginning of each shift the Med/Surg charge nurse will notify appropriate personnel of their assigned duties. If a person is unable to carry out their assignment for the entire shift, it is THEIR RESPONSIBILITY TO NOTIFY THE MED/SURG CHARGE NURSE.

B. The designated rescue team assignment will be maintained in the Med/Surg Nurses' Station.

C. This policy is specific for codes occurring in areas other than the Emergency Department.

PROCEDURE

Code White team members function within their respective scopes of practice and utilize guidelines set by the American Heart Association on Advanced Cardiac Life Support. The members perform functions that include, but are not limited to, the following:

A. Response

1. Person discovering a child in cardiopulmonary arrest:
   a. Assesses patient's airway, breathing and circulation.
   b. Calls for help.
   c. Initiates CPR and notes time
   d. Does not leave the patient.

2. First responding physician:
   a. Assumes the role of Code White team leader.
   b. Initiates direct emergency orders, as appropriate.
   c. May transfer responsibility of team leader to attending physician or emergency department physician.
   d. In the absence of attending physician, ascertains the "endpoint" of the procedure - the patient is revived, transferred, or pronounced.
   e. Documents outcome and other pertinent information in progress notes.
   f. Team leader signs the Code Blue record.

3. Personnel from department calling the Code White:
   a. Initiates Code White per facility protocol.
   b. Assesses patient and begins procedures to open airway, begins rescue breathing and/or initiates CPR, as indicated.
   c. Obtains Broselow cart.
   d. Attaches monitor leads.
   e. Assumes compressions and/or ventilation until the Code White response team arrives.

4. Nurse assigned to patient:
   a. Provides most recent data on the patient, including the pertinent history and vital signs.
   b. Brings chart to room and acts as information source.
   c. Takes responsibility for completion of the Code Blue record, other facility designated forms, and distribution of forms to appropriate departments.
   d. Marks and maintains monitor strips.
   e. Signs Code Blue record.

5. Designated nurse with appropriate training (e.g., ACLS/PALS), two (2) every shift, to be determined by policy:
   a. Responds to area/department where Code White is called.
   b. Ensures placement of cardiac monitor and assesses initial rhythm.
   c. Directs and delegates code responsibilities to nursing and other personnel.
   d. Directs Code White until physician arrives.
   e. Aids physician in obtaining history of arrest event and other pertinent medical history.
   f. Performs ongoing evaluation of patient status.
   g. Monitors and evaluates CPR procedures.
   h. Establishes IV line and administers medications according to appropriate guidelines (e.g., ACLS/PALS or other approved protocol) or as ordered.

i. Interprets EKG rhythm and defibrillates according to appropriate guidelines (e.g., ACLS/PALS).
j. Signs Code Blue record.

6. Respiratory therapy personnel:
   a. Assumes ventilation responsibilities upon arrival.
   b. Assists with intubation and obtains blood gases when needed.
   c. Establishes bedside tracheal suction capability as needed.
   d. Stays with patient through transport.
   e. Ensures ventilatory assistance arranged when patient transferred to ICU.
   f. Signs Code Blue record.

7. Department charge nurse:
   a. Assumes notification of switchboard operator to overhead page "Code White".
   b. Notifies attending physician of event.
   c. Notifies family of patient's deteriorating condition.
   d. Notifies and/or acts as family support person; also, as patient advocate when patient desires for treatment become known.
   e. Acts as resource and helps coordinate Code White.
   f. Coordinates and reviews interdisciplinary Code White team.
   g. Assists staff in evaluation of performance during code event.

8. Pharmacy:
   a. Exchanges the used medication tray immediately after Code White to ensure readiness of the cart.
   b. After hours, department charge nurse is responsible for replacing the medication tray.
   c. Mixes medication, solutions, and labels medication during code, if pharmacist is available.
   d. Calculate drip rates and dosages.
   e. Acts as a resource/consultant to code team during and immediately post-resuscitation.
   f. Signs the Code Blue record.
      i. ***Note:*** *Services of the pharmacist will be available during operational hours. Not available during hours when the pharmacy is closed.*

9. Recorder:
   a. Using Code Blue record, documents chronological events of resuscitation efforts, including but not limited to, CPR, dysrhythmias, medical interventions, person(s) present, pertinent history, etc.

10. Communication Service/facility operator:
    a. Voice pages Code White and location three (3) times when notified.

11. Pastoral Services/Social Worker (if requested):
    a. Supports the family.

12. Security:
    a. Coordinates necessary movement of other patients and visitors.
    b. Manages crowd control.

B. Training and Education

1. All direct patient care personnel will maintain BLS certification as required.

2. Specialized cardiac life support training (e.g., ACLS/PALS) as required.

3. Training of personnel should follow the guidelines of the American Heart Association on Advanced Cardiac Life Support.

4. Review of all policies and procedures.

5. Review of regulatory standards.

REFERENCE

Joint Commission Standard PC.02.0111 EP1
PALS Provider Manual, 2020 CPR & ECC Guidelines, ISBN:978-1-61669-785-3

OAK VALLEY HOSPITAL DISTRICT
Clinical Manual

Policy/Procedure:	****Bi-Annual Review***
BLOOD RECIPIENT ID BANDS	

Effective Date: 1982	**Page 1 of 3**
Areas Affected: All Divisions and Departments of the Hospital District	
Composed by: Unknown	
❒ Reviewed X Revised by: Manager, Laboratory	

Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP of Nursing	05/06/2026	X
Department of Medicine	Medical Staff Coordinator	05/12/2026	
Medical Executive Committee	Medical Staff Coordinator	05/19/2026	
District Board	Board Liaison	06/04/2026	
Revised: 3/17; 11/19; 4/26	**Reviewed**: 07/12	**Next Review Date**: 04/2028	

PURPOSE

To provide a positive identification link of a blood product to the intended recipient. This identification is of such importance that no crossmatch will be performed, or any product issued, on any specimen lacking this method of identification. All patients receiving any blood product, Packed Red Blood Cells, Fresh Frozen Plasma, Platelets or Rhogam must have a Blood Recipient ID Band in place **before** administration.

Supplies Needed:

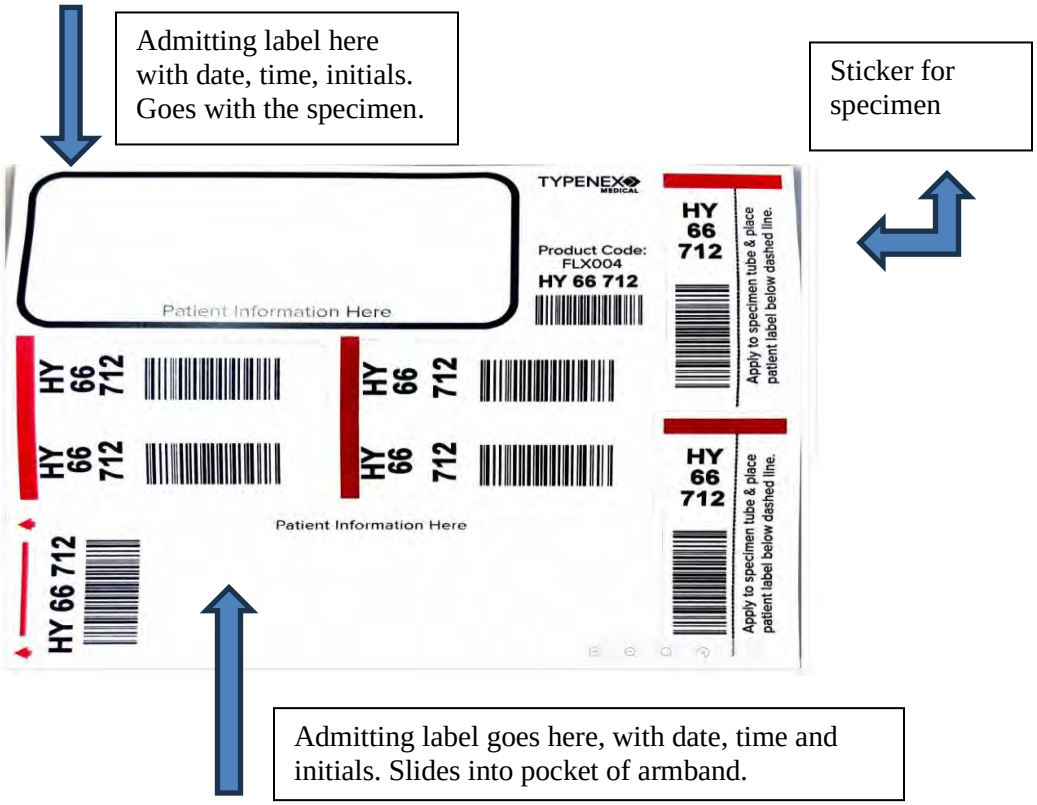
- Typenex Flexi 2.1 Green Blood Bank Armband
- Typenex Flexi Blood Bank Armband # form
- Patients Admitting stickers (at least 4~~3~~)
- Pink top EDTA collection tube

Procedure

Phlebotomist/Registered Nurse

1. Gather supplies
2. Confirm patient identity (Name and Date of Birth) verbally and with patient armband. (See routine venipuncture procedure for ID of unresponsive patients)
3. Collect one Ethylenediaminetetraacetic acid (EDTA) tube (pink top) for Blood Banking requests like hold clot, type screen and hold, type and cross or rhogam.
4. Label the tube with the blood bank band form sticker (The one with the unique number)that says " apply to specimen" see example below. Then place the patients admitting label up to the dotted line on the numbered sticker on the tube. Include the date, time and your initials.

   ~~4. Label the tube with the blood bank band form sticker that says " apply to specimen" see example below. Then place the patients admitting label up to the dotted line on the numbered sticker on the tube. Include the date, time and your initial~~ls.



5. Place admitting labels in the spots above. Make sure to include date, time and initials.
~~5.~~6. Remove the portion of the sticker form that goes into the armband. Slide the label with number into the open end of the plastic arm band. The opening is closest to the tail with the holes. Remove the white tape over the seal and press the pocket closed to form a watertight seal.
~~6.~~7. Fasten the armband to the patients wrist, tight enough that it can not be slipped over their hand. Cut off the excess portion of the band.
~~7.~~8. Double check completion of labels on tube, card and armband.
9. Deliver the tube and its sticker card, along with the extra admitting labels to the lab.
~~8.~~

*** The Meditech label does not need to be attached to the specimen. Write initials, date and time on stickers and send to Blood Bank with specimen. ***

Technologist

1. When preparing blood products always compare information on the pink tube label with that on the patient labels from Admitting and Meditech.

2. Place peel-off blood recipients ID numbers on luggage tag attached to each unit.

3. If the amount of peel-off numbers are insufficient for the units being cross matched, the number may be written on a small label and placed on the unit.

Nursing (See complete Blood Products Procedure)

1. When preparing to obtain blood product from the lab, verify that the patient has a Blood Recipient armband on and that the number of the armband matches the number on the copy of the Blood Transfusion Record. A comparison of the product will be made with the numbers appearing on the blood product unit and its paperwork before the blood is released to you. Make sure to take a copy of the order to transfuse to lab when picking up blood. Except in cases of emergency transfusions (i.e., a "code blue", an ongoing surgical case), staff should verify there is a physician's order present in the chart to transfuse the blood product and that there is a signed blood transfusion consent.

2. If the patient does not have the proper armband on, notify the laboratory transfusion service. The patient will be redrawn, re-banded and re-crossed if indicated.

   NOTE: Presence of the Blood Recipient armband is the only positive proof that the units were tested against this patient.

3. Before nursing administers the blood, two nurses must make a bedside comparison of the information on the patient's Blood Recipient armband and the patient's information on the blood product and its paperwork. (See Blood Products Procedure)

4. If the blood recipient I.D. band needs to be removed, notify lab before removing, lab personnel will observe removal and replacement. The person that cuts the band is responsible for reattaching the band. The band should be taped immediately. The tape must be dated, timed and initialed by the person that cut the band. The person that cut the band must also make note of it in the patient's progress notes. It is not acceptable to transfuse blood to a patient that is not properly banded.

   NOTE: Blood Bank recipient ID bands are only good for the life of the specimen, usually 72 hours. After that time patient will be redrawn and re-banded.

REFERENCES

1. Standards for Blood Banks and Transfusion Services, AABB, current edition.
2. Technical Manual, AABB, current edition.

OAK VALLEY HOSPITAL DISTRICT
Clinical Manual

Policy/Procedure:			
RAPID RESPONSE TEAM			
Effective Date: 2/08		**Page 1 of 4**	
Areas Affected: All Divisions and Departments of the Hospital			
Composed by: Unknown			
☐ Reviewed ☒ Revised by: ED Manager			
Dept./ Committee Approval:	**Dept./Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP of Nursing	02/04/26	
Department of Medicine	Medical Staff Coordinator		
Medical Executive Committee	Medical Staff Coordinator		
District Board	Board Liaison		
Revised: 3/14; 5/16; 12/18, 12/23, 8/25, 02/26	**Reviewed:** 12/23	**Next Review Date:**	

POLICY

Oak Valley Hospital District (OVHD) is committed to providing a safe environment for patients through early detection and response to patient's deteriorating condition.

PURPOSE

1) To rapidly provide a multidisciplinary team responding to assess acute changes on patient's condition
2) To enable staff at the bedside to directly request additional assistance from specifically trained staff.

3) To facilitate and expedite transfer to a higher level of care as needed.

DEFINITION

Acute: Sudden change from baseline.

ROLE OF RAPID RESPONSE TEAM:

a. Assist with the assessment and management of the patient.
b. Summon additional help if needed.
c. Obtain physician orders.
d. Work under the guidance of the Hospitalist or by the approved RRT protocols.
e. Assists with and facilitate transfer to the emergency department (For TCU patients only) or to a higher level of care.
f. Manage therapy that is not normally performed on the unit (vasopressors, antiarrhythmics, intubation) prior to transfer.

SUPPORTIVE DATA

Criteria for calling the Rapid Response Team (RRT) includes, but is not limited to:

ADULTS
• Acute change in heart rate less than 40 or greater than 140
• Acute change in systolic blood pressure (less than 90mmHg or greater than 180mmHg • 20% change in heart rate or blood pressure • Telemetry Changes • Acute change in respiratory rate (less than 8 or greater than 28)

ADULTS
• Acute change in pulse oximetry saturation (less than 90% despite oxygen therapy)
• Temperature greater than 38.3 degrees Celsius or less than 36 degrees Celsius
• WBC greater than 12,000 or less than 4,000
• Hemodynamic instability
• Acute change in mental status
• Seizure activity
• Slurred speech
• Acute change in urine output (less than 50ml in 4 hours)
• Acute increase use of oxygen to maintain saturation
• Concern about patient's condition
• A rapid response can be activated in response to a change in the patient's condition or the perception of change by the staff, the patient, and family.

PEDIATRICS
1. Acute change in Respiratory Rate or threatened airway. • Infant (less than 30 per min or greater than 60 per min) • Toddler (less than 24 per min or greater than 40 per min) • Preschooler (less than 22 per min or greater than 34 per min) • School Age (less than 18 per min or greater than 30 per min) • Adolescent (less than 12 per min or greater than 16 per min)
2. Staff member/family are concerned/worried about the patient.
3. Acute change in Heart Rate • 1 month-3 months (less than 85 per min or greater than 205 per min) • 3 months-2 years (less than 100 per min or greater than 190 per min) • 2 years- IO years (less than 60 per min or greater than 140 per min) • Greater than 10 years (less than 60 per min or greater than 100 per min)

4. Acute change in Systolic Blood Pressure
   - Infants (I to 12 months) less than 70 mmHg
   - Children (1 to 10 years) less than 86mmHg
   - Children (greater than 10 years) less than 90mmHg

PROCEDURE

1. Anyone can activate the Rapid Response Team (RRT) by notifying a hospital staff person or by dialing 33 on a hospital phone.

2. Staff activating the RRT will notify the hospital operator dialing 33 on the hospital phone and state the need for the RRT and room number

RAPID RESPONSE IN M/S TELE

1. **House Supervisor, RRT Nurse, Hospitalist, & RT will respond, assess, intervene, and stabilize patient.**
2. **If it's determined that the patient is stable and doesn't need further treatment, the patient will remain on unit and RRT will return to ED.**
3. **If it's determined that the patient meets criteria for higher level of care RRT will remain on unit, take over care of patient with the assistance of the M/S primary nurse, and facilitate the transfer to the receiving facility.**

RAPID RESPONSE to TCU

- TCU RN/CNA~~AN~~ will dial "33" to call the hospital operator and activate Rapid Response, state the need for RRT and state the room number.
- House Supervisor, RRT Nurse, Hospitalist, & RT will respond, assess, intervene, and stabilize patient
- RRT Nurse shall be staffed by either the Emergency Department or Intensive Care Unit as determined by the House Supervisor.
- If it's determined that the patient is stable and doesn't need further treatment, the patient will remain on unit and RRT will return to ED. House Supervisor will communicated with the Primary Care physician.
- If it's determined that the patient ~~need~~needs further treatment and/or meets criteria for higher level of care the patient will be transported to ED and admitted as an ED patient.
- If patient has been determined to be stable after treatment with a discharge to home disposition patient will be discharged back to TCU. House Supervisor will inform TCU of patient's discharge from the Emergency Department.

- If the patient has been determined to be stable but meets admission criteria for M/S Tele unit or Intensive Care Unit at OVHD by ED Physician and Hospitalist the patient will remain at OVHD and transported to M/S Tele or Intensive Care unit as an inpatient
- If it's determined that the patient meets criteria for a higher level of care the ED will facilitate the transfer to the receiving facility

DOCUMENTATION

1) Complete RRT documentation form
2) Document in Meditech:
   a. Time RRT called
   b. Ongoing treatment, care, and monitoring

RELATED FORMS

1. Form0476 Rapid Response Team Documentation

REFERENCE:

Agency for Healthcare Research and Quality (September 7, 2019).
Rapid Response Systems
Valley Children's Resuscitation Guidelines 2021

OAK VALLEY HOSPITAL DISTRICT
Oakdale Nursing & Rehab Center Manual

Policy/Procedure: **PRESSURE INJURY / SKIN BREAKDOWN PREVENTION AND MANAGEMENT**			
Effective Date:		**Page 1 of 5 (+Attachment)**	
Areas Affected: All Patient Care Divisions and Departments of the Oakdale Nursing and Rehabilitation Center			
Composed by: ☐ Reviewed ☒ Revised by:			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Continuous Quality Improvement	ONRC	04/30/2026	
Policy, Procedures, Forms Comm.	VP of Nursing	05/05/2026	
Medical Executive Committee	Medical Staff Coordinator	05/19/2026	
District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**:	**Next Review Date**:	

PURPOSE

To outline nursing responsibilities in the prevention, recognition and treatment of pressure injuries and other forms of skin breakdown.

SCOPE

Interdependent – some treatments require a physician's order.

SUPPORTIVE DATA

1. The physician must be notified for all pressure injuries/skin breakdowns.

2. A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful.

3. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

4. Pressure Injury Stages:

    a. **Stage 1 Pressure Injury: Non-blanchable erythema of intact skin**
    Intact skin with a localized area of non-blanchable erythema, which may appear

differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

b. **Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis**
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.

    i. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

c. **Stage 3 Pressure Injury: Full-thickness skin loss**
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

    i. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

d. **Stage 4 Pressure Injury: Full-thickness skin and tissue loss**
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.

    i. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

e. **Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss**
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

    i. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

f. **Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration**
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle

interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

i. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4).

ii. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

5. Additional pressure injury definitions:

a. **Medical Device Related Pressure Injury:**

i. This describes an etiology.
Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

b. Mucosal Membrane Pressure Injury: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

6. Risk factors for development of pressure injuries include general debilitation, failure to thrive, multi-system failure, trauma, impaired nutritional and/or fluid status, chronic disease states, decreased activity/mobility, circulatory impairment or incontinence.

7. All wounds require a moist, clean, warm, dark environment for healing to occur.

8. Other definitions:

a. Undermining = interior of the wound is larger than the opening of the wound.

b. Tunneling = tunnels between wounds or other openings in the tissues are present.

c. Denuded = skin has been stripped by enzymes from incontinence and/or wound drainage.

d. Excoriated = scratch marks

e. Maceration = water logged tissue

PROCEDURE

Initial Admission Assessment

1. Complete Skin Assessment on Nursing Admission Screening/History upon admission/readmission.

2. Use the Braden Scale on admission, then quarterly or with any change in condition.
   - Very High Risk = a score of 9 or below
   - High Risk = a score of 10 – 12.
   - Moderate Risk = a score of 13 – 14.

- At Risk = a score of 15 – 18

3. Initiate a plan of care for patients/residents identified as at risk for development of skin breakdown or who present with tissue damage on admission. Capture on admission nursing assessment.

4. Contact the wound care nurse, physician or crescent wound care for patients/residents identified as at risk for development of skin breakdown, who present with tissue damage on admission to determine the need for a specialty bed and/or to obtain assistance with determining appropriate treatment.

On-going Assessment

1. Assess wounds and document the status weekly(at least bi-weekly) or as recommended by physician or wound provider(Crescent Wound Care) and document the status/findings.

2. Upon finding a new pressure injury, wound, skin injury, etc., contact wound nurse, physician, or crescent wound care to provide appropriate treatment. Document on progress notes or assessment and initial assessment.

Prevention of Skin Breakdown

1. Turn the immobile patient/resident at least every two (2) hours.

2. Encourage the patient/resident to be as active as possible, i.e., up in a chair, ambulate, etc.

3. Keep skin clean and dry.
   - Use soap and water or other skin cleaning product
   - Use ointments to protect and moisturize the skin
   - Use barriers to protect the skin

4. A foley catheter may be used after consultation with the physician.

5. Talcum powders (i.e. baby powder) are never used. Avoid other powders and use creams, paste, or ointments instead except after consultation with the wound care nurse/physician.

6. Avoid the use of occlusive protective pads to prevent complications and ensure effective wound healing.

7. Keep heels propped or "bridged" off the mattress. Foam boots may be used but must be removed every shift to observe heels. Foam boots do not prevent the need for elevation.

8. Use lift sheets or other assistive devices when moving the patient/resident in bed. Be careful not to drag the patient/resident over the bedding or the mattress. This prevents shear and friction.

9. Encourage adequate nutritional and fluid intake. Obtain a nutritional consult as appropriate.

10. For fecal incontinence consider the use of protective barrier creams/ointments.

11. A special bed or mattress may be used after consultation with the physician. A physician's order is required.

12. Encourage patients in a wheel chair/other chair to shift their weight and/or perform "chair push ups" at least every two (2) hours. Use a pressure-relieving cushion in the chair, especially for high-risk patients.

13. Do not use hydrogen peroxide for irrigation or as a cleansing solution.

PATIENT/RESIDENT and/or FAMILY EDUCATION

1. Include the patient or resident and/or family in the plan of care.
2. Explain the wound care treatment to them and teach self-care as appropriate.
3. Provide appropriate printed education information to the patient and/or family.

DOCUMENTATION

- Document all assessments, the plan of care, evaluation, education and treatment provided in the appropriate section of the electronic medical record/point click care system.
- Relevant Documentation may be found in point click care under weekly skin observation, progress notes or scanned visit notes from hospice or wound nurse/physician.

REFERENCES

1. *NPUAP Pressure Injury Stages*. (2016). Retrieved April 27, 2026, from National Pressure Ulcer Advisory Panel: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages

OAK VALLEY HOSPITAL DISTRICT
Radiology Manual

Policy/Procedure:			***Reviewed Annually**
Computed Tomography (CT) Reportable Events			
Effective Date: 2/17/26		**Page 1 of 5**	
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: Anna Wahdan			
☐ Reviewed ☐ Revised by: ***Posted in DRAFT 2/17/26***			
Dept / Committee Approval:	**Dept/Title: Radiology**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP of Nursing	05/06/2026	
Department of Medicine	Medical Staff Coordinator	05/12/2026	
Medical Executive Committee	Medical Staff Coordinator	05/19/2026	
District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**: 2/17/26	**Next Review Date**:	

1. Purpose

To establish standardized procedures for identifying, reporting, documenting, and managing **Computed Tomography (CT) radiation administration events** in compliance with the **California Health & Safety Code (HSC)** and guidance from the **California Department of Public Health Radiologic Health Branch (RHB).**

This policy ensures patient safety, regulatory compliance, and appropriate reporting of CT radiation exposure incidents.

2. Regulatory Authority

This policy is based on the following California statutes:

- **HSC §115111** – CT dose recording requirements
- **HSC §115112** – CT accreditation requirements
- **HSC §115113** – CT and therapeutic radiation reportable events and notification requirements

3. Policy Statement

All CT examinations performed in this facility shall comply with California law requiring:

1. **Recording of CT radiation dose** in the patient record.

2. **Accreditation of CT equipment** through approved accrediting organizations.
3. **Identification and reporting of CT radiation administration events** to the California Department of Public Health.

4. CT Dose Recording Requirements

(HSC §115111)

The facility shall:

1. Record the **dose of radiation for every diagnostic CT study** in the patient record.
2. Include the radiation dose in the **interpretive radiology report** or attach a protocol page with dose information.
3. Record dose using one of the following metrics:
    - **CTDIvol**
    - **Dose Length Product (DLP)**

These requirements apply only to CT systems capable of calculating and displaying dose values.

5. CT Accreditation Requirements

(HSC §115112)

All CT X-ray systems used for diagnostic imaging must be accredited by one of the following:

- A CMS-approved accrediting organization
- An accrediting organization approved by the Medical Board of California
- The California Department of Public Health

Exemptions include CT systems used for:

- Radiation therapy planning
- Attenuation correction for nuclear medicine
- Interventional radiology image guidance.

6. Reportable CT Radiation Events

(HSC §115113)

The facility shall report a CT radiation event to CDPH if the administration of radiation results in the following situations **and exceeds dose thresholds**, unless caused by patient movement.

6.1 Repeat CT Examination Due to Error

Code Section: HSC §115113(a)(1)

A reportable event occurs when a CT examination must be repeated (not ordered by a physician) and the radiation dose exceeds:

- **0.05 Sv (5 rem) effective dose**, OR
- **0.5 Sv (50 rem) to an organ or tissue**, OR
- **0.5 Sv (50 rem) shallow dose to the skin**.

Examples include:

- Equipment malfunction
- Incorrect technical factors
- Incorrect patient positioning.

6.2 CT Examination Performed Without Physician Authorization

Code Section: HSC §115113(a)(2)

A reportable event occurs when a CT exam is performed **without physician approval** and exceeds:

- **0.05 Sv (5 rem) effective dose**, OR
- **0.5 Sv (50 rem) organ dose**, OR
- **0.5 Sv (50 rem) skin dose**.

6.3 CT Irradiation of Wrong Body Part

Code Section: HSC §115113(a)(3)

A reportable event occurs when a CT examination exposes **a body part other than the intended anatomy** and exceeds the dose thresholds listed above.

6.4 Radiation Causing Unanticipated Injury

Code Section: HSC §115113(a)(3)

Reportable events include radiation exposure resulting in:

- Unanticipated permanent functional damage to an organ or physiological system
- Radiation-induced hair loss
- Radiation erythema (skin injury)

as determined by a qualified physician.

6.5 Excess Radiation Dose to Embryo or Fetus

Code Section: HSC §115113(a)(4)

A reportable event occurs if:

- A **known pregnant patient** receives radiation exposure, and
- The **dose to the embryo or fetus exceeds 50 mSv (5 rem)**
- The exposure was **not approved in advance by a qualified physician**.

7. Reporting Requirements

Notification to CDPH

The facility must notify the **California Department of Public Health Radiologic Health Branch**:

- **Within 5 business days** of discovery of the event.

Patient Notification

The facility must provide written notification to the affected patient:

- **Within 15 business days** of discovery of the event.

Notification must also be provided to the referring physician.

8. Responsibilities

Radiologic Technologists

- Follow approved CT protocols
- Document radiation dose metrics
- Immediately report potential events to the radiologist or supervisor.

Radiologists

- Confirm appropriateness of examinations
- Review dose documentation
- Assist in event evaluation.

Radiation Safety Officer / Medical Physicist

- Evaluate radiation dose estimates
- Assist with regulatory reporting
- Perform dose verification and QA review.

Radiology Director / Manager

- Ensure compliance with CDPH regulations
- Oversee event reporting and corrective action.

9. Documentation

All CT events must be documented in:

- Radiology incident reporting system
- Patient medical record
- Radiation safety logs.

10. Corrective Action

Following a CT event, the facility shall:

- Conduct a root cause analysis
- Implement corrective actions
- Provide staff education if required
- Maintain documentation for regulatory inspection.

References

1. California Department of Public Health, **Radiologic Health Branch**. *CT Dose Recording and Reporting Requirements.* https://www.cdph.ca.gov/Programs/CEH/DRSEM/RHB
2. California Health and Safety Code Section 115111 – *CT Radiation Dose Recording Requirements.*
3. California Health and Safety Code Section 115112 – *CT X-ray System Accreditation Requirements.*
4. California Health and Safety Code Section 115113 – *Reportable CT and Therapeutic Radiation Events.*
5. American College of Radiology. *CT Accreditation Program Requirements.*
6. U.S. Food and Drug Administration. *Radiation Dose in X-ray and CT Exams.*

OAK VALLEY HOSPITAL DISTRICT

Radiology Manual

Policy/Procedure:			***Reviewed Annually**
C-ARM CONE REMOVAL POLICY			
Effective Date: 2/17/26	**Page 1 of 8**		
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: Anna Wahdan			
☐ Reviewed ☐ Revised by: ***Posted in DRAFT 2/17/26***			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP of Nursing	05/06/2026	X
Department of Medicine	Medical Staff Coordinator	05/12/2026	
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District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**: 2/12/26	**Next Review Date**:	

1. PURPOSE

The purpose of this policy is to establish standardized procedures governing the **removal, use, and replacement of the C-arm cone or beam-limiting device** during fluoroscopic procedures within the Radiology Department.

The policy ensures that the use of C-arm fluoroscopic equipment is performed in a manner that protects patients, staff, and the public from unnecessary radiation exposure while maintaining compliance with regulatory requirements established by the **California Department of Public Health Radiologic Health Branch** and the **California Code of Regulations Title 17 Radiation Control Regulations.

This policy also supports implementation of the **As Low As Reasonably Achievable (ALARA)** radiation safety principle.

2. SCOPE

This policy applies to all personnel who operate or assist in procedures involving **mobile fluoroscopy (C-arm) equipment**, including:

- Radiologic technologists
- Radiologists
- Surgeons and procedural physicians
- Interventional specialists
- Operating room staff assisting with fluoroscopic procedures

- Biomedical engineering personnel responsible for equipment maintenance
- Students and trainees working under supervision

This policy applies to all hospital areas where C-arm fluoroscopy may be used, including:

- Operating rooms
- Interventional suites
- Emergency department
- Orthopedic procedure rooms
- Intensive care units
- Any location where mobile fluoroscopy equipment is utilized

3. DEFINITIONS

C-Arm

A mobile fluoroscopic imaging system commonly used in surgical, orthopedic, and interventional procedures that provides real-time X-ray imaging.

Cone (Beam Limiting Device)

A removable device attached to the X-ray tube housing that limits the size and shape of the X-ray beam to reduce patient and staff radiation exposure and improve image quality.

Collimation

The restriction of the X-ray beam to the smallest field necessary to perform the procedure.

Radiation Safety Officer (RSO)

A designated individual responsible for implementation and oversight of the hospital's radiation protection program.

4. POLICY STATEMENT

All C-arm fluoroscopic systems shall be operated with **proper beam-limiting devices in place whenever possible** to minimize radiation exposure.

Removal of the C-arm cone or beam-limiting device is **generally discouraged** and shall only occur under specific circumstances when necessary to perform a medically justified procedure.

When cone removal is required:

- The radiation field must be limited through alternative collimation methods.
- Exposure time must be minimized.
- Radiation protection practices must be strictly followed.

- The cone MUST be re-affixed on the c-arm according to the manufacturer requirements once the procedure is completed.

All use of fluoroscopic equipment must comply with regulatory standards established by the **California Department of Public Health Radiologic Health Branch**.

5. RESPONSIBILITIES

Radiation Safety Officer (RSO)

The Radiation Safety Officer is responsible for:

- Oversight of fluoroscopy radiation safety practices
- Reviewing policies regarding C-arm operation
- Monitoring radiation exposure trends
- Investigating radiation safety incidents
- Providing staff education regarding safe fluoroscopy practices
- Ensuring compliance with CDPH regulatory requirements

Radiologists and Physicians

Physicians performing fluoroscopic procedures shall:

- Ensure medical necessity for fluoroscopy use
- Minimize fluoroscopy time
- Use beam limitation whenever possible
- Ensure radiation safety practices are followed
- Approve any necessary cone removal during procedures

Radiologic Technologists

Radiologic technologists operating C-arm equipment shall:

- Verify equipment is functioning properly
- Ensure beam collimation is optimized
- Maintain proper positioning of protective shielding
- Monitor fluoroscopy time and radiation output
- Document procedures involving cone removal when required

Operating Room Staff

Operating room personnel assisting with fluoroscopy shall:

- Maintain safe positioning during radiation exposure
- Use personal protective equipment
- Follow technologist and physician radiation safety instructions

6. GENERAL RADIATION SAFETY REQUIREMENTS FOR C-ARM USE

When operating mobile fluoroscopy equipment:

- Use the lowest radiation dose settings appropriate for the procedure.
- Keep the image receptor as close to the patient as possible.
- Maximize distance between staff and the X-ray source.
- Utilize pulsed fluoroscopy whenever available.
- Wear appropriate radiation protection including lead aprons, thyroid shields, and protective eyewear when required.
- Monitor fluoroscopy time during procedures.

These practices support the ALARA principle and reduce occupational radiation exposure.

7. CONE REMOVAL POLICY

7.1 General Requirement

The C-arm cone or beam-limiting device shall **remain attached during fluoroscopic procedures whenever feasible**.

The device provides:

- Radiation field restriction
- Reduction of scatter radiation
- Improved image contrast
- Decreased radiation dose to patients and staff

7.2 Acceptable Circumstances for Cone Removal

Cone removal may be permitted under limited circumstances including:

- Surgical field obstruction caused by the cone
- Orthopedic procedures requiring large field visualization
- Anatomical constraints preventing proper imaging
- Emergency procedures where cone removal is necessary to obtain critical diagnostic information
- Specialized procedures requiring unobstructed access

In such situations, the physician performing the procedure must determine that cone removal is medically necessary.

7.3 Required Safety Measures When Cone is Removed

When the cone is removed, the following radiation safety precautions must be implemented:

Beam Limitation

The X-ray beam must be restricted using electronic collimation to the smallest field size necessary.

Distance Control

Personnel must maximize distance from the radiation source whenever possible.

Protective Shielding

All personnel in the room must wear:

- Lead aprons
- Thyroid shields
- Additional protective equipment if appropriate

Fluoroscopy Time Management

Fluoroscopy time should be minimized through:

- Intermittent fluoroscopy
- Use of last-image hold
- Avoidance of continuous fluoroscopy when possible

Positioning

Whenever possible:

- The X-ray tube should be positioned under the table
- The image receptor should be above the patient

This configuration significantly reduces staff radiation exposure.

8. DOCUMENTATION

If the C-arm cone is removed during a procedure, documentation may include:

- Procedure type
- Reason for cone removal
- Physician authorization
- Duration of fluoroscopy exposure if required
- Any unusual radiation exposure conditions

Documentation may be maintained in the procedure report or radiation safety log if required by departmental policy.

9. TRAINING REQUIREMENTS

All personnel involved in fluoroscopy procedures must receive training on:

- Radiation safety principles
- Proper operation of fluoroscopy equipment
- Use of beam limiting devices
- Risks associated with cone removal
- ALARA radiation protection practices

Training must occur:

- Upon initial employment
- When new equipment is introduced
- Periodically as part of radiation safety education

10. QUALITY ASSURANCE AND EQUIPMENT COMPLIANCE

C-arm equipment must be maintained according to regulatory and manufacturer standards.

Quality assurance activities include:

- Routine equipment inspections
- Preventive maintenance
- Medical physics evaluations
- Verification of beam limitation functionality
- Fluoroscopy dose monitoring

All fluoroscopic equipment must be registered with the **California Department of Public Health Radiologic Health Branch** as required by state regulations.

11. RADIATION INCIDENT REPORTING

Any suspected radiation safety violation or abnormal radiation exposure must be reported immediately to:

- The Radiation Safety Officer
- Department leadership

Reportable radiation events shall be handled according to regulatory reporting requirements established by the **California Department of Public Health.

12. COMPLIANCE AND AUDIT

Compliance with this policy may be monitored through:

- Radiation safety audits
- Procedure observation
- Equipment inspections
- Review of fluoroscopy usage reports
- Radiation exposure monitoring

Corrective action may be implemented if unsafe practices are identified.

13. REFERENCES

1. California Department of Public Health Radiologic Health Branch – Radiation Safety Regulations and Guidance.
2. California Code of Regulations Title 17, Division 1, Chapter 5 – Radiation Control Regulations.
3. 10 CFR Part 20 – Standards for Protection Against Radiation.
4. National Council on Radiation Protection and Measurements (NCRP) – Radiation Protection Guidance for Fluoroscopy.
5. American College of Radiology – Radiation Safety in Fluoroscopic Procedures.
6. Food and Drug Administration – Fluoroscopy Radiation Safety Guidance.

OAK VALLEY HOSPITAL DISTRICT
Radiology Manual

Policy/Procedure:			***Reviewed Annually**
RADIATION SAFETY & PROTECTION PROGRAM			
Effective Date: 4/5/2017	**Page 1 of 6**		
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: Anna Wahdan			
☐ Reviewed ☐ Revised by: ***Posted in DRAFT 2/17/26***			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
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Department of Medicine	Medical Staff Coordinator	05/12/2026	
Medical Executive Committee	Medical Staff Coordinator	05/19/2026	
District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**: 2/17/26	**Next Review Date**:	

RADIATION PROTECTION PROGRAM

Radiology Department Policy

1. PURPOSE

The purpose of this Radiation Protection Program is to ensure the safe and effective use of ionizing radiation within the Radiology Department and to protect patients, staff, and the public from unnecessary radiation exposure.

This program ensures compliance with requirements established by the **California Department of Public Health Radiologic Health Branch and applicable regulations in the **California Code of Regulations Title 17 governing radiation safety.

The program supports implementation of the **As Low As Reasonably Achievable (ALARA)** principle.

2. SCOPE

This policy applies to all individuals working in or supporting the Radiology Department including:

- Radiologists
- Radiologic technologists
- Physicians performing fluoroscopy

- Medical physicists
- Nursing staff assisting in radiologic procedures
- Students and trainees
- Biomedical engineering staff
- Contractors servicing imaging equipment

3. DEFINITIONS

ALARA
A radiation protection principle requiring that radiation exposure be kept as low as reasonably achievable while achieving the required diagnostic or therapeutic outcome.

Controlled Area
An area where access is limited for the purpose of protecting individuals from radiation exposure.

Occupational Dose
Radiation dose received by an individual in the course of employment.

Public Dose
Radiation dose received by individuals who are not occupationally exposed workers.

Radiation Safety Officer (RSO)
A qualified individual responsible for implementing and overseeing the Radiation Protection Program.

4. POLICY STATEMENT

The Radiology Department shall maintain a comprehensive Radiation Protection Program designed to:

- Maintain radiation exposures within regulatory limits
- Minimize radiation exposure through ALARA practices
- Ensure safe operation of radiation-producing equipment
- Protect patients, staff, and the public
- Maintain compliance with CDPH regulations

5. RESPONSIBILITIES

Radiation Safety Officer (RSO)

The Radiation Safety Officer shall:

- Oversee implementation of the Radiation Protection Program
- Monitor occupational radiation exposure
- Conduct radiation safety training

- Investigate abnormal radiation exposure events
- Maintain radiation safety records
- Ensure compliance with CDPH regulations
- Coordinate radiation safety inspections and audits

Radiation Safety Committee (if applicable)

Responsibilities include:

- Reviewing radiation safety policies
- Evaluating radiation exposure reports
- Monitoring compliance with ALARA practices
- Reviewing radiation incidents

Department Staff

Personnel working with radiation shall:

- Follow radiation safety policies and procedures
- Wear radiation monitoring devices when required
- Use appropriate protective equipment
- Participate in required training
- Report unsafe conditions or radiation incidents

6. ALARA PROGRAM

The department shall implement the ALARA principle through:

Administrative Controls

- Radiation safety training
- Standardized imaging protocols
- Monitoring occupational exposure reports

Engineering Controls

- Shielded imaging rooms
- Protective barriers
- Equipment safety features

Work Practice Controls

- Minimizing exposure time
- Maximizing distance from radiation sources
- Use of shielding devices

7. OCCUPATIONAL RADIATION DOSE LIMITS

The following dose limits are established according to **California Code of Regulations Title 17.

Category	Annual Dose Limit
Whole Body (Total Effective Dose Equivalent)	5 rem (50 mSv)
Lens of the Eye	15 rem (150 mSv)
Skin or Extremities	50 rem (500 mSv)
Declared Pregnant Worker (Embryo/Fetus)	0.5 rem (5 mSv) during pregnancy
Public Exposure	0.1 rem (1 mSv) per year

Personnel exposures shall be monitored and reviewed regularly to ensure doses remain within these limits and consistent with ALARA.

8. PERSONNEL MONITORING

Dosimetry Requirements

Personnel who may receive significant occupational exposure shall wear radiation monitoring devices including:

- Whole body dosimeters
- Extremity dosimeters (if applicable)

Dosimeters must be:

- Worn during radiation work
- Stored properly when not in use
- Exchanged at required intervals

Radiation exposure reports shall be reviewed by the Radiation Safety Officer.

9. DECLARED PREGNANCY POLICY

Employees who declare pregnancy may voluntarily submit written notification to the Radiation Safety Officer.

Upon declaration:

- Additional fetal dosimetry monitoring may be provided
- Work assignments may be reviewed
- Exposure limits for the embryo/fetus shall not exceed **0.5 rem (5 mSv)** during the pregnancy

Participation in this program is voluntary and confidential.

10. PATIENT RADIATION SAFETY

The department shall ensure:

- Imaging procedures are medically justified
- Exposure parameters are optimized
- Repeat imaging is minimized
- Pediatric and adult protocols are appropriately adjusted
- Radiation dose monitoring is implemented where applicable

11. FLUOROSCOPY SAFETY

Fluoroscopy procedures shall follow radiation safety practices including:

- Use of pulsed fluoroscopy when available
- Minimizing fluoroscopy time
- Maximizing distance from the source
- Use of protective shielding
- Monitoring fluoroscopy time and dose indicators

Only qualified physicians and technologists shall operate fluoroscopic equipment.

12. EQUIPMENT QUALITY ASSURANCE

The Radiology Department shall maintain a Quality Assurance (QA) program including:

- Equipment performance testing
- Preventive maintenance
- Medical physics evaluations
- Image quality assessments
- Radiation output measurements

Equipment must be registered with the **California Department of Public Health Radiologic Health Branch.

13. AREA MONITORING AND POSTING

Radiation areas shall include:

- Warning signs
- Shielded control areas
- Restricted access where required
- Protective equipment

Required radiation notices shall be posted in accordance with **California Code of Regulations Title 17.

14. INCIDENT REPORTING

Any radiation incidents, abnormal exposures, or equipment malfunctions shall be reported immediately to the Radiation Safety Officer.

Reportable events shall be reported to CDPH as required by regulation.

15. RECORD KEEPING

Records maintained by the department include:

- Personnel radiation exposure reports
- Dosimetry records
- Equipment testing reports
- Training documentation
- Radiation safety audits
- Incident reports

Records shall be retained according to regulatory requirements.

16. PROGRAM REVIEW

The Radiation Protection Program shall be reviewed annually to ensure:

- Continued regulatory compliance
- Effectiveness of radiation safety measures
- Implementation of corrective actions when necessary

17. REFERENCES

1. California Department of Public Health Radiologic Health Branch – Radiation Safety Guidance.
2. California Code of Regulations Title 17 – Radiation Control Regulations.
3. 10 CFR Part 20 – Standards for Protection Against Radiation.
4. National Council on Radiation Protection and Measurements (NCRP) Radiation Protection Recommendations.
5. American College of Radiology (ACR) Radiation Safety Guidelines.

Recommend Retire

OAK VALLEY HOSPITAL DISTRICT

Diagnostic Imaging Manual

Policy/Procedure: **RADIATION SAFETY AND PROTECTION**			
Effective Date: 4/5/2017		**Page 1 of 10**	
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: Manager, Imaging Department			
❒ Reviewed (Annually) ❒ Revised by:			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Imaging Department	Manager	01/10/2023	X
Policy, Procedures, Forms Comm.	Medical Staff Coord.	02/15/2023	X
Department of Medicine	Medical Staff Coord	03/14/2023	X
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District Board	Board Liaison	04/06/2023	X
Revised:	**Reviewed**:	**Next Review Date**: 4/2026	

PURPOSE

Defines the responsibilities of the organization and individuals in radiation control. It provides general safety rules and procedures for all users of radiation sources.

ALARA Program

The Department of diagnostic Imaging will implement procedures as noted in Title 17, California Radiation Control Regulations, to reduce levels of radiation exposure to "As Low as Reasonably Achievable".

PROCEDURE

1. Digital Radiology Fluoroscopy will be used

2. High Kilo Volts (KV) technique will be used when appropriate.

3. All women of childbearing age will be asked if there is any possibility of them being pregnant **BEFORE** they are exposed to any X-rays.

4. A film reject analysis program will be used to ascertain any areas of weakness within the department requiring correction. This program is also used for on-going in-service and teaching purposes with the staff.

5. A certified radiation physicist will inspect the entire department each year. The inspection will include all X-ray producing equipment, all radiation protective devices, and monitors policy and procedure manuals for recommendations of any possible additions or changes.

6. Specific quality control measures will be in place relative to mammography.

7. All physicians who operate equipment ("C" arm unit) will hold a current "X-ray and Supervisor" permit, issued by the State of California Department of Health Services. A list of those physicians will be maintained in the Medical Staff Office.

8. All technologists will be certified by the State of California and possess a current fluoroscopy permit before they will be allowed to use a fluoroscopy unit to position or spot patients.

9. All personnel are monitored for exposure by a film badge program.

10. On a routine basis there shall be within the department an ongoing evaluation of:
    a. Types of radiology equipment to replace or purchase
    b. Processing equipment in use
    c. Needed safety protection equipment

Dosimetry Program

1. Personnel film badges will be provided to all radiation workers (e.g. radiologists, radiology technologists) and various personnel involved with frequent fluoroscopy procedures (e.g. speech therapists, surgery nurses). The film badges will be worn at all times while utilizing fluoroscopy.

2. The body badges will be worn at the waist or on the collar except when lead aprons are worn. When wearing a lead apron the badge will be worn on the collar outside the apron. When two badges are worn, one badge should be worn on the inside of the lead apron at the waist. The second will be worn outside the lead apron on the collar.

3. Film badges will be distributed each month and the prior months badges will be returned at the same time. The exposed film badge will be mailed to the Laudauer Company in the envelope provided.

4. Maximum annual total effective dose equivalent (TEDE) is 5rem as set by state and federal regulatory agencies. An investigation will be made for all film badge exposures exceeding 400-millirem a monthly period. The investigation will be initiated by the radiation safety officer and will require a statement from the individual and their manager. Any action will be dependent upon the circumstances and the severity of the exposure.

5. A copy of the monthly dosimeter exposure report will be posted for all to inspect and (initial their individual report) signed off by the Radiation Safety Officer (RSO).

6. Personnel dosimeters will not be worn when medical radiation procedures are being performed on the wearer.

Radiological Controls

1. Entry and Exit Controls
    a. There are 4 evacuation signs posted within the department

2. Posting
    a. Every radiation door has a sign posted
    b. WARNING - X-ray in Use - English
       ADVERTENCIA - Rayos x en Uso - Spanish
    c. CAUTION - If you are pregnant or think you may be pregnant you must inform the technologist before you begin - English

CUIDADO - Si esta embarazada o cree estarlo debera informar al tecnico antes de comenzar - Spanish

d. There is a current copy of 17 CCR, incorporated sections of 10CFR 20 located in the Radiology Manager's office.

3. Current copies of Department Form RH-2364 (Notice to Employees) are located in the CAT scan rooms, X-ray room and control areas.

4. Any notice of violation involving radiological working conditions or any order issued pursuant to the Radiation Control Law and any required response from the hospital.

Disposal of Equipment
The Hospital shall report in writing to the Department of Health the sale, transfer and discontinuance of any reportable source of radiation.

http://www.cdph.ca.gov/programs/pages/radiologichealthbranch.aspx

Other Controls

1. Rooms housing radiation sources shall be properly marked with only authorized personnel being allowed within the area.

2. Where portable X-ray units are used, only the patient and trained personnel shall be allowed within the area. Keys are not allowed to be left in any portable unit.

3. All X-ray controls shall be locked to prevent unintentional energizing of the unit.

4. All doors shall be kept closed when X-ray equipment is in use.

5. All X-ray equipment shall be checked before each use to ensure that secondary radiation cones and filters are in place.

6. Film badges will be worn by all personnel. (See policy titled "Radiation Safety Film Badges")

7. Lead aprons, gloves, and eye protection shall be worn by all personnel working in the direct field or where scatter radiation levels are high.

8. Personnel shall (wear proper eye protection to prevent exposure when using or repairing UV and infrared instruments or equipment)?
    a. Protective aprons shall be worn in the fluoroscopic room by the operating staff.
    b. The operator of a Mobile unit shall stand at least six feet from the patient and well away from the useful beam. The operator shall wear a protective apron.
    c. No radiologic technologist may operate a fluoroscope for diagnostic purposes unless licensed by the state of California, Department of Health Services.

Emergency Exposure Situations and Radiation Accident Dosimetry

1. The Radiology Department is committed to maintaining a safe and healthy environment for all patients, visitors, and employees.

2. All Radiology Department employees are required to participate in safety training sessions annually. These sessions will include:
    - Fire Safety and Proper Use of Fire Extinguishers

- Infection Control
- Disaster Response
- Electrical Safety
- Radiation Safety

3. All new employees will receive required safety training sessions during their orientation period and before they perform duties independently.

4. All safety training must be documented. Attendance records and post-test documentation will be maintained.

5. The Director of Radiology is responsible for coordinating the unit's safety program.

Other Safety Precautions/Actions

1. A visual inspection to check all external wiring to and from all components of the X-ray units shall be made daily by the technologist assigned to that room. The technologist will also do a minimal check of all moveable parts.

2. A visual check will also be made of all other equipment in the room, such as suction, blood pressure cuff, etc.

3. Any unsafe items or conditions must be reported to the director of the department. Steps to correct the condition must be instituted as soon as possible.

4. Special attention should be paid to the hazards associated with wet floors and blocked exits, slipping and tripping hazards, and other unsafe conditions.

5. Every employee of radiology should be familiar with the evacuation plans for their area.

6. It is the responsibility of all employees to know and adhere to the safety policies of the hospital.

7. All incidents and accidents involving patients, visitors, and/or employees, must be recorded as soon as possible on the Incident Form. All Incident Reports are given to the department director.
    a. Routes of exposure
    b. PPE to use

Safety

The Radiation Safety Program operates under the ALARA philosophy - As Low as Reasonably Achievable. All radiation workers shall be dedicated to the ALARA goal and be continually working toward reducing exposure to the patient, visitors, and other employees.

1. All personnel working in restricted areas are monitored by film badges. If the film badge readings are above ALARA action levels, an investigation is initiated by the Radiation Safety Officer to determine the cause of the exposure and a means to reduce future exposures.

2. When protective clothing or devices are worn on portions of the body and a personnel monitoring device is required, at least one such device shall be used as follows:
    a. When an apron is worn, the monitoring device shall be worn at the collar outside the apron.

3. The dose to the whole body based on the maximum dose attributed to the most critical organ shall be recorded. If more than one device is used and a record is made of the data, each dose shall be identified with the area where the device was worn.

4. Exposure of a personnel monitoring device to deceptively indicate a dose delivered to an individual is prohibited.

5. In addition, periodic checks are made by the manager to note if lead gloves, aprons, ands protective shielding for patients are being used.

6. All questions relating to radiation exposure shall be referred to the Radiation Safety Officer and/or a board certified radiation physicist.

7. A Radiation Safety Committee shall exist and shall meet quarterly to review past performance and to recommend to the Medical Director changes as proposed or recommended by National Council of Radiation Protection (NCRP) and other regulatory agencies. The Safety Committee shall follow all appropriate licensing agencies and government body rules, when applicable. The committee shall recommend guidelines for protecting personnel and patients from radiation and shall review personnel exposure to radiation.
    a. Members of the Radiation Safety Committee shall include but not be limited to:
        - Chair (Radiation Safety Officer)
        - Director Medical Imaging
        - Quality Safety Coordinator, Radiology Department
        - Operating Room RN

Steps Taken to Minimize Patient and Employee Exposure

1. Patients will not be exposed to the useful beam except for healing arts purposes and unless such exposure has been authorized by a licensed practitioner. The provision also prohibits deliberate exposure for the purpose of training and demonstration.

2. Only the medical and ancillary personnel required to perform the procedure (or in training for the procedure) shall be in the room during the radiological procedure. All personnel will be protected so that the useful beam will strike no part of their bodies unless protected by at least 0.5-mm lead equivalent shields.

3. All persons in the examination room will be protected from scattered radiation by protective aprons or whole body protective barriers of not less than 0.25-mm lead equivalent.

4. Procedures and auxiliary equipment designed to minimize patient and personnel exposure shall be used. Such procedures and equipment shall include, but not be limited to the following:
    a. The exposure to the patient shall be the minimum exposure required to produce images of good diagnostic quality.
    b. Portable equipment shall be used only for examinations where it is impractical to bring the patient to radiology.
    c. X-ray systems shall not be used in procedures where the source to patient distance is less than 30cm.

Collimation

1. Strict collimation to the part being examined shall be required.

2. All radiation fields shall be collimated to the area of the patient being examined or the size of the image receptor. Under no circumstances shall the radiation field be larger than the image receptor.

Record Keeping and Reporting

1. A copy of the monthly dosimeter exposure report will be posted for all to inspect and (initial their individual report) signed off by Radiation Safety Officer (RSO).

2. Personnel dosimeters will not be worn when medical radiation procedures are being performed on the wearer.

3. All Surgical Services RN's and CST's will participate in the dosimetry (film badge) program.

4. All personnel are to follow procedural guidelines for radiation safety in the operating room.

5. Any Surgical Services employee who becomes pregnant, will follow procedural guidelines to limit the total radiation dose to the fetus, with an exposure limited to 500 mrem during the period of that pregnancy.

EQUIPMENT

- Personal Film Badge (Dosimeter)
- Lead Aprons
- Screens

PROCEDURE

1. All personnel will wear a film badge whenever X-ray/fluoroscopy is used for patient procedures or while caring for patients who have received radioactive materials in therapeutic amounts.
    a. Provide the supervisor with the following information necessary to participate in the dosimetry program:
        i. Birth Date
        ii. Social Security Number
    b. On a monthly basis, obtain new film badge and return exposed film badge to the Radiology Supervisor
    c. Film badges are to be worn outside of any protective wear.
    d. Badges are to be kept in a safe, non-radiation area when not in use.
    e. Badges will be read monthly by a radiation detection company and reviewed by a designee of the hospital radiation detection company. Individual personnel reports are available in the Surgical Services Nurse Manager's office for review.
    f. The Radiation Safety Officer will contact individuals who receive radiation dose in excess of the program limits. Established dose levels are:
        i. 200 mrem to whole body in any month
        ii. 400 mrem to whole body in any calendar quarter
        iii. 1000 mrem to whole body in any year

Procedure for the use of Portable X-ray in the Operating Room

a. Put X-ray cassette holder on operating room table as necessary
b. All Surgical Services personnel will wear lead aprons for any planned X-ray exposure done during the surgical procedure.
c. If unavoidable, Circulating Nurse may leave room momentarily, while X-rays are being taken.

d. All sterile personnel in the room will stand behind mobile lead shield, while X-rays are being taken.
e. Personnel will stand at least six (6) feet away from X-ray source, when possible.

The following guidelines are for use by pregnant personnel working in the Surgical Services Department:

a. Female employees must report their confirmed pregnancy as soon as possible to the supervisor.
b. The supervisor will notify the Radiation Safety Officer in writing.
c. If possible, the supervisor will adjust or revise the workload of the employee, to reduce the expected radiation dose to her abdomen to below 500 mrem during the entire term of pregnancy. If this is not possible, the employee will be placed on leave.
d. An additional badge will be ordered by the supervisor and will be worn by the pregnant employee at the waist and under any protective apparel.
e. The pregnant employee will be directed the Radiation Safety Officer to receive a copy of the Appendix of United states Nuclear Regulatory Commission Guide, Number 8.13 "Possible Health Risk to Children of Women Who Are Exposed to Radiation During Pregnancy" (Form 307), and to ask any questions she may have.
f. At the conclusion of the pregnancy, the supervisor will inform the Radiation Safety Officer.
g. A review of monthly film badge readings will be performed by the designee of the Radiation Safety Officer to verify that the 500 mrem limit will not be exceeded during the pregnancy.

2. On a yearly basis all lead protective gear, aprons, lead gloves, thyroid shields, and gonadal shields must be inspected.

3. All lead gear will be numbered and a log kept of all the lead protective gear and the date inspected.

4. Each piece of leaded gear will be brought into a fluoroscopic room and fluoroscope to look for cracks and pinholes in the lead.

5. If the piece of lead gear exhibits any cracks or holes, that piece must be sent out for repair or discarded. A notation will be made in the log book describing the problem and the disposition of the item.

6. The log book will be made available for inspections.

Reports to Individuals

The Medical Director shall be responsible for:

1. Establishing an effective working relationship with the Medical Staff through the Chairman of the Department of Medicine. This includes interaction with referring physicians relative to the interpretation of radiographs and consultation on specific findings. This may occur in person or over the telephone.

2. Be accountable to the Chair of the Department of Medicine for effective operations of the service.

3. Coordinate, along with the Manager of the service, the integration of the services provided into other appropriate functions of the Hospital District.

4. Develop and implement policies and procedures that guide and support the provision of services.

5. Monitor all clinically related activities of the service. This includes the hospital wide performance improvement program, as well as quality control programs within the service.

6. Review the qualifications and competency of employees performing services.

7. Act as **Radiation Safety Officer** for the facility. This includes inspection and verification of film badge readings, film quality, and radiation safety concerns and/or in-service.

8. Participate in determining equipment and space needs for the service, including recommendations to administration for the appropriate budget to meet those needs.

9. Assess and recommend to the Medical Staff and administration, relevant off-site sources for patient care not provided by the District.

10. Determine appropriate orientation and continuing education programs for hospital employees.

11. Participate in annual assessment of the service and set goals for improvement of the service.

Quality Assurance Programs
The following are the quality control steps performed:

1. Lead Apron Check
   Each lead apron, glove, and/or shield will be checked for possible cracks on an annual basis. This is done by taking each lead shield item and placing under a fluoroscope and the image viewed by the technologist. The entire device will be checked for holes, cracks, etc., and the results recorded on the special form. Any defective units will be brought to the attention of the department manager for disposition.

2. Digital and X-ray Cassette Cleaning
   Digital and Xray film cassettes will be cleaned a minimum of every six (6) months. Each cassette is numbered. A record of the date of cleaning is posted on the back of each cassette.

   The cleaning supplies will consist of 4 x 4 gauze and special X-ray cassette cleaning fluid. The unexposed film will be removed from the cassette and placed in the film bin. Cassette will be opened and lightly wiped with lightly moistened 4 x 4 gauze to remove any dirt. A follow-up wipe with a dry 4 x 4 is required. The cassette is allowed to dry for a few minutes and the film replaced. The date of cleaning should now be recorded on the posted sticker on the back of the cassette.

3. Quality Assurance Checks
   On a weekly basis, the accuracy of the KV/MA for all fluoroscopy equipment will be checked. The equipment to be checked is:
   a. Toshiba (Room #4)
   b. G.E. C-Arm 9900
   c. Lorad Selenia (Digital Mammography equipment)

   This test will be performed by using the four Lucite Phantoms centered under the fluoroscopy beam and exposed. This will be for Rooms #1 and #2. The "C-Arm" will use two layers of Lucite Phantoms. Readings will be made off each unit and recorded in the proper place in each record book.

   Note: These books are kept in the Imaging Department
   Imaging Department will maintain certain on-going quality control checks and measures. Among these checks will be the following:

Test	Interval Between Tests
1. Fluoroscopic MA Check	Weekly
2. Film Retake Analysis	Monthly
3. Lead aprons, gloves, and shields	Annually
4. CT Quality Control	Daily

DOCUMENTATION

Documented records will be maintained on the above Quality Control Program.

Internal Audit Procedures

1. Personnel film badges will be provided to all radiation workers (e.g. radiologists, radiology technologists and various personnel involved with frequent fluoroscopy procedures (e.g. speech therapists, surgery nurses). The film badges will be worn at all times while doing procedures.

2. The body badges will be worn at the waist or on the collar except when lead aprons are worn. When wearing a lead apron the badge will be worn on the collar outside the apron. When two badges are worn, one badge should be worn on the inside of the lead apron at the waist. The second will be worn outside the lead apron on the collar.

3. Film badges will be distributed each month and prior months badges will be returned at the same time. The exposed film badge will be mailed to the company in the envelope provided.

4. The maximum annual total effective dose equivalent (TEDE) is 5rem as set by state and federal regulatory agencies. An investigation will be made for all film badge exposures exceeding 400-millirem in a monthly period. The investigation will be initiated by the Radiation Safety Officer and will require a statement from the individual and their manager. Any action will be dependent upon circumstances and the severity of the exposure.

5. A copy of the monthly dosimeter exposure report will be posted for all to inspect and (initial their individual report) signed off by the Radiation Safety Officer (RSO).

6. Personnel dosimeters will not be worn when medical radiation procedures are being performed on the wearer.

7. A certified radiation physicist will inspect the entire department each year. The inspection will include all X-ray producing equipment, equipment, all radiation protective devices, and policy and procedure manuals for recommendations of any possible additions or changes.

8. In addition, periodic checks are made by the manager to note if lead gloves, aprons, and protective shielding for patients are being used.

9. All questions relating to radiation exposure shall be referred to the Radiation Safety Officer and/or a board radiation physicist.

REFERENCES

State of California, Department of Health, Radiologic Health Branch, P.O. Box 997414, Sacramento, CA 95899-7414

OAK VALLEY HOSPITAL DISTRICT
Respiratory Therapy Manual

Policy/Procedure:			
PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) INSERTION			
Effective Date: NEW POLICY	**Page 1 of 3**		
Areas Affected: All Divisions and Departments of the Hospital District			
Composed by: RT Manager			
❒ Reviewed ❒ Revised by:			
Dept / Committee Approval:	**Dept/Title:**	**Date**	**Approved**
Policy, Procedures, Forms Comm.	VP Nursing	05/06/2026	X
Department of Medicine	Medical Staff Coord	05/12/2026	
Medical Executive Committee	Medical Staff Coord	05/19/2026	
District Board	Board Liaison	06/04/2026	
Revised:	**Reviewed**:	**Next Review Date**:	

PURPOSE

Procedure for Placement of Peripherally Inserted Central Catheter (PICC).

Note: The procedure specific to the manufacturer's guidelines must be followed. Some PICC lines may have slight deviations from this procedure, depending on the style and type of catheter.

1. RCP trained in PICC insertion (Designated Vascular Access Team)
2. Observe standard precautions
3. Use sterile technique

EQUIPMENT

- 1–5 Pair sterile gloves
- 1 sterile gown
- 1 large sterile drape
- 6 sterile 4x4 gauze
- 1 hair cover
- 1 chloraprep sponge
- 3 alcohol swab sticks
- 1 transparent dressing
- 2–3 10 ml syringes of Normal Saline
- 1–3 needleless connectors
- 1 tourniquet

PICC tray with:

- Dilator/introducer set
- Micro puncture needle
- Guidewire 0.018"

Additional:

- 1 tourniquet
- 1 tape measure
- 1 eye protection/face mask
- 1 scalpel – size 11
- 1 sterile tape measure
- 1 vial 1% Lidocaine
- 1 20–21 gauge needle
- Ultrasound machine and sterile probe cover with sterile gel

PROCEDURE

1. Verify Physician's orders for placement of PICC line.
2. Facilitate patient's consent on the PICC Line Consent Form, which explains:
   A. The Patient's Healthcare Provider (Physician) has discussed the risks, benefits, and any alternatives with the patient, and determined that the patient would benefit from a special intravenous line inserted by a Respiratory Therapist
   B. The Patient had questions answered by his/her Healthcare Provider (Physician)
   C. Patient Education document was given to the patient
   D. Ensure patient has been educated regarding the intended procedure
3. Ascertain patient's allergies, INR, GFR (if GFR is low verify with physician the need for a PICC)
4. Gather all necessary equipment. It is recommended to use a standardized checklist to assure that sterility is maintained.
5. To determine approximate length the PICC will need to be inserted, measure from planned venipuncture site to clavicle to the xiphoid process.
6. Place patient in supine position with selected arm at 90-degree angle to the trunk, if possible. Wash hands.
7. Place 3CG cardiac leads on patient's chest, attach fin to 3CG Sherlock sensor, place on patient's chest under neck area.
8. Clean arm with chlorhexidine wipes unless contraindicated. Place a sterile, poly-lined drape under the patient's arm.
9. Tape the patient's arm in procedural position, if indicated.
10. May apply tourniquet to selected arm at this time.
11. Open the PICC tray on a clean, dry surface. Don surgical cap, face mask and eye protection. You may prefer to use sterile gloves of a different size than those in the kit.
12. Apply ultrasound gel to probe, in preparation of the probe cover.
13. If you haven't done so, apply tourniquet at this time and discard outer gloves. Place a full body sterile drape(s) over the patient to ensure sterility throughout procedure.
14. Open all supplies in a sterile field. Prep the insertion site at least 3 inches above and below the intended insertion site, and from one side of the sterile drape to the other in a sterile manner.
15. Scrub the site for 2 minutes with 2% chlorhexidine and allow to dry.
    a. a. If 2% chlorhexidine is contraindicated:
        i. Scrub the site with 70% isopropyl alcohol, allow drying. Follow with a three-minute scrub with Betadine 1–2% solution.
16. Don sterile gown and sterile gloves using the closed gloving method. Some practitioners will wish to double glove at this time.
17. Prepare supplies, fill syringes with solutions, apply sterile cover to ultrasound probe, and flush PICC with normal saline.
18. Locate vein with ultrasound.

19. Unless contraindicated, anesthetize the insertion site with 1% Lidocaine.
20. Perform vein puncture into chosen vein at chosen site.
21. Slowly insert the introducer needle using the standard technique.
22. Observe for blood return into the flashback chamber.
23. Observe the pattern of blood flow to ensure venous access, and not arterial. Any pulsating pattern would indicate arterial catheterization.
24. Feed guidewire through the introducer needle, removing BOTH the guidewire and introducer needle if obstruction is encountered.
25. If able to feed guidewire smoothly through introducer needle, remove the needle from the introducer, leaving the wire in place.
26. Release the tourniquet through the sterile drape without compromising the sterile field.
27. Thread peel-away dilator over the wire. A skin nick with the scalpel may be required, after further numbing with xylocaine.
28. Remove inner cannula of peel-away dilator, covering exit site with thumb to minimize bleeding.
29. Carefully insert the PICC until desired measurement is met. Slowly withdraw dilator from the vein, peeling away dilator while feeding PICC gently back into vein.
30. Ascertain positive blood return, and flush with Normal Saline.
31. Secure with Stat lock type device. Apply dressing to site. (Per "Central Line Care" Policy)
32. Practitioner may wish to leave stylet in place until x-rays are complete. If not, remove stylet at this time.
    a. Verify position of catheter per X-Ray, unless using equipment designed to eliminate need for post-insertion x-rays. Using 3CG technology to identify SA node at the cavo-atrial junction. In cases where the patient is in atrial fibrillation, atrial flutter, or a cardiac rhythm without P-WAVE, you must obtain a chest X-ray. Optimal position of PICC tip is in the distal SVC, close to the right atrium. Review X-Ray, consult with Radiologist, and reposition catheter if necessary – reapply sterile dressing.
33. Document all procedures in the patient's medical record.
34. Complete "Central Line Insertion Form" (CLIP)
35. Change PICC dressing per "CLABSI Prevention-Central Venous Catheter Management" Policy

REFERENCES

Lippincott Procedures. Peripherally Inserted Central Catheter (PICC) Insertion and Care. Wolters Kluwer/Lippincott Williams & Wilkins. Accessed May 8, 2026. Available at: *procedures.lww.com*

OAK VALLEY HOSPITAL DISTRICT
MEDICAL STAFF OFFICERS BALLOT
June 2026 – December 2027 Vice COS

Term of Office – June 2026, through December 2027
In accordance with the medical staff bylaws, the Vice Chief of Staff shall accede to the position of Chief of Staff upon the Chief of Staff's completion of his or her term (page 17, 7.2-1)

Chief of Staff: Matthew Tilstra, M.D.

NUMBER OF BALLOTS SENT OUT: 55

NUMBER RETURNED: 20

OFFICER NOMINEES:

Vice Chief of Staff:

Andrew Huber, MD	**9**
(other)	**0**