

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Enclosure 5 NYSDOH AIIR Survey

New York State Department of Health

AIRBORNE INFECTION ISOLATION ROOM SURVEY

As part of our bioterrorism preparedness effort, the New York State Department of Health is requesting your assistance in documenting the current airborne infection isolation room (AIIR) capacity in your health care facility. A critical element of emergency preparedness is ensuring the ability to isolate patients with conditions that may be transmitted via airborne droplet nuclei. The health and safety of patients, visitors and staff will depend upon early recognition, prompt isolation and appropriate treatment of suspect and confirmed cases. The results of this survey will enable the Department to assess current AIIR capacity, identify gaps in the health care facility infrastructure and develop strategies to enhance public health and safety in the event of an emergency.

The enclosed survey is to be completed by Plant Management/Engineering staff in consultation with Infection Control and Hospital Epidemiology. It is crucial that the answers be as accurate as possible. The information is then to be submitted electronically via the NYSDOH Health Provider Network (HPN), a secure Internet site.

In order to expedite this process, your hospital's NYPORTS coordinator has been given access to the survey on the HPN. Links to the electronic survey and instructions for data entry are found in the News Bulletins section of the HPN Home Page - located at the following secure Internet address:

<https://commerce.health.state.ny.us/hpn>

Please submit the completed survey data to the Department electronically by Thursday, **December 12, 2002**. Should you have any questions regarding this electronic process or in the identification of the NYPORTS coordinator for your facility, please contact John Kushner at (518) 473-1809. Should you have any questions specifically regarding the survey questions, please contact Rachel Stricof at (518) 474-7000. Thank you for your prompt attention to this important matter.

Emergency Department – General Ventilation

1) Do any air handling systems in the emergency department also serve other areas?

Yes ___ No ___

If yes, list the other area(s): _____

2) Is air that is removed from the emergency department by the air handling system(s) recirculated to other areas?

Yes ___ No ___

If yes, list the other area(s): _____

If yes, do the air handling system(s) contain HEPA filters or germicidal UV radiation to treat the air prior to recirculation?

HEPA filtration?	Yes ___	No ___
germicidal UV?	Yes ___	No ___

3) Does the emergency department have inward airflow (i.e. negative pressure) relative to all other adjacent indoor areas?

Yes ___ No ___ Don't Know ___

If there is only *inward* airflow to the ED, how has airflow direction been documented? (check all that apply)

Balance reports ___
Smoke testing ___
Other, please specify _____

If there is any *outward* airflow from the ED, list the other area(s) potentially affected:

If there is any *outward* airflow, is the hospital planning modifications to establish inward airflow (i.e. negative pressure) from all adjacent areas?

Yes ___ No ___ Not applicable ___

If yes, anticipated date of completion: _____

Patient Cohorting

- 4) Is there an area of the hospital that can be used or quickly converted to be used for cohorting patients with a potential airborne transmissible disease? (for example: a ward or building with a dedicated air handling system)

Yes ___ No ___

If yes, specify the area(s), type of unit (e.g. med/surg, ICU), maximum patient capacity, and whether modification to the air handling or other building systems would be needed:

<u>Area</u>	<u>Type</u>	<u>Max. Pt. Capacity</u>	<u>Modification Needed? (describe)</u>
_____	_____	_____	_____
_____	_____	_____	_____

- 5) Is the facility planning to modify or create an area that can be used to cohort patients with potential airborne transmissible diseases?

Yes ___ No ___

If yes, anticipated date of completion: _____

If yes:

<u>Area</u>	<u>Type</u>	<u>Max. Pt. Capacity</u>	<u>Modification Needed? (describe)</u>
_____	_____	_____	_____
_____	_____	_____	_____

Airborne Infection Isolation Rooms

Please complete the attached line list describing all existing Airborne Infection Isolation Rooms throughout the facility (emergency department, inpatient and outpatient settings).

- 6) Is the facility planning to create additional airborne infection isolation rooms in the emergency department?

Yes ___ No ___

If yes, number of rooms _____ Anticipated date of completion: _____

- 7) Is the facility planning to create additional airborne infection isolation rooms in the inpatient facility?

Yes ___ No ___

If yes, number of rooms _____ Anticipated date of completion: _____

Name of Person Completing Form (print) Title

Signature Date Phone Number