

# C. Airborne Infection Isolation Room Pressure Monitor Checklist

## AIRBORNE INFECTION ISOLATION ROOM PRESSURE MONITOR CHECKLIST

ROOM NAME AND NUMBER \_\_\_\_\_

MONITOR MANUFACTURER AND MODEL NUMBER \_\_\_\_\_

This form should be completed annually and updated monthly for each room pressure monitor. Negative pressure should be verified monthly\* to validate the monitor. A copy of the completed form should be kept in the Policies and Procedures binder for the department.

MONITOR SETTINGS	
Normal pressure reading (monitor reading with door closed)	_____ " water gauge
Alarm will sound if pressure differential drops to	_____ " water gauge
Time delay	_____ seconds
Remote alarm location(s)	_____

ANNUAL MONITOR CHECKS		
TASK	DATE COMPLETED	SIGNED OFF BY
Monitor calibrated in accordance with manufacturer's requirements		
Confirmed negative pressure using smoke tube testing ( <b>this test should be repeated monthly* and signed below to confirm</b> )		
Verified alarm operation (by holding door open or blocking off exhaust grille)		
Alarm sounded after _____ seconds		
Pressure reading at alarm _____ " water gauge		
Monitor use and functions demonstrated to all floor staff		

MONTHLY* NEGATIVE PRESSURE CHECK		
Initials _____ Month/Year_____	Initials _____ Month/Year_____	Initials _____ Month/Year_____
Initials _____ Month/Year_____	Initials _____ Month/Year_____	Initials _____ Month/Year_____
Initials _____ Month/Year_____	Initials _____ Month/Year_____	Initials _____ Month/Year_____
Initials _____ Month/Year_____	Initials _____ Month/Year_____	Initials _____ Month/Year_____

\*Daily when in use for suspected or known pulmonary or laryngeal TB