Background: The purpose of isolation is to reduce transmission of infectious microorganisms from recognized and unrecognized sources in the hospital. Review of isolation procedures in our perioperative areas indicated confusing policies and inconsistent implementation. Our operating room provides over 50,000 procedures annually and reduction in infections is an important safety concern. Our evidence-based practice team decided to review policy and processes.

Objectives: The objective was to reduce the “Isolation Patient’s Footprint”. Using quality-improvement methodology, we analyzed policies and processes; reviewed literature and benchmarked against other organizations. We found staff did not understand policies, personal protective equipment (PPE) was often unavailable and information regarding multi-drug resistant organisms was frequently incorrect.

Process Improvement: Our interprofessional team established and implemented guidelines, including: universal preoperative MRSA screening with decolonization strategies; hand hygiene, contact precautions and availability of PPE. We developed new flow processes for patients in isolation and formalized environmental cleaning policies. We provided extensive education for physicians and staff regarding new processes.

Successful Practice: To assure effective implementation, we empowered staff to address non-compliance with the Isolation Policy and Hand Hygiene Policy; identified “isolation experts” in each perioperative area; and implemented compliance audits that are reviewed monthly.

Implications: Our shared-governance evidence-based council identified the need for practice changes and implemented a comprehensive strategy to improve care. We used a quality improvement methodology to reduce the “Isolation Patient’s Footprint”, leading to better infection control and satisfaction of staff. Through this process we learned valuable tools that we will continue to utilize for future issues.