



Isolation: Observation of Area Exterior to Contact Isolation Rooms

Instructions: Observe areas outside of isolation rooms. Observe each practice and record the observation. In the column on the right, sum (across) the total number of “Yes” and the total number of observations (“Yes” + “No”). Sum all categories (down) for overall performance. Disregard not applicable categories. For example, cover gowns should be outside contact precautions rooms, but may not be required outside a room with airborne isolation precautions only.

Isolation room: Observation Categories		Room 1	Room 2	Room 3	Summary of Observations	
					Yes	Total “Yes” & “No”
1	Is an isolation sign at the patient’s door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2	Are gloves available outside of each patient room or treatment area?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
3	Are cover gowns available near each patient room or treatment area?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4	Is other PPE for standard precautions (e.g., eye protection, face masks) available near each patient room or treatment area?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
5	Are surgical face masks or face shields or N95 respirators available near patient room?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
6	Is dedicated patient equipment, such as stethoscopes or blood pressure cuffs, available?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
TOTAL (Do not include N/A in totals)						



Date: _____

Observer Role: Nurse Tech Other _____ Initials: _____

Location/Unit: _____

Notes and comments: