

HAND HYGIENE MONITORING TOOL

Unit: _____

Date: _____

Day of week (circle) M Tu W Th F Sa Su

Time started _____ am pm (circle) Time finished _____ am pm (circle)

Name of Observer _____

Profession (circle one)	Did the employee wash hands or use Alcohol gel/foam			
	Entering room		Exiting room	
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No
MD ES RN RT PT NA Other (name) _____	Yes	No	Yes	No



IMPROVING QUALITY
.....
REDUCING INFECTION

