Hand Hygiene Audit Tool

**UNIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Auditor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1 2 3 4 5**

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| --- | --- | --- | --- | --- | --- |
| **Date and Time of Audit:** |  |  |  |  |  |
| **Discipline: (Tech, RN, MD, etc.)** |  |  |  |  |  |
| **Name of Person Audited:** (If nameunknown, insert “**U**” for unknown) |  |  |  |  |  |
| **HH Before Patient Contact?** |  |  |  |  |  |
| **HH After Patient Contact?** |  |  |  |  |  |
| **Were Gloves Worn?** |  |  |  |  |  |

**6 7 8 9 10**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date and Time of Audit:** |  |  |  |  |  |
| **Discipline:** |  |  |  |  |  |
| **Name of Person Audited:** (If nameunknown, insert “**U**” for unknown) |  |  |  |  |  |
| **HH Before Patient Contact?** |  |  |  |  |  |
| **HH After Patient Contact?** |  |  |  |  |  |
| **Were Gloves Worn?** |  |  |  |  |  |

Respond **Y** (for *Yes*, hand hygiene performed) or **N** (for *No*, hand hygiene not performed).

**Manager Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_