

Hand hygiene observation – Data Collection Form

Organisation: _____

Depart./Ward: _____

Date: ____ / ____ / ____

Auditor: _____

Start Time: _____ Finish Time: _____

Session no: _____

Five Moments for Hand Hygiene

1. Before touching a patient
2. Before a procedure
3. After a procedure or body fluid exposure risk
4. After touching a patient
5. After touching a patient's surroundings

Notes: _____

HCW	Moment	Action	Gloves	HCW	Moment	Action	Gloves	HCW	Moment	Action	Gloves
	<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on
	<input type="radio"/> 2				<input type="radio"/> 2				<input type="radio"/> 2		
	<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off
	<input type="checkbox"/> 4				<input type="checkbox"/> 4				<input type="checkbox"/> 4		
	<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.
	<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on
	<input type="radio"/> 2				<input type="radio"/> 2				<input type="radio"/> 2		
	<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off
	<input type="checkbox"/> 4				<input type="checkbox"/> 4				<input type="checkbox"/> 4		
	<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.
	<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on
	<input type="radio"/> 2				<input type="radio"/> 2				<input type="radio"/> 2		
	<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off
	<input type="checkbox"/> 4				<input type="checkbox"/> 4				<input type="checkbox"/> 4		
	<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.
	<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on
	<input type="radio"/> 2				<input type="radio"/> 2				<input type="radio"/> 2		
	<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off
	<input type="checkbox"/> 4				<input type="checkbox"/> 4				<input type="checkbox"/> 4		
	<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.
	<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on
	<input type="radio"/> 2				<input type="radio"/> 2				<input type="radio"/> 2		
	<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off
	<input type="checkbox"/> 4				<input type="checkbox"/> 4				<input type="checkbox"/> 4		
	<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.
	<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on		<input type="radio"/> 1	rub	on
	<input type="radio"/> 2				<input type="radio"/> 2				<input type="radio"/> 2		
	<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off		<input type="checkbox"/> 3	wash	off
	<input type="checkbox"/> 4				<input type="checkbox"/> 4				<input type="checkbox"/> 4		
	<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.		<input type="checkbox"/> 5	missed	cont.

Total Correct Moments: _____

Total Moments: _____