

## HAND HYGIENE Compliance Rate Request Form

This form is used to request hand hygiene self assessment and patient satisfaction survey results.

All components are required – Incomplete forms will be returned to the requestor, at the e-mail provided.

|   |                             |
|---|-----------------------------|
| <b>Requestor's Name:</b>  | <b>Requestor's Manager:</b> |
| <b>Requestor's IH E-mail:</b>   | <b>Request Date:</b>        |
| <b>Reason for Report:</b> (Please specify any comparisons or trend analysis needed in the report) |                             |
|   |                             |

## REPORT CONTENT AND SCOPE

|  |                 |
|--|-----------------|
| <b>IH Facility: (At least one is required)</b> | <b>Unit(s):</b> |
|  |                 |
|  |                 |
|  |                 |
|  |                 |
|  |                 |

|                                    |                                    |   |  |
|------------------------------------|------------------------------------|---|--|
| <b>Report Start:</b>               | <b>Report End:</b>                 | <b>Report By:</b><br><i>Select all that apply</i> | <b>Report Health-Care Worker Group(s):</b><br><i>Select all that apply</i> |
| Fiscal Year _____                  | Fiscal Year _____                  | <input type="checkbox"/> By Quarter               | <input type="checkbox"/> Nursing   |
| <input type="checkbox"/> Quarter 1 | <input type="checkbox"/> Quarter 1 | <input type="checkbox"/> By Fiscal Year           | <input type="checkbox"/> Physician   |
| <input type="checkbox"/> Quarter 2 | <input type="checkbox"/> Quarter 2 |   | <input type="checkbox"/> Clinical Support Staff                            |
| <input type="checkbox"/> Quarter 3 | <input type="checkbox"/> Quarter 3 |   | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Quarter 4 | <input type="checkbox"/> Quarter 4 |   | <input type="checkbox"/> All (Combined)                                    |

Please direct any questions or comments concerning this form to [IPAC@interiorhealth.ca](mailto:IPAC@interiorhealth.ca)