



Instructions: Observe patient care areas or areas outside of patient rooms. For each category, 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.

Standard Precautions: Observation Categories		Room 1	Room 2	Room 3	Room 4	Room 5	Summary of Observations	
							Yes	Total Observed
1	Are functioning sinks readily accessible in the patient care 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2	Are all handwashing supplies, such as soap and paper towels, 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3	Is the sink area clean and dry?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Are any clean patient care supplies on the counter within a splash-zone of the sink?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5	Are signs promoting hand hygiene displayed in the 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6	Are alcohol dispensers readily accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7	Are alcohol dispensers filled and working properly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 YES and TOTAL OBSERVED								



Standard Precautions: Observation of Hand Hygiene Provision of Supplies

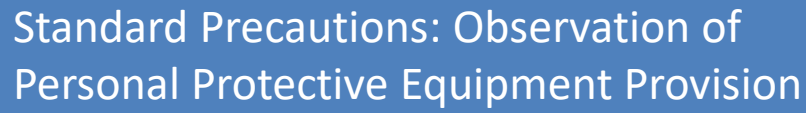
AMB-1

Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Instructions: Observe patient care areas or areas outside of patient rooms. For each category, 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.

Standard Precautions: Observation Categories		Room 1	Room 2	Room 3	Room 4	Room 5	Summary of Observations	
							Yes	Total Observed
1	Are gloves readily available outside each patient room or any point of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 cover gowns readily available near each patient room or point of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3	Is eye protection (face shields or goggles) readily available near each patient room or point of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Are face masks readily available near each patient room or point of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5	Are alcohol dispensers readily accessible and functioning?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 YES and TOTAL OBSERVED								



Standard Precautions: Observation of Personal Protective Equipment Provision

AMB-2

Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Isolation: Observation of Area Exterior to Contact Isolation Rooms

AMB-3

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)						



Isolation: Observation of Area Exterior to Isolation Rooms

AMB-3

Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Isolation: Observation of Area Exterior to Airborne Infection Isolation Rooms

AMB-4

Instructions: If there are any patients requiring Airborne Infection Isolation on unit, observe area outside of each isolation room. 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.

Isolation room: Observation Categories		Room 1	Room 2	Room 3	Summary of Observations	
					Yes	Total Observed
1	Is an Airborne Infection 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	Is the door to the room closed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3	Does a manometer or other measurement mechanism indicate negative pressure in the room?	<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	Are appropriate respirators, (N-95) in multiple sizes and/or charged, powered air purifying respirators (PAPR), 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		
5	Are respirators stored outside the room or in an anteroom?	<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 YES and TOTAL OBSERVED						



Isolation: Observation of Area Exterior to Airborne Infection Isolation Rooms

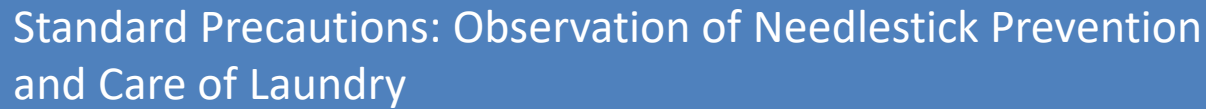
AMB-4

Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Instructions: Observe patient care areas or areas outside of patient rooms. For each category, 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.

Standard Precautions: Observation Categories		Room/ Area 1	Room/ Area 2	Room/ Area 3	Room/ Area 4	Room/ Area 5	Summary of Observations	
		Yes	Total Observed					
1	Are sharps containers 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2	Are sharps containers properly secured and not full?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3	Are sharps containers positioned at 52” to 56” above floor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	Are hampers for soiled laundry labeled or color-coded?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5	Are clean linen supplies spatially separated from soiled areas or waste and covered or contained within a cabinet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 YES and TOTAL OBSERVED								



Standard Precautions: Observation of Needlestick Prevention and Care of Laundry

AMB-5

Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Injection Safety: Observation of Centralized Medication Area

AMB-6

Instructions: Observe medication preparation area. For each category, record the observation. Observe each practice below and answer Yes, No, or N/A. Sum all Yes and No responses. Divide by sum of "Yes"+"No". Disregard not applicable categories.

Medication preparation room: Observation Categories				
1	If multi-dose injectable medications are present, is the medication container maintained in a dedicated medication preparation space?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2	Is the medication preparation area free of opened single dose vials or opened single use containers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3	If open multi-dose vials are present, are they dated and within the Beyond Use Date (BUD) and the manufacturer's expiration period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
4	Medications are prepared in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5	Are splash guards installed at sinks that are located close to medication prep areas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6	Are sinks readily accessible to healthcare providers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7	Are hand washing supplies, such as soap, and paper towels, available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8	Are alcohol dispensers readily available, filled, and functioning properly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
TOTAL (Total YES and No Only)				



Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Cough Courtesy: Waiting Room

AMB-7

Instructions: Observe the ambulatory care point of care testing area. For each category, record the observation. Sum all Yes and No responses. Divide by sum of "Yes" + "No".

Ambulatory Waiting Room: Observation Categories		Summary of Observations	
1	As patients first register for care, is there visible signage instructing them to alert the staff of a respiratory infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Are face masks and tissues readily available for patients and visitors with respiratory or flu-like symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Are hand hygiene supplies readily available to visitors in the waiting room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Are trash receptacles readily available to visitors in the waiting room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TOTAL			



Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Instructions: Observe vaccine storage area. For each category, record the observation. Sum all Yes and No responses. Divide by sum of "Yes" + "No".

Vaccine Storage Area: Observation Categories		Summary of Observations	
1	Are vaccine storage refrigerator and freezer temperatures within the appropriate ranges (Refrigerator: 2° C to 8° C; 36° F to 46° Freezer: -50° C to -15° C; -58° F to +5° F)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Are vaccine storage refrigerator and freezer temperatures recorded twice daily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Are safeguards, such as self-closing hinges and door alarms, in place to ensure that the refrigerator/freezer doors remain closed.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Are refrigerator/freezer door gaskets clean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	Are vaccines stored in the center of the refrigerator and freezer spaces, in the original packaging, and inside designated storage trays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6	Are drinks and food absent from the refrigerator/freezer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TOTAL			



Environment of Care: Vaccine Storage Areas

AMB-8

Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments:



Injection Safety: Point of Care Testing

AMB-9

Instructions: Observe the ambulatory care point of care testing area. For each category, record the observation. Sum all Yes and No responses. Divide by sum of "Yes" + "No".

Patient Care Area: Observation Categories		Summary of Observations		
1	Are sharps containers properly secured and not full?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2	Are sharps containers available at the point of use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3	Are cleaning and disinfection supplies for examination tables and test surfaces readily available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4	Is a new single-use auto-disabling lancing device used for each patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
5	Are all point of care testing devices being disinfected after each use with an EPA-registered product that is consistent with manufacturer instructions for use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6	Is the required personal protective equipment for disinfectant use readily available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
TOTAL				



Injection Safety: Point of Care Testing

AMB-9

Date: _____

Observer Role: ☐ Nurse ☐ Tech ☐ Other _____ Initials: _____

Location/Unit: _____

Notes and comments: