

3M™ Tegaderm™ Antimicrobial Transparent Dressing and 3M™ Tegaderm™ Antimicrobial I.V. Advanced Securement Dressing

Product Evaluation Form for peripheral IV dressings

Facility Information

Facility: _____ Start Date: _____ End Date: _____
 Evaluator's Initials: _____ Shift: _____ IV team nurse RN Tech Other: _____

Current Protocol

What kind of peripheral IV dressing do you currently use? (please check all that apply)

Transparent dressing Securement device (specify) _____ Other antimicrobial in the adhesive dressing
 Bordered securement dressing Antimicrobial disk Other: _____

Check the 3M dressing you evaluated:

3M™ Tegaderm™ Antimicrobial Transparent Dressing (9124) 3M™ Tegaderm™ Antimicrobial IV Advanced Securement Dressing (9132)

How many evaluation dressings did you apply? None 1-2 3-5 ≥6

How many evaluation dressings did you remove? None 1-2 3-5 ≥6

How many patients did you observe with the evaluation dressing? None 1-2 3-5 ≥6

Evaluation of Dressing

Using the chart below, please rate the performance of the evaluation dressing compared to your current peripheral I.V. dressing:

| Performance Attribute | Much Worse | Worse | Same As | Better | Much Better | N/A or Not Observed |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|
| Ease of application | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Ability to apply dressing one-handed | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Ease of removal | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Ability to visualize insertion site | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Catheter securement | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Dressing adherence throughout expected wear time | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Frequency of unscheduled dressing changes | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Gentle to skin (lack of skin irritation, redness, itching) | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Patient comfort | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |
| Overall performance (based on above attributes) | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> NA |

Comments

What did you like about the evaluation dressing? _____

What concerns, if any, did you have about the evaluation dressing? _____

Did any patients offer any comments or feedback about the evaluation dressing? If so, please describe: _____

Would you recommend the evaluation dressing to replace your current dressing?

Yes No Why or why not: _____

Please submit your completed evaluation form to your evaluation coordinator. Thank you.



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