Date	Date
K-Card PIVIE	K-Card PIVIE
*Identify a patient with an intravenous	*Identify a patient with an intravenous
medication infusing for at least an hour.	medication infusing for at least an hour.
1. Observe TLC assessment for appropriate	1. Observe TLC assessment for appropriate
тоисн	тоисн
• RN physically palpates the PIV site above, below, and	• RN physically palpates the PIV site above, below, and
dependent surfaces where fluid may accumulate (e.g.,	dependent surfaces where fluid may accumulate (e.g.,
palm of hand for top of hand PIV).	palm of hand for top of hand PIV).
2. Observe TLC assessment for appropriate	2. Observe TLC assessment for appropriate
LOOK	LOOK
 RN inspects the site and dependent surfaces of the 	 RN inspects the site and dependent surfaces of the
extremity.	extremity.
3. Observe TLC assessment for appropriate	3. Observe TLC assessment for appropriate
COMPARE	COMPARE
• RN assesses whether the PIV site is the same size as the	• RN assesses whether the PIV site is the same size as the
other extremity.	other extremity.
 4. Observe PIV dressing/securement Securement dressing is dry and intact/occlusive and site 	 4. Observe PIV dressing/securement Securement dressing is dry and intact/occlusive and site
is visible; use of joint stabilization board if indicated (i.e.,	is visible; use of joint stabilization board if indicated (i.e.,
at or near joint, unable to independently hold arm straight).	at or near joint, unable to independently hold arm straight).
5. Verify TLC assessment documentation	5. Verify TLC assessment documentation
• Documentation: "Please show me where the PIV	• Documentation: "Please show me where the PIV
assessment is charted."	assessment is charted."
o Look at 2-hour window for 2 documented PIV	o Look at 2-hour window for 2 documented PIV
assessments within 75 minutes of each other; real time	assessments within 75 minutes of each other; real time
documentation should occur within 2 hours of the physical assessment.	documentation should occur within 2 hours of the physical assessment.
6. Verify knowledge of PIVIE notification and	6. Verify knowledge of PIVIE notification and
assessment process	assessment process
 Interview: "What do you do if you discover a PIVIE?" 	• Interview: "What do you do if you discover a PIVIE?"
o Stop medication(s), leave catheter in place, elevate	o Stop medication(s), leave catheter in place, elevate
extremity, and refer to policy	extremity, and refer to policy
σ Notify Vascular Assess Team/NICU shift leader, and MD	$\sigma~$ Notify Vascular Assess Team/NICU shift leader, and MD
 o Assess and document on PIVIE every 1 hour x2 and then every 4 hours until resolved 	o Assess and document on PIVIE every 1 hour x2 and then
7. Verify patient and family engagement	every 4 hours until resolved 7. Verify patient and family engagement
 Interview patient/family: "Have you received education 	 Interview patient/family: "Have you received education
on the importance of your healthcare team checking the	on the importance of your healthcare team checking the
IV every hour using Touch, Look, Compare?"	IV every hour using Touch, Look, Compare?"
Reliability Criteria - Card is GREEN if:	Reliability Criteria - Card is RED if:
All items are in compliance	 One or more items are non-compliant
Follow-Up:	Follow-Up:
	 Give in the moment coaching and ensure RN addresses non-
• Give in the moment praise for keeping the patient safe.	compliant item(s).
 Insert card into slot with green side showing and document 	Insert card into slot with red side showing and document
compliance and opportunities on K-Card Daily Results form	compliance and opportunities on K-Card Daily Results form