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| **SECTION 1: INFORMATION ABOUT THE REQUEST** |
| **Nature of request** |
| New Document |  | * Modification
 | * Replacement
 | * Archiving
 | * Revision
 |
| **Type of document** |
| * Policy and Procedure
 |  | * Guideline
 | Form |  | * Order set
 |  |
| * Medical directive (if impact in Epic, please indicate number):
 |
| **Required Approval Committee**Program Council ☐ Pharmacy and Therapeutic Committee ☐ Medical Advisory Committee (MAC)* Policy and Procedure Committee ☐ Other:
 |
| Document title and no.: | Colonoscopy Preparation (4L, 2L and Pico-Salax) |
| Document owner (including service or department): | Endoscopy Booking |
| Document Review: | * Annually
 |  | * Biennially
 | Triennially (recommended) |
| ***Existing documents only*** |  |  |  |  | ***Forms only***To be published on HGH’s public websiteInternal use (published in *PolicyMedical* only) |
| Current document no.: |  |  |  |
| Current version no.: |  |
| **Explain briefly the reason for this document management request** (purpose of creation, modification, replacement, archiving or translation)The existing documents provided to patients during the endoscopy booking process are lengthy and complex, often making them difficult to understand. As a result, staff are required to spend considerable time explaining thecontent to ensure patient comprehension. |
| **Does this request have an impact on other HGH documents (e.g., policies, procedures, forms, etc.)? If so, provide details.** |
| **SECTION 2: IMPLEMENTATION PLAN – EDUCATION AND COMMUNICATIONS** |
| **Publication Date:** | Indicate the date this document should be published **for educational and communication purposes**. | **Date: May 26th 2025** |
| **Effective Date:** | Indicate the date this document **comes officially into effect once** the education and communication plans have been implemented. | **Date: May 26th 2025** |
| **Detail your Education and/or Communication Plan:***For additional guidance, please refer to policy ADM-04-104* |
| **SECTION 3: ATTESTATION** |
| **Are employees required to attest to reading this policy?** | No ☐ Yes |
| **Please indicate which staff members are required to attest:** |

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| **How long do you want the attestation exercise to last?** | **From (yy/mm/dd):** | **To (yy/mm/dd):** |
| **SECTION 4 : AUTHOR OR REVIEWER****(Most Responsible person(s):name required and not that of the committee):** |
| Authors | Elizabeth Durocher |
| Reviewer | Kyana Sauvé |
| Other (please specify) | Veronique Brochu, specialty Chiefs |
| **SECTION 5: STAKEHOLDER FEEDBACK** |
| **Stakeholder feedback obtained from:** (*this will help us ensure the appropriate stakeholders have been consulted in the development or review of the document).*Please use the list below and specify levelof stakeholder engagement obtained and any relevant comments. *For additional guidance, please refer to policy ADM-04-104.* |
|  | **Date** | **Comments** |
| Allied Health |  |  |
| Ambulatory Care Services |  |  |
| Bed Flow |  |  |
| Booking |  |  |
| Clinical Educators |  |  |
| Communications |  |  |
| Emergency Preparedness |  |  |
| Finance |  |  |
| Housekeeping |  |  |
| Health Records |  |  |
| Human Resources |  |  |
| Infection Prevention and Control (IPAC) |  |  |
| Laboratory Services |  |  |
| Maintenance / Building Services |  |  |
| Materials Management |  |  |
| Medical Affairs |  |  |
| Medical Imaging |  |  |
| Medical Device Reprocessing |  |  |
| MIS |  |  |
| Occupational Health |  |  |
| Pharmacy |  |  |
| Quality and Risk |  |  |
| ***Committees/Groups:*** |  |  |
| Quality and Performance Committee |  |  |
| Medical Advisory Committee |  |  |
| Ethics Committee |  |  |
| Patient and Family Advisory Committee |  |  |
| Medication Safety Committee |  |  |
| Accessibility and Diversity Committee |  |  |

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| Occupational Health and Safety Committee |  |  |
| Program Council (please specify in comments) |  |  |
| Pharmacy and Therapeutics Committee |  |  |
| Infection Prevention and Control Committee |  |  |
| Other - please specify: |  |  |
| Other - please specify: |  |  |
| Other - please specify: |  |  |
| Other - please specify: |  |  |
| Other - please specify: |  |  |
| Other - please specify: |  |  |
| Other - please specify: |  |  |
|  |
| **SECTION 5: APPROVAL OF FINAL DRAFT****For approval requirements, please refer to policy ADM-04-104** | **NAME**(Individual or committee chair) | **SIGNATURE**(electronic) | **DATE OF APPROVAL**(should be noted in meeting minutes) (YYYY-MM-DD) |
| **APPROVAL**(All applicable based on document approval flows set out in policy ADM-04-104) |
| **Program Council*****Please specify*:** |  |  |  |
| **Department or Program Director** | Elizabeth Durocher |  |  |
| **Policy and Procedure Approval Committee** | Kyana Sauvé |  | 2025-05-13 |
| **Pharmacy & Therapeutics Committee** |  |  |  |
| **Medical Advisory Committee** |  |  |  |
| **Senior Leader** |  |  |  |
| ***Other******Please specify:***  | Dre. Roxanne Leblanc |  |  |

*Once a document has been published by the Quality Office, a notification of publication will be sent out to the stakeholders above* and they will be responsible to share with their teams.