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| **Name of document:**  |
| Is this a new document? ☐ Yes ☐ NoIs this patient information?Is this a policy/guideline? | Is this a review of a current document? ☐ Yes ☐ No*If yes, please go to question 11.*Is this document still required? [ ]  Yes [ ]  NoIs this for discontinuation of a current document? ☐ Yes ☐ No *Please go to question 12.* |
| 1. What is the desired outcome when the document is introduced? |
| 2. What problem is the document addressing? |
| 3. What process will you employ to ensure it is effective (audit)? |
| 4. Area of Impact:  |
| [ ]  Maternity inpatients only Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  All maternity clientsPlease specify: \_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  DHB wide(all locations, including rural and community) | [ ]  External Provider(e.g. Lab tests, Primary Health service) |
| **Due diligence**  | Please specify details: |
| [ ]  5. Who will be the main distributors of the pamphlet/handout/form? How are you intending to consult with them?e.g. Midwives, LMCs, other Health practitioners, external providers (e.g. Primary health providers, Lab tests), etc. |  |
| [ ] 6. Who will be the main audience? How are you intending to consult with them?e.g., Maternity consumers |  |
| ☐ 7. How will you undertake an unbiased pilot with maternity consumers? |  |
| [ ]  8. What pamphlets/handouts/forms (electronic and paper), already exist that are similar, will be impacted or be replaced by this document? How will you consult with these document owners? |  |
| [ ]  9. How will the document enhance workflow and communication? |  |
| [ ] 10. What is your plan for socialising this document? |  |
| [ ]  11. Information has been updated to reflect current research and practice.*For reviews only* |  |
| 12. If this document is to be discontinued, what alternative ways will this information be given to women.*For discontinuations only* |  |
| **Document Management** | Today’s date | dd/mm/yyy |
| Document author |  | Signed |  |
| Document Owner |  | Position |  |
| Department |  |
| Cost Code Manager(consumer information only) |  | Signed |  |
| Existing forms affected*Please list all codes and indicate replacement or removal e.g. A1234HWF* | Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  To be removed [ ]  To be replacedTitle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  To be removed [ ]  To be replacedConfirmed above with department owner(s): [ ]  Yes [ ]  No |
| Review Date and Frequency | New Document review date \_\_\_\_\_\_\_\_\_\_ (dd/mm/yy)Ongoing review: [ ]  3 years [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Specifications | Expected document usage per month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Approvals** | **Approved to proceed** | **Final sign-off** |
| [ ]  Maternity client Information Committee | *Name dd/mm/yy*  | *Name dd/mm/yy* |
| ☐ Midwifery Director |  | *Name dd/mm/yy* |
| [ ] Director Women’s Health |  | *Name dd/mm/yy* |
| Other |  |  |
| Has this been placed on the agenda for the Maternity Governance Group?  | *dd/mm/yy* |
| Discontinuation | Title: Confirmed with department owner: [ ]  Yes [ ]  NoReason: |
|  | *Master copy to be kept by NWH Information Officer* |