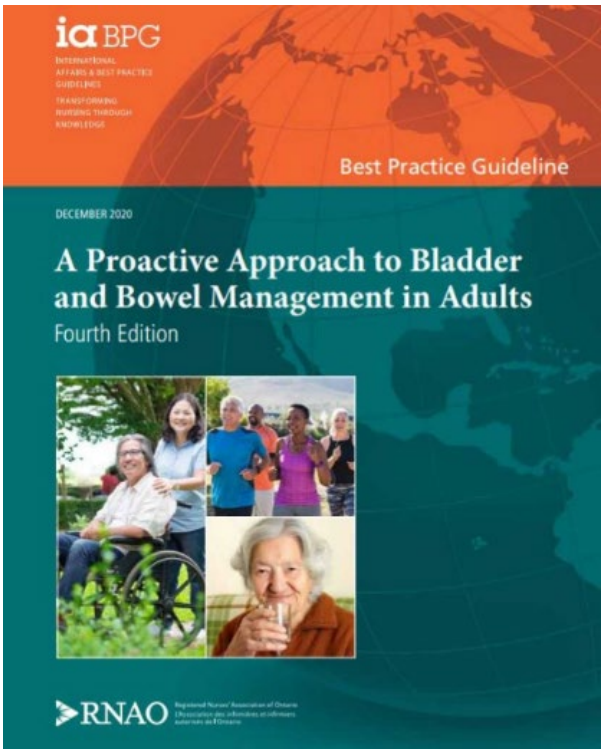
Gap (opportunity) analysis worksheet:
Comparing your practices to best practices

A Proactive Approach to Bladder and Bowel Management in Adults, Fourth Edition
2022



Download this guideline for free at: A Proactive Approach to Bladder and Bowel Management in Adults | RNAO.ca

Review RNAO's evidence-based implementation resource, Leading Change Toolkit, Fourth edition, at RNAO.ca/leading-change-toolkit

What is a gap (opportunity) analysis?

This is a process widely used to determine if best practices have been met after the practice change has been completed. A gap (opportunity) analysis helps you compare your organization's current practice with evidence-based best practice recommendations and/or good practice statements to determine:

- Existing practices and processes that are currently implemented and supported by best practices. This information is useful to reinforce practice strengths.
- Recommendations/good practice statements that are currently partially implemented in practice. These would be good first targets for change efforts.
- Recommendations/good practice statements that are not currently being met.
- Recommendations/good practice statements that are not applicable to your practice setting.

Why should we conduct a gap (opportunity) analysis?

- Contributes to annual evaluation by allowing you to compare practice from year to year and choose which areas to focus on changing within the year.
- Focuses on needed practice change which prevents a total overhaul of practice and builds on established practices and processes.
- Informs next steps such as development of infrastructure to support implementation, internal/external partner engagement, identification of barriers and facilitators, resource requirements, selection of implementation strategies and evaluation approaches.
- Leads to sustained practice change by informing plans related to process, staff and organization and reinforces current evidence-based practices.

How can we get started conducting a gap (opportunity) analysis?

Review the best practice guideline (BPG) in its entirety including its purpose, scope, guiding frameworks, good practice statements and evidence. This will help you gain a full understanding of the actionable best practices, implementation strategies and resources available to you.

If you are new to reading evidence-based guidelines, please watch our 2024 video "How to read, use and interpret a best practice guideline".

Engage the team and internal and external partners as needed in gathering information for the gap (opportunity) analysis. Collect information on:

- Current practice – is it known and is it consistent? (met, unmet, partially met)
    - Partially met recommendations/good practice statements may only be implemented in some parts of the organization, or you may feel it is only half done.

- Are there some recommendations/good practice statements that must be implemented before others?
- Can any recommendations/good practice statements be implemented quickly? (TIP: These are, “easy wins” and build confidence in the change.)
- Are there recommendations based on higher levels of evidence than others?
- Are there any barriers to implementation? (Examples include: staffing, skill mix, budget, workload issues, etc.)
- What are the time frames in relation to specific actions and people or departments who can support the change effort?
- Are there links with other practices and programs in your organization?
- Are there existing resources and education that your organization can access?
- Are there any must-do recommendations/good practice statements crucial to client/resident/patient and staff safety?
- What alignment do we consider with legislation, policy, accreditation, etc.?

Important note for long-term care homes: Completing this gap (opportunity) analysis each year helps you compare your current practices with evidence-based standards set by the Ministry of Health and Long-Term Care, as required by the Fixing Long-Term Care Act, 2021 and Ontario Regulation 246/22.

Next steps

1. Celebrate the recommendations/good practice statements you are meeting.
2. Prioritize the areas you want to work on. Start with practice changes that can be made easily or are crucial to client/resident/patient and staff safety. Start by reinforcing success and focusing on quick wins.
3. These priority areas become the foundation for planning your program or implementing practice change.
4. For more information on taking your gap (opportunity) analysis to the next level, see the RNAO Leading Change Toolkit, Fourth edition
5. **For long-term care homes:** Contact your LTC implementation coach, – by visiting Find your implementation coach | RNAO.ca for assistance with completing a gap (opportunity) analysis.
6. **For all other BPSOs:** Contact your implementation coach.
7. Not a LTCH or a BPSO and have questions about using this worksheet-Send us a message | RNAO.ca

For more information about the interpretation of evidence and recommendation statements, please see RNAO's explainer, *Advancements in RNAO Best Practice Guideline Methodology: Transition to the GRADE Approach*.

Gap (opportunity) Analysis worksheet

Site: _____

Date completed: _____

Team members participating in the gap (opportunity) analysis:

- _____
- _____
- _____
- _____
- _____
- _____

RNAO guideline *A Proactive Approach to Bladder and Bowel Management in Adults*	**Met, partially met or unmet?**	**Notes** (Examples of what to include: is this a priority to our organization, information on current practice, possible overlap with other programs or partners)
Good Practice Statement: Prior to developing a plan of care or carrying out interventions, health providers conduct a focused initial continence assessment in collaboration with the person experiencing urinary incontinence (does not require GRADE application). Sections for components and detail of assessments 1-5 & 6 from pages 36-40.		
Components of Assessment (1): Obtain a clinical history to accurately determine: ☐ Identification of the type of urinary incontinence: 1. stress incontinence: involuntary loss of urine that occurs due to sudden increase in abdominal pressure due to coughing, sneezing, laughing, lifting, exercise 2. urgency incontinence: sudden compelling urge to urinate and the bladder contracts and empties in an involuntary fashion 3. mixed incontinence: involuntary loss of urine associated with urgency and physical exertion 4. functional incontinence: normal urine control but have trouble getting to bathroom in time due to mobility issues also referred to as disability incontinence ☐ Determine possible underlying causes or contributing factors to guide the plan of care and support appropriate interventions.		
Components of Assessment (2): Obtain a voiding record to evaluate the frequency of incontinence and voided volume**.**		

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Components of Assessment (3): Assess urinary urgency using validated questionnaires.		
Components of Assessment (4): Use dipstick urinalysis as a screening tool to further assess glycosuria, hematuria, proteinuria and pyuria in accordance with policies and procedures of local setting. **Caution**: A dipstick should not be used to diagnose a urinary tract infection (UTI).		
Components of Assessment (5): Measure post-void residual (PVR) volume within a few minutes of voiding, either by calculating bladder volume using a portable ultrasound scanner or by in and out catheterization (unless otherwise directed).		
Components of Assessment (6): Report findings.		
Recommendation 1.1 The expert panel recommends that health providers encourage individualized toileting strategies in persons living with urinary incontinence. Strength of recommendation: Strong Strength of evidence of effects: Low Low Confidence of Evidence: N/A		
All strategies may not be appropriate or realistic. ☐ Consider individualized toileting strategies based on a person's age, physical limitations and cognitive status. **Prompted Voiding** *refers to using verbal or physical cues to prompt a person to attend to their wet/dry status and then encouraging them to use the toilet through positive reinforcement.* ☐ For residents 65 yrs and older, including persons with cognitive impairment. ☐ Intervention period 6 months ☐ Residents prompted to void every 2 to 2.5 hours, from 0700 hrs to 1900 hrs, seven days a week ☐ Best predictor of success to prompted voiding is the success during a trial of		

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PV. Responsive to PV relates to recognizing need to void, higher number of self initiating requests to toilet, ability to void successfully when given assistance to toileting, able to ambulate unassisted, more cognitively intact, higher completion of assigned prompted voiding sessions by HCP **Bladder Training** *involves lifestyle modifications (eliminating bladder irritants from diet, managing fluid intake, weight control, bowel regulation and smoking cessation) and the use of relaxation and distraction techniques for the control of urinary frequency and urgency*. ☐ Evidence reflecting mostly women between ages 22-65 years ☐ Training includes urge suppression techniques, self-monitoring (voiding diaries), lifestyle modifications (i.e., eliminating bladder irritants from diet, managing fluid intake, weight control, bowel regulation, and smoking cessation) and timed voiding ☐ Evidence reflecting men and women 40 yrs and older living with idiopathic overactive bladder ☐ A 30-minute bladder training program that consisted of: education on normal daytime frequency and amount, normal physiology of urination, holding urine until a certain goal is met ☐ Train the bladder by: refraining from going to bathroom after feeling an urge to void, ceasing action and thought temporarily in order to stop thinking about voiding; and performing pelvic floor exercises 5-6 times a day ☐ Feedback and problem shooting with a specialized nurse practitioner ☐ Do not routinely use continence containment products (including briefs or pads) for older adults to reduce risk of adverse outcomes such as diminished self-esteem, perceived		

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QoL, dermatitis, pressure wounds, and UTIs ☐ Assessment conducted to determine the risk of such outcomes before initiating or continuing the use of such products		
Recommendation 2.1: The expert panel recommends that health providers encourage persons who live with urinary incontinence to engage in low-intensity physical activity, as tolerated. Strength of recommendation: Strong Strength of evidence of effects: Low Low Confidence of Evidence: N/A		
Low-intensity physical activity refers to light, non-strenuous and repetitive bodily movement. It should be individualized and appropriate to the person's age, physical ability, and associated health status. Research suggested that low-intensity physical activity may decrease episodes of UI and physical limitations (improves the degree of physical and functional activities such as walking and climbing) Research suggested that low-intensity exercise included: ☐ Yoga for 6 weeks ☐ Stretching followed by stationary cycling ☐ Treadmill exercises ☐ Resistance training for 52 weeks		
Adopted recommendation: The expert panel recommends that health providers offer women who live with stress or mixed urinary incontinence a trial of supervised PFMT for at least three months as first-line management. A comprehensive assessment should be conducted to determine the applicability of PFMT for these women. Strength of recommendation: Strong Strength of evidence of effects: Very Low to Low Low Confidence of Evidence: N/A		
PFMT is an exercise program aimed at improving specific deficiencies in pelvic floor muscle structure or function. It is based on the ability to contract the pelvic floor muscle. In practice, it has been applied to both men and women, and for men after prostate surgery. ☐ Comprehensive assessment would be conducted by a health provider who		

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has the appropriate knowledge and skills pertaining to in performing PFMT such as Nurse Continence Advisor (NCA) or Pelvic health PT (find a health care professional at https://pelvichealthsolutions.ca/) ☐ Non invasive conservative measures should be considered prior to medication or surgery ☐ PFMT program should comprise of at least 8 contractions, performed 3 times per day ☐ Do not use perineometry or pelvic floor electromyography as biofeedback, as a routine part of PFMT. ☐ Continue exercise program if PFMT is beneficial **CAUTION:** PFMT may not be appropriate for frail older women or those living with cognitive impairments. It should be facilitated and supervised by a health provider with the appropriate knowledge and skills such as an NCA or pelvic health PT.		
Recommendation 3.1: The expert panel suggests that health-service organizations implement an interprofessional approach to providing care for persons living with urinary incontinence. Strength of recommendation: Conditional Strength of evidence of effects: Low Confidence of Evidence: N/A		
IP approach refers to a coordinated approach to continence care by a team of health providers- including reporting and/or referring to a continence specialist based on individual needs ☐ IP may include nurses, Nurse Continence Advisors, nurses specialized in wound, ostomy and continence (NSWOC), physicians (general, urologists, urogynecologists, colorectal surgeons), PSWs, PTs, OTs, dieticians, pharmacists ☐ IP approach to care includes: triage and referral, categorization of person reports, consultation and consideration by relevant specialists, and discussion of complex problems in weekly IP meetings		

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Good Practice Statement: Prior to developing a plan of care or carrying out interventions, health providers conduct a focused initial assessment in collaboration with the person experiencing fecal incontinence and/or constipation. (does not require GRADE application).		
Definition of Constipation: The difficult or infrequent passage of stools (less than 3 bowel movements per week). Constipation may be acute or chronic (lasting more than 3 months) and it may be in response to a variety of physiological, mechanical, and medically related factors, including medication use. However, the most common type of is functional constipation for which there is no underlying cause. ☐ Understand types of fecal incontinence 1. Passive fecal incontinence – involuntary leakage of feces without warning, small amount of seepage between buttocks, frequently related to internal anal sphincter dysfunction 2. Urge fecal incontinence – inability to defer defecation once the urge is perceived for long enough to reach a toilet. 3. Functional fecal incontinence – involuntary leakage of feces "due to limitation in mobility, manipulating clothing, or toileting ability or delayed assistance with toileting ☐ Identify a list of risk factors for fecal incontinence ☐ Bardsley indicates that an initial assessment of constipation can be guided by the following steps: 1. Obtain a baseline history of person's bowel pattern: type and quantity of stool, frequency and timing of bowel movements, and any straining with bowel movements. 2. Assess stool consistency using a Bristol Stool Chart. 3. Obtain a seven-day diet history of daily fluid and fibre intake. 4. Conduct a review of medications to evaluate their effect on constipation.		

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5. Examine co-morbid conditions that may cause or contribute to constipation. 6. Assess the individual's functional and cognitive status. 7. Perform a digital rectal examination to determine fecal impaction.		
Recommendation 4.1: The expert panel recommends that as part of a wider multicomponent program, health providers encourage persons living with constipation to engage in low-intensity physical activity for about 30-60 minutes (as tolerated) at least three times a week to help manage constipation. Strength of recommendation: Strong Strength of evidence of effects: Low Confidence of Evidence: N/A		
Low intensity physical activity refers to light, non strenuous repetitive body movement such as: ☐ walking, low-impact aerobic exercise, ☐ light resistance training and ☐ engaging in leisure-level sports. Low-intensity exercise alone is not enough. Behaviours need to be encouraged such as: ☐ adequate dietary fibre, ☐ a low-calorie diet (for obesity), ☐ adequate fluid intake and appropriate ☐ appropriate squat positions for defecation		
Recommendation 5.1: The expert panel suggests that health providers counsel persons on adequate fibre intake to prevent and manage constipation. Strength of recommendation: Conditional Strength of evidence of effects: Low Confidence of Evidence: N/A		
Adequate fibre intake may decrease laxative use. **Caution**: *psyllium fibre is not recommended for those with opioid-induced constipation as it can lead to bowel obstruction* ☐ encourage adequate fluid intake along with fiber intake ☐ refer to dietician for incorporating fibre into a diet		

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☐ along with fibre supplements, fibre rich foods and plant-based fiber for optimal microbiota diversity can be recommended		
Recommendation 5.2: The expert panel recommends that as part of a wider multicomponent program, health providers counsel persons living with constipation on adequate fluid intake to help manage constipation. Strength of recommendation: Strong Strength of evidence of effects: Very Low Confidence of Evidence: N/A		
Aside from fluid intake, health providers counsel persons living with constipation on: ☐ adequate fluid intake (1500 – 2000 ml) but would need to be tailored individually for adults living with kidney failure or heart disease or other relevant health conditions ☐ dietary fibre consumption ☐ balanced diet ☐ exercise ☐ optimal positions to defecate ☐ indications of appropriate laxative use Refer to registered dietician for incorporating fluid into diets to prevent constipation if further support required.		
Recommendation 5.3: The expert panel suggests that health providers promote the option of using psyllium fibre supplements for persons living with fecal incontinence in the community. Strength of recommendation: Conditional Strength of evidence of effects: Moderate Confidence of Evidence: N/A		
Psyllium fibre supplements may improve stool consistency, QoL and reduce episodes of fecal incontinence in the community. It is not recommended for the long-term care setting. **Caution:** *Psyllium fibre may cause potential harms such as constipation or fecal impaction if used in persons who are not mobile and do not have adequate hydration. Therefore, it is not indicated for persons who are bed bound or older adults living in long term care settings.*		

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Recommendation 6.1: The expert panel suggests that health-service organizations implement an interprofessional approach to providing care for persons living with fecal incontinence and/or constipation. Strength of recommendation: Conditional Strength of evidence of effects: Low Confidence of Evidence: Low		
☐ IP team approach tailored to individual care needs. ☐ Primary care settings use evidence-based management and have resources for referral to continence specialists and/or continence care services such as continence clinic ☐ Use of clinical pathways with referrals and consults to a continence team for fecal incontinence ☐ Clinical pathway includes anorectal surgeons, pelvic physiotherapists, anorectal NP, bowel function nurse continence team, and researcher **Quality Improvement:** ☐ Constipation audits ☐ IP team to develop an algorithm to prevent, detect and treat constipation ☐ IP team of nurses, nurse manager, dieticians, PT and doctors		
Recommendation 7.1: The expert panel recommends that health-service organizations implement a bowel protocol to manage constipation, which can be individualized. Strength of recommendation: Strong Strength of evidence of effects: Very Low Confidence of Evidence: N/A		
Individualized for person's needs, preferences and health history **Components of a bowel protocol** ☐ ☐ Promotion of fibre and fluid intake ☐ Health teaching regarding exercise/mobility ☐ Medication review, followed by physical assessments ☐ Medication for relief ☐ If still no bowel movement, the protocols suggested contacting the physician		

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Developing a bowel protocol Include a IP working group (physician, pharmacist, nurse, researcher, dietician, management, nurses, PTs)		