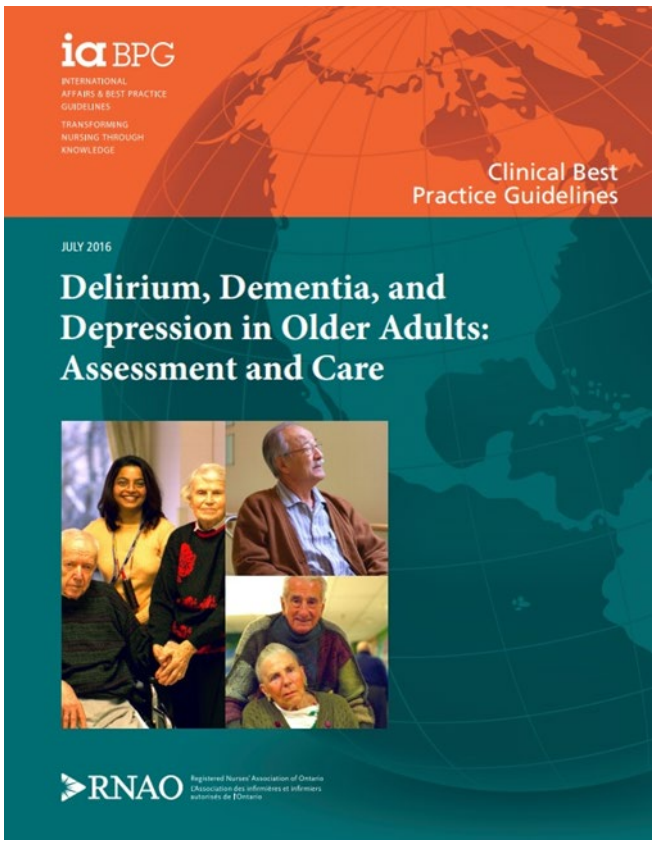
Gap (opportunity) analysis worksheet:
Comparing your practices to best practices

Delirium, Dementia and Depression in Older Adults: Assessment and Care, June 2016



Download this guideline for free at: RNAO.ca/sites/rnao-ca/files/bpg/assessment-and-care-older-adults-delirium-dementia-and-depression

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 Delirium, Dementia, and Depression in Older Adults: Assessment Care *People*	**Met, partly 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)
Practice Recommendations **1.0 General Recommendations Related to Delirium, Dementia, and Depression**		
1.1 Establish therapeutic relationships and provide culturally sensitive person- and family-centred-care when caring for and providing education to people with delirium, dementia, and depression and their families and care partners (Level of Evidence = Ia, V)		
1.2 Identify and differentiate among signs and symptoms of delirium, dementia, and/or depression during assessments, observations, and interactions with older persons, paying close attention to concerns expressed by the person, his/her family/care partners, and the Interprofessional team. (Level of Evidence = V)		
1.3 Refer older adults suspected of delirium, dementia, and/or depression to the appropriate clinicians, teams, or services for further assessment, diagnosis, and/or follow-up care. (Level of Evidence = Ia)		
1.4a Assess the person's ability to understand and appreciate information relevant to making decisions and, if concerns arise regarding the person's mental capacity, collaborate with other members of the health-care team as necessary. (Level of Evidence = V)		

1.4b Support the older person's ability to make decisions in full or in part. If the older person is incapable of making certain decisions, engage the appropriate substitute decision-maker in decision-making, consent, and care planning. (Level of Evidence = V)		
1.5 Exercise caution in prescribing and administering medication to older adults (within the health-care provider's scope of practice), and diligently monitor and document medication use and effects, paying particular attention to medications with increased risk for older adults and polypharmacy. (Level of Evidence = Ia)		
1.6 Use principles of least restraint/restraint as a last resort when caring for older adults. (Level of Evidence = Ia, V)		
Recommendations Related to Delirium: Assessment		
2.1 Assess older adults for delirium risk factors on initial contact and if there is a change in the person's condition. (Level of Evidence = Ia, V)		
Recommendations Related to Delirium: Planning		
3.1 Develop a tailored, non-pharmacological, multi-component delirium prevention plan for persons at risk for delirium in collaboration with the person, his/her family/care partners, and the interprofessional team. (Level of Evidence = Ia)		
Recommendations Related to Delirium: Implementation		
4.1 Implement the delirium prevention plan in collaboration with the person, his/her family/care partners, and the interprofessional team. (Level of Evidence = Ia)		
4.2 Use clinical assessments and validated tools to assess older adults at risk for delirium at least daily (where appropriate) and whenever changes in the person's cognitive function, perception, physical function, or social behaviour are observed or reported. (Level of Evidence = Ia, V)		

4.3 Continue to employ prevention strategies when caring for older adults at risk for delirium who have not been identified as having delirium. (Level of Evidence = Ia, V)		
4.4 For older adults whose assessments indicate delirium, identify the underlying causes and contributing factors using clinical assessments and collaboration with the interprofessional team. (Level of Evidence = Ia)		
4.5 Implement tailored, multi-component interventions to actively manage the person's delirium in collaboration with the person, the person's family/care partners, and the interprofessional team. These interventions should include: • treatment of the underlying causes (level of evidence = Ia), • non-pharmacological interventions (level of evidence = V), and • appropriate use of medications to alleviate the symptoms of delirium and/or manage pain (level of evidence = Ia). (Level of Evidence = Ia, V)		
4.6 Educate persons who are at risk for or are experiencing delirium and their families/care partners about delirium prevention and care. (Level of Evidence = V)		
Recommendations Related to Delirium: Evaluation		
5.1 Monitor older adults who are experiencing delirium for changes in symptoms at least daily using clinical assessments/observations and validated tools, and document the effectiveness of interventions. (Level of Evidence = V)		
Recommendations Related to Dementia: Assessment		
6.1a Assess older adults for possible dementia when changes in cognition, behaviour, mood, or function are observed or reported. Use validated, context-specific screening or assessment tools, and collaborate with the person, his/her family/care partners, and the interprofessional team for a comprehensive assessment. (Level of Evidence = Ia, V)		

6.1b Refer the person for further assessment/diagnosis if dementia is suspected. (Level of Evidence = Ia)		
6.2 Assess the physical, functional, and psychological status of older adults with dementia or suspected dementia, and determine its impact on the person and his/her family/care partners using comprehensive assessments and/or standardized tools. (Level of Evidence = V)		
6.3 Systematically explore the underlying causes of any behavioural and psychological symptoms of dementia that are present, including identifying the person's unmet needs and potential "triggers." Use an appropriate tool and collaborate with the person, his/her family/care partners, and the interprofessional team. (Level of Evidence = Ia)		
6.4 Assess older adults with dementia for pain using a population-specific pain assessment tool. (Level of Evidence = Ia)		
Recommendations Related to Dementia: Planning		
7.1 Develop an individualized plan of care that addresses the behavioural and psychological symptoms of dementia (BPSD) and/or the person's personal care needs. Incorporate a range of non-pharmacological approaches, selected according to: • the person's preferences, • the assessment of the BPSD, • the stage of dementia, • the person's needs during personal care and bathing, • consultations with the person's family/care partners and the interprofessional team, and • ongoing observations of the person. (Level of Evidence = Ia)		
Recommendations Related to Dementia: Implementation		
8.1 Implement the plan of care in collaboration with the person, his/her family/care partners, and the interprofessional team. (Level of Evidence = V)		

8.2 Monitor older adults with dementia for pain, and implement pain-reduction measures to help manage the behavioural and psychological symptoms of dementia. (Level of Evidence = Ia V)		
8.3 Employ communication strategies and techniques that demonstrate compassion, validate emotions, support dignity, and promote comprehension when caring for people with dementia. (Level of Evidence = Ia)		
8.4 Promote strategies for people living with dementia that will preserve their abilities and optimize their quality of life, including but not limited to: • exercise (level of evidence = Ia), • interventions that support cognitive function (level of evidence = Ia), • advanced care planning (level of evidence = Ia), and • other strategies to support living well with dementia (level of evidence = V). (Level of Evidence = Ia, V)		
8.5a Provide education and psychosocial support to family members and care partners of people with dementia that align with the person's unique needs and the stage of dementia. (Level of Evidence = Ia)		
8.5b Refer family members and care partners who are experiencing severe stress or depression to an appropriate health-care provider. (Level of Evidence = V)		
Recommendations Related to Dementia: Evaluation		
9.1 Evaluate the plan of care in collaboration with the person with dementia (as appropriate), his/her family/care partners, and the interprofessional team, and revise accordingly. (Level of Evidence = V)		

(continued on next page)

Recommendations Related to Depression: Assessment		
10.1 Assess for depression during assessments and ongoing observations when risk factors or signs and symptoms of depression are present. Use validated, context-specific screening or assessment tools, and collaborate with the older adult, his/her family/care partners, and the interprofessional team. (Level of Evidence = Ia, V)		
10.2 Assess for risk of suicide when depression is suspected or present. (Level of Evidence = V)		
10.3 Refer older adults suspected of depression for an in-depth assessment by a qualified health-care professional. Seek urgent medical attention for those at risk for suicide and ensure their immediate safety. (Level of Evidence = V)		

Recommendations Related to Depression: Planning		
11.1 Develop an individualized plan of care for older adults with depression using a collaborative approach. Where applicable, consider the impact of co-morbid dementia. (Level of Evidence = Ia, V)		
Recommendations Related to Depression: Implementation		
12.1 Administer evidence-based pharmacological and/or non-pharmacological therapeutic interventions for depression that are tailored to the person's clinical profile and preferences. (Level of Evidence = Ia, V)		
12.2 Educate older adults with depression (and their families/care partners, if appropriate) about depression, self-management, therapeutic interventions, safety, and follow-up care. (Level of Evidence = V)		
Recommendations Related to Depression: Evaluation		
13.1 Monitor older adults who are experiencing depression for changes in symptoms and response to treatment using a collaborative approach. Document the effectiveness of interventions and changes in suicidal risk. (Level of Evidence = V)		
Education Recommendations		
14.1 All entry-level health-care programs include content and practice education opportunities that are specific to caring for older adults who have or are suspected of having delirium, dementia, and/or depression, and that are tailored to the discipline's scope of practice. (Level of Evidence = V)		
14.2 Organizations provide opportunities for nurses and other health-care providers to enhance their competency in caring for older adults with delirium, dementia, and depression. Pertinent educational content should be provided during the orientation of new staff and students, and continuously		

through refresher courses and professional development opportunities. (Level of Evidence = Ia, V)		
14.3 Design dynamic, evidence-based educational programs on delirium, dementia, and depression that support the transfer of knowledge and skills to the practice setting. Such programs should be: • interactive and multimodal (level of evidence = Ia), • interprofessional (level of evidence = Ia), • tailored to address learners' needs (level of evidence = V), • reinforced at the point of care by strategies and tools (level of evidence = Ia), and • supported by trained champions or clinical experts (level of evidence = Ia). (Level of Evidence = Ia, V)		
14.4 Evaluate educational programs on delirium, dementia, and depression to determine whether they meet desired outcomes, such as practice changes and improved health outcomes. Refine programs as required. (Level of Evidence = V)		
Organization and Policy Recommendations		
15.1 Organizations demonstrate leadership and maintain a commitment to foundational principles that support care for older adults with delirium, dementia, and depression, including: • person- and family-centred care (level of evidence = 1a), • collaborative, interprofessional care (level of evidence = 1a), and • healthy work environments (level of evidence = V). (Level of Evidence = Ia, V)		
15.2 Organizations select validated screening and assessment tools for delirium, dementia, and depression that are appropriate to the population and health-care setting, and provide		

training and infrastructure to support their application. (Level of Evidence = V)		
15.3 Organizations implement comprehensive, multi-component programs, delivered by collaborative teams within organizations, to address delirium, dementia, and depression (level of evidence = Ia). These should be supported by: • comprehensive educational programs (level of evidence = V), • clinical experts and champions (level of evidence = Ia), and • organizational processes that align with best practices (level of evidence = V). (Level of Evidence = Ia, V)		
15.4 Establish processes within organizations to ensure that relevant information and care planning for older adults with delirium, dementia, and depression is communicated and coordinated over the course of treatment and during care transitions. (Level of Evidence = Ia, V)		