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

Transitions in Care and Services, (2nd edition),
June 2023

Download this guideline for free at: RNAO.ca/sites/rnao-ca/files/bpg/guidelines/transitions-in-care

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 Transitions in Care and Services	**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 1.0: It is good practice that health and social service providers collaborate with persons and their support network before, during and after a transition in care in order to ensure a safe and effective transition. (pg.30). **This good practice statement is an overarching statement that is foundational to implementing all other recommendations and good practice statements*		
To achieve the best outcomes during a transition in care, it is imperative for health and social service providers to use an informed, shared decision-making process (38,51,52). Shared decision-making; • is a collaborative process that involves a person and their health or social service provider working together to reach a mutual decision about their current or future care (53). • it also involves determining and integrating a person's wishes and preferences (53)		
GOOD PRACTICE STATEMENT 2.0: It is good practice that health and social service providers assess with persons and their support network their care needs and readiness for a transition. (pg37)		
Assessing readiness for a transition is a central component of transition planning (62). Readiness assessments are based on clinical criteria, such as: medical stability; functional ability to manage self-care; and having the knowledge, skills, confidence and supports necessary to manage the transition and cope with common		

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challenges that may arise (62). ***Assessments are to focus on what interventions best suit the person's goals of care.*** **CAUTION:** The expert panel highlighted that while assessments are critical to prepare for a transition in care, health and social service providers should avoid repeating assessments unnecessarily (pg. 36)		
GOOD PRACTICE STATEMENT 3.0: It is good practice that members of the interprofessional team collaborate to develop a transition plan that supports the unique needs of persons and their support network. (pg.49)		
Transition plans are necessary to promote continuity of care and ensure that the necessary services, supports and resources have been arranged for the person encountering the transition (71).		
RECOMMENDATION 3.1: The expert panel suggests that health and social service organizations collaborate to implement a formal interprofessional cross-sectoral approach to support persons encountering transitions in care. (pg.54) Strength of recommendation: Conditional Certainty of the evidence of effects: Very Low		
For the purposes of this BPG, an interprofessional cross-sectoral approach refers to a collaborative approach where two or more health or social service providers from different disciplines and in different sectors work together in a formal way to ensure that persons and their support network experience a safe transition in care.		
GOOD PRACTICE STATEMENT 4.0: In order to ensure medication safety, it is good practice for health providers to conduct the following in collaboration with the person encountering a transition and their support network: • obtain a best possible medication history; and • perform medication reconciliation at all transition points (pg.61)		
During transitions, medications are frequently stopped, adjusted or newly prescribed. Communication and care processes can break down at various points during a transition in care, resulting in unintended medication errors or discrepancies (88).		

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GOOD PRACTICE STATEMENT 5.0: It is good practice for health and social service providers to provide persons and their support network with information and support to manage their needs during and after transitions in care. (pg.65)		
Health and social service providers need to provide persons and their support network with information that is clear and timely, involve and support them when making care decisions, and advocate and help them access the health care they require (93).		
Recommendation 5.1: The expert panel suggests that navigation support be provided by health or social service providers for persons with complex care needs encountering a transition in care. This support includes regular follow-up by the provider(s) to assess and respond to the person's current and evolving health and social care needs. (pg.68) Strength of recommendation: Conditional Certainty of evidence of effects: Very Low		
Navigation support refers to individualized and coordinated support provided by health or social service providers to help persons and their support network overcome challenges related to navigating the health and social care system during transitions in care. This can include providing persons with the information and resources they need to achieve their goals of care, connecting persons with other health and social service providers, helping reduce barriers that prevent persons from accessing timely care, providing social and emotional support, and improving access to culturally safe care. Feedback should be collected from persons and their support network with respect to how well supported they feel when receiving navigation support. This will give the person and their support network an opportunity to voice any concerns.		

<table>
<tr><th>RNAO guideline Transitions in Care and Services</th><th>Met, partially met or unmet?</th><th>Notes
(Examples of what to include: is this a priority to our organization, information on current practice, possible overlap with other programs or partners)</th></tr>
<tr><td colspan="3">Recommendation 5.2: The expert panel suggests that peer workers with lived experience offer support to persons with mental health needs who are encountering a transition in care. (pg.76)
Strength of recommendation: Conditional Certainty of evidence of effects: Very Low</td></tr>
<tr><td>Peer workers with lived experience (hereafter referred to as “peer workers”) are non-regulated providers who have lived through experiences similar to those of their peers (e.g., a mental health challenge or illness) and are trained to support others in their journey by providing a consistent presence along with emotional and practical support (14).

Peer workers are to meet specific qualifications and possess the appropriate skills and abilities in order to provide peer support. This includes the need to have appropriate representation to address intersectionality.</td><td></td><td></td></tr>
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