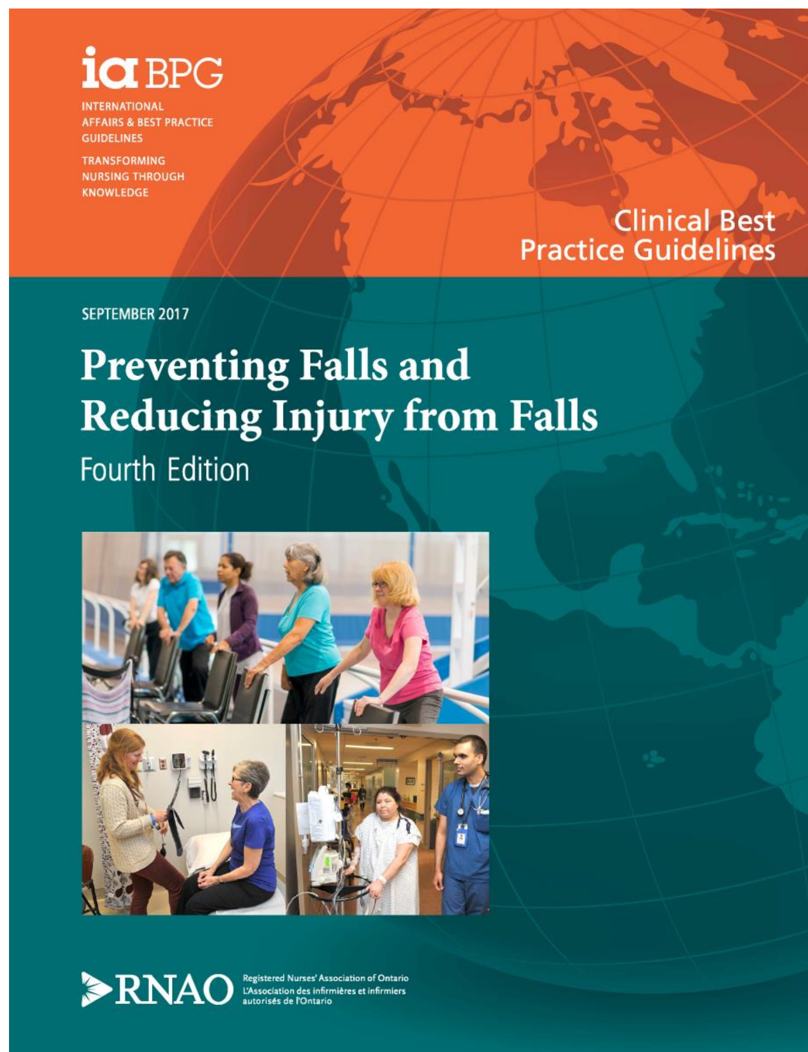
RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Example of a completed gap (opportunity) analysis:
Preventing Falls and Reducing Injury from Falls BPG, Fourth Edition
Focus: Resident/Long-Term Care



This guideline can be downloaded for free at:
http://rnao.ca/bpg/guidelines/prevention-falls-and-fall-injuries

Long-Term Care (LTC) Best Practices Toolkit section for falls prevention is available at:
http://ltctoolkit.rnao.ca/clinical-topics/falls-prevention

What is a gap analysis?

A process comparing your organization's current practice with evidence-based best practice recommendations to determine:

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

Uses of a gap 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, stakeholder 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.

Conducting a gap analysis

Engage the team, and internal and external stakeholders as needed in gathering information for the gap analysis. Collect information on:

- Current practice – is it known and is it consistent? (met, unmet, partially met)
- Partially met recommendations may only be implemented in some parts of the home, or you may feel it is only half done.
- Are there some recommendations that must be implemented before others?
- Can any recommendations be implemented quickly? 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? These may 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 the LTC home?
- Are there existing resources and education that your LTC home can access?
- Are there any must-do recommendations that are crucial to resident and staff safety?

Next steps

1. Celebrate the recommendations 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 resident 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 analysis to the next level see the RNAO Toolkit: Implementation of Best Practice Guidelines (Second edition).

Long-Term Care Homes:

Contact your Long-Term Care Best Practice Co-ordinator to assist you in completing a gap analysis. Visit **RNAO.ca/ltc**.

What are "levels of evidence"?

After each guideline recommendation you will notice a level of evidence. A level of evidence is a ranking system used to describe the strength of results measured in clinical trials and other types of research studies.

- Ia: Evidence obtained from meta-analysis or systematic reviews of randomized controlled trials, and/or synthesis of multiple studies primarily of quantitative research.
- Ib: Evidence obtained from at least one randomized controlled trial.
- IIa: Evidence obtained from at least one well-designed controlled study without randomization.
- IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.
- III: Synthesis of multiple studies primarily of qualitative research.
- IV: Evidence obtained from well-designed non-experimental observational studies, such as analytical studies or descriptive studies, and/or qualitative studies.
- V: Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

Gap Analysis - *Preventing Falls and Reducing Injury from Falls BPG*

Date cCompleted: ______________________________

Team Members participating in the gap analysis:

- ______________________ • ______________________
- ______________________ • ______________________
- ______________________ • ______________________

Completion of this gap analysis allows for the annual comparison of your current practice to evidence-based practices as regulated by the MOHLTC. See Appendix A for this and other regulations that apply to a falls program in your home.

RNAO Best Practice Guideline Recommendations	Met	Partially Met	Unmet	**Notes** (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners)
Practice Recommendations: 1.0				
1.1 Screen all adults to identify those who are at risk for falls. Conduct screening as part of admission processes, after any significant change in health status, or at least annually. Screening should include the following approaches: • identifying a history of previous falls; • identifying gait, balance, or mobility difficulties; and • using clinical judgment.		x		Falls risk assessment and Morse fall tool are not used well Limited reporting of resident's falls history – no reporting of falls in the past 30 days, cause or circumstances of the fall, presence of injuries or follow-up care History of hypotension or comorbidities as falls risks are included in the care plan Residents are asked about their fear of falling when hesitancy is noticed as part of a transfer assessment Considerations: Explore other falls risk assessment tools that may be more LTC specific Develop new documentation to detail a history of falls, the circumstances, cause and injury, as well as any follow-up such as physio or specialist appointments Make sure that any fears of falling are included in the admission report
1.2a For adults at risk for falls, conduct a comprehensive assessment to identify factors contributing to risk and determine appropriate interventions. Use an approach and/or validated tool appropriate for the person and health-care setting.		x		Current assessment includes the Morse tool, presence of comorbidities, falls history, use of ambulatory aids, as well as gait, transfer and mental status Categorizing of residents in care plan as no/Low or high risk Use of falls risk identifiers such as yellow name tags, wrist bands) No use of falls risk score No rounding for residents who are identified as high falls risk Considerations: Use the falls risk score to identify residents at high risk of fractures Implement educational webinars Consider rounding for high-risk residents

RNAO Best Practice Guideline Recommendations	Met	Partially Met	Unmet	Notes (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners)
1.2b Refer adults with recurrent falls, multiple risk factors or complex needs to the appropriate clinician(s) or interprofessional team for further assessment and to identify appropriate interventions.	x			Resident assessment on admission Referral to dietary with injury made Refer to pharmacy for recurrent falls and make physician and nurse practitioners aware Post-fall assessment that includes causative symptoms, time, and circumstances: - results not communicated to all stakeholders, only some. - documentation not always consistent Falls committee has nursing and physiotherapy only – need to add other health professionals Considerations: Develop a checklist for post-fall assessment to better direct documentation. Include dietary and housekeeping staff on falls committee
Practice Recommendations: 2.0				
2.1 Engage adults at risk for falls and fall injuries using the following actions: • explore their knowledge and perceptions of risk, and level of motivation to address risk; • communicate sensitively about risk and use positive messaging; • discuss options for interventions and support self-management; • develop an individualized plan of care in collaboration with the person; • engage family (as appropriate) and promote social support for interventions; and • evaluate the plan of care together with the person (and family) and revise as needed.		x		Staff talk to the resident and family regarding interventions and what they would agree to Power of attorney (POA) is not called automatically after a fall for a capable resident – instead, the resident is asked whether they want a call made regarding the fall Speak with residents regarding abilities and reinforcing interventions that may work for them Fear of falling is not routinely asked of residents. Lack of fall brochures available for residents and families Talk to the resident about interventions when developing a care plan and include details in Point Click Care Considerations: Ask residents about their fear of falling Conduct an audit to ensure care plans are resident-centred Develop a tracking form to ensure all resident falls have been reviewed and interventions documented at each level. Develop a falls brochure
2.2 Provide education to the person at risk for falls and fall injuries and their family (as appropriate) in conjunction with other falls prevention interventions. This includes providing information about risk for falls, falls prevention, and interventions. Ensure that the information is provided in a variety of formats and in the appropriate language.		x		Education is provided to members of the family council but on an interim basis only No education was given to members of the resident council Discussions of falls risk with resident and POA No education brochures or handouts on falls risk Considerations: Develop a brochure for the residents and families on falls

RNAO Best Practice Guideline Recommendations	Met	Partially Met	Unmet	Notes (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners)
				Include fall prevention information in the annual newsletter and admission package
2.3 Communicate risk for falls and related plan of care/interventions with the next responsible health-care provider and/or interprofessional team at all care transitions to ensure continuity of care and to prevent falls or fall injuries.		x		Identify residents at high risk for falls with a yellow name tag Update staff on risk of falls at shift change, as needed Improve follow-up with communication of falls risk with personal support workers (PSW) History of falls is included in the report on shift change Considerations: Develop a process that better identifies falls risk for PSWs
2.4 Implement a combination of interventions tailored to the person and health-care setting to prevent falls or fall injuries.	x			Current interventions being used include mats, assistive devices, medication reviews, last blood work, routine toileting, sensor, Velcro seatbelt, non-skid socks and proper footwear Education provided to the family and resident not always well documented Equipment routinely checked to ensure safety Considerations: Ensure documentation for education is complete and resident and POA (when appropriate) are aware and in agreement.
2.5 Recommend exercise interventions and physical training for adults at risk for falls to improve strength and balance. Encourage an individualized, multicomponent program/activity that corresponds to the current abilities and functioning of the person. (Level of Evidence = Ia)		x		Lack of restorative and physiotherapy care available – referral to physiotherapy when falls risk changes are identified Lack of fall prevention exercise programs Considerations: Consider developing a restorative program focused on falls prevention
2.6 Collaborate with prescribers and the person at risk for falls to reduce, gradually withdraw, or discontinue medications that are associated with falling, when the person's health condition or change in status allows. This includes the following actions: • Identify polypharmacy and medications that increase the risk for falls; • Conduct medication review, or refer to appropriate health-care provider and/or prescriber; and • Monitor for side effects of medications known to contribute to risk for falls.		x		Following a fall, registered staff review the incident including any major changes to health status or new medications. Pharmacy not regularly referred. Considerations: Have a review of medications by a pharmacist following a minimum of three falls.

RNAO Best Practice Guideline Recommendations	Met	Partially Met	Unmet	Notes (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners)
2.7 Refer adults at risk for falls or fall injuries to the appropriate health-care provider for advice about vitamin D supplementation.		x		Most residents taking Vitamin D but family doctors and nurse practitioners haven't ordered it Considerations: Audit Vitamin D usage Look at falls risk score; if high ensure Vitamin D is prescribed
2.8 Encourage dietary interventions and other strategies to optimize bone health in adults at risk for falls or fall injuries, particularly those at risk for fracture. Refer to the appropriate health-care provider for advice and individualized interventions.	x			Dietary referred to after all injuries with falls Intake not routinely reviewed post-fall No referrals on admission if identified as high risk, or if health status changes to high fall risk Dietary changes are made by the dietician in cases of a Vitamin D and/or calcium deficiency is determined – pharmacy may suggest vitamin D and calcium if history of falls Considerations: Review intake for the past 48 hours if a fall occurs Develop a checklist for staff for residents post-fall
2.9 Consider hip protectors as a possible intervention to reduce the risk of hip fracture among adults at risk for falls and hip fracture. Review the evidence, potential benefits, harms, and barriers to use, to support individualized decisions.		x		Hip protectors are available if residents want to wear them however there is low compliance as they are difficult to put on Considerations: Explore alternatives in regard to types of hip protectors
Practice Recommendations: 3.0				
3.1 After a person falls, provide the following interventions: • conduct a physical examination to assess for injury and determine the severity of the fall injury; • provide appropriate treatment and care for injury; • monitor for injuries that may not be immediately identified; • conduct a post-fall assessment to determine factors contributing to the fall; • collaborate with the person and the interprofessional team to conduct further assessments and determine appropriate interventions; and • refer to the appropriate health-care provider(s), (as needed), for physical rehabilitation or to support psychological well-being.		x		The Falls committee includes PSW and nursing staff as well as the pharmacist, RAI MDS coordinator however there are no dietary or housekeeper staff on the committee The Falls committee meets once a month Falls are reviewed at the unit level when they occur The Falls committee does not review specific falls data except the residents who have had a minimum of three or four falls per year Post-fall protocol: • the PSW calls the nurse and makes sure that the resident is safe and comfortable • the nurse asks the resident about their pain and assesses if the fall is related to their range of motion • the nurse asks the resident if they are able to get up • scan the environment for contributing factors • Document in the progress note how the fall happened, any referrals sent and whether it was communicated to the physician or nurse practitioner

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				• For the next 48 hours (or six shifts), report and document any focused interventions (for example, changes to toileting). Any residents with serious injuries should be sent to the hospital for assessment Considerations: Explore the possibility of housekeeping and dietary staff joining the falls committee Consider if time permits to review each fall especially if two or more for a resident for trends, and prevention strategies Explore the need for a restorative program
Education Recommendations: 4.0				
4.1 Educational institutions incorporate content on fall prevention and injury reduction into health-care education and training programs.				Non-applicable
4.2 Health-care organizations provide ongoing organization-wide education to all staff in conjunction with other activities to prevent falls and reduce injuries.	x			Education provided annually using the learning edge platform Practice using simulation and hazard room Considerations: Consider having a fall simulation and hazard room in the summer for staff Create a falls prevention Jeopardy-style game for staff Routinely discuss fall prevention strategies at each report and after a resident has had a fall
Organization and Policy Recommendations: 5.0				
5.1 To ensure a safe environment: • implement universal falls precautions, and • identify and modify equipment and other factors in the physical/structural environment that contribute to risk for falls and fall injuries.	x			Environmental scans are done regularly, most done daily at beginning of care Equipment is visually checked but not documented. If equipment is broken, a referral for repairs is sent. Routine maintenance is done regularly No check-off list is available
5.2 Organizational leaders, in collaboration with teams apply implementation science strategies to enable successful implementation and sustainability of fall prevention/injury reduction initiatives. This includes identifying barriers and establishing formalized supports and structures within the organization.	x			Gap (opportunity) analysis completed Staff participated in the falls community of practice with RNAO Four new RNAO champions trained Considerations: Have members of the falls committee and nursing management take the Champions workshop
5.3 Implement rounding as a strategy to proactively meet the person's needs and prevent falls.			x	No formal rounding. Attempts at intentional rounding unsuccessful Considerations: Explore barriers to success Develop a plan for education and training Plan for an audit of the formal rounding process

RNAO Best Practice Guideline Recommendations	Met	Partially Met	Unmet	Notes (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners)
				Pilot the process with residents identified as high-risk for falls on one unit, then roll out to the rest of the home when ready

Appendix A

Applicable Ministry of Health and Long-Term Care Regulations for a Falls Prevention and Management Program

Required programs

48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

(2) Each program must, in addition to meeting the requirements set out in section 30,

(a) provide for screening protocols; and

(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Section 30

30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

(2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Falls prevention and management

49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

(2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

(3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).