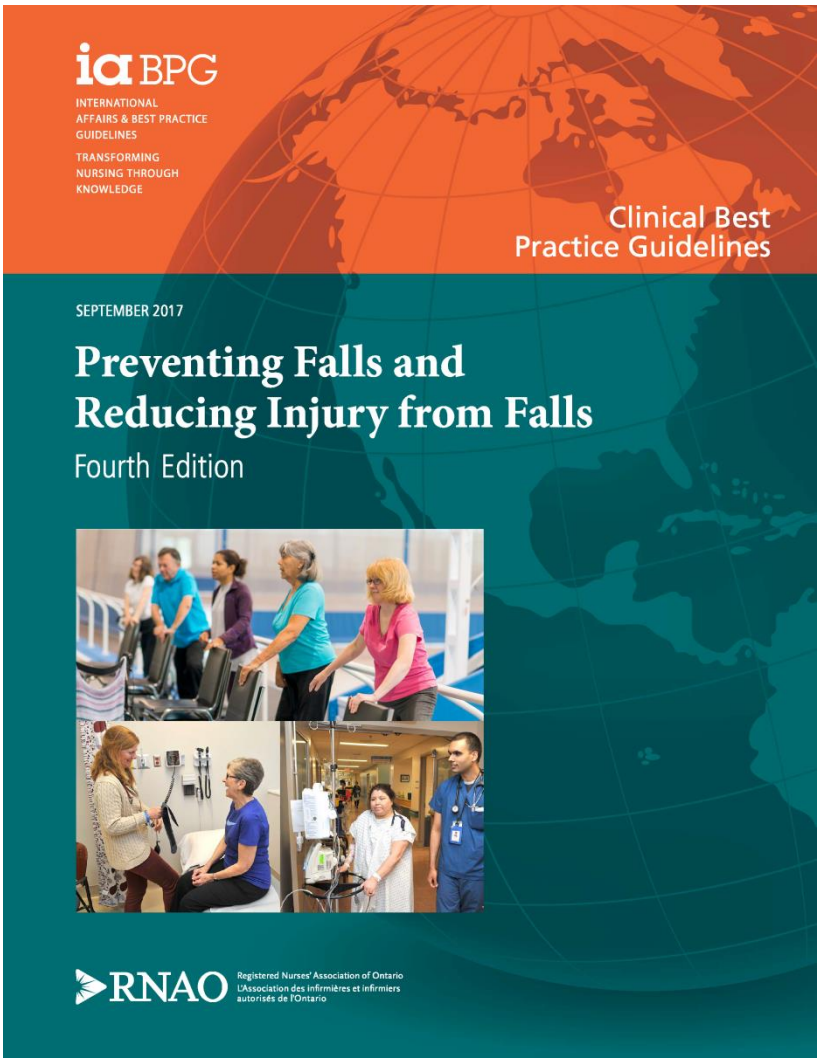
RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Gap Analysis:
Preventing Falls and Reducing Injury from Falls, Fourth Edition 2017
Work Sheet



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

The RNAO *Toolkit: Implementation of Best Practice Guidelines*, Second Edition is also available at:
http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

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 do Levels of Evidence mean?

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.

Date Completed: _____

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. (Level of Evidence = Ia & V)				
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. (Level of Evidence = III)				
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. (Level of Evidence = V)				
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				

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)
• evaluate the plan of care together with the person (and family) and revise as needed. (Level of Evidence = Ia, III, & V)				
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. (Level of Evidence = Ia & V)				
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. (Level of Evidence = V)				
2.4 Implement a combination of interventions tailored to the person and health-care setting to prevent falls or fall injuries. (Level of Evidence = Ia)				
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)				
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 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. (Level of Evidence = Ia & V)				
2.7 Refer adults at risk for falls or fall injuries to the appropriate health-care provider for advice about vitamin D supplementation. (Level of Evidence = V)				
2.8 Encourage dietary interventions and other				

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)
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. (Level of Evidence = V)				
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. (Level of Evidence = Ia)				
Practice Recommendations: 3.0				
3.1 After a person falls, provide the following interventions: • conduct a physical examination to assess for injury and determine severity of 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 appropriate health-care provider(s), (as needed), for physical rehabilitation or to support psychological well-being. (Level of Evidence = III & V)				
Education Recommendations: 4.0				
4.1 Educational institutions incorporate content on falls prevention and injury reduction into health-care education and training programs. (Level of Evidence=V)				
4.2 Health-care organizations provide ongoing organization-wide education to all staff in conjunction with other activities to prevent falls and reduce injuries. (Level of Evidence = Ia)				
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				

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)
and fall injuries. (Level of Evidence = Ia)				
5.2 Organizational leaders, in collaboration with teams apply implementation science strategies to enable successful implementation and sustainability of falls prevention/injury reduction initiatives. This includes identifying barriers and establishing formalized supports and structures within the organization. (Level of Evidence = Ia)				
5.3 Implement rounding as a strategy to proactively meet the person's needs and prevent falls. (Level of Evidence = Ia)				

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).