

GAP ANALYSIS TOOLS

Goal: To identify process improvement opportunities within each department and develop overall strategies to achieve highly reliable care.

Where to use: This set of tools should be used within the patient safety hubs of critical care, medical/surgical, operating room, and the emergency department.

Who should use: Director- and manager-level staff within the patient safety hubs of critical care, medical/surgical, operating room and the emergency department, with support from NYSPFP Project Managers.

Overview: This tool provides a format to identify gaps between established best practices and your own hospital's practices. Teams will identify if a highly reliable process within each clinical focus area exists in an effort to achieve "No Harm Across the Board." Upon completing the gap analysis, teams will have an understanding of specific instances where best practices are not being implemented or not being regularly implemented.

- The gap analysis tools for each patient safety hub contain a list of Best Practices. Each **Best Practice** area outlines specific **Focus Areas and Prevention Strategies**. Rate each Focus Area and Prevention Strategy as *always*, *usually*, *sometimes*, or *never* in terms of having in place a process/strategy and applying that process/strategy to address each Focus Area and Prevention Strategy. When assigning a rating, think about how often each process/strategy is really being done. Consider overnight shifts, as well as weekend shifts, in your review.
- Next to each rating, there is space to complete an **Action Plan For Improvement**, addressing *who* will be involved in the plan, *what* the plan will entail, *where* the plan will take place, and by *when* the plan will occur.
- It is most useful to first focus on discussing and addressing those strategies that are rated as *never* or *sometimes*. If there is capacity, you can then turn to addressing the instances rated *usually*.

