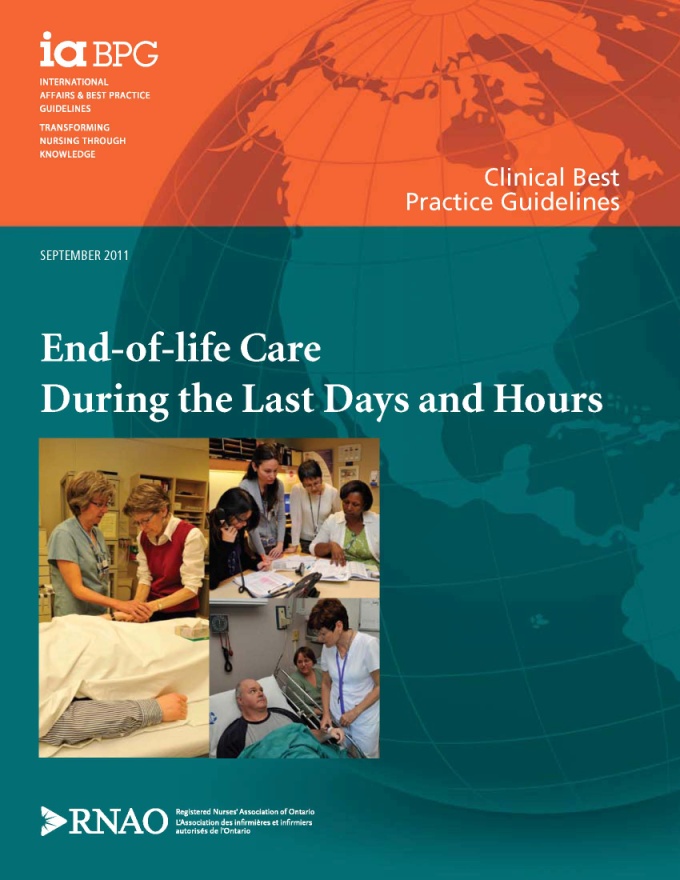
**RNAO_Logo_H_CMYK.tif**

**Gap Analysis:**

***End-of-Life Care During the Last Days and Hours*, September 2011**

**Work Sheet**

****

This guideline can be downloaded for free at:

<http://rnao.ca/bpg/guidelines/endoflife-care-during-last-days-and-hours>

The RNAO Leading Change Toolkit 3rd Edition

<https://rnao.ca/leading-change-toolkit>

****

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 per Fixing Long-Term Care Act, 2021 at <https://www.ontario.ca/laws/statute/21f39> &

[O. Reg. 246/22: GENERAL (ontario.ca)](https://www.ontario.ca/laws/regulation/r22246)

| **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 for Assessment at the End of Life** | | | | | | | | |
| 1.1 Nurses identify individuals who are in the last days and hours of life.  (Level IIa–IV Evidence) | | | | |  |  |  |  |
| 1.1.1 Use clinical expertise, disease specific indicators and validated tools to identify these individuals.  (Level IIa–IV Evidence) | | | | |  |  |  |  |
| 1.1.2 Understand the end-of-life trajectories.  (Level IIa–IV Evidence) | | | | |  |  |  |  |
| 1.2 Nurses understand the common signs and symptoms present during the last days and hours of life.  (Level IIb–IV Evidence) | | | | |  |  |  |  |
| 1.2.1 Common signs of imminent death, may include, but are not limited to: | | | | |  |  |  |  |
| * Progressive weakness; * Bedbound state; * Sleeping much of the time; * Decreased intake of food and fluid; * Darkened and/or decreased urine output; * Difficulty swallowing (dysphagia); | | * Delirium not related to reversible causes; * Decreased level of consciousness not related to other causes; * Noisy respiration/excessive respiratory tract secretion; * Change in breathing pattern (Cheyne-Stokes respiration, periods of apnea); and * Mottling and cooling extremities. | | |
| (Level IIb–IV Evidence) | | | | |
| 1.3 Nurses complete a comprehensive, holistic assessment of individuals and their families based on the Canadian Hospice Palliative Care Association Domains of Care, which include the following: | | | | |  |  |  |  |
| * Disease management; * Physical; * Psychological; * Spiritual; | * Social; * Practical; * End-of-life care/death management; and * Loss, grief. | | | |
| (Level IIb–IV\* Evidence) | | | | |
| 1.3.1 Include information from multiple sources to complete an assessment. These may include proxy source such as the family and other health-care providers.  (Level IIb–IV\* Evidence) | | | | |  |  |  |  |
| 1.3.2. Use evidence-informed and validated symptom assessment and screening tools when available and relevant.  (Level IIb–IV\* Evidence) | | | | |  |  |  |  |
| 1.3.3. Reassess individuals and families on a regular basis to identify outcomes of care and changes in care needs.  (Level IIb–IV\* Evidence) | | | | |  |  |  |  |
| 1.3.4 Communicate assessments to the interprofessional team.  (Level IIb–IV\* Evidence) | | | | |  |  |  |  |
| 1.3.5 Document assessments and outcomes.  (Level IIb–IV\* Evidence) | | | | |  |  |  |  |
| 1.4 Nurses:   * Reflect on and are aware of their own attitudes and feelings about death; * Assess individuals’ preferences for information; * Understand and apply the basic principles of communication in end-of-life care;. * Communicate assessment findings to individuals(if possible and desired) and the family on an ongoing basis; * Educate the family about the signs and symptoms of the last days and hours of life, with attention to their ; faith and spiritual practices; age-specific needs; developmental needs; cultural needs; and * Evaluate the family’s comprehension of what is occurring during this phase.   (Level III–IV Evidence) | | | | |  |  |  |  |
| **Practice Recommendations for Decision Support at the End of Life** | | | | | | | | |
| 2.1. Nurses recognize and respond to factors that influence individuals and their families’ involvement in decision-making.  (Level Ib, IV, IV\* Evidence) | | | | |  |  |  |  |
| 2.2. Nurses support individuals and families to make informed decisions that are consistent with their beliefs, values and preferences in the last days and hours of life.  (Level Ia – IV\* Evidence) | | | | |  |  |  |  |
| **Practice Recommendations for Care and Management at the End of Life** | | | | | | | | |
| 3.1 Nurses are knowledgeable about pain and symptom management interventions to enable individualized care planning.  (Level III–IV Evidence) | | | | |  |  |  |  |
| 3.2 Nurses advocate for and implement individualized pharmacologic and non-pharmacologic care strategies.  (Level Ia–IV Evidence) | | | | |  |  |  |  |
| 3.3. Nurses educate and share information with individuals and their families regarding: | | | | |  |  |  |  |
| * Reconciliation of medications to meet the individual’s current needs and goals of care; * Routes and administration of medications; * Potential symptoms; * Physical signs of impending death; | | | | * Vigil practices; * Self care strategies; * Identification of a contact plan for family when death has occurred; and * Care of the body after death. |
| (Level Ib–III Evidence) | | | | |
| 3.4 Nurses use effective communication to facilitate end of life discussions related to: | | | | |  |  |  |  |
| * Cultural and spiritual values, beliefs and practices; * Emotions and fears; * Past experiences with death and loss; * Clarifying goals of care; | | | * Family preference related to direct care involvement; * Practical needs; * Informational needs; * Supportive care needs; * Loss and grief; and * Bereavement planning. | |
| (Level III Evidence) | | | | |
| **Education Recommendations** | | | | | | | | |
| 4.1. Entry to practice nursing programs and post-registration education incorporate specialized end-of-life care content including:   * Dying as a normal process including the social and cultural context of death and dying, dying trajectories and signs of impending death; * Care of the family (including caregiver); * Grief, bereavement and mourning; * Principles and models of palliative care; * Assessment and management of pain and other symptoms(including pharmacologic and non-pharmacologic approaches); * Suffering spiritual/existential issues and care; * Decision-making and advance care planning; * Ethical issues; * Effective and compassionate communication; * Advocacy and therapeutic relationship-building; * Interprofessional practice and competencies; * Self-care for nurses, including coping strategies and self-exploration of death and dying; * End-of-Life issues in mental health, homelessness and the incarcerated; * The roles of grief and bereavement educators, clergy, spiritual leaders and funeral directors; and * Knowledge of relevant legislation.   (Level Ia–III Evidence) | | | | |  |  |  |  |
| 4.2 Successful education in end-of-life care includes specific attention to the structure and process of learning activities and incorporates:   * Small group learning; * Dyadic and experiential learning approaches; * Integration and consolidation of theory and practice; * Opportunities to practice the skills and competencies acquired; * Constructive feedback and/or reflection on acquired knowledge, skills and competencies; and * Contact with knowledgeable and supportive clinical supervisors and mentors.   (Level Ib–III Evidence) | | | | |  |  |  |  |
| **Organization & Policy Recommendations** | | | | | | | | |
| 5.1 Models of care delivery support the nurse, individual and family relationship.  (Level III–IV Evidence) | | | | |  |  |  |  |
| 5.2 Organizations recognize that nurses’ well-being is a critical component of quality end-of-life care and adopt responsive strategies.  (Level III–IV Evidence) | | | | |  |  |  |  |
| 5.3 Organizations providing end-of-life care demonstrate evidence of a philosophy of palliative care based on the Canadian Hospice Palliative Care Association’s The model to Guide Hospice Palliative Care.  (Level III–IV Evidence) | | | | |  |  |  |  |
| 5.4 Nursing best practice guidelines can be successfully implemented only when there are adequate planning, resources, organizational and administrative supports, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:   * An assessment of organization readiness and barriers to implementation. * Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. * Dedication of a qualified individual to provide the support needed for the education and implementation process. * Opportunities for reflection on personal and organizational experience in implementing guidelines.   (Level IV Evidence) | | | | |  |  |  |  |