Executive Summary

From National Crisis to Local Change: Addressing End-of-Life Care in a Rural North Carolina Nursing Home

Kara Waldrop

East Carolina University

NURS 8377

Dr. Dillon-Spruill and Dr. Conway

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Project at a Glance

- Education improved nursing staff knowledge and confidence regarding advance care planning and MOST form utilization.
- Twenty-one nursing staff completed pre- and post-intervention surveys; 32 patients/family members completed post-intervention surveys.
- 62% of staff strongly agreed and 31% agreed that their knowledge of the MOST form improved.
- 58% of staff strongly agreed and 36% agreed they felt more confident discussing end-of-life care.
- 66% of patients/families strongly agreed and 31% agreed that the education improved discussions about future care wishes.
- Quarterly chart audits confirmed that 100% of residents had signed and current MOST forms.
- Education created a sustainable process for advance care planning within the facility.

Background and Significance

Advance care planning is an essential component of high-quality, patient-centered care in skilled nursing facilities, where residents often have advanced chronic illness and complex healthcare needs. Delayed goals-of-care discussions and inconsistent Medical Orders for Scope of Treatment (MOST) documentation can result in

care that does not align with patient preferences, leading to unnecessary interventions and avoidable hospital transfers (Harrison et al., 2021). Evidence demonstrates that standardized communication processes, staff education, and patient and family engagement improve advance care planning, documentation accuracy, and goal-concordant care (Chisholm et al., 2021; Gonella et al., 2020; Phua et al., 2023).

As the nurse practitioner in a rural skilled nursing facility, I identified inconsistent staff knowledge regarding MOST forms and varying levels of confidence initiating advance care planning conversations. Patients and families also demonstrated a limited understanding of advance directives, hospice, palliative care, and comfort-focused treatment. These practice gaps, together with evidence supporting standardized workflows, leadership engagement, and ongoing education (Krishnan et al., 2025), established the need for a structured educational intervention to improve communication, documentation, and patient-centered decision-making.

Purpose

Guided by evidence supporting structured communication, targeted staff education, standardized workflows, and patient and family engagement, this quality improvement project implemented a multifaceted intervention to strengthen advance care planning within a rural skilled nursing facility (Chisholm et al., 2021; Gonella et al., 2020; Phua et al., 2023).

The purpose of this Doctor of Nursing Practice project was to improve end-of-life care decision-making through education on advance care planning and Medical Orders for Scope of Treatment (MOST) form utilization. Project aims included improving nursing staff knowledge and confidence, increasing patient and family understanding of advance

care planning, and strengthening organizational processes to support accurate and current MOST documentation.

Project Design and Implementation

Using the Plan-Do-Study-Act framework, an evidence-based educational intervention was implemented in a rural skilled nursing facility. Interactive education for nursing staff addressed advance directives, hospice, palliative care, goals-of-care conversations, comfort-focused treatment, and completion of the MOST form using realistic clinical scenarios. Twenty-one nursing staff completed pre- and post-intervention surveys measuring knowledge and confidence. Separate educational sessions were provided for patients and family members, with 32 participants completing post-intervention surveys evaluating understanding of advance care planning and confidence discussing future healthcare wishes. Documentation quality was monitored through routine chart audits of MOST forms. Interactive education for nursing staff addressed advance directives, hospice, palliative care, goals-of-care conversations, comfort-focused treatment, and completion of the MOST form using realistic clinical scenarios. Twenty-one nursing staff completed pre- and post-intervention surveys measuring knowledge and confidence. Separate educational sessions were provided for patients and family members, with 32 participants completing post-intervention surveys evaluating understanding of advance care planning and confidence discussing future healthcare wishes. Documentation quality was monitored through routine chart audits of MOST forms.

Results

The intervention produced meaningful improvements across all measured outcomes. Following the educational intervention, 62% of nursing staff strongly agreed

and 31% agreed that their knowledge of the MOST form had improved (see Figure 1). Likewise, 58% strongly agreed and 36% agreed they felt more confident discussing end-of-life care and advance care planning with patients and families (see Figure 2). Patient and family education was similarly successful, with 66% strongly agreeing and 31% agreeing that the education helped them discuss future care wishes (see Figure 3).

Practice improvements extended beyond survey responses. Quarterly chart audits demonstrated that 100% of residents had a completed and signed MOST form that was reviewed and updated at least every quarter. This standardized process improved documentation consistency and supported communication across the interdisciplinary team.

Figure 1

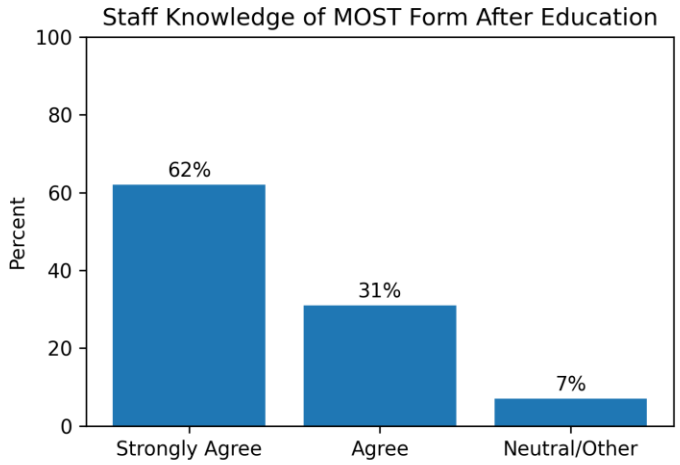


Figure 2

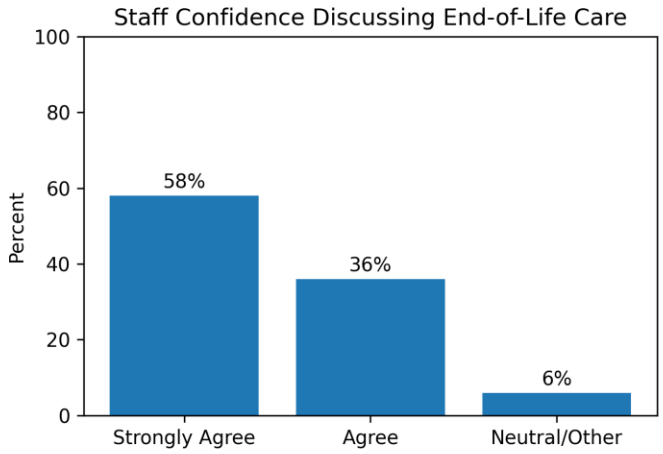
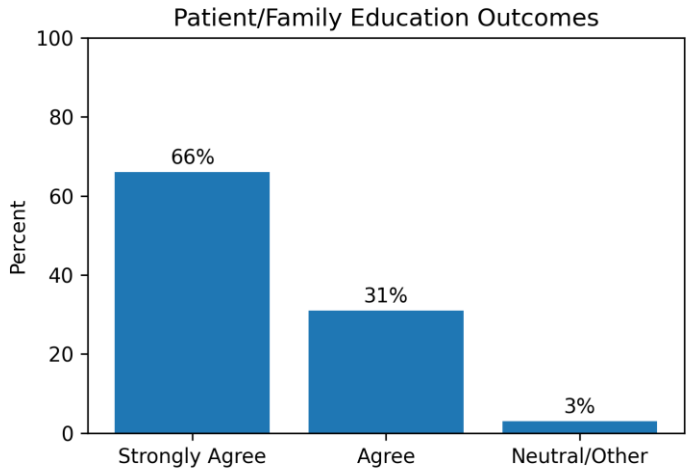


Figure 3



Implications for Nursing Practice

The improvements observed in staff knowledge and confidence (Figures 1 and 2) demonstrate that structured, evidence-based education can prepare clinicians to initiate

meaningful goals-of-care discussions. Similarly, the positive patient and family outcomes (Figure 3) suggest that education enhances understanding of advance care planning and supports informed, shared decision-making. Together with the documentation improvements identified through quarterly chart audits, these findings support the incorporation of advance care planning education into routine practice within skilled nursing facilities.

Organizational Impact

The project established a standardized workflow for advance care planning that can be sustained through routine educational programming and documentation review. Although reductions in hospital transfers could not be directly attributed to the intervention because of multiple influencing variables, the project strengthened communication across disciplines and promoted continuity of care by ensuring treatment preferences remained current and accessible.

Strengths and Limitations

Strengths included implementation in a real-world rural setting, engagement of both healthcare professionals and patients/families, evidence-based educational content, and evaluation using surveys and chart audits. Limitations included implementation at a single facility, a modest sample size, reliance on self-reported survey responses, and the use of only a post-survey for patients and families.

Sustainability and Future Recommendations

Long-term sustainability will be supported by incorporating advance care planning education into new employee orientation, annual competency training, quarterly

MOST audits, and interdisciplinary review of goals of care following significant changes in resident condition. Future projects should evaluate implementation across multiple facilities and examine longer-term effects on quality indicators, healthcare utilization, and resident-centered outcomes.

Conclusion

This Doctor of Nursing Practice quality improvement project demonstrated that education, communication, and standardized processes can strengthen advance care planning in long-term care. By improving nursing staff knowledge and confidence, increasing patient and family understanding, and supporting accurate MOST documentation, the project advanced patient-centered end-of-life care and provides a sustainable model for future practice.

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