Geriatric Assessment for Nurses

Clinical guide: Nutritional Assessment of Older Adults

Clinical Training Guide

Learning outcomes

1. Explain the purpose, components, scoring, and clinical significance of key geriatric nutritional assessment tools.
2. Demonstrate correct administration of:
   - Mini Nutritional Assessment (MNA)
   - Malnutrition Screening Tool (MST) / Malnutrition Universal Screening Tool (MUST)
   - Subjective Global Assessment (SGA)
   - DETERMINE Your Nutritional Health Checklist
3. Demonstrate correctly obtaining Anthropometric measurements.
4. Identify normal and abnormal nutritional findings in older adults.
5. Interpret nutritional assessment scores and categorize patients into nutritional risk groups.
6. Develop appropriate nursing interventions and care plans based on assessment findings.
7. Educate older adults and caregivers on nutrition, meal planning, hydration, and risk reduction for undernutrition.

Required assessment tools

Paper-Based Screening Tools

- Mini Nutritional Assessment (MNA) full form & MNA-Short Form
- Malnutrition Screening Tool (MST)
- Malnutrition Universal Screening Tool (MUST)
- Subjective Global Assessment (SGA) forms
- DETERMINE Checklist
- Food diary / 24-hour dietary recall forms

Anthropometric Tools

- Stadiometer or height chart
- Weight scale (calibrated)
- Tape measure (for MUAC & calf circumference)
- BMI chart (older adult cutoffs)

Additional Equipment

- Chair with back support
- Gloves, pen, clipboard
- Calculator

Clinical skills procedures

A. General preparation

1. Introduce yourself, explain the purpose of nutritional assessment.
2. Ensure privacy and respect for older adults.
3. Confirm use of hearing aids/glasses if needed.
4. Collect relevant history:
    - Appetite changes
    - Weight loss/gain
    - Chewing/swallowing difficulties
    - Chronic diseases
    - Medication review

B. Assessment tool procedures

1. Mini nutritional assessment (mna)

Components

- Anthropometric measures
- General assessment
- Dietary assessment
- Global subjective assessment

Procedure

1. Measure weight, height, bmi or muac if height cannot be measured.
2. Ask questions related to food intake decline, mobility, psychological stress, neuropsychological problems.
3. Score according to guidelines.

Interpretation

- 24–30: normal nutritional status
- 17–23.5: at risk of malnutrition
- <17: malnourished

2. Malnutrition screening tool (mst)

Components

- Weight loss
- Appetite

Procedure

1. Ask about unintentional weight loss in past 6 months.

2. Ask about appetite reduction.
3. Score 0–5.

Interpretation

- 0–1: low risk
- 2–3: medium risk
- 4–5: high risk

3. Malnutrition universal screening tool (must)

Components

- BMI
- Weight loss
- Acute disease effect

Procedure

1. Calculate bmi using height & weight.
2. Assess unintentional weight loss %.
3. Assess acute illness that may restrict intake.
4. Add scores.

Interpretation

- 0: low risk
- 1: medium risk
- ≥2: high risk

4. Subjective global assessment (sga)

Components

- Weight change
- Dietary intake change
- Gi symptoms
- Functional capacity
- Muscle wasting
- Fat loss
- Edema/ascites

Procedure

- Perform history + physical assessment.
- Classify into:
    - A = well nourished

- B = moderately malnourished
- C = severely malnourished

5. Determine your nutritional health checklist

Procedure

1. Ask questions covering:
   - Disease
   - Eating poorly
   - Tooth loss
   - Economic hardship
   - Reduced social contact
   - Multiple medications
   - Weight loss/gain
   - Needs assistance
   - Advanced age
2. Add total score.

- Interpretation
- 0–2: good
- 3–5: moderate nutritional risk
- ≥6: high risk

6. Anthropometric measurements

A. Body mass index (BMI)

Older adult cutoffs:

- <22 = underweight
- 22–27 = healthy
- 27 = overweight

B. Mid–upper arm circumference (muac)

- <23 cm = suggests undernutrition
- C. Calf circumference
- <31 cm = reduced muscle mass

D. Weight trends

- Unintentional weight loss >5% in 1 month or >10% in 6 months = severe risk

Nursing care planning guide

A. Common Nursing Diagnoses

- Imbalanced nutrition: less than body requirements
- Risk for malnutrition
- Difficulty chewing/swallowing
- Inadequate food intake
- Risk for dehydration
- Self-care deficit: feeding

B. Goals / Expected Outcomes

- Patient maintains weight or achieves desirable weight.
- Adequate nutritional intake (≥75% of needs).
- Improved anthropometric measures over time.
- Reduced nutritional risk score on reassessment.

C. Nursing Interventions

- Provide calorie-dense, protein-rich meals.
- Offer small, frequent meals.
- Assist with feeding if needed.
- Encourage proper denture use and oral hygiene.
- Monitor for swallowing difficulties.
- Collaborate with dietician for meal planning.
- Manage contributing medical conditions (dysphagia, depression, GI issues).
- Educate on hydration needs and safe food practices.

D. Evaluation

- Repeat MNA/MUST/MST every 3 months.
- Monitor weight trends weekly/monthly.
- Document changes in dietary intake and functional status.

Clinical Practice Activity

Activity Steps

1. Students perform MNA on a standardized patient.
2. Students complete MUST and MST using given data.
3. Students perform:
    - Weight measurement
    - Height
    - MUAC
    - Calf circumference
4. Students complete SGA through interviewing and physical exam.
5. Students summarize findings & develop a nursing care plan.

Expected Deliverables

- Completed assessment tools
- Risk categorization
- One-page interpretation
- Nursing care plan

Assessment criteria for students

Competency Area	Excellent (5)	Good (4)	Satisfactory (3)	Needs Improvement (1–2)
Tool administration	Accurate, complete	Minor omissions	Mostly correct	Incorrect administration
Anthropometric measurement	Perfect technique	Minor errors	Acceptable	Incorrect measurement
Scoring accuracy	100% correct	1–2 mistakes	Some errors	Frequent mistakes
Interpretation	Clear, clinically sound	Minor gaps	Adequate	Incorrect
Nursing care plan	Comprehensive	Good	Basic	Incomplete
Communication & professionalism	Excellent rapport	Good	Acceptable	Poor

Patient education checklist

Explain Purpose

- Screening for risk of malnutrition
- Importance of early detection
- Relation to immunity, recovery, muscle strength

Dietary Advice

- Balanced diet with adequate proteins
- Include fruits, vegetables, whole grains
- Encourage hydration (6–8 cups/day unless restricted)
- Choose soft foods if chewing difficulty exists
- Avoid skipping meals

Address Barriers

- Poor appetite
- Loneliness and eating alone
- Financial limitations
- Poor denture fit
- Medication side effects

Weight Monitoring

- Weekly weight checks (home or clinic)
- Report unintentional weight loss

Food Safety

- Proper storage
- Avoid expired foods
- Safe reheating practices

When to Seek Help

- Sudden weight loss
- Persistent poor appetite
- Swallowing difficulties
- Signs of dehydration

Caregiver Guidance

- Meal planning
- Encouraging social meals
- Monitoring intake using food diary