Geriatric assessment: malnutrition

ASSIGN BUSTER

In a continuously growing geriatric population, malnutrition is one of the most common and most undiagnosed problems. Malnutrition is not only the indicator of existing medical and socio-economic problems, but can also be a cause of physiological and psychological dysfunctions. Proper nursing assessment in the elderly should be applied in order to identify and address this problem. In this paper I would like to focus on two main points of geriatric assessment – physiologic and psychosocial. There are two categories of factors that can contribute to malnutrition in the elderly population.

Physiological factors include chewing or swallowing disorders, cardiac insufficiency, respiratory problems, problems with digestion, absorption, and elimination, as well as diabetes, chronic pain, and infection. Psychosocial factors can be divided into two sub-categories psychological – depression, mental retardation, alcoholism, and Alzheimer’s disease, as well as the socio-economical category, which includes social isolation, poverty, cultural diversity, and an inability to access food, either due to physical disability or absence of transportation.

Assessment of all these factors should be done thoroughly and routinely for older people a population to identify existing or potential problems related to malnutrition. Nursing assessment is the process of gathering a comprehensive data about the client's present, past, and potential health problems, as well as a description of the client as a whole in his or her environment (Lagerquist, 2006).

For proper assessment and interpretation of the results, it is very important to understand the physiologic changes unique to this population, as well as

the differences between normal aging-related changes and health alterations caused by illnesses and social changes (Cary, 2011). In providing proper nursing care and to prevent from future health issues nurses should perform a nutritional assessment on geriatric clients. This assessment should include questions about eating habits – number of meals per day, preferred snacks, amount of liquid consumed during the day, favorite foods, cultural preferences and limitations.

The nursing nutritional assessment includes taking weight and height measurements, calculating body mass index (BMI), and establishing the current nutritional status of the patient. In case assessed data suggests nutritional deficiency, which can be presented by either too high or too low BMI, further nutritional assessment is suggested. The most widely used and extensively validated screening tool used by dieticians, and can be utilized by nurses, is the Mini-Nutritional Assessment (MNA). The advantage of the MNA is that it is applicable to a wide range of elderly patients (i.

e. , from those who are well to hospitalized elderly), and is also short and quite informative (Wells & Dumbrell, 2006). Other suitable tools for evaluating the nutritional status of elderly persons are weight loss within the last 6 months, the Subjective Global Assessment (SGA), laboratory tests, and collateral history from family or caregivers. Comprehensive geriatric head-to-toe assessment may reveal underlining physiological causes of malnutrition in an aging client. For example, polypepsia and polyuria may contribute to a weight loss in hyperthyroidism or new-onset diabetes.

Progressive renal or hepatic insufficiency may also cause anorexia, a malnutritive condition with highly morbid implications in the elderly. Weight

loss related to poor oral intake is also associated with peptic ulcer disease, GERD, and congestive heart failure, as well as dental or chewing problems (Wells & Dumbrell, 2006). Assessment of grip strength, gait speed, and activity can reveal symptoms of the frailty syndrome which is defined as unintentional weight and muscle loss (Heuberger, 2011).

A medication review is also an important part of the nursing assessment of the patient. For example, cholinesterase inhibitors as a class can cause nausea, vomiting, anorexia, or diarrhea and can be associated with weight loss (Wells & Dumbrell, 2006). Polypharmacy is another factor, which can contribute to malnutrition, and should be carefully assessed therefore. Nurses should assess psycho-social factors, which could lead to nutritional alterations.

Factors such as loss of caregiver support, social isolation, limited access to food, an inability to cook and prepare food because of cognitive problems, or inability to recognize hunger may contribute to patient’s malnutrition. Collateral history from a caregiver and a home visit can provide invaluable insight into these issues (Wells & Dumbrell, 2006). Knowledge of the normal and pathological changes in cognition that occur in aging is an essential background to understanding interventions to optimize cognition in older adults.

(Williams & Kemper, 2010). Nutrition has been identified as a critical factor in successful cognitive aging as well as in abnormal cognitive decline, including dementia. Thus, nurses need to assess cognitive aging as a basis for educating clients about their nutritional needs and for developing interventions to promote cognitive and physiological wellbeing. There is

strong evidence that a balanced nutrition can improve cognitive performance in older adults (Scott at al. , 2006).

An evidence based nutrition assessment provides valuable information about the current nutritional status of a geriatric patient as well as serves as a prognostic tool for potential health changes related to malnutrition. Assessing the health needs of elderly patients can reduce their hospitalization rate and enhance their quality of life and independence. Information obtained from an accurate assessment serves as the foundation for age-appropriate evidence based nursing care (Cary, 2011).