NURSING ASSESSMENT IN ELDERLY

GRACY MATHAI
CEO

INTRODUCTION

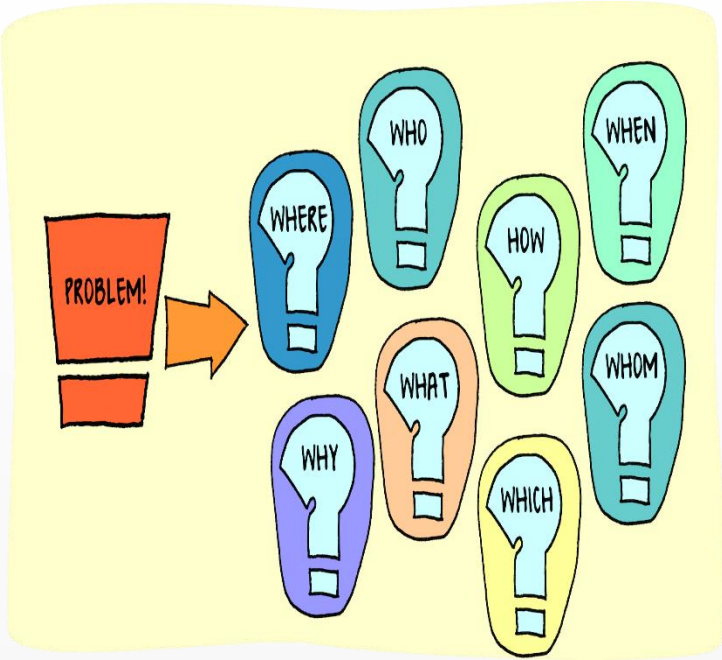
It refers to the systematic process of gathering relevant information about the health status, functional abilities, and psychosocial needs of older adults.

The purpose of nursing assessment in the elderly is to identify:

- Unique needs and challenges
- Detect potential health problems
- Develop individualised care plans

OBJECTIVES

- ***Understand*** the significance of nursing assessments in the elderly population
- ***Identify*** key areas to assess in the nursing evaluation for older adults
- ***Highlight*** assessment tools and scores used in geriatric nursing assessments



IMPORTANCE OF NURSING ASSESSMENT IN ELDERLY

1. Early detection of health issues
2. Tailoring care plans to individual needs
3. Monitoring changes in health status
4. Facilitating appropriate interventions

Key areas of focus in nursing assessment for the elderly includes:

Health History

Physical Assessment

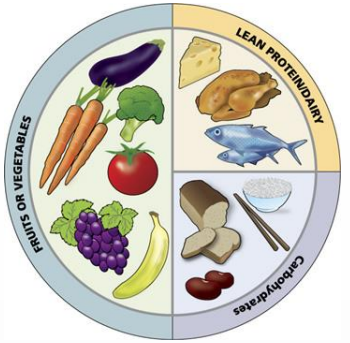
Mental Health

Cognitive Function

Fall risk assessment

Functional Abilities

Medication Review



Nutritional Assessment

Social Support and Resources

Palliative care and needs

Health History

Gathering a detailed health history is essential to understand the person's medical conditions :

- past illnesses
- surgeries
- Allergies
- Current medications.

This helps identify potential health risks and guides appropriate care planning

Cognitive Function

Evaluating cognitive function is crucial in identifying conditions such as:

- dementia or delirium.

a. memory
b. orientation
c. attention
d. language
e. problem-solving abilities

Mental Health

Assessing the elderly person's mental health includes evaluating their:

- mood
- emotional well-being
- and any signs of depression
- anxiety
- other psychiatric conditions.

Fall risk

As falls are a common concern among the elderly, assessing factors such as :

- Balance
- Gait
- Mobility
- Vision

The presence of environmental hazards helps determine the risk of falls and guide preventive measures

Physical Assessments

A thorough physical examination is conducted to assess:

- vital signs (blood pressure, heart rate, respiratory rate, temperature)
- overall appearance
- skin integrity
- mobility
- sensory function
- nutrition
- any signs of discomfort or pain.

Functional abilities

Assessing the individual's ability to perform activities of daily living (ADL).
Instrumental activities of daily living (IADL) helps determine their level of independence and need for assistance.
This includes assessing their ability to

- bathe
- dress
- eat
- use the toilet
- manage finances
- shop for groceries
- prepare meals
- perform household tasks.

Social Support and resources

Evaluating the elderly person's :

- social support network
- living situation
- access to community resources
- caregiver availability
- helps identify potential gaps in support and the need for additional services or interventions.

Nutritional assessment

Evaluating the elderly person's nutritional status and dietary intake helps identify

- malnutrition risk
- hydration status
- the need for dietary modifications or nutritional support.

Palliative care and needs

For elderly individuals with chronic or life-limiting illnesses, assessing their palliative care needs, including

- pain management
- symptom control
- end-of-life preferences

is important to ensure their comfort and quality of life.

Medication review

Assessing the individual's medication regimen

- prescription medications
- over-the-counter drugs
- herbal supplements
- helps identify potential medication-related issues such as adverse effects, interactions, or non-adherence.

ASSESSMENT TOOLS AND SCORES

Following tools are used commonly in geriatric nursing :

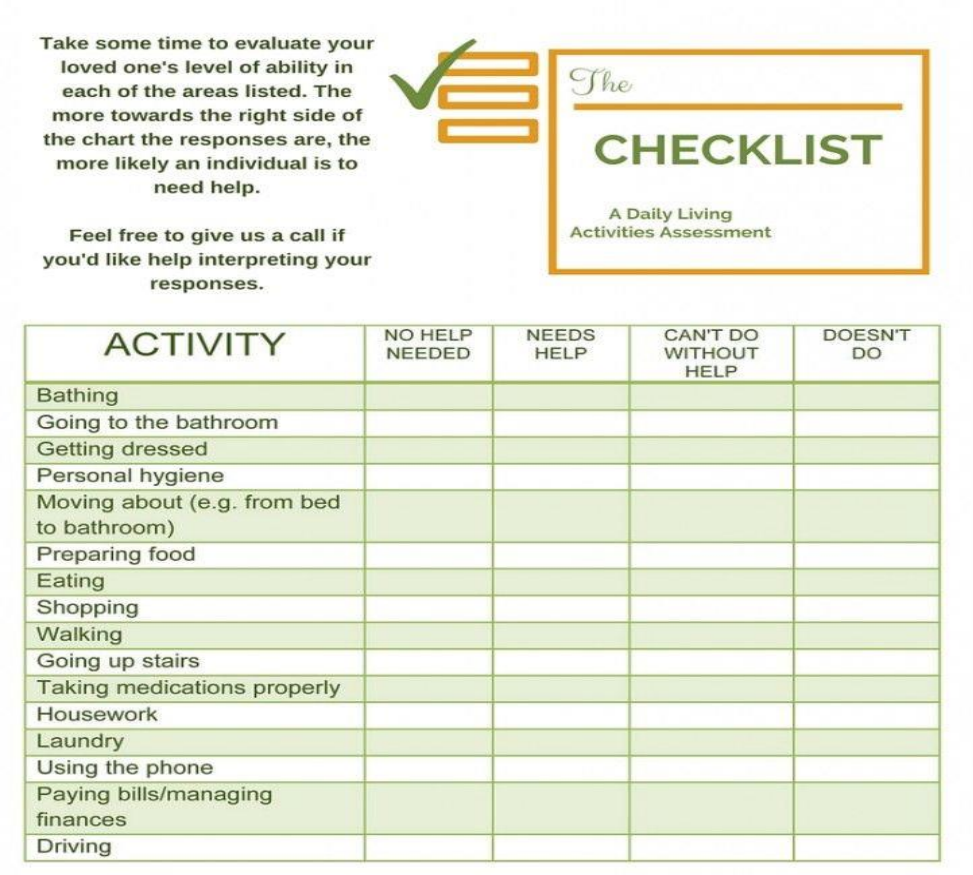
- Activities of Daily Living (ADL)
- Instrumental Activities of Daily Living (IADL)
- Mini-Mental State Examination (MMSE)
- Geriatric Depression Scale (GDS)
- Fall Risk Assessment Tools
- Pain Assessment Tools

ACTIVITIES OF DAILY LIVING - ADL

- The Activities of Daily Living (ADL) tool is a measurement used in healthcare to assess an individual's functional abilities and level of independence in performing basic self-care tasks.
- ADLs are essential activities that people typically perform on a daily basis to take care of themselves and maintain their well-being.
- The ADL tool is commonly used in geriatric care, rehabilitation settings, and assessments for individuals with disabilities or chronic illnesses.

The specific activities included in the ADL tool may vary slightly depending on the assessment tool or healthcare setting, but they generally cover the following six categories:

- Personal Hygiene
- Continence
- Dressing
- Transferring
- Feeding
- Mobility



Take some time to evaluate your loved one's level of ability in each of the areas listed. The more towards the right side of the chart the responses are, the more likely an individual is to need help.

Feel free to give us a call if you'd like help interpreting your responses.

The CHECKLIST

A Daily Living Activities Assessment

ACTIVITY	NO HELP NEEDED	NEEDS HELP	CAN'T DO WITHOUT HELP	DOESN'T DO
Bathing				
Going to the bathroom				
Getting dressed				
Personal hygiene				
Moving about (e.g. from bed to bathroom)				
Preparing food				
Eating				
Shopping				
Walking				
Going up stairs				
Taking medications properly				
Housework				
Laundry				
Using the phone				
Paying bills/managing finances				
Driving				

General approach to scoring ADL assessments:

1. Familiarize yourself with the scoring criteria: Review the specific scoring criteria provided by the ADL assessment tool or scale you are using. Each ADL category will typically have defined levels of independence or dependence that correspond to specific scores.

2. Observe the individual's performance: Evaluate the individual's ability to perform each ADL task. This can be done through direct observation, interviews with the individual or their caregivers, or a combination of both.

3. Assign scores based on the observed level of independence: Using the scoring criteria, assign the appropriate score for each ADL category based on the individual's observed level of independence or dependence. This could involve selecting a score from a predefined scale (e.g., 0-2, 1-4) or using descriptors to rate the level of independence (e.g., independent, partially dependent, dependent).

Calculate the total score: Sum up the scores for all ADL categories to obtain a total score. This score reflects the individual's overall functional status in performing activities of daily living.

Score	Ability
4	Independent
3	Independent with supervision
2	Requires help of 1
1	Requires help of 2
1	Independent
2	Needs supervision
3	Needs help
4	Impossible
0	Unable
1	With help of 2
2	With help of 1
3	Independent with aid
4	Independent

Scoring of ADL Tool:

Independent (I) :The individual is able to perform the activity without any assistance or supervision

Modified Independence (MI) : The individual can perform the activity independently but requires the use of adaptive equipment or techniques.

Supervision or setup assistance (S): The individual requires someone to be present or provide assistance with setting up the activity but can perform it independently once set up.

Limited Assistance (LA) : The individual requires some help or guidance from another person to perform the activity. Assistance may involve physical or verbal cues, but the individual participates actively.

Extensive Assistance (EA) : The individual needs substantial assistance from another person to complete the activity. They may actively participate, but they rely heavily on assistance.

Total Dependence (TD) :The individual is unable to participate in or complete the activity and requires full assistance from another person.

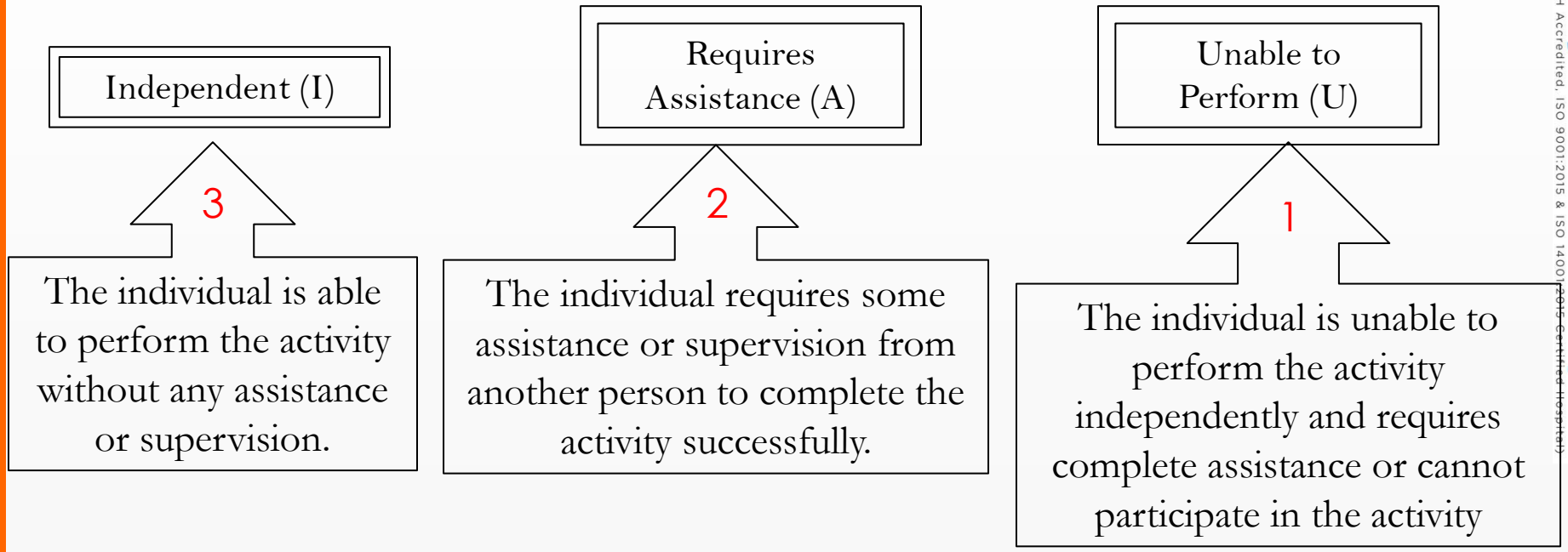
INSTRUMENTAL ACTIVITIES OF DAILY LIVING - IADL

The Instrumental Activities of Daily Living (IADL) tool is another assessment commonly used in healthcare to evaluate a person's ability to perform more complex activities that are necessary for independent living. While ADLs focus on basic self-care tasks, IADLs assess higher-level skills required for functioning in society.

- Managing Finances
- Transportation
- Meal preparation and planning
- Medication Management
- House keeping and home maintenance
- Communication & Technology use

Scoring of IADL Tool:

Typically, the scoring of IADLs is based on a scale that measures the individual's level of independence or assistance required for each activity. The scale may vary in the number of points or categories, but here is an example of a common scoring system:



MINI-MENTAL STATE EXAMINATION TOOL - MMSE

- The Mini-Mental State Examination (MMSE) is a widely used screening tool to assess cognitive impairment and detect changes in cognitive function over time. It evaluates various cognitive domains including orientation, memory, attention, language, and visuospatial abilities.

- The MMSE is a brief questionnaire or test used to assess various cognitive functions, including memory, attention, language, and orientation.

- Each section is scored, typically ranging from 0 to 30 points, with higher scores indicating better cognitive function. The interpretation of the results should take into account factors like age, education level, and cultural background.

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: Ask the questions in the order listed.
Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79,72, 65, . . .) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		**TOTAL**

1. Orientation	Ask the person their current location (e.g., city, state, country). Ask the person the current date (day, month, year).
2. Registration	Give the person three unrelated words to remember (e.g., apple, table, penny). After a few minutes, ask the person to recall the three words.
3. Attention and Calculation	Ask the person to count backward from 100 by subtracting 7 (e.g., 100, 93, 86, etc.).
4. Recall	Ask the person to recall the three words mentioned earlier.
5. Language	Ask the person to name common objects or body parts (e.g., pen, watch, nose). Ask the person to follow a written command, such as "Close your eyes.“

6. Repetition	Present a short phrase and ask the person to repeat it (e.g., "No ifs, ands, or buts").
7. Three Stage command	Ask the person to perform a three-part command, such as "Take a paper, fold it in half, and place it on the floor."
8. Reading and writing	Ask the person to read a written sentence or paragraph out loud. Ask the person to write a sentence or copy a written sentence.
9. Visuospatial abilities	Ask the person to copy a geometric figure or draw a clock face showing a specific time.

GERIATRIC DEPRESSION SCALE TOOL - GDS

The Geriatric Depression Scale (GDS) is a widely used screening tool to assess depression in older adults. It consists of a series of questions designed to evaluate the presence and severity of depressive symptoms. The GDS has two versions: the GDS-15, which contains 15 items, and the GDS-30, which contains 30 items.

Instructions for the GDS-15: For each question, the individual is asked to choose the response that best describes how they have been feeling over the past week. The options typically include "Yes," "No," or "Not sure."

1.Are you basically satisfied with your life?
2.Do you often feel helpless?
3.Do you feel that you have more problems with memory than most?
4.Do you think it is wonderful to be alive now?
5.Do you often get bored?
6.Do you often feel helpless?
7.Do you prefer to stay at home rather than going out and doing new things?
8.Do you feel pretty worthless the way you are now?
9.Do you feel full of energy?
10.Do you feel that your situation is hopeless?
11.Do you think that most people are better off than you are?
12.Do you feel that your life is empty?
13.Do you often feel restless or fidgety?
14.Do you think that things are better than they used to be?
15.Do you often feel downhearted and blue?

Geriatric Depression Scale (GDS) – Short Form

Instructions Circle the answer that best describes how you felt over the past week:

1.	Are you basically satisfied with your life?	Yes	No
2.	Have you dropped many of your activities and interests?	Yes	No
3.	Do you feel that your life is empty?	Yes	No
4.	Do you often get bored?	Yes	No
5.	5. Are you in good spirits most of the time?	Yes	No
6.	Are you afraid that something bad is going to happen to you?	Yes	No
7.	Do you feel happy most of the time?	Yes	No
8.	Do you often feel helpless?	Yes	No
9.	Do you prefer to stay at home, rather than going out and doing things?	Yes	No
10.	Do you feel that you have more problems with memory than most?	Yes	No
11.	Do you think it is wonderful to be alive now?	Yes	No
12.	Do you feel worthless the way you are now?	Yes	No
13.	Do you feel full of energy?	Yes	No
14.	Do you feel that your situation is hopeless?	Yes	No
15.	Do you think that most people are better off than you are?	Yes	No

Total Score _____

FALL RISK ASSESSMENT TOOLS

A fall risk assessment tool is a standardized instrument used by healthcare professionals to evaluate an individual's risk of falling. These tools help identify factors that contribute to falls, allowing healthcare providers to implement appropriate interventions and preventive measures.

There are several commonly used fall risk assessment tools, including:

- Morse Fall Scale
- Timed up and go test
- Berg Balance Scale
- Hendrich II Fall risk model
- STRATIFTY
- FRAT (Fall Risk Assessment Tool)

FRAT

	Score 1 for every category and total at the bottom of the two columns	Yes	No
1	Is there a history of any falls in the previous year? **How assessed?** Ask the question		
2	Is the patient/client on four or more medications per day? **How assessed?** Identify number of prescribed medications.		
3	Does the patient/client have a diagnosis of stroke or Parkinson's? **How assessed?** Ask the question		
4	Does the patient/client report any problems with their balance? **How assessed?** Ask the person		
5	Is the patient/client **unable** to rise from a chair of knee height without using their arms? **How assessed?** Ask the person (are they able to stand up from a chair of knee height without using their arms)?		
total			

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FALLS RISK ASSESSMENT TOOL (FRAT)

UR NUMBER .....

SURNAME .....

GIVEN NAMES.....

DATE OF BIRTH .....

Please fill in if no patient/resident label available

(see instructions for completion of FRAT in the FRAT PACK-Falls Resource Manual)

PART 1: FALL RISK STATUS

RISK FACTOR	LEVEL	RISK SCORE
RECENT FALLS *(To score this, complete history of falls, overleaf)*	none in last 12 months.....	2
	one or more between 3 and 12 months ago.....	4
	one or more in last 3 months.....	6
	one or more in last 3 months whilst inpatient / resident....	8
MEDICATIONS *(Sedatives, Anti-Depressants Anti-Parkinson's, Diuretics Anti-hypertensives, hypnotics)*	not taking any of these.....	1
	taking one	2
	taking two	3
	taking more than two.....	4
PSYCHOLOGICAL *(Anxiety, Depression √Cooperation, √Insight or √Judgement **esp. re mobility**)*	does not appear to have any of these.....	1
	appears mildly affected by one or more.....	2
	appears moderately affected by one or more.....	3
	appears severely affected by one or more.....	4
COGNITIVE STATUS *(AMTS: Hodkinson Abbreviated Mental Test Score)*	AMTS 9 or 10 / 10 **OR** intact.....	1
	AMTS 7-8 mildly impaired.....	2
	AMTS 5-6 mod impaired.....	3
	AMTS 4 or less severely impaired	4
(Low Risk: 5-11 Medium: Risk: 12-15 High Risk: 16-20)	**RISK SCORE**	/20

Automatic High Risk Status: *(if ticked then circle* **HIGH** *risk below)*

☐ Recent change in functional status and / or medications affecting safe mobility (or anticipated)

☐ Dizziness / postural hypotension

FALL RISK STATUS: *(Circle):* **LOW / MEDIUM / HIGH** → **List Fall Status on Care Plan/ Flow Chart**

IMPORTANT: IF **HIGH,** *COMMENCE FALL ALERT*

PART 2: RISK FACTOR CHECKLIST

		Y/N
Vision	Reports / observed difficulty seeing - objects / signs / finding way around	
Mobility	Mobility status unknown or appears unsafe / impulsive / forgets gait aid	
Transfers	Transfer status unknown or appears unsafe ie. over-reaches, impulsive	
Behaviours	Observed or reported agitation, confusion, disorientation	
	Difficulty following instructions or non-compliant (observed or known)	
Activities of Daily Living (A.D.L's)	Observed risk-taking behaviours, or reported from referrer / previous facility	
	Observed unsafe use of equipment	
	Unsafe footwear / inappropriate clothing	
Environment	Difficulties with orientation to environment i.e. areas between bed / bathroom / dining room	
Nutrition	Underweight / low appetite	
Continence	Reported or known urgency / nocturia / accidents	
Other		

Fall Risk Score Criteria (I'M SAFE)	Score if Present	Score if not Present	Score Assigned to Patient
Impairment (OT/PT service involved, orthostatic/dizzy)	1	0	
Medications (seizure medications, narcotics, epidurals)	2	0	
Sedation/anesthesia within the previous 24 hours	2	0	
Admitting diagnosis (neuro or ortho diagnosis)	1	0	
Fall History	1	0	
Environment of care (restraints, oxygen, IV tubing, foley catheter, other per RN judgment)	1	0	
Fall Risk Score (sum of the scores assigned for each criteria)			

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PAIN ASSESSMENT TOOLS

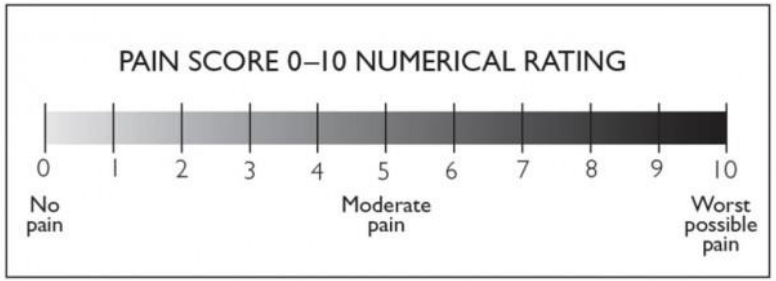
Pain assessment tools are used to evaluate and measure the intensity, location, and characteristics of pain experienced by individuals. These tools help healthcare professionals gather objective information about pain, monitor its changes over time, and guide appropriate pain management strategies.

Here are some commonly used pain assessment tools:

- Numeric Rating Scale (NRS)
- Visual Analog Scale (VAS)
- Verbal Descriptor Scale (VDS)
- Brief Pain Inventory (BPI)
- McGill Pain Questionnaire
- Color Analog Scale (CAS)

Scoring of some of the pain assessment tools:

Numeric Rating Scale (NRS): The NRS assigns a numerical value to the individual's self-reported pain intensity on a scale from **0 to 10.** The score is simply the number selected by the individual.



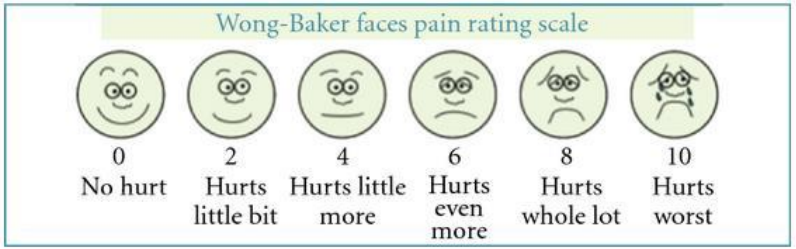
Visual Analog Scale (VAS): The VAS involves measuring the distance in millimeters from the starting point to the marked point on the line. This distance is used as the pain score.

Verbal Descriptor Scale (VDS): The VDS uses descriptive words or phrases to represent pain intensity. Each descriptor is assigned a corresponding numerical value, and the numerical score is determined based on the chosen descriptor.

None	Mild	Moderate	Severe
Choose the word that best describes your pain.			

Figure 3 : Verbal rating scale.

Wong-Baker FACES Pain Rating Scale: The Wong-Baker FACES scale consists of a series of faces ranging from a smiling face (0) to a crying face (10). The individual points to the face that best represents their pain experience, and the corresponding numerical value is used as the score.



Brief Pain Inventory (BPI): The BPI includes questions about pain severity and interference with daily activities. The severity score is typically obtained from the numerical rating scale (**0-10**), and the interference score is calculated by averaging the responses to interference-related questions.

McGill Pain Questionnaire: The McGill Pain Questionnaire uses a scoring system based on the words chosen by the individual to describe their pain experience. Each word is assigned a numerical value, and the total score is calculated based on the selected words.

CONCLUSION

- ✓ In conclusion, nursing assessments play a crucial role in ensuring the well-being and safety of elderly individuals. These comprehensive evaluations provide valuable insights into their physical, psychological, social, and cognitive health, allowing healthcare professionals to tailor care plans to meet their unique needs.

- ✓ Through meticulous examination of functional abilities, chronic conditions, medication management, fall risk, and cognitive status, nurses can identify potential health issues early, implement timely interventions, and prevent adverse outcomes

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more than care

Ensure that your ageing population is happy & safe

Thank you

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