Environmental Assessment Rating Scale

Section I. Ratings of the Overall Site

(Check the appropriate box)

1. As a *neighborhood* for living, how does the area around this site look?

☐ (3) Very pleasant and attractive
☐ (2) Mildly pleasant and attractive
☐ (1) Ordinary, perhaps even slightly unattractive
☐ (0) Unattractive, slum-like

Score _____

2. How attractive are the site *grounds*?

☐ (3) Very attractive	Landscaping or very attractive natural growth; well maintained; no litter or weeds; clean paths; neatly trimmed
☐ (2) Somewhat attractive	Shows signs of care and frequent maintenance
☐ (1) Ordinary	Ordinary looking or somewhat attractive but poorly maintained; little landscaping; some weeds or litter
☐ (0) Unattractive	No grounds; sidewalks only; shows little or no maintenance

Score _____

3. How attractive are the site *buildings*?

☐ (3) Very attractive	Unique and attractive design; excellent maintenance
☐ (2) Somewhat attractive	May show some deterioration on close inspection, or design is adequate but not unusually attractive
☐ (1) Ordinary	Buildings are somewhat attractive but poorly maintained; or are not notable in design or maintenance
☐ (0) Unattractive	Buildings are deteriorated or unattractive

Score _____

_____ **Total Score for Section I and record on last page**

Section II: Ratings of Environmental Characteristics

Part 1. Ratings of Four Major Living Areas

a. Lounge, common room, living room
b. Dining room
c. Residents' bedrooms or individual apartments
d. Hallways

Directions: Rate each of these four areas and enter your rating (0,1,2,3) in the appropriate space.

1. Noise Level

(3) Very quiet	Noticeable absence of sounds, even when area is being used by many residents
(2) Quiet	Some sounds present, but reading would be easy
(1) Somewhat noisy	Many sounds present or occasional loud interruptions
(0) Noisy	Sounds are loud and distracting (e.g., sustained noise from buzzers, cleaning equipment, etc.)

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

2. Odors

(3) Fresh	Living spaces have pleasantly fresh odor
(2) No odors	Nothing noticeable about the air; "normal"
(1) Slightly objectionable	Air is slightly tainted in some way; stale, close, musty, medicinal
(0) Distinctly objectionable	Unpleasant odors are apparent

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

3. Level of illumination

(3) Ample lighting	Brightly illuminated but without glare reading easy in all areas of room

(2) Good lighting	Lighting basically good, but may be low, uneven or glaring in some areas; reading easy in most areas of room
(1) Barely adequate	Lighting is low, uneven or glaring; reading is difficult in only certain areas of the room
(0) Inadequate lighting	Illumination very low or very glaring in most areas of room; reading difficult

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

4. Cleanliness of Walls and Floors (or Rugs)

(3) Very clean	Both walls and floors are kept very clean; spotless; floors are polished
(2) Clean	Both walls and floors are cleaned regularly; some dust in corners, fingerprints on walls
(1) Somewhat dirty	Either walls or floors need cleaning; considerable dust, fingerprints or stains
(0) Very dirty	Both walls and floors need a major cleaning; surfaces stained, scuff mark, surfaces dirty to the touch

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

5. Condition of Walls and Floors (or Rugs)

(3) Like new	Both walls and floors are new looking; appear recently installed or painted
(2) Good condition	Good condition; either walls and floors are show wear on close examination
(1) Fair condition	Walls and floors show wear, but only in heavily used areas
(0) Poor condition	Walls and floors show evident wear; worn spots, cracks, peeling, faded

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

6. Condition of Furniture

(3) Excellent condition	Like new; well kept, spotless, highly polished or without stains
(2) Good condition	Not new, but in good condition; slightly worn, small scratches, dusty, a few stains, some dirt in creases
(1) Fair condition	Older but still structurally sound and kept moderately clean
(0) Deteriorated	Old and in poor repair; some tears, stains, dirt or dust; may be structurally unsound or dangerous

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

7. Window areas

(3) Many windows	Living space has large window areas that give an open feeling
(2) Adequate windows	Windows are sufficient to allow good light; there is no closed-in feeling
(1) Few windows	Room tends to be dark, even on sunny days; there is a feeling of being closed-in
(0) No windows	There are no windows, or the windows are not functional

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

8. Views from Window - Interest

(3) Very interesting	View overlooks very interesting and continuous activities (e.g., children playing)
(2) Interesting	View overlooks some activities that draw mild attention (e.g., pedestrian or cars passing)
(1) Lacks interest	View is fairly dull or only rarely captures interest
(0) No interest	Basically nothing happening; looking outside is boring

_____ Lounge _____Dining room _____ Apartment _____ Hallways

Score _____

_____ **Total Score for Section II, Part 1 and record on last page**

Part II. Ratings of Residents' Bedrooms or Apartments
(Check the appropriate box)

9. Variation in Design of Residents' Rooms (Apts.)

☐ (3) Distinct variation	As if effort was made to vary style and décor from room to room
☐ (2) Moderate variation	Rooms (apartments) are distinct, but there is general décor throughout
☐ (1) Nearly identical	Some variation in size, shape, or furniture arrangement; variation is not noticeable unless looked for.
☐ (0) Identical	No variation except for except for decorational detail such as paint or rug color

Score _____

10. Personalization of Residents' Rooms (Apts.)

☐ (3) Much personalization	Most of the furnishings and objects in the room belong to the individual; time and energy have been spent in personalizing the rooms
☐ (2) Some personalization	Residents have added personal objects such as rugs, pictures, chairs, favorite objects
☐ (1) Little personalization	Some family pictures of personal articles, but room does not seem to "belong" to an individual.
☐ (0) No personalization is evident	

Score _____

_____ **Total Score for Section II, Part 2 and record on last page**

Part III. Ratings the Facility as a Whole
(Check the appropriate box)

11. Distinctiveness of All Living Spaces

☐ (3) Much distinctiveness	A concerted effort has been made to vary the décor from room to room
☐ (2) Moderate distinctiveness	Furnishings vary from room to room, but the overall room design is the same; wall textures and floor coverings show little variation
☐ (1) Some distinctiveness	Very little variation, even in furnishings; somewhat institutional, but some areas are

distinct such as the lounge or lobby (e.g., floor coverings vary, pictures, or signs)

☐ (0) Little distinctiveness — Institutional appearance; most areas are quite similar, as in a hospital (without furniture, all rooms look about the same)

12. Overall Pleasantness of the Facility

☐ (3) Quite pleasant — "I would feel good about placing a person in this housing."

☐ (2) Pleasant — "I would not feel badly about placing a person in this housing if they were in some way limited to this choice (finances, closeness to friends, etc.)"

☐ (1) Somewhat unpleasant — "I would feel uneasy about placing a person here."

☐ (0) Distinctively unpleasant — "I would not place a person here."

Score _____

13. Overall Attractiveness of the Facility

☐ (3) Highly appealing — Attractive enough to be desirable for one's own home

☐ (2) Appealing — Overall effect is favorable, although there may be some drawbacks (old furnishings, inconvenient)

☐ (1) Neutral — Neither positive nor negative features especially stand out; ordinary

☐ (0) Unattractive — Physical plant is unattractive or unappealing; it may be cold or somewhat sterile; arouses negative feelings

Score _____

_____ **Total Score for Section II, Part 3 and record below**

Scores – Maximum Score is 120

_____ **Score for Section I**
_____ **Score for Section II, Part 1**
_____ **Score for Section II, Part 2**
_____ **Score for Section II, Part 3**
_____**Total Score/120 = _____ X 100 = _____ %**

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders
for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. These medical orders are based on the person's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name/ First/ Middle Initial

Address

City / State / Zip

Date of Birth (mm/dd/yyyy) ____ / ____ / ____

Last 4 SSN ☐☐☐☐

Gender ☐ M ☐ F

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C *Check One*

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if medically indicated.

Additional Orders: _____

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E

REASON FOR ORDERS AND SIGNATURES

My signature below indicates to the best of my knowledge that these orders are consistent with the person's **current** medical condition and preferences as indicated by **discussion with**:

☐ Patient ☐ Health Care Representative ☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
☐ Parent of Minor ☐ Court-Appointed Guardian
☐ Other _____

Print Primary Care Professional Name

Print Signing Physician / NP / PA Name and Phone Number
( )

Physician / NP / PA Signature (mandatory) | Date

Office Use Only

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information for Person Named on this Form

Person's Name (print) _____

This voluntary form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Signature of Person or Surrogate

Signature	Name (print)	Relationship (write "self" if patient)

Opt Out ☐ **Check box if you do not want this form included in the electronic POLST registry.**

Contact Information

Surrogate (optional)	Relationship	Phone Number	Address

Health Care Professional Preparing Form (optional)	Preparer Title	Phone Number	Date Prepared

PA's Supervising Physician	Phone Number

Directions for Health Care Professionals

Completing POLST

- Should reflect current preferences of persons with advanced illness or frailty. Encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form, refer to *Guidance for Health Care Professionals* at http://www.ohsu.edu/polst/programs/docs/guidance.pdf.

Sending to POLST Registry (Required unless "Opt Out" box is checked)

- For the POLST Registry, the following information on the other side of the form must be completed:
  - Person's full name
  - Date of birth
  - Section A
  - Physician / NP / PA Signature and date signed
- Send a copy of both sides of this POLST form to the POLST Registry.
  - FAX or eFAX: (503) 418-2161 **Date**____/____/____
  - or
  - Mail: Oregon POLST Registry **Date**____/____/____
    Mail Code: CDW-EM
    3181 SW Sam Jackson Park Road
    Portland, OR 97239

Reviewing POLST

This POLST should be reviewed periodically and if:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

PUT REGISTRY ID STICKER HERE:

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry as above (Required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

try this: Best Practices in Nursing Care to Older Adults
from The Hartford Institute for Geriatric Nursing

Issue Number 6, November 1999 Series Editor: Meredith Wallace, PhD, RN, MSN, CS

The Pittsburgh Sleep Quality Index (PSQI)

By: Carole Smyth, RNC, MSN

WHY: Sleep is a necessary part of life. However, normal aging changes, medical problems, psychiatric problems, and psychosocial issues can alter the pattern and quality of sleep as one grows older, and thus affect the quality of life in the older adult. Assessment of sleep patterns enables the nurse to intervene immediately by implementing interventions with the client, or by referring the client for further assessment.

BEST TOOL: The Pittsburgh Sleep Quality Index (PSQI) is an effective instrument used to measure the quality and patterns of sleep in the older adult. It differentiates "poor" from "good" sleep by measuring seven areas: subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medication, and daytime dysfunction over the last month. The client self-rates each of these seven areas of sleep. Scoring of answers is based on a 0 to 3 scale, whereby 3 reflects the negative extreme on the Likert Scale. A global sum of "5" or greater indicates a "poor" sleeper. Although there are several questions that request the evaluation of the client's bedmate or roommate, these are not scored (not reflected in attached instrument). Refer to "More on the Topic", Buysse et al., 1989, for these questions.

TARGET POPULATION: The PSQI can be used for both an initial assessment and ongoing comparative measurements with older adults across all health care settings.

VALIDITY/RELIABILITY: The PSQI has internal consistency and a reliability coefficient (Cronbach's alpha) of 0.83 for its seven components. Numerous studies using the PSQI have supported high validity and reliability.

STRENGTHS AND LIMITATIONS: The PSQI is a subjective measure of sleep. Self-reporting by clients can empower the client, but can reflect inaccurate information if the client has difficulty understanding what is written, or can not see or physically write out responses. Moreover, the scale is presented in English. The scale can be adapted to enable the client to respond verbally to items on the scale by having the nurse read the statements to the client.

MORE ON THE TOPIC:

Beaton, S.R., Voge, S.A. (1998). Measurements for Long-Term Care (pp.169-170). Thousand Oaks, CA: Sage Publications.

Beck-Little, R., Weinrich, S.P. (1998). Assessment and Management of Sleep Disorders in the Elderly. *Journal of Gerontological Nursing,* 24(4), 21-29.

Buysse, D.J., Reynolds III, C.F., Monk, T.H., Berman, S.R., Kupfer, D.J. (1989). The Pittsburgh Sleep Quality Index: a New Instrument for Psychiatric Practice and Research. *Journal of Psychiatric Research,* 28 (2), 193-213.

Pittsburgh Sleep Quality Index (PSQI)

Instructions: ***The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.***

During the past month,

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. When have you usually gotten up in the morning? _____
4. How many hours of actual sleep did you get that night? (This may be different than the number of hours you spend in bed) _____

5. During the past month, how often have you had trouble sleeping because you…	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s):				
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
	Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)
9. During the past month, how would you rate your sleep quality overall?				

Component 1 #9 Score C1_____

Component 2 #2 Score (≤ 15min (0), 16-30 min (1), 31-60 min (2), >60 min (3))
+ #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3) C2_____

Component 3 #4 Score (>7(0), 6-7(1), 5-6(2), <5 (3) C3_____

Component 4 (total # of hours asleep)/(total # of hours in bed) x 100 C4_____
>85%=0, 75%-84%=1, 65%-74%=2, <65%=3

Component 5 # sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3) C5_____

Component 6 #6 Score C6_____

Component 7 #7 score + #8 score (0=0; 1-2=1; 3-4=2; 5-6=3) C7_____

Add the seven component scores together _____ **Global PSQI Score** _____

INDICATORS OF RELOCATION MALADJUSTMENT ASSESSMENT FORM

(Author developed: Hertz, J. E., Rossetti, J., Robertson, J. F., & Koren, M. E., 2004)

Client _____ Age_____ Room (if applicable) _____
Date_____

NOTE: If the response to a question is "other", explain in the comments section.

Maladjustment Indicator	Question	Response (Circle one)
Self-rated health	Would you say your health is--?	Excellent, Very Good, Good, Fair, or Poor
Depression	Simple screen[1]: Are you sad most of the time?	Yes No Other
Life satisfaction	Are you satisfied with your life at the present time?	Yes No Other
Self-esteem	Do you usually feel good about yourself?	Yes No Other
Cognitive function[2]	Have you had any changes in remembering things since you moved (or the last time you were here)?	Yes No Other
	Is the older adult oriented to person, time and place?	Yes No Other
Social network & participation	How often do you see your family and friends?	Daily, Weekly, Monthly, ___ times per year
	Are you satisified with how often you see your family and friends?	Yes No Other
	Have you made any new friends since you moved?	Yes No Other
	Do you participate in activities?	Yes No Other
	If yes, what activities?	List:
Sense of control and mastery	Do you feel in control of your life and your everyday activities at the present time?	Yes No Other
	Are you adjusted to your (new) home?[3]	Yes No Other
	Do you feel safe in your (new) home?[3]	Yes No Other
Expectations	Did the move here take place as you expected?[4]	Yes No Other
	Is living here like you expected it to be?	Yes No Other
Comments:		

[1]Substitute this one question regarding depression with a formal screening tool for depression. The Geriatric Depression Scale is available in a short-form with 15 questions and long-form with 30 questions, has been widely used with older adults, and is available at http://www.stanford.edu/~yesavage/GDS.html

[2] Substitute questions regarding cognitive function with a standardized screening tool such as the Mini-Mental™ State Exam (Folstein et al., 2005) or the Confusion Assessment Method (Wyszynski, 2001)

[3] Add the word "new" for those persons being assessed for the first time after relocation.

[4] Only include this question the first time assessed after relocation.

INDICATORS OF RELOCATION MALADJUSTMENT FLOWSHEET

Client: ____

Date	Age	Presence of Indicators Denoting Relocation Maladjustment (Check All that Apply)	Comments (Specific information regarding items that are checked)
		___Decline in health status ___Depression ___Change in or low level of: ___ life satisfaction ___ self-esteem ___ Memory ___ Orientation to person, time, place ___Unsatisfied with frequency of visiting family/friends ___Lack of new friends ___Uninvolved in social activities ___Lack of control over daily life: ___feels unsafe ___Poor perceived adjustment to home ___Move is not what expected ___New home is not what expected	
		___Decline in health status ___Depression ___Change in or low level of: ___ life satisfaction ___ self-esteem ___ Memory ___ Orientation to person, time, place ___Unsatisfied with frequency of visiting family/friends ___Lack of new friends ___Uninvolved in social activities ___Lack of control over daily life: ___feels unsafe ___Poor perceived adjustment to home ___Move is not what expected ___New home is not what expected	
		___Decline in health status ___Depression ___Change in or low level of: ___ life satisfaction ___ self-esteem ___ Memory ___ Orientation to person, time, place ___Unsatisfied with frequency of visiting family/friends ___Lack of new friends ___Uninvolved in social activities ___Lack of control over daily life: ___feels unsafe ___Poor perceived adjustment to home ___Move is not what expected ___New home is not what expected	

NOTE: Presence of multiple indicators and an increase in the number of indicators signifies a need to implement the Post-relocation Practice guideline.

try this: Best Practices in Nursing Care to Older Adults
from The Hartford Institute for Geriatric Nursing

Issue Number 9, Revised Summer 2004 Series Editor: Marie Boltz, APRN, MSN, GNP

Assessing Nutrition in Older Adults

By: *James F. Lawrence, MSN, RN, A/GNP, PhD student and Elaine J. Amella, PhD, APRN, BC*

WHY: While poor nutrition is not a natural concomitant of aging, older adults who experience several concurrent diseases are at higher risk for under- or malnutrition. Persons who are underweight (Body Mass Index < 19) and those who are overweight (Body Mass Index > 25) often have loss of muscle mass, a compromised immune system and have increased complications and premature death. The progression to malnutrition is often insidious, and is often undetected. The nurse plays a key role in prevention and early intervention of nutritional problems.

BEST TOOLS: The **Mini Nutritional Assessment (MNA)** is an assessment tool that can be used to identify older adults (>65 years) who are at risk of malnutrition. It is a clinician-completed instrument with two components: screening and assessment. A score of 11 or less on the **screen** indicates a problem and the need for a completion of the assessment portion. The **assessment** score is then added to the screen score; if the total score on both parts totals 17 – 23.5, there is a risk of malnutrition, while a score of < 17 indicates existing malnutrition. The MNA should be supplemented with information regarding the patient's cultural factors, preferences, social needs/desires surrounding meals. A review of symptoms and objective clinical findings, including pertinent physiological measures used to assess nutritional status should be assessed (including serum pre-albumin, serum albumin, transferrin, and total lymphocyte count as well as hemoglobin and hematocrit). A 72- hour food dairy, recording the patent's consumption, is another important supplement to the MNA.

TARGET POPUTLATIONS: The MNA provides a simple and quick method of identifying older adults who are at risk of malnutrition. The MNA should be completed at regular intervals, no matter the setting.

VALIDITY / RELIABILITY: The MNA is both a screening and assessment tool for the identification of malnutrition in the older adult. This tool eliminates the need for more invasive tests such as blood sampling. The MNA has been validated in many research studies in older adults throughout the world in hospital, nursing home and ambulatory care patients and in community screening. Internal consistency, inter-observer reliability and validity were shown to be acceptable (Beck, Oversen, & Schroll, 2001; Bleda, Bolibar, Pares, & Salva, 2002).

STRENGTHS / LIMITATIONS: Unlike many other nutritional instruments, the MNA was developed to be user-friendly, quick, non-invasive, and inexpensive. The MNA has been tested predominantly on Caucasians with involvement of Mexican-Americans in studies conducted in New Mexico (Sheirlinkx K et al., 1998). A limiting factor may be clinician lack of familiarity with the requirement, in the assessment portion, of measuring both the mid-arm and calf circumference.

References:

Beck A. ed according to risk by the Mini Nutritional Assessment. *European Journal of Clinical Nutrition,* 55 (11), 1028 – 1033.

Bleda M. J., *Journal of Nutrition, Health, & Aging,* 6 (2), 134 – 137.

Sheirlinkx K., Nicolas A.S., Nourhashemi F., Vellas B., Albarèdem J.L., Garry P. (1998). The MNA score in successfully aging persons. In: B. Vellas B. P. J.Garry, Y. Guigoz (eds). *Mini Nutritional Assessment (MNA): Research and practice in elderly* (pp. 61 – 66). Nestlé Clinical and Performance Nutrition Workshop Series, Vol 1. Philadelphia: Lippincott-Raven.

A website with further information and most recent research data can be found at: http://www.mna-elderly.com/ and has excellent information for both nurses and older adults.

NESTLÉ NUTRITION SERVICES

Mini Nutritional Assessment
MNA®

Last name: First name: Sex: Date:

Age: Weight, kg: Height, cm: I.D. Number:

Complete the screen by filling in the boxes with the appropriate numbers.
Add the numbers for the screen. If score is 11 or less, continue with the assessment to gain a Malnutrition Indicator Score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe loss of appetite
1 = moderate loss of appetite
2 = no loss of appetite ☐

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss ☐

C Mobility
0 = bed or chair bound
1 = able to get out of bed/chair but does not go out
2 = goes out ☐

D Has suffered psychological stress or acute disease in the past 3 months
0 = yes 2 = no ☐

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems ☐

F Body Mass Index (BMI) (weight in kg) / (height in m)²
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater ☐

Screening score (subtotal max. 14 points) ☐☐
12 points or greater Normal – not at risk – no need to complete assessment
11 points or below Possible malnutrition – continue assessment

Assessment

G Lives independently (not in a nursing home or hospital)
0 = no 1 = yes ☐

H Takes more than 3 prescription drugs per day
0 = yes 1 = no ☐

I Pressure sores or skin ulcers
0 = yes 1 = no ☐

J How many full meals does the patient eat daily?
0 = 1 meal
1 = 2 meals
2 = 3 meals ☐

K Selected consumption markers for protein intake
- At least one serving of dairy products (milk, cheese, yogurt) per day? yes ☐ no ☐
- Two or more servings of legumes or eggs per week? yes ☐ no ☐
- Meat, fish or poultry every day yes ☐ no ☐

0.0 = if 0 or 1 yes
0.5 = if 2 yes
1.0 = if 3 yes ☐.☐

L Consumes two or more servings of fruits or vegetables per day?
0 = no 1 = yes ☐

M How much fluid (water, juice, coffee, tea, milk…) is consumed per day?
0.0 = less than 3 cups
0.5 = 3 to 5 cups
1.0 = more than 5 cups ☐.☐

N Mode of feeding
0 = unable to eat without assistance
1 = self-fed with some difficulty
2 = self-fed without any problem ☐

O Self view of nutritional status
0 = views self as being malnourished
1 = is uncertain of nutritional state
2 = views self as having no nutritional problem ☐

P In comparison with other people of the same age, how does the patient consider his/her health status?
0.0 = not as good
0.5 = does not know
1.0 = as good
2.0 = better ☐.☐

Q Mid-arm circumference (MAC) in cm
0.0 = MAC less than 21
0.5 = MAC 21 to 22
1.0 = MAC 22 or greater ☐.☐

R Calf circumference (CC) in cm
0 = CC less than 31 1 = CC 31 or greater ☐

Assessment (max. 16 points) ☐☐.☐
Screening score ☐☐
Total Assessment (max. 30 points) ☐☐.☐

Malnutrition Indicator Score
17 to 23.5 points at risk of malnutrition ☐
Less than 17 points malnourished ☐

Ref.: Guigoz Y, Vellas B and Garry PJ. 1994. Mini Nutritional Assessment: A practical assessment tool for grading the nutritional state of elderly patients. *Facts and Research in Gerontology.* Supplement #2:15-59.
Rubenstein LZ, Harker J, Guigoz Y and Vellas B. Comprehensive Geriatric Assessment (CGA) and the MNA: An Overview of CGA, Nutritional Assessment, and Development of a Shortened Version of the MNA. In: "Mini Nutritional Assessment (MNA): Research and Practice in the Elderly". Vellas B, Garry PJ and Guigoz Y , editors. Nestlé Nutrition Workshop Series. Clinical & Performance Programme, vol. 1. Karger, Bäle, in press.

try this: Best Practices in Nursing Care to Older Adults

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Beers Criteria

Table 1. 2002 Criteria for Potentially Inappropriate Medication Use in Older Adults: Independent of Diagnoses or Conditions

Drug	Concern	Severity Rating (High or Low)
Propoxyphene (Darvon) and combination products (Darvon with ASA, Darvon-N, and Darvocet-N)	Offers few analgesic advantages over acetaminophen, yet has the adverse effects of other narcotic drugs.	Low
Indomethacin (Indocin and Indocin SR)	Of all available nonsteroidal anti-inflammatory drugs, this drug produces the most CNS adverse effects.	High
Pentazocine (Talwin)	Narcotic analgesic that causes more CNS adverse effects, including confusion and hallucinations, more commonly than other narcotic drugs. Additionally, it is a mixed agonist and antagonist.	High
Trimethobenzamide (Tigan)	One of the least effective antiemetic drugs, yet it can cause extrapyramidal adverse effects.	High
Muscle relaxants and antispasmodics: methocarbamol (Robaxin), carisoprodol (Soma), chlorzoxazone (Paraflex), metaxalone (Skelaxin), cyclobenzaprine (Flexeril), and oxybutynin (Ditropan). Do not consider the extended-release Ditropan XL.	Most muscle relaxants and antispasmodic drugs are poorly tolerated by elderly patients, since these cause anticholinergic adverse effects, sedation, and weakness. Additionally, their effectiveness at doses tolerated by elderly patients is questionable.	High
Flurazepam (Dalmane)	This benzodiazepine hypnotic has an extremely long half-life in elderly patients (often days), producing prolonged sedation and increasing the incidence of falls and fracture. Medium- or short-acting benzodiazepines are preferable.	High
Amitriptyline (Elavil), chlordiazepoxide-amitriptyline (Limbitrol), and perphenazine-amitriptyline (Triavil)	Because of its strong anticholinergic and sedation properties, amitriptyline is rarely the antidepressant of choice for elderly patients.	High
Doxepin (Sinequan)	Because of its strong anticholinergic and sedating properties, doxepin is rarely the antidepressant of choice for elderly patients.	High
Meprobamate (Miltown and Equanil)	This is a highly addictive and sedating anxiolytic. Those using meprobamate for prolonged periods may become addicted and may need to be withdrawn slowly.	High
Doses of short-acting benzodiazepines: doses greater than lorazepam (Ativan), 3 mg; oxazepam (Serax), 60 mg; alprazolam (Xanax), 2 mg; temazepam (Restoril), 15 mg; and triazolam (Halcion), 0.25 mg	Because of increased sensitivity to benzoadiazepines in elderly patients, smaller doses may be effective as well as safer. Total daily doses should rarely exceed the suggested maximums.	High
Long-acting benzodiazepines: chlordiazepoxide (Librium), chlordiazepoxide-amitriptyline (Limbitrol) clidinium-chlordiazepoxide (Librax), diazepam (Valium), quazepam (Doral), halazepam (Paxipam), and chlorazepate (Tranxene)	These drugs have a long half-life in elderly patients (often several days), producing prolonged sedation and increasing the risk of falls and fractures. Short- and intermediate-acting benzodiazepines are preferred if a benzodiazepine is required.	High
Disopyramide (Norpace and Norpace CR)	Of all antiarrhythmic drugs, this is the most potent negative inotrope and therefore may induce heart failure in elderly patients. It is also strongly anticholinergic. Other antiarrhythmic drugs should be used.	High
Digoxin (Lanoxin) (should not exceed >0.125 mg/d except when treating atrial arrhythmias)	Decreased renal clearance may lead to increased risk of toxic effects.	Low
Short-acting dipyridamole (Persantine). Do not consider the long-acting dipyridamole (which has better properties than the short-acting in older adults) except with patients with artificial heart valves	May cause orthostatic hypotension.	Low
Methyldopa (Aldomet) and methyldopa-hydrochlorothiazide (Aldoril)	May cause bradycardia and exacerbate depression in elderly patients.	High
Reserpine at doses >0.25 mg	May induce depression, impotence, sedation, and orthostatic hypotension.	Low
Chlorpropamide (Diabinese)	It has a prolonged half-life in elderly patients and could cause prolonged hypoglycemia. Additionally, it is the only oral hypoglycemic agent that causes SIADH.	High
Gastrointestinal antispasmodic drugs: dicyclomine (Bentyl), hyoscyamine (Levsin and Levsinex), propantheline (Pro-Banthine), belladonna alkaloids (Donnatal and others), and clidinium-chlordiazepoxide (Librax)	GI antispasmodic drugs are highly anticholinergic and have uncertain effectiveness. These drugs should be avoided (especially for long-term use).	High
Anticholinergics and antihistamines: chlorpheniramine (Chlor-Trimeton), diphenhydramine (Benadryl), hydroxyzine (Vistaril and Atarax), cyproheptadine (Periactin), promethazine (Phenergan), tripelennamine, dexchlorpheniramine (Polaramine)	All nonprescription and many prescription antihistamines may have potent anticholinergic properties. Nonanticholinergic antihistamines are preferred in elderly patients when treating allergic reactions.	High
Diphenhydramine (Benadryl)	May cause confusion and sedation. Should not be used as a hypnotic, and when used to treat emergency allergic reactions, it should be used in the smallest possible dose.	High
Ergot mesyloids (Hydergine) and cyclandelate (Cyclospasmol)	Have not been shown to be effective in the doses studied.	Low
Ferrous sulfate >325 mg/d	Doses >325 mg/d do not dramatically increase the amount absorbed but greatly increase the incidence of constipation.	Low
All barbiturates (except phenobarbital) except when used to control seizures	Are highly addictive and cause more adverse effects than most sedative or hypnotic drugs in elderly patients.	High

(continued)

Beers Criteria

Table 1. 2002 Criteria for Potentially Inappropriate Medication Use in Older Adults: Independent of Diagnoses or Conditions (cont)

Drug	Concern	Severity Rating (High or Low)
Meperidine (Demerol)	Not an effective oral analgesic in doses commonly used. May cause confusion and has many disadvantages to other narcotic drugs.	High
Ticlopidine (Ticlid)	Has been shown to be no better than aspirin in preventing clotting and may be considerably more toxic. Safer, more effective alternatives exist.	High
Ketorolac (Toradol)	Immediate and long-term use should be avoided in older persons, since a significant number have asymptomatic GI pathologic conditions.	High
Amphetamines and anorexic agents	These drugs have potential for causing dependence, hypertension, angina, and myocardial infarction.	High
Long-term use of full-dosage, longer half-life, non–COX-selective NSAIDs: naproxen (Naprosyn, Avaprox, and Aleve), oxaprozin (Daypro), and piroxicam (Feldene)	Have the potential to produce GI bleeding, renal failure, high blood pressure, and heart failure.	High
Daily fluoxetine (Prozac)	Long half-life of drug and risk of producing excessive CNS stimulation, sleep disturbances, and increasing agitation. Safer alternatives exist.	High
Long-term use of stimulant laxatives: bisacodyl (Dulcolax), cascara sagrada, and Neoloid except in the presence of opiate analgesic use	May exacerbate bowel dysfunction.	High
Amiodarone (Cordarone)	Associated with QT interval problems and risk of provoking torsades de pointes. Lack of efficacy in older adults.	High
Orphenadrine (Norflex)	Causes more sedation and anticholinergic adverse effects than safer alternatives.	High
Guanethidine (Ismelin)	May cause orthostatic hypotension. Safer alternatives exist.	High
Guanadrel (Hylorel)	May cause orthostatic hypotension.	High
Cyclandelate (Cyclospasmol)	Lack of efficacy.	Low
Isoxsurpine (Vasodilan)	Lack of efficacy.	Low
Nitrofurantoin (Macrodantin)	Potential for renal impairment. Safer alternatives available.	High
Doxazosin (Cardura)	Potential for hypotension, dry mouth, and urinary problems.	Low
Methyltestosterone (Android, Virilon, and Testrad)	Potential for prostatic hypertrophy and cardiac problems.	High
Thioridazine (Mellaril)	Greater potential for CNS and extrapyramidal adverse effects.	High
Mesoridazine (Serentil)	CNS and extrapyramidal adverse effects.	High
Short acting nifedipine (Procardia and Adalat)	Potential for hypotension and constipation.	High
Clonidine (Catapres)	Potential for orthostatic hypotension and CNS adverse effects.	Low
Mineral oil	Potential for aspiration and adverse effects. Safer alternatives available.	High
Cimetidine (Tagamet)	CNS adverse effects including confusion.	Low
Ethacrynic acid (Edecrin)	Potential for hypertension and fluid imbalances. Safer alternatives available.	Low
Desiccated thyroid	Concerns about cardiac effects. Safer alternatives available.	High
Amphetamines (excluding methylphenidate hydrochloride and anorexics)	CNS stimulant adverse effects.	High
Estrogens only (oral)	Evidence of the carcinogenic (breast and endometrial cancer) potential of these agents and lack of cardioprotective effect in older women.	Low

Abbreviations: CNS, central nervous system; COX, cyclooxygenase; GI, gastrointestinal; NSAIDs, nonsteroidal anti-inflammatory drugs; SIADH, syndrome of inappropriate antidiuretic hormone secretion.

Beers Criteria

Table 2. 2002 Criteria for Potentially Inappropriate Medication Use in Older Adults: Considering Diagnoses or Conditions

Disease or Condition	Drug	Concern	Severity Rating (High or Low)
Heart failure	Disopyramide (Norpace), and high sodium content drugs (sodium and sodium salts [alginate bicarbonate, biphosphate, citrate, phosphate, salicylate, and sulfate])	Negative inotropic effect. Potential to promote fluid retention and exacerbation of heart failure.	High
Hypertension	Phenylpropanolamine hydrochloride (removed from the market in 2001), pseudoephedrine; diet pills, and amphetamines	May produce elevation of blood pressure secondary to sympathomimetic activity.	High
Gastric or duodenal ulcers	NSAIDs and aspirin (>325 mg) (coxibs excluded)	May exacerbate existing ulcers or produce new/additional ulcers.	High
Seizures or epilepsy	Clozapine (Clozaril), chlorpromazine (Thorazine), thioridazine (Mellaril), and thiothixene (Navane)	May lower seizure thresholds.	High
Blood clotting disorders or receiving anticoagulant therapy	Aspirin, NSAIDs, dipyridamole (Persantin), ticlopidine (Ticlid), and clopidogrel (Plavix)	May prolong clotting time and elevate INR values or inhibit platelet aggregation, resulting in an increased potential for bleeding.	High
Bladder outflow obstruction	Anticholinergics and antihistamines, gastrointestinal antispasmodics, muscle relaxants, oxybutynin (Ditropan), flavoxate (Urispas), anticholinergics, antidepressants, decongestants, and tolterodine (Detrol)	May decrease urinary flow, leading to urinary retention.	High
Stress incontinence	α-Blockers (Doxazosin, Prazosin, and Terazosin), anticholinergics, tricyclic antidepressants (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride), and long-acting benzodiazepines	May produce polyuria and worsening of incontinence.	High
Arrhythmias	Tricyclic antidepressants (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride)	Concern due to proarrhythmic effects and ability to produce QT interval changes.	High
Insomnia	Decongestants, theophylline (Theodur), methylphenidate (Ritalin), MAOIs, and amphetamines	Concern due to CNS stimulant effects.	High
Parkinson disease	Metoclopramide (Reglan), conventional antipsychotics, and tacrine (Cognex)	Concern due to their antidopaminergic/ cholinergic effects.	High
Cognitive impairment	Barbiturates, anticholinergics, antispasmodics, and muscle relaxants. CNS stimulants: dextroAmphetamine (Adderall), methylphenidate (Ritalin), methamphetamine (Desoxyn), and pemolin	Concern due to CNS-altering effects.	High
Depression	Long-term benzodiazepine use. Sympatholytic agents: methyldopa (Aldomet), reserpine, and guanethidine (Ismelin)	May produce or exacerbate depression.	High
Anorexia and malnutrition	CNS stimulants: DextroAmphetamine (Adderall), methylphenidate (Ritalin), methamphetamine (Desoxyn), pemolin, and fluoxetine (Prozac)	Concern due to appetite-suppressing effects.	High
Syncope or falls	Short- to intermediate-acting benzodiazepine and tricyclic antidepressants (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride)	May produce ataxia, impaired psychomotor function, syncope, and additional falls.	High
SIADH/hyponatremia	SSRIs: fluoxetine (Prozac), citalopram (Celexa), fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft)	May exacerbate or cause SIADH.	Low
Seizure disorder	Bupropion (Wellbutrin)	May lower seizure threshold.	High
Obesity	Olanzapine (Zyprexa)	May stimulate appetite and increase weight gain.	Low
COPD	Long-acting benzodiazepines: chlordiazepoxide (Librium), chlordiazepoxide-amitriptyline (Limbitrol), clidinium-chlordiazepoxide (Librax), diazepam (Valium), quazepam (Doral), halazepam (Paxipam), and chlorazepate (Tranxene). β-blockers: propranolol	CNS adverse effects. May induce respiratory depression. May exacerbate or cause respiratory depression.	High
Chronic constipation	Calcium channel blockers, anticholinergics, and tricyclic antidepressant (imipramine hydrochloride, doxepin hydrochloride, and amitriptyline hydrochloride)	May exacerbate constipation.	Low

Abbreviations: CNS, central nervous systems; COPD, chronic obstructive pulmonary disease; INR, international normalized ratio; MAOIs, monoamine oxidase inhibitors; NSAIDs, nonsteroidal anti-inflammatory drugs; SIADH, syndrome of inappropriate antidiuretic hormone secretion; SSRIs, selective serotonin reuptake inhibitors.

Drug Regimen Unassisted Grading Scale (DRUGS)

Resident Initials: _____ Date: _____

(Reference list of medications will be obtained from the medical record and from container labels)

Instructions: Have the resident:

1. Choose the appropriate medication (identification).
2. Open the appropriate container (access).
3. Dispense the correct number of doses (dosages).
4. Place the medication at the appropriate time on this sheet (timing).
5. For each medication, residents are given one point for each of steps 1 through 4 that are completed correctly and 0 points for the steps not completed correctly.

Time	**Meals**	**Medication**
7 a.m.		
8 a.m.	**Breakfast**	
9 a.m.		
10 a.m.		
11 a.m.		
12 noon	**Lunch**	
1 p.m.		
2 p.m.		
3 p.m.		
4 p.m.		
5 p.m.		
6 p.m.	**Dinner**	
7 p.m.		
8 p.m.		
9 p.m.		
10 p.m.	**Bedtime**	
11 p.m.		

Scoring:

Medication List -record	Self reported Medications	Identification		Access		Dosage		Timing	
Obtain list from chart	Ask resident to state meds	Able	Unable	Able	Unable	Able	Unable	Able	Unable
Maximum score:		Total score:				Summary score: %			

Score 1 if able; zero if unable. Maximum score is 4 times the number of medications (1 point each for Identification, Access, Dosage and Timing). Total all columns to obtain total score. Divide total score by maximum and multiply by 100 score to obtain summary score.