How Useful Is the MNA in Clinical Practice?

Results from a recent survey.

Although the Mini Nutritional Assessment (MNA) has been used extensively in research—a 2006 review found that it had been used to screen about 35,000 study participants in various settings in several countries[1]—little is known about its use in clinical practice in the United States. In 2007 a survey on the use of the MNA for nutrition assessment was sent electronically to 5,850 members of the American Society for Parenteral and Enteral Nutrition (ASPEN) and posted online for Nurses Improving Care for Healthsystem Elders members. Of the 706 respondents, 95% were ASPEN members and 75% were dietitians. Forty-one respondents (6%) reported using the MNA in their clinical practice, for an average of 4.3 years.

The 41 respondents who used the MNA were also asked to identify its advantages and disadvantages. The advantages most often cited were that the MNA is "fast/quick" (29%), "simple/easy to use" (27%), "accurate/objective" (15%), and "validated" (12%). Other reported advantages were that the tool is noninvasive, prioritizes patients at highest risk, completes the nutritional picture when used with a comprehensive geriatric assessment, and is easy to use with people older than age 70.

Asked about disadvantages, 44% who used the MNA reported no difficulties. The disadvantages most often cited were that the tool was too long or cumbersome (17%), some questions weren't always applicable (9%), and it's often difficult to measure height in the elderly (9%). Others were that its measures are subjective, "not everyone uses it," micronutrient data aren't included, its use in patients who have trouble with memory recall is problematic, and anthropometric measures may not be reliable.

Of 308 who gave responses on the other standardized nutrition assessment tools they used, 41% percent reported using none, 24% reported using the Subjective Global Assessment, and 8% reported using tools their institutions developed.

One limitation of this survey is that although it was sent primarily to ASPEN members who are physicians, nurses, dietitians, pharmacists, and researchers interested in specialized nutrition support, not all ASPEN members provide care to older adults.

What's next? These findings suggest that the MNA isn't widely used by nutrition support professionals caring for older adults. Yet many such professionals report using no standardized nutrition assessment tool *at all.* Bringing evidence to bear on practice is typically a long, time-consuming process. Titler has discussed the use of implementation models that break this process down into stages.[2] One such model, developed by the Agency for Healthcare Research and Quality, describes three stages of implementation: "knowledge creation and distillation," "diffusion and dissemination," and "adoption, implementation, and institutionalization." If we consider the MNA, the terms of the first two stages have been met: the tool has been the subject of numerous studies, and the research has been widely published. It's time for nurses, and other clinicians, to continue to the third stage, incorporating the MNA into their practices and encouraging its use at their institutions.—*Rose Ann DiMaria-Ghalili, PhD, RN, CNSN, and Peggi A. Guenter, PhD, RN, CNSN*

REFERENCES

1. Guigoz Y. The Mini Nutritional Assessment (MNA) review of the literature—what does it tell us? *J Nutr Health Aging* 2006; 10(6):466-85; discussion 85-7.
2. Titler M. Translating research into practice. *Am J Nurs* 2007; 107(6 Suppl):26-33.