Rapid Elderly Assessment and Care in Hospital (REACH): Proactive identification of Frailty within an Acute Medical Unit

Authors: L. McKay, R. Russell, J. Rimer, M. Corretge, L. Munang.
St. John’s Hospital, West Lothian.

Background
West Lothian has a population of 180,000. By 2039, the number of people of pensionable age will increase by 48% and by 131% for those ≥75 years – the largest increase in these age groups in Scotland.1

To improve outcomes, all older people should be routinely assessed for frailty during any healthcare encounter.2

Those who receive Comprehensive Geriatric Assessment (CGA) rather than routine medical care after admission to hospital are more likely to be living at home and are less likely to be admitted to a nursing home at up to a year after hospital admission.3

Aims
• Timely identification and management of frailty
• Support the challenges associated with a changing demography
• Develop an enhanced role in unscheduled care to improve the patient journey
• Enable a partnership working between multiple agencies
• Nurture a positive patient and carer experience

Approach
• The Rapid Elderly Assessment and Care in Hospital (REACH) team was established to improve the pathway for frail patients admitted to hospital.
• We adapted the Health Improvement Scotland (HIS) frailty screening tool to screen all patients ≥65 years admitted under General Medicine, enabling proactive identification and management of frailty. Patients severely unwell in the High Dependency Unit and those at end of life were excluded.
• A positive score of ≥1 prompted clinical review by the REACH nurse.
• The team started with one REACH nurse in September 2015, joined by a second nurse in September 2016. The team was further enhanced by a physiotherapist and occupational therapist for winter 2016/17 reflecting the current situation.

Outcomes
Pre-intervention baseline data was collected during the week of 23rd–29th January 2015. All medical admissions ≥65 years were included. Data was collected again during the same week in January 2016 following appointment of the first REACH nurse, again in January 2017 following appointment of the second and in January 2018 with addition of OT and PT.

Figure 1 illustrates the introduction and development of REACH screening and intervention appears to be associated with:
• An increase of patients ≥65 seen by REACH and assessed, initiating appropriate care and involvement of others.
• A reduction in average length of stay for Frail patients
• A reduction in occupied bed days and associated financial savings for Frail patients

Figure 2 illustrates patient, family and staff feedback.

References
2. Care of Older People in Hospital: Health Improvement Scotland standards, June 2015.

Next Steps
We are seeking funding to expand the REACH model to a 7-day service to all older patients throughout St. John’s Hospital.

Aiming to deliver the benefits to more patients and facilitate a positive patient experience.

Figure 1: Quantitative data demonstrating the impact of the REACH model.

Figure 2: Qualitative feedback demonstrating the impact of the REACH model.