



# HOW THE NURSE-LED **OPTION E** SERVICE COMPLIES WITH THE 2016 BHIVA GUIDELINES FOR MONITORING OF STABLE HIV POSITIVE PATIENTS



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# AIMS



Compare the care given to stable HIV positive patients in the nurse-led OptionE service at 56 Dean Street against the BHIVA guidelines 2016 for the monitoring and assessment of adults with HIV

Identify areas of strength in the nurse-led model of care and areas in need of improvement



# OPTIONE



- 56 Dean Street OptionE service established 2004
- Stable patients seen twice yearly
- 25 minute appointments
- Results emailed to patients 1 week later
- Recall/Admin/letters
- Referred for physician review according to clinical need



### 3.5 Monitoring of patients established on ART and with the viral load suppressed

<p>Cover all annual issues as outlined in Table 3.2:</p> <p>In addition:</p> <p><b>History at each visit:</b></p> <ul style="list-style-type: none"> <li>• Full medication history and recreational drug use</li> <li>• Understanding of dosing instructions</li> <li>• Adherence</li> <li>• Mood</li> <li>• Adverse effects</li> <li>• Patients' concerns about medication</li> </ul> <p><b>Examination</b></p> <ul style="list-style-type: none"> <li>• According to any symptoms</li> </ul> <p><b>Investigations</b></p> <p><i>HIV viral load</i></p> <ul style="list-style-type: none"> <li>• Every 6 months<sup>1</sup> – could be up to 12 months if on a protease inhibitor</li> </ul>	<p><i>CD4 cell count</i></p> <ul style="list-style-type: none"> <li>• If <math>&lt;200</math> cells/mm<sup>3</sup>, test 3–6-monthly. If 200–350 cells/mm<sup>3</sup>, test annually</li> <li>• If <math>&gt;350</math> cells/mm<sup>3</sup> on two occasions <math>&gt;1</math> year apart, no further CD4 cell counts required<sup>2</sup></li> </ul> <p><i>6–12 monthly:</i></p> <ul style="list-style-type: none"> <li>• Full blood count</li> <li>• Renal profile</li> <li>• Liver profile</li> <li>• Bone profile</li> <li>• Dipstick urinalysis</li> </ul> <p><i>Annually:</i></p> <ul style="list-style-type: none"> <li>• Urine protein/creatinine ratio if protein positive in the urine dipstick analysis (may be more frequent if other co-morbidities that affect renal function)</li> <li>• Metabolic assessment: (if aged <math>\geq 40</math> years) lipid profile, HbA1c</li> </ul>
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<sup>1</sup>If ART is used as a 'treatment as prevention' strategy, viral load may need to be measured every 3–4 months.

<sup>2</sup>Unless there is subsequent treatment failure or new HIV-related symptoms.

### 3.2 Monitoring asymptomatic patients who currently do not want ART

<p><b>History</b></p> <ul style="list-style-type: none"> <li>General health and wellbeing enquiry to be performed at least annually</li> </ul> <p>Since last visit any new or changes in:</p> <ul style="list-style-type: none"> <li>Symptoms</li> <li>Contraception/pregnancy</li> <li>Sexual history</li> <li>Mental health</li> <li>Newly diagnosed co-morbidities and treatment changes</li> <li>Smoking status</li> <li>Alcohol/drugs including over the counter/recreational drugs</li> <li>Vaccines: flu/HPV vaccine</li> <li>Safeguarding</li> <li>Children/partner status and whether tested</li> <li>Housing, occupation/student, income/benefits</li> <li>Vaccinations</li> <li>Travel plans and history</li> <li>Patient's ideas about HIV and its treatment</li> </ul> <p><b>Examination</b></p> <p>Only if new symptoms or signs</p>	<p><b>Investigations</b></p> <p><i>Annually if CD4 cell count <math>&gt;500</math> cells/mm<sup>3</sup></i></p> <ul style="list-style-type: none"> <li>HIV viral load</li> <li>CD4 count</li> <li>FBC / renal / liver profiles</li> <li>STI screen</li> <li>Hepatitis A/B /C infection/immunity status</li> <li>Cervical smear for women if not done by GP</li> </ul> <p><i>6-monthly</i></p> <ul style="list-style-type: none"> <li>CD4 if previous result <math>&lt;500</math> cells/mm<sup>3</sup></li> </ul> <p><i>3-monthly</i></p> <ul style="list-style-type: none"> <li>CD4 if previous result <math>&lt;350</math> cells/mm<sup>3</sup></li> <li>STI/hepatitis screen for higher risk patients<sup>1</sup></li> </ul> <p><i>Other</i></p> <ul style="list-style-type: none"> <li>Annual lipids in patients <math>\geq 40</math> years, if smoker and /or BMI <math>&gt;30</math></li> <li>Cardiovascular risk assessment for patients <math>&gt;40</math> years old (QRISK2)</li> <li>Bone fracture risk assessment using FRAX tool in everyone aged <math>&gt;50</math> years, post-menopausal women, or other high-risk patients every 3 years</li> </ul>
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# METHODOLOGY



August 2016 – July 2017 = 2590 OptionE appointments attended

249 of these were transfers of care in to the service

Non-stable patients

Around 1000 **yearly reviews** undertaken

- Retrospective data collected by nurse practitioners direct from 200 electronic case notes & results – LastWord, Evolve, Lille
- 10% double checked.
- Demographic information collected included age, ethnicity, gender



# DATA COLLECTED

- Medical / Mental health
- ART review / Drug review
- Annual bloods attended/ Urinalysis
- Cardiovascular risk/ Bone Profile
- STI screen offered / Partner status/children
- ETOH/ Recreational drugs/ Smoking status
- Safeguarding/ Social history/ Recent travel
- GP correspondence



# DEMOGRAPHICS



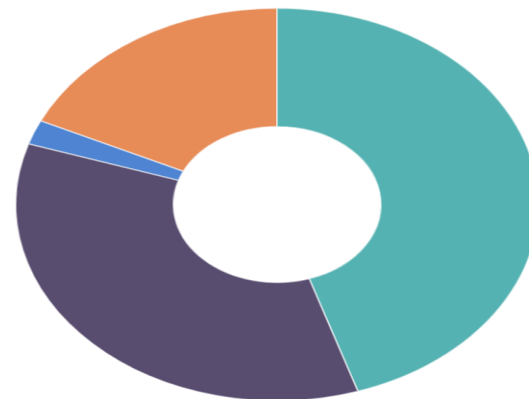
Age



20-40 80 40-50 35 50 plus 85



Ethnicity



White British 45 White other 35  
Black African 2 Other 18

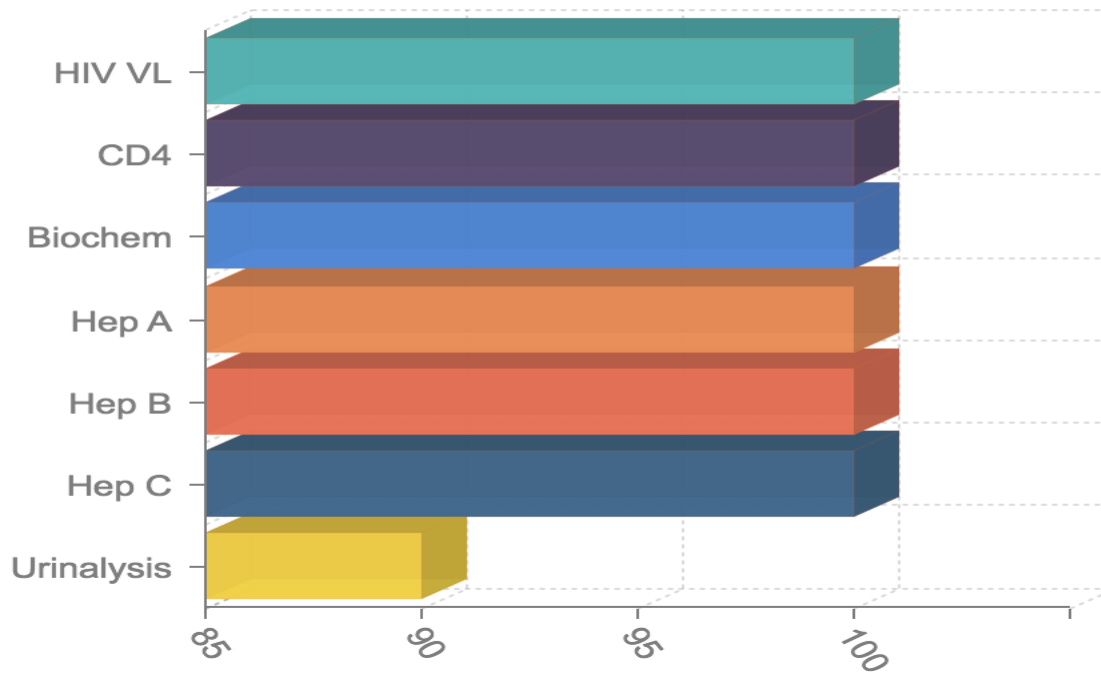




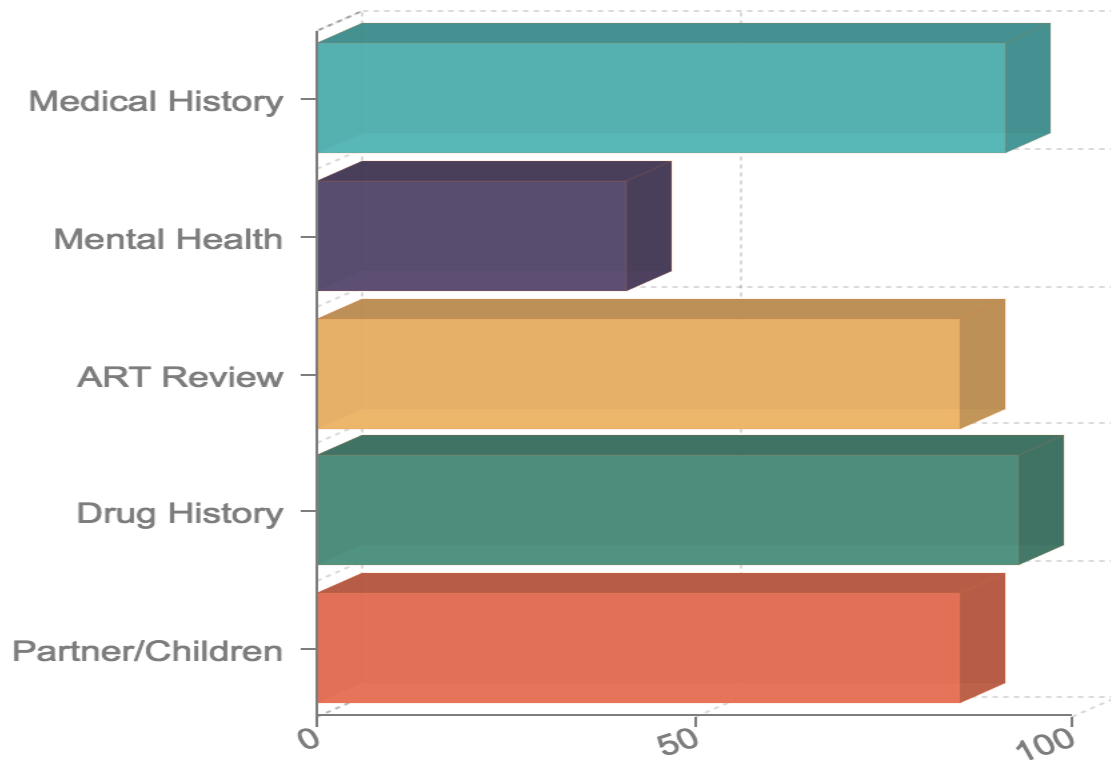
# Results



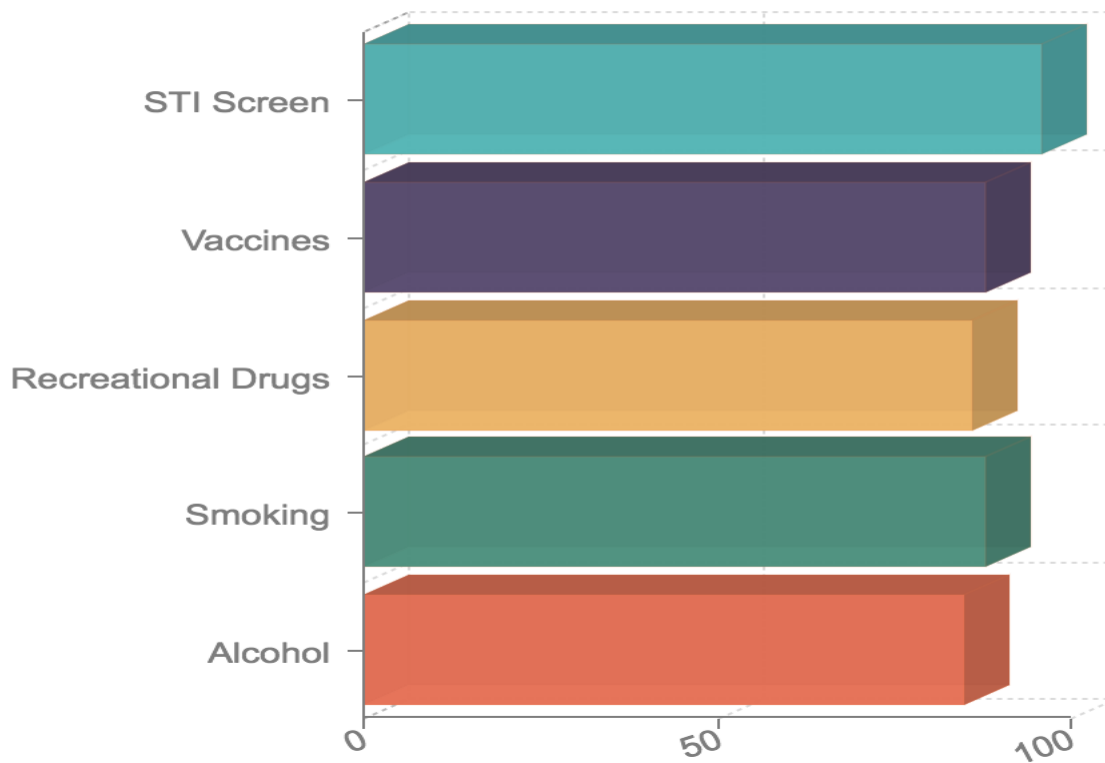
## Results

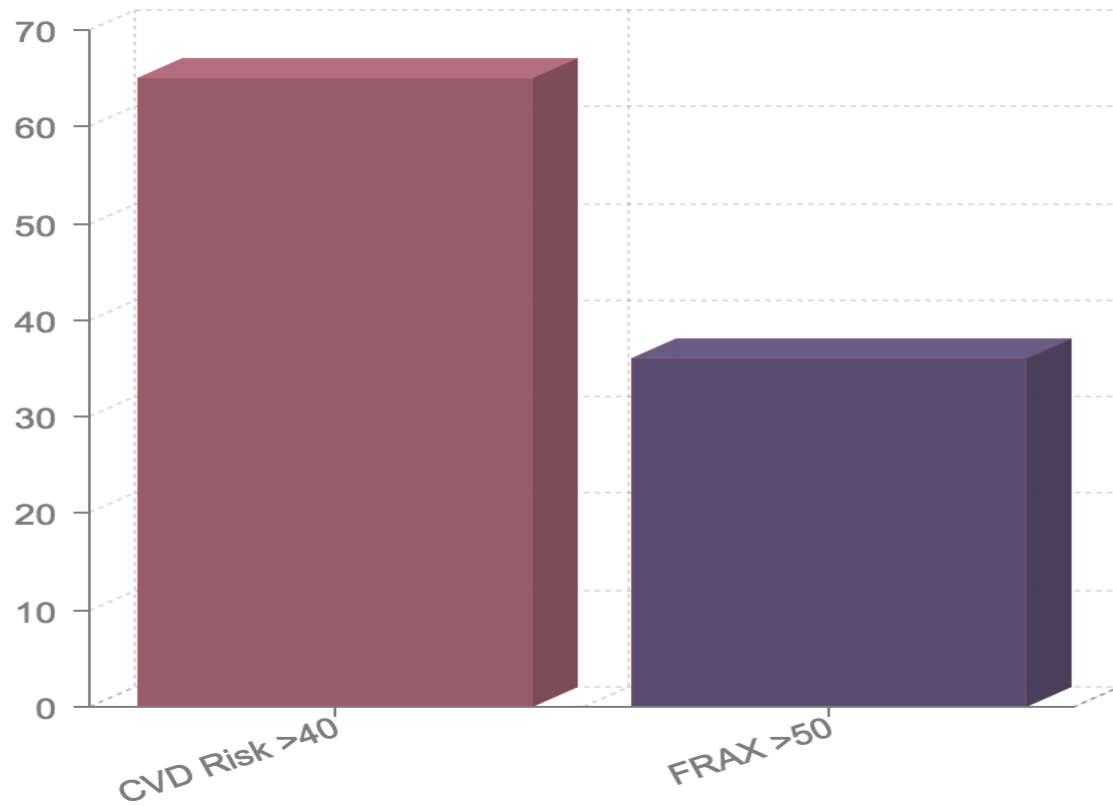


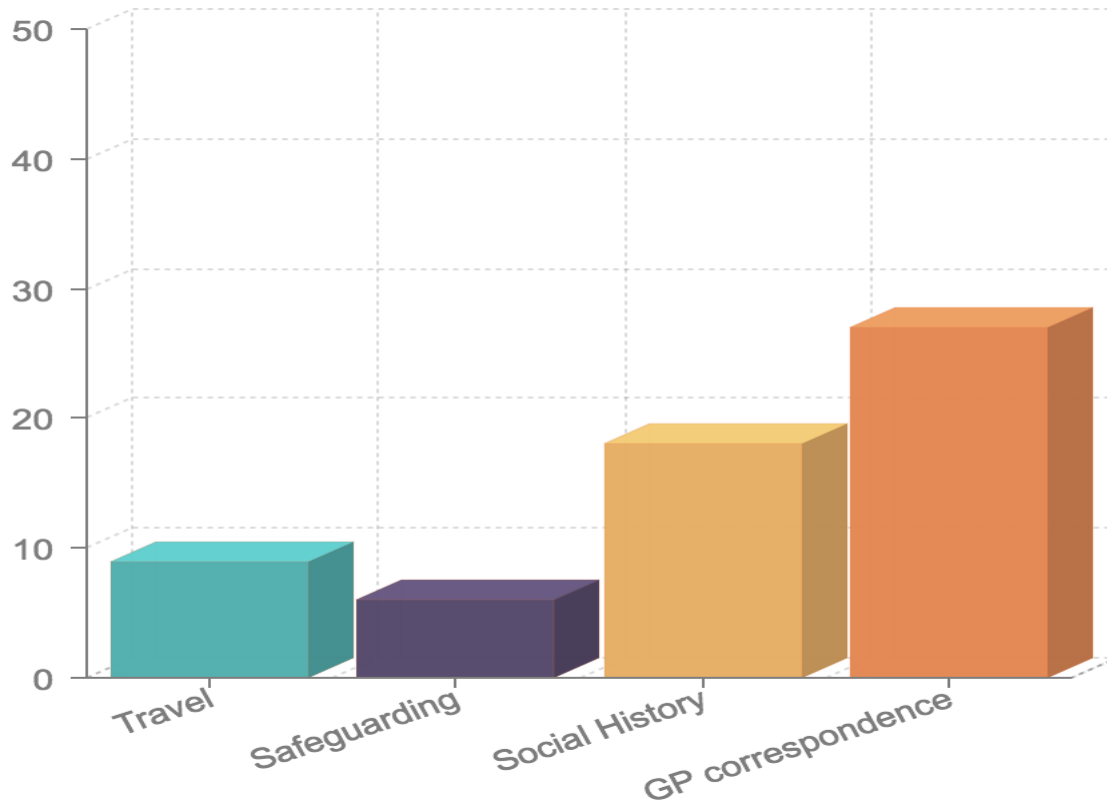
## Results



## Results







# DISCUSSION

## Strengths

- Accurate and timely blood tests
- Up-to-date medical & drug history (including ART)
- Sexual Health
- Substance misuse

## Improvement

- Mental Health
- Safeguarding
- GP correspondence
- Older patient needs
- Documentation

