

# Remote HIV Care – A community nursing approach

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Liverpool HIV Community



#### **Conflict of Interest**

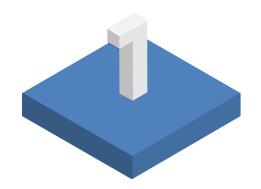
In relation to this presentation, I declare that I have no conflict of interest

Speakers are required by the Federation of the Royal Colleges of Physicians to disclose conflicts of interest at the beginning of their presentation, with sufficient time for the information to be read by the audience. They should disclose financial relationships with manufacturers of any commercial product and/or providers of commercial services used on or produced for patients relating to the 36 months prior to the event. These include speaker fees, research grants, fees for other educational activities such as training of health professionals and consultation fees. Where a speaker owns shares or stocks directly in a company producing products or services for healthcare this should also be declared. Finally, other conflicts of interest including expert functions in health care or healthcare guidance processes should be declared (eg if the professional is a member of a health board). The Federation considers it good practice to also make speakers' disclosures available in digital format(s) relating to the educational event.





# **Audit What and Why**



Assess level of care delivered by the Nurse Led Liverpool Community Team against BHIVA standards



Identify any gaps or issues to improve standards of care by the identification of new working practices

## **Background and Process**

### 2,560 data entry during the data collection

Unit Number, emis	****	****	****			****	****	****		****	****	****		****	****	****	****	****		****	****		****	****	****	****		****	****	****					****		****	****
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Country of Birth		****				****	****	****						****				****																				****
Country of Exposure	****					****	****	****			****		****	****	****										****	****	****			****			****			****		****
initial Diagnosis Setting		***	***	****	***	***	***	***	***			***		****			****								****	****	****	****	****				****			****	****	****
GP Disclosure		****	***	****	***	***	***	***	***			***	****	****	****	****			****					****	****	****	****	****	****				****				****	
Disabilities	****	****	****			****			****	***	****	****	****	****	****				***	****			****	****	****	****		****	****	****			****		****	****		****
Has patient been asked to complete a satisfaction survey in the last 2 years?	****	****	****	****	****	****	****	****	****		****	****	****	****	****	****		****		****			****	****	****	****	****	****	****	****			****		****	****	****	****
How many patients completed the satisfaction survey			****	****	****	****	****	****				****						****	****				****	****						****				****	****	****	****	****
Of those who completed   Oces the patient feel supported to manage their HIV?	****	****	****		****	****	****	****	****		****																											
Does individual feel satisfied with decisions about their care?	****	****	****		****	****	****	****				****				****							****	****														****
Does individual feel involved in making decisions about their care?			****		****	****																																
is there documented evidence that the patient has received written/verbal HIV drug information?		****									****	****		****	****	****													****							****		****
is there documented evidence of discussion/referral for benefits and financial hardship support?						****					****	****		****		****			****					****					****									****
Has patient been retained in care for 12 months following referal to community WV service?											****				****		****																		1111			
is there documention of efforts to re engage those patients who were not retained in care? Is there documention of communication with GP in last 12 months for those who has consented to																												****				-						
information sharing?																																						
is there documentation of communication with GP when new health problem/chance in medication		_		-						****								_					+ -					***				-	-		+	-	-	-
identified?						****	****	****					****	****		****	****		****				****	****			****	****		****						****	****	
to there documentation of adherence discussion of starting ART and annually there after?		****		****						***	****		****	****	****	****					****								****	****					****			****
is there documentation of a medication review in the past 15 months?	****	****	****	****	****	****	****	****	****		****	****	****	****	****	****	****	****	****		****		****	****	****	****	***	****	****	****		***		****	****	****	****	****
is there documentation of patient being offered written information when making treatment decisions.																																	-				-	$\neg$
and reporting side effects?	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****		****	****	****	****	****	****	****	****						****	****	****
is there documentation of patient being offered peer support when making treatment decisions and in																																					$\neg$	$\neg$
reporting side effects?	****	****	****		****	****	****	****		****	****	****	****	****	****	****	****	****	****		****		****	****	****		****		****	****				****		****	****	****
Has patient experienced viral rebound or falled to suppress on current ARV therapy?		****	****	****		****	****	****	****		****	****	****	****	****	****		****	****	****	****		****	****		****	****		****	****			****	****	****	****	****	****
Of those who failed to suppress or experienced rebound, were they managed according to National	1	1	1	1 1		1	- 1	- 1	l l		1			1		1		- 1		1		- 1	1	1		l l		,	1				1	1	1			
gidelineO		****	****		****	****		****		****		****		****	****	****		****		****	****					****		****		****								****
Has the individual had an annual review		****						****				****						****						****				****		****						****		****
Within the annual health review have you discussed the following:		****									****	****		****	****	****			****																		****	****
Screening for alcohol use in past 12 months?					****						****				****			****						****					****							****		
Screened for recreational Drug use in the last 12 months (Of those identified with a drug/alcohol problem) have they been referred for drug/alcohol support																																						
unices?																																						
sthere documentation of sexual health discussion and offer a sexual health screen in the last 12				_																												_	-		_		-	
months?	****	****	****	****	****	****	****	****	****		****	****	****	****	****	****	****	****	****		****		****	****	****	****	****	****	****	****					****	****	****	****
(Of those who have been diagnopsis with an STI), have they received appropriate treatment?	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****		****		****			****	****	****	****	****	****	****	****			****	****	****	****	****	****
																																					-	$\overline{}$
is there documented evidence of discussion about individual need for healthy diet and exercise plan?	****	****	****	****	****	****	****	****		****	****	****	****	****	****	****	****	****	****	****			****	****	****	****	****	****	****	****				****	****	****	****	****
Does the individual have a documented record of smoking history in past 12 months?	****	****	****	****				****	****		****	****	****	****	****	****		****	****	****	****		****	****		****	****	****	****	****			****	****	****	****	****	****
Does the individual have a documented blood pressure in part 12 months?	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****		****	****	****	****	****	****	****	****		***		****	****	****	****	****
Does the individual have a documented cardiovascular risk score in past 12 months where appropriate?														l																						l I		
(Faged over 40 years)											****																											
Does the individual have a documented assessment of renal function (eGFR and proteinuria)? Does the individual have a bone fracture risk assessment in last 12 months where appropriate? (if aged																												****				-						
our SO)																																						
Does the individual have a latent 18 screen? (iffrom a high risk country)	****	****	****	****	****	****	****	****			****	****	****	****	****	****		****	****		****		****	****	****			****	****	****					****	****	****	****
Has the individual been offered Hep A vaccine, (if required), as per BHIVA guidelines	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****		****	****	****	****	****	****
Has the individual been offered Hep & vaccine, (if required), as per BHTVA guidelines	****	****	****	****	****	****	****	****			****	****	****	****	****	****	****	****	****		****	****	****	****	****	****		****	****	****			****	****	****	****	****	****
Bfindividual has HIV co-infection with Hep B or C), have they documentation of assessment of Liver																																					-	_
disease staging?	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****			****	****	****	****	****	****	****	****				****	****	****	****	****
\$findividual with HEV has cirrhosiq, have they had HCC screening in past 12 months?	****	****	****			****	****	****						****				****					****		****	****	****			****						****		****
Documented evidence of CNT assuming role of care co-ordination? (for individuals with increased	1	1	1				$\neg$	$\neg$			1			1	1		-	$\neg$	-		$\neg$			1 -					1			$\neg$	7			1 -		
needs)	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****		***	****	****	****	****	****	****
L		l										l l																							1	l l		
Does individual have ducumentation of current reproductive/contracegtive choice in last 12 months?									*****																		*****	****										
Does individual have documentation of discussion about menopause and enquiry about symptoms? (as appropriate)																																[			1	l		
appropriate) Has the individual required referral to agreed contraceptive fertility or menogause services?					****	****	****	****			****	****	****	****	****		****	****	****		****		****		****				****	****						****		****
Oper individual have documented evidence of discussion about partner notification and referral to	_	_	_	-			_	_						_				_	-		_		_									_	-	_	_		-	-
book individual have documented evidence of discussion about partner not fication and reterral to health advisors if required?	****	****	****		****	****	****	****			****	****	****	****	****	****	****		****		****		****					****	****	****				****		****	****	****
Does the Individual have documented discussion about recreational drug use /chem sex and STI risk (If		1		-										1					_				1	1									-t				-	-
appropraite) annually?	****	****	****			****	****	****		****	****	****	****	****	****	****	****	****	****		****		****		****			****	****	****						****	****	****
Does the patient have documentation of annual screening for mental health difficulties?	****	****	****		****	****					****		****	****	****	****		****											****	****						****	****	****
Of those identified with mental health problems) have they been referral for appropriate specialist	1	1	1				$\neg$	$\neg$			1			1	1		-	$\neg$	-		$\neg$			1 -					1			$\neg$	7			1 -		$\neg$
wruices?	****	****	****	****	****	****	****	****	****	***	****	****	****	****	****	****	****	****		****	****		****	****	****	****		****	****	****				****		****	****	****
Does the individual have documentation of pro active screening for identification of potential		1 -		1 —										1 -																				1 -	1 -	1 7		7
comorbidities?		****	****		****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****		****	****	****	****		****	****	****					****	****	****	****
Does the individual have documentation of discussion about peer support and emotional support		l	l	I																				I										l	1	l		
services? Is there documented evidence of referral for Peer support or emotional support services?	****	****	****		J	****					****			****	****	****			****				****		****			****	****	****				****		****	****	****
is there documented evidence of referral for Peer support or emotional support services?  Those individual hour individual surfibores care plan to support improved With treatment with source?				222														****					2000													****		
Does individual have individualised home care plan to support improved WV treatment adherence? In there evidence of individualised prescribing of ART to account for specific needs of patient?				****														****					2000															
Is there evidence of individualised prescribing of ART to account for specific needs of patient?  Has individual achieved improved adherence of ART since referal to LCC CNT?																																						
Has the individual achieved HIV viral suppression since referral to LCC CNT?					****						****		****		****		****	****	****										****	****								****
EXTRace with identified problems/issued have they been offered support/onward referral to modify		+		1 -			_	_						<del>                                     </del>	_			_	_		-		+	+		- "			_				-	_	+		-	-
(of those with identified problems, results) they been offered support, onward reterral to modify behaviours to improve health?	****	****	****	****		****	****	****			****	****	****	****	****	****	****	****	****	****			****	****	****		****	****	****	****						****	****	
Has the individual had a cancer/malignancy-diagnosis?		****		****	****	****	****	****			****	****	****	****	****	****	****	****		****	****			****		****	****	****	****	****					****			****
(Of those with cancer diagnosis) has CNT supported individuals to establish and maintain links to				1 1			$\neg$	$\neg$									-	-															-				-	
specialist oncology services?	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****	****		****	****	****	****	****	****	****	****					****	****	****	****
(if patient has a life limiting liness) is there documentation of conversation regarding prognosis and		1																																				
preferences for end of life care?	****	****	****	****	****	****	****	****			****	****	****	****	****	****	****	****	****		****		****	****	****	****			****	****				****	****	****	****	****

## **Background and Process**

## Standards of Care for People Living with HIV 2018



#### Standards selected for this audit

- Standard 2. Patient-centred Care
- Standard 3. HIV Out-patient care and treatment
- Standard 4. Complex HIV Care
- Standard 5. Sexual & Reproductive Health
- Standard 6. Psychological Care
- Standard 7. HIV across the Life Course

## Results table



Table 1 – HIV Community Nursing – Annual health review overvie	ew .		
Description (n=34)	BHIVA Target	Yes	% <u>to</u> achieve target
Has the individual had an annual review	100%	88.2%	11.8%
GP Disclosure	95%	95%	0%
GP communication when new health problem or change in medication	95%	76.5%	18.5%
Documentation of adherence discussion about ART annually	90%	94.1%	0%
Documentation of a medication review in the past 15 months	90%	97.1%	0%
Screening for alcohol use in past year	90%	79.4%	10.6%
Screened for recreational Drug use in the last 12/12	90%	79.4%	10.6%
Evidence of discussion about individual need for healthy diet and exercise plan	100%	55.9%	44.1%
Documented record of smoking history in past year	95%	82.4%	12.1%
Documented blood pressure in past year	100%	85.3%	14.7%
Documentation of sexual health discussion and offer a screen in the last year	90%	70.6%	19.4%
Documented cardiovascular risk score in past 12 months on patients 40+( n=33)	90%	81.9%	8.1%
Documented assessment of renal function (eGFR and proteinuria)	90%	94.1%	0%
Bone fracture risk assessment in last 12 months, if aged 50+ (n=18)	90%	77.8%	12.2%
Evidence off TB screen, If from a high-risk country (n=4)	90%	100%	0%
Offered Hep A vaccine, (if required), as per BHIVA guidelines (n=17)	95%	29.4%	65.6%
Offered Hep B vaccine, (if required), as per BHIVA guidelines (n=30)	95%	46.7%	48.3%
Assessment of Liver disease staging? (n=5)	95%	40%	55%
Evidence of CNT¹ acting as care co-ordination for those with increased needs	90%	91.2%	0%
Documentation of current reproductive/contraceptive choice in last year (n=14)	90%	71.5%	18.5%
Documented evidence of discussion about PN <sup>2</sup> / health advisors' referral	100%	38.2%	61.8%
Documented discussion about recreational drug/chemSex /STI risk (if appropriate)	90%	26.5%	63.5%
Documentation of annual screening for mental health difficulties	90%	90%	0%
Documentation of proactive screening for identification of potential comorbidities	100%	100%	0%
Documentation of discussion about peer and emotional support services	100%	64.7%	35.3%
Evidence of home care plan to support adherence	100%	85.3%	14.7%
individualised prescribing of ART to account for specific needs of patient	100%	100%	0%
Achieved improved adherence of ART since referral to CNT <sup>1</sup>	100%	70.6%	29.1%
Detectable <sup>3</sup> viraemia on current ARV therapy? 18/34	90%	52.9%	37.1%
Was detectable viraemia managed according to National guidelines? 18/34	90%	56%	34%
Patient satisfaction survey n=16	100%	100%	2.70
Evidence that patient received HIV drug information	90%	32%	58%
Evidence of discussion/referral for financial hardship support	100%	21%	79%
Retention in care for 12-months after referral to the HIV community team	90%	97%	0%
Evidence to re-engage LTFU / Need to find	95%	100%	0%
<sup>1</sup> CNT, community team; <sup>2</sup> PN, partner notification; <sup>3</sup> Virological rebound or failure		/ .	- 70



## **Results: Red Outcomes**

Table 1 – HIV Community Nursing – Annual health review overview			
Description (n=34)	BHIVA Target	Yes	% to achieve target
Evidence of discussion about individual need for healthy diet and exercise plan	100%	55.9%	44.1%
Offered Hep A vaccine, (if required), as per BHIVA guidelines (n=17)	95%	29.4%	65.6%
Offered Hep B vaccine, (if required), as per BHIVA guidelines (n=30)	95%	46.7%	48.3%
Documented evidence of discussion about PN2 / health advisors' referral	100%	38.2%	61.8%
Documented discussion about recreational drug/chemSex /STI risk (if appropriate)	90%	26.5%	63.5%
Evidence that patient received HIV drug information	90%	<b>32</b> %	58%
Evidence of discussion/referral for financial hardship support	100%	21%	79%
Evidence of discussion about individual need for healthy diet and exercise plan	100%	55.9%	44.1%
Offered Hep A vaccine, (if required), as per BHIVA guidelines (n=17)	95%	29.4%	65.6%
Offered Hep B vaccine, (if required), as per BHIVA guidelines (n=30)	95%	46.7%	48.3%
Assessment of Liver disease staging? (n=5)	95%	40%	55%

Implementing vaccination as-needed

Changing proforma documentation to include prompts

Knowing patients – a good and bad thing



## Results: Amber Outcomes

Table 1 – HIV Community Nursing – Annual health review overview			
Description (n=34)	BHIVA Target	Yes	% to achieve target
Has the individual had an annual review	100%	88.2%	11.8%
GP communication when new health problem or change in medication	95%	76.5%	18.5%
Screening for alcohol use in past year	90%	79.4%	10.6%
Screened for recreational Drug use in the last 12/12	90%	79.4%	10.6%
Documented record of smoking history in past year	95%	82.4%	12.1%
Documented blood pressure in past year	100%	85.3%	14.7%
Documentation of sexual health discussion and offer a screen in the last year	90%	70.6%	19.4%
Documented cardiovascular risk score in past 12 months on patients 40+( n=33)	90%	81.9%	8.1%
Bone fracture risk assessment in last 12 months, if aged 50+ (n=18)	90%	77.8%	12.2%
Documentation of current reproductive/contraceptive choice in last year (n=14)	90%	71.5%	18.5%
Documentation of discussion about peer and emotional support services	100%	64.7%	35.3%
Evidence of home care plan to support adherence	100%	85.3%	14.7%
Achieved improved adherence of ART since referral to CNT1	100%	70.6%	29.1%
Detectable3 viraemia on current ARV therapy? 18/34	90%	52.9%	37.1%
Was detectable viraemia managed according to National guidelines? 18/34	90%	56%	34%
¹CNT, community team			

Annual health review proforma prompts

Patientcentred care information gathering

Individualised holistic care planning (patient choice)

GP communication implemented Peer support to be reimplemented



## **Results: Green Outcomes**

Table 1 – HIV Community Nursing – Annual health review overview			
Description (n=34)	BHIVA Target	Yes	% to achieve target
GP Disclosure	95%	95%	0%
Documentation of adherence discussion about ART annually	90%	94.1%	0%
Documentation of a medication review in the past 15 months	90%	97.1%	0%
Documented assessment of renal function (eGFR and proteinuria)	90%	94.1%	0%
Evidence off TB screen, If from a high-risk country (n=4)	90%	100%	0%
Evidence of CNT <sup>1</sup> acting as care co-ordination for those with increased needs	90%	91.2%	0%
Documentation of annual screening for mental health difficulties	90%	90%	0%
Documentation of proactive screening for identification of potential comorbidities	100%	100%	0%
individualised prescribing of ART to account for specific needs of patient	100%	100%	0%
Patient satisfaction survey n=16	100%	100%	0%
Retention in care for 12-months after referral to the HIV community team	90%	97%	0%
Evidence to re-engage LTFU / Need to find	95%	100%	0%
¹CNT, community team			

Individualised prescribing routine

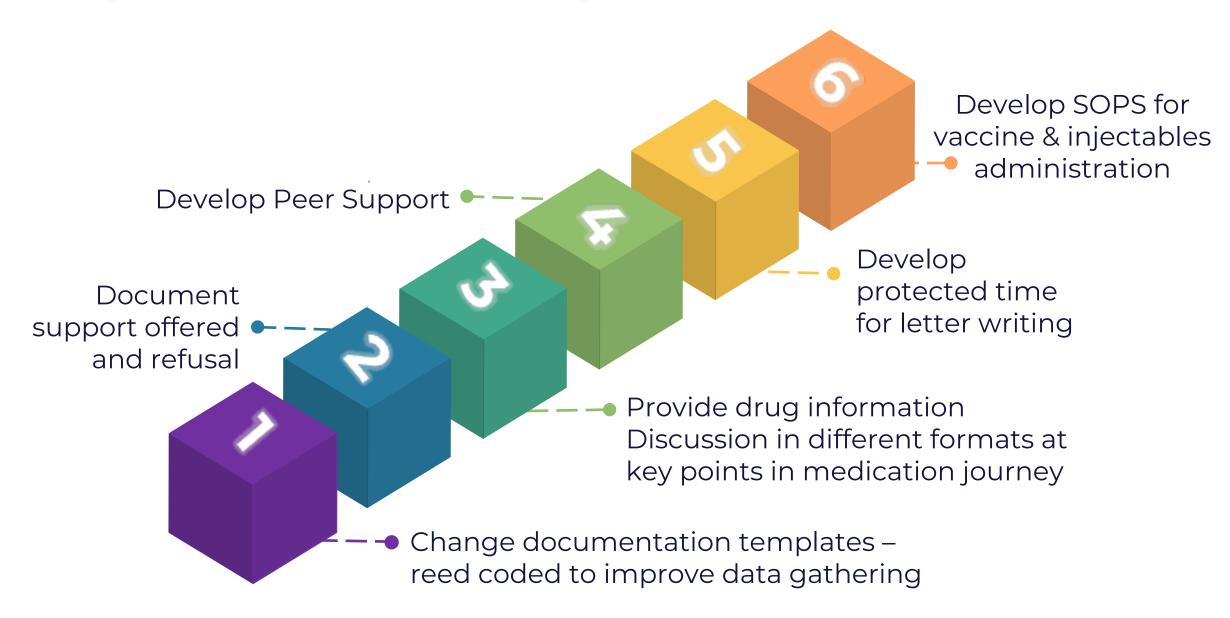
Medication review is essential for prescribing

Individualised medication adherence

Care co-ordination

Annual health review ensures standards of care are maintained

## Implications for clinical practice



## Implication for clinical audits

