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Audit Report:medical referrals to nurse-led HIV maintenance clinic.

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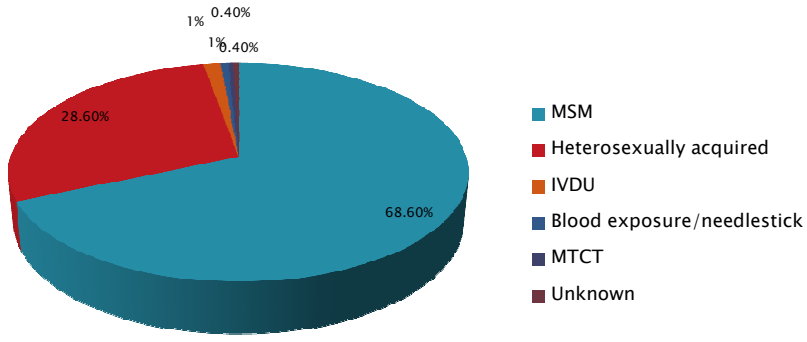
Background

- The Brownlee Infectious Disease Centre has a cohort of 1333 HIV patients.
- Single integrated GUM/HIV cohort with shared accommodation
- Multi-disciplinary
- Last financial year cohort increased by 4.5% (138 new patients).
- 81.1% of the total cohort is on ARVs.
- 88.7% of the total patients on treatment are undetectable (<40 copies ml).[1]
- Audit was conducted in patients under GU consultants.

Demographics of acquisition of HIV infection in GUM cohort



Background

- BHIVA standards of care state that centres providing out-patient HIV care should develop their own clinical pathways for care. [2]
- Regular CD4 count and viral load monitoring leads to better virological control for patients on treatment and better long term outcomes for patients not on HAART.
- There is also evidence that care within a multi-disciplinary setting leads to better outcomes.[3]

Nurse-Led Clinic

- Run by " BBV Community nurse specialists"
- Two clinics a week with 20 appointment slots
- Shared with Hep C patients

- BP, pulse, weight and BMI
- General health check
- Smoking
- Alcohol intake
- CVD risk
- Social and Relationship Issues
- CD4 count, VL, FBC, LFTs, UEs and syphilis serology
- Sexual Health Screen

Referral Criteria

- **On treatment**
  - Regular attenders
  - CD4 >200
  - VL <40
  - Stable on same treatment for >6 months
  - No adherence issues

- **Patients not on treatment**
  - Regular attenders
  - CD4 >350
  - VL <30,000
  - Stable >6 months

Nurse-led clinic

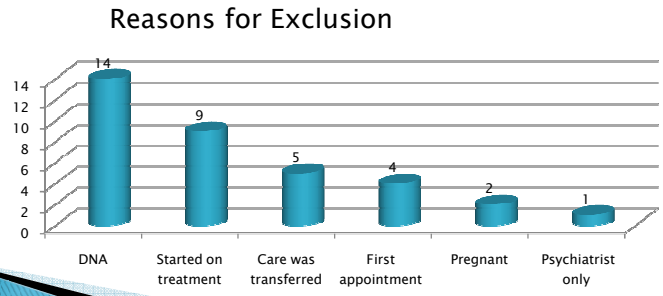
- This should result in stable patients alternating between the nurse-led and medical clinics every 3-4 months.
- On average 30/80 unused nurse-led clinic appointments per month.
- No increase in funding for HIV care but more patients therefore we need to make full use of all our resources.
- As patients live longer and our cohort continues to grow the use of this clinic will become increasingly important.

Aims

- Were all eligible patients being referred?
- What were the reasons for non-referral in stable patients?

Methods

- All 133 patients who were booked to attend the GUM clinics in March 2010 had their notes examined.
- 35 patients were excluded initially for the following reasons.



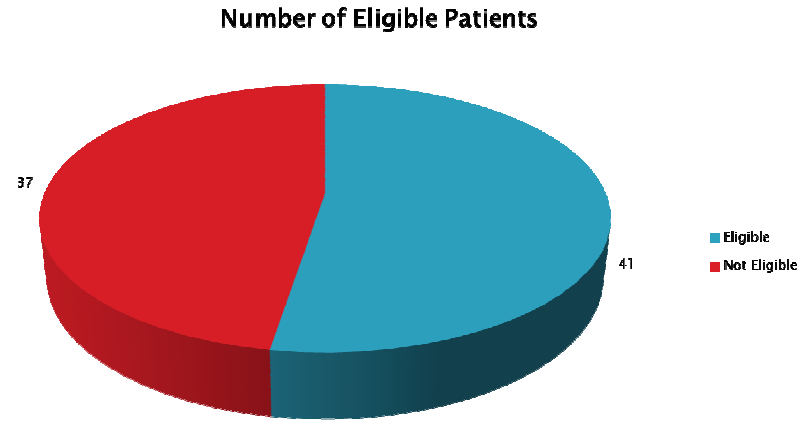
Methods

- 98 patients had their notes audited.
- Split into treatment (78) and not on treatment groups (20)

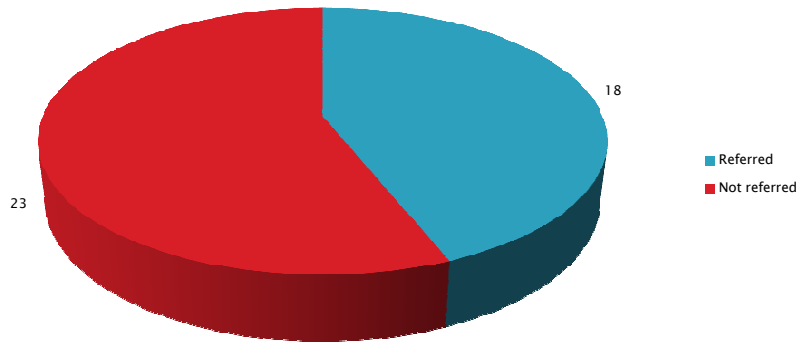
- Audited against referral criteria
- Poor attender was defined as 2 or more DNAs in the past 12 months

- Any other on-going issues not directly related to control of their HIV infection was also recorded

Results – on treament (78)



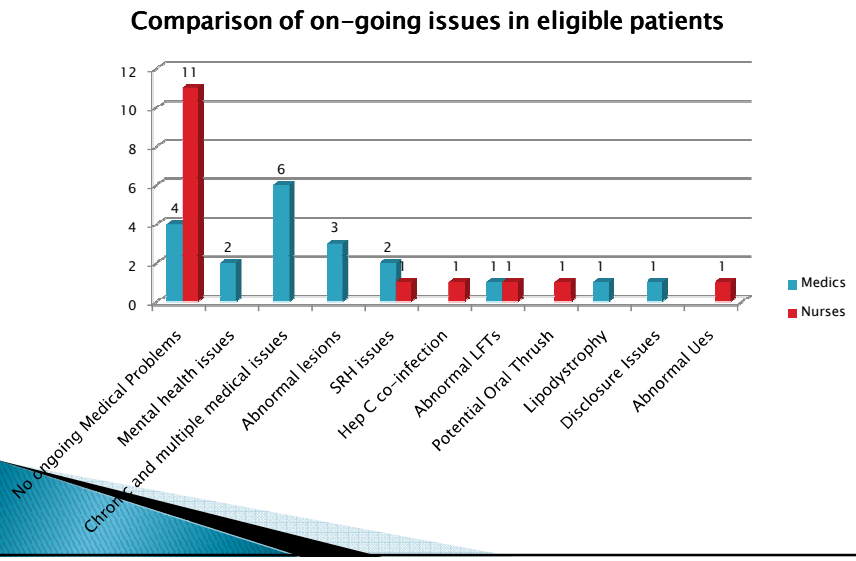
Results – on treatment



Results – On Treatment

- 23 patients missed the opportunity for referral
- Three documented reasons for non-referral:
  - Patient wanted to wait to discuss with his consultant first
  - Doctor wrote "wanted to wait until patient was very stable"
  - Doctor was concerned about the patients mood issues so organised medical follow-up.
- 20 patients had no specific documented discussion around the potential for referral to nurse-led clinic

Results – On treatment



Results not on treatment

Table 1: not on treatment

	Yes	No	Total
Eligible	9	11	20
Referred	2	7	9

Results – Not on treatment

- 7/9 (82%) missed opportunity for referral
- 1 documented reason
  - Patient declined
- 1 patient had no on-going issues
- 5 patients had on-going issues
  - 1 trying to conceive
  - 2 mental health issues
  - 1 on hep C treatment
  - 1 needed interpreter

Results

- In both groups patients who did not meet the criteria were referred.
- 6 on treatment and 3 not on treatment
- No documentation to explain deviation from protocol

- Table 2: Reasons for non-eligibility

Reason for non-eligibility	No. of patients
Not been UD in past 6 months	3
Poor Attender	2
No results available for past 4 months	2
<200	1
Viral load >30,000	1

In summary

- 50/98 (51%) were eligible for referral
- 30/50 (60%) missed opportunity for referral

Conclusions

- Less than half eligible patients are being referred.
- Poor documentation was a barrier to exploring why referrals are not being made.
- HIV infection is often very stable and it is the other medical, psychiatric or SRH issues that appear to prevent doctors from referring.
- Would a more qualitative study interviewing doctors allow us to explore barriers to referrals more?

What Happened Next...

- Audit results discussed at multi-disciplinary meeting.
- Agreed to “increase general awareness”.
- Then nurses conducted their own audit
- 22% of cohort in 6m period is attending nurse-led clinic[4]
- Introduced competitive element with the consultants with the most referrals receiving a prize.

- Discussed again as a team how to improve referral rates.
- Idea to have added to Clinical Review Form or reminder in notes rejected – "already too many things to remember".
- Conclusion was to generally increase awareness again and to regularly audit and present the results.
- Yet to see if the promise of a prize and title of "best referring consultant" will encourage more referrals.

References

- 1.HIV Service Report, March 2011, Brownlee Infectious Disease Centre, Gartnavel Hospital, Glasgow. Sandie Kerr.
- 2. BHIVA. Standards for HIV Clinical Care 2007. See www.bhiva.org (last accessed January 2011).
- 3. Medical Foundation for AIDS and Sexual Health. Recommended standards for NHS HIV Services 2010. See www.medfash.org (last accessed January 2011).
- 4. Nurse-Led Clinic Audit, September 2010-March 2010, Presentation May 2011Bronwlee Infectious Disease Centre Lorna Mclean