

Innovation in HIV nursing: the Liverpool Community Clinic

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Abstract

The Liverpool Community Clinic (LCC) was established to address the pressing problem of non-attendance to hospital by people who are living with HIV (PLWH). This group now receives timely, safe and appropriate care while being managed remotely. The aims of the LCC are to reduce hospital admissions, manage side effects, guarantee medication and adherence, identify psychosocial factors that impact on engagement and retention in care, and enable person-centred care incorporating shared decision-making. Patients and the HIV community nursing

team (HCNT) agree on the frequency of home visits and deliver a wide range of interventions such as: prescribing; treatment starts and switches; venepuncture for monitoring; secondary dispensing; medicine reconciliation; side-effects management; adherence support; diagnosis support; and liaison with multidisciplinary teams. The LCC consists of HIV consultants (infectious diseases or genitourinary medicine) and an HIV community nursing team, who meet monthly to discuss existing and potential patients.

Background

The Liverpool HIV community nursing team (HCNT) became operational in 1993, prior to the advent of highly active antiretroviral therapy (HAART) and was one of the first HCNTs outside London. Liverpool is a relatively small city with only one HIV treatment centre at the local hospital. Clinics are delivered by genitourinary medicine (GUM) and infectious disease (ID) units. During the pre-treatment era, the core functions of the HCNT were to optimise quality of life, facilitate end-of-life care at home, provide diagnosis support to patients and significant others, teaching, audit and research. This was a difficult time to work in HIV nursing and good nursing care, exercising advanced communication skills, empathy, trust and symptom control were all we had to offer. Following implementation of HAART, post 1996, core functions of service delivery changed to include managing patients with inadequate adherence, late diagnosis, and engaging with those struggling to attend hospital clinics. Nursing by the HCNT has evolved over the years; Piercy *et al.* have described it as highly responsive to the changing needs of people living with HIV (PLWH) in Liverpool and mentioned the introduction of a range of initiatives to improve the service [1].

The nursing model in Figure 1 represents HIV nursing in Liverpool.

Development of Liverpool Community Clinic

Many patients, both complex and non-complex, attend their hospital clinic appointments regularly, without issue, where they are managed and

supported by hospital HIV specialist nurses. HCNT may know some of these patients but they are not active on their caseload. This is represented in the first circle (Figure 1).

PLWH in Liverpool are also managed via shared care between HCNT and hospital HIV nurses. These two groups support and manage those who attend hospital inconsistently and require additional nursing support at home. Alternatively, some may receive the bulk of their care at home but still attend hospital. Nurses meet monthly to discuss shared-care patients in addition to a weekly multidisciplinary team (MDT) meeting where the doctors are present. This is represented by the middle circle in Figure 1.

Over the years it became increasingly difficult to manage patients who could not attend hospital for reasons shown in Figure 2. HCNT often took blood samples for monitoring in the patients' homes, and were comprehensively involved in the care of the patient, who was then required to attend hospital for

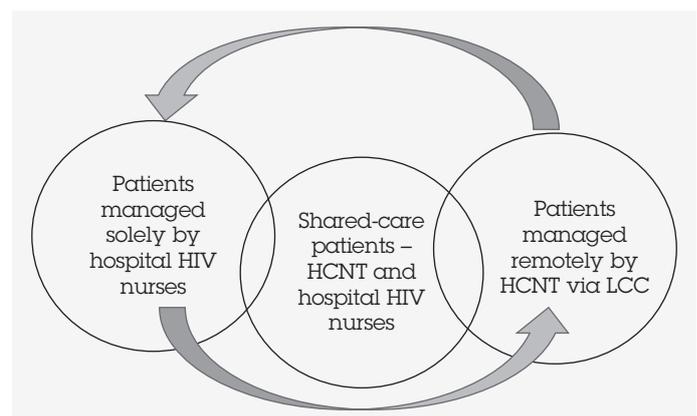


Figure 1: Liverpool HIV nursing care model

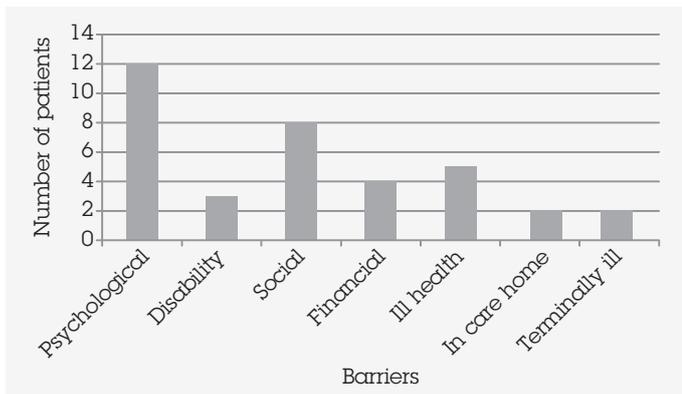


Figure 2: The main reasons why PLWH cannot, or do not attend hospital clinics and are managed via LCC. Some experience more than one issue, which suggests medical and psychosocial complexity.

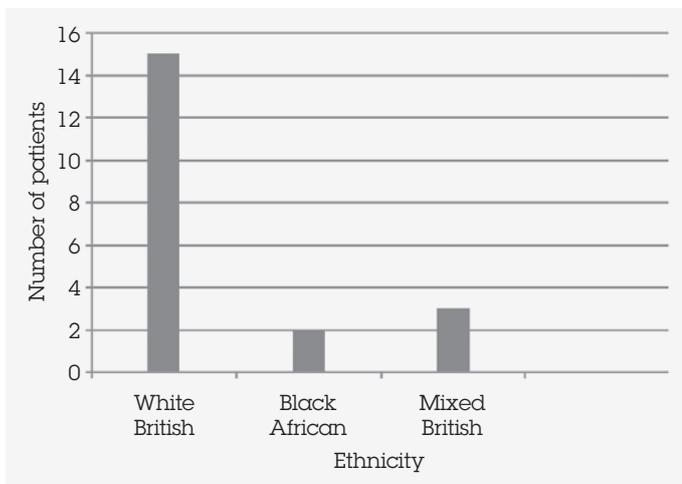


Figure 3: Ethnicity of patients managed by LCC.

a prescription. Some viewed the requirement to attend hospital as punitive, resulting in poor or non-attendance and treatment interruptions. This situation also became frustrating and difficult for the nurses and doctors at the hospital who hadn't seen the patient for some time and felt compromised when HCNT requested prescriptions. It became apparent that although patients were adherent to their medication, the pressing problem was attending hospital. This issue was the catalyst for a different approach as although self-management and taking responsibility for one's own health were promoted, some PLWH could not, or would not, attend hospital.

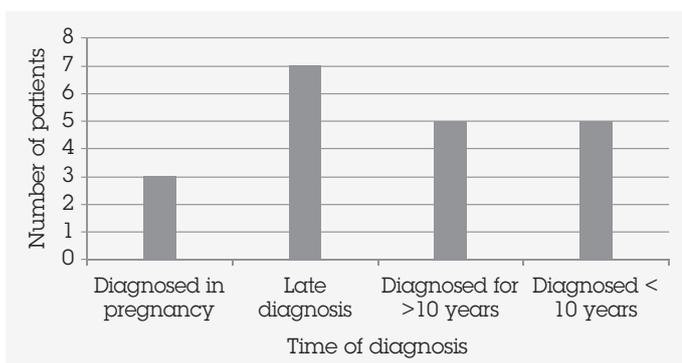


Figure 4: Stage of diagnosis.

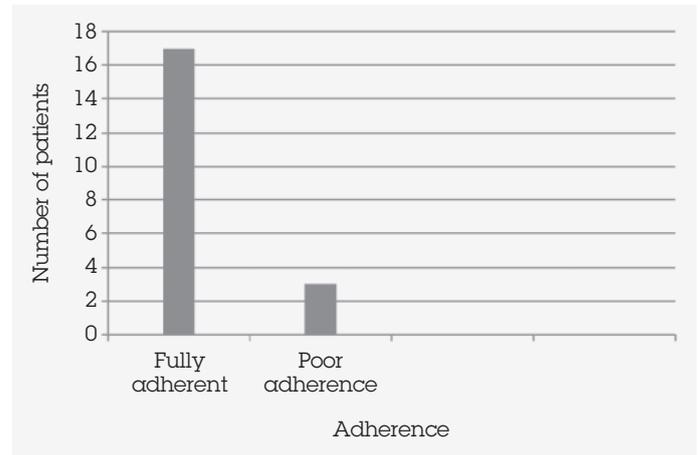


Figure 5: LCC patient adherence.

Following discussions with HIV consultants, it was decided that the remote management arrangement be formalised and supported. From September 2015 this intervention was branded the Liverpool Community Clinic (LCC). This has enabled PLWH who do not, or cannot attend hospital to receive timely, safe and appropriate care whilst being managed remotely. This is represented in the third circle (Figure 1). The arrows surrounding the circles in the model represent a throughput or flow of patients being managed in various ways that are responsive and tailored to their needs. So for example, if a patient has a leg fracture rendering them housebound, they can be managed via LCC until rehabilitation is complete when they may return to shared or hospital care. Some, who are terminally ill, physically disabled or in care homes, are exclusively managed via LCC.

The inclusion criteria for LCC management are: not attending clinic for 6 months or more, or being identified as needing additional support. Barriers to attending HIV clinics in hospital are identified as: physical disability; social isolation; homelessness; poor mental health; imprisonment; financial constraints; psychological issues; or challenging behaviour. Some patients experience several of these barriers (Figure 2).

The aims of managing PLWH via LCC are to reduce hospital admissions, prevent complications due to

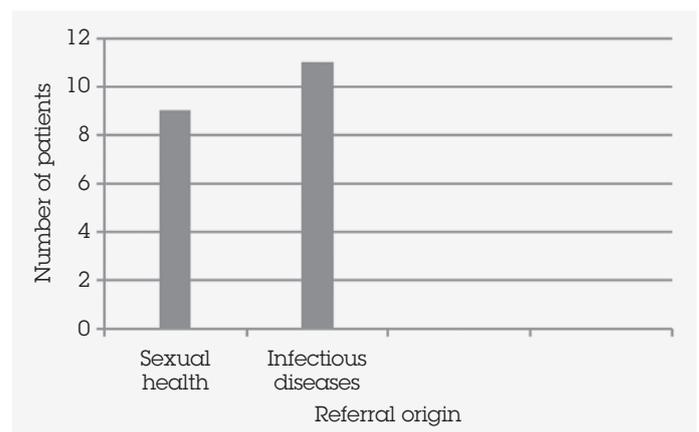


Figure 6: Referral sources.

disease progression and comorbidities, manage side effects, guarantee medication and adherence review, identify psychosocial factors that impact on engagement and retention in care, and facilitate a holistic MDT approach enabling person-centred care incorporating shared decision-making.

Methods

Patients and HCNT agree on the frequency of home visits, for example, monthly, thrice weekly, weekly or even daily for a finite period. HCNT deliver a wide range of interventions such as prescribing, treatment starts and switches (initiated by consultant), venepuncture for monitoring, secondary dispensing, medicine reconciliation, side-effects management, observations, adherence support, safety visits, diagnosis support and liaising with the MDT. These interventions are supported by standard operating procedures and lone-worker policies, which include the use of a lone-worker device while undertaking home visits.

LCC consists of HIV consultants (ID or GUM) and HCNT, who meet monthly to discuss existing and potential patients. Each patient is reviewed medically and from a community nursing perspective. Individualised nursing care plans are formulated, discussed and agreed with the patient at home to ensure that care decisions are shared. Additional factors that influence care or engagement are presented for discussion. A consultant and a community nurse undertake a joint annual domiciliary visit to review the patient.

At the monthly meeting, discussion and subsequent actions are documented in an LCC action template, which is accessed and managed via an HCNT team NHS net account to ensure confidentiality and a paperless approach. The HIV and AIDS reporting system (HARS) documentation is also completed during the meeting.

Outcomes

To date there are 20 patients managed via LCC, which is approximately one-third of the total HCNT caseload, the remaining patients being managed via shared care.

A majority (75%) of patients managed via LCC are white British and local to Liverpool, which is relatively small. There is only one HIV treatment centre in the city and it is based at the local hospital. The anxieties PLWH report in presenting often relate to meeting a relative or someone they know, which can potentially cause compromise in terms of unintended disclosure, see Figure 3. A difference in time of diagnosis of LCC patients was not significant, although, slightly more patients were diagnosed late, see Figure 4. Of patients managed via LCC, 85% are currently fully adherent. However, when initially admitted to LCC, 40% had ongoing adherence issues due to social and psychological issues. This shows a good outcome for

these patients, see Figure 5. Figure 6 shows referral sources into LCC. Slightly more referrals originate from infectious disease units (IDU) as opposed to sexual health clinics. This could indicate that patients managed within IDU are more complex, presenting with comorbidities and, therefore, sicker.

In order to evaluate and improve service provision via the LCC an audit is currently being undertaken. Some examples from audit questions along with patient responses are shown below.

1. What are your reasons for being unable to attend hospital for HIV care?

'I am too ill, I am going to die'
'Because sometimes I am very poorly'
'I have anxiety and get very anxious going into hospital for appointments'
'It causes a lot of stress attending and is financially difficult'

2. What difference has being managed by LCC made to you?

'I am on my medication and undetectable. Before I often had gaps in my medication'
'I feel comfortable seeing nurses.'
'I know who I am going to see'
'It made my life easier to manage'
'All my tablets are regular, don't forget or get confused'

3. What do you most value about being managed by LCC?

'I like knowing the nurses, makes me feel at ease'
'Care, support and love'
'Tablets were a big worry for me, I don't have that now'
'They are very good at doing dossette box'
'If there are any problems they are there'
'It's a lot less stressful, I used to miss appointments'

4. If you were unable to be managed via LCC, how do you think you would access HIV care?

'I would have problems with my tablets and get mixed up'
'I would probably not be on my medication'
'I would have to go to hospital but would miss appointments if unwell or have no money'
'Wouldn't be able to access'
'It would be very difficult for me'
'I would have to go to hospital which would affect my emotional wellbeing'
'I would probably miss my appointments'

5. How could we improve the service?

'No way'
'Come every day!'
'I don't think it needs improving'
'Very important because of my poor health'
'No improvement needed'

Discussion

HCNT members are advanced nurse practitioners fulfilling many of the attributes identified by the National HIV Nurses Association [2]. Managing PLWH via LCC demands advanced communication skills, autonomy, working within a wider multi-profession team, prescribing and expert problem solving in non-clinical environments. HCNT is closely aligned with specialist HIV services in the acute, primary and community care, social and voluntary sector, and often defaults to a 'key worker' role. Clinical supervision, support and guidance is sought from the supervising consultant who conducts the monthly meeting with the team, and is available, accessible and approachable at all times. The model strongly promotes the value of home visits, and care closer to home, involving non-medical prescribers who support and maintain consultant-led care.

LCC intervention aligns well with standards 2, 3, 4, 6, 9, and 10 of the BHIVA Standards of Care [3], and has improved the health, well-being, and quality of life for PLWH.

To date, LCC has improved patient outcomes, satisfaction and experience by improving adherence, initiating HAART within a patient's home environment, improving monitoring, effecting robust communication, strong clinical governance, and high-quality, safer care. LCC is proving to be cost effective: by delivering care closer to home by reducing or avoiding hospital attendance and admissions and reducing drug wastage. Added value and additional cost avoidance as a result of interventions by HIV community nurses is asserted by Watson [4]. Piercy *et al.* concur and indicate that a community nursing workforce with specialist skills and expertise has significant cost savings through reduced hospital admissions and improved health outcomes [1].

The drive for innovation and creativity in delivering care for PLWH has never been greater to meet the needs of an ageing population with unrelenting financial pressures on services. NHSE stipulate that a 'one size fits all' approach is not viable due to diverse populations in England [5]. This prompts the need for radical new care-delivery options that should be supported by NHS national leadership in relation to

implementation support and resources. Some options will be integrated hospital and primary care, or multispecialty community providers; LCC fits well into both of these scenarios.

The drive to develop and implement innovation in HIV care in response to long-term condition status and an ageing population continues to gather pace driven by austerity and unprecedented NHS financial pressures. Yet HIV remains unique in many ways that differentiate it from other long-term conditions, one of which is the stigma associated with HIV [6]. HIV nurses are well placed to ensure that implementation is timely, planned and considered to prevent a change happening too fast, potentially resulting in compromising the needs of PLWH. An intervention such as LCC is key in influencing a smooth transition.

HCNT will also be undertaking annual reviews for PLWH managed via this initiative.

References

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