South London Healthcare NHS Trust

HIV testing in the Acute Medical Unit: Setting the scene for universal opt-out testing

Julian Rycroft, Rebecca Hall, Stephen Kegg *Queen Elizabeth Hospital, London*

introduction

Universal opt-out HIV testing has been evaluated in a range of healthcare settings across the UK. BHIVA guidelines (2008), endorsed by NICE in 2011, recommend that where local prevalence exceeds 2 in 1000, all general medical admissions should be offered a test. [1, 2]

Over a quarter of the UK's cases of HIV are in the South East London region, with a prevalence of up to 13.9 in 1000 in some areas. Greenwich Teaching PCT has a HIV prevalence of 6.01 *known* cases per 1000 with half as many again estimated to be unaware of their positive status – exceeding the estimated limit of cost effectiveness by a factor of nine. [3] Although early diagnosis is the single most important prognostic factor, a fifth of newly-diagnosed individuals will have presented to acute services in the year preceding diagnosis, implying missed opportunities for earlier diagnosis and management.

We sought to determine the rates of HIV testing in patients admitted to the Acute Medical Unit and to understand some of the barriers to wider HIV testing.

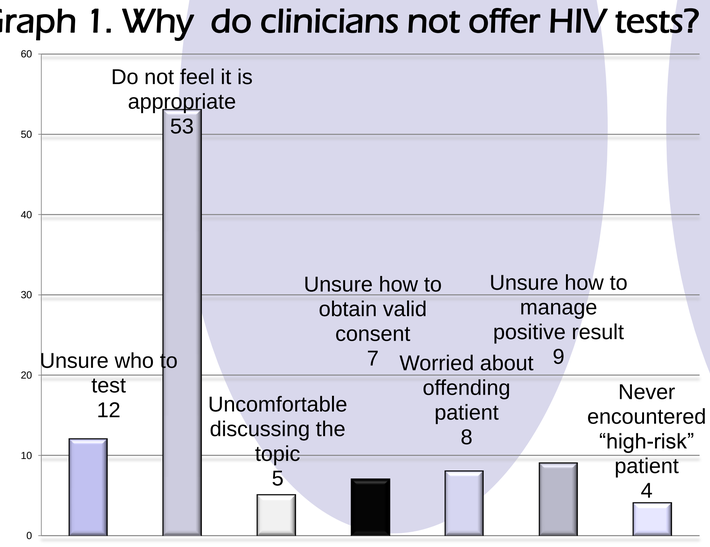
methods

- Self-completed multiple choice questionnaire – with knowledge-based and practice-based section to assess barriers to the implementation of HIV testing guidelines
- Retrospective audit of acute medical admissions during 1-14 June and November 1-14 2011 matching clinical and demographical data from the trust coding department with laboratory data of recent HIV tests

questionnaire results

68 clinicians completed the questionnaire: 42 (62%) of respondents were F1/F2 trainees, 17 (25%) were SHO grade, 4 (6%) were ST3+ and 4 (6%) were consultants.

Graph 1. Why do clinicians not offer HIV tests?



41% (28) knew that all SE London patients should be offered a test but no clinicians reported testing all patients
22% (15) never/rarely offer tests to patients, even if perceived as high-risk
45% (31) did not know how to order a HIV test in the trust; and
58% (40) believed thorough pre-test counselling should be provided.
29% (20) were unaware of the 'window period' of the HIV test.
21% (14) believed documenting a HIV test was forbidden; and
16% (11) believed it was illegal to test comatose patients.
41% (28) felt confident explaining about HIV to patients
53% (36) felt confident in to whom they should offer a HIV test

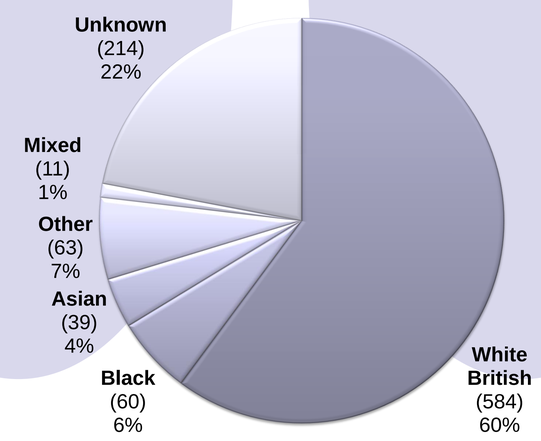
References

1. BHIVA, BASHH & BIS (2008). UK National Guidleines for HIV Testing. *British HIV Association, London.* www.bhiva.org
2. NICE (2011). NICE Pathways: Strategy, policy and commissioning on HIV testing and prevention. *National Institute for Health and Clinical Excellence, Manchester.* www.nice.org.uk
3. HPA (2010). Areas where wider HIV testing policies should be considered. *Health Protection Authority, London.* www.hpa.org.uk

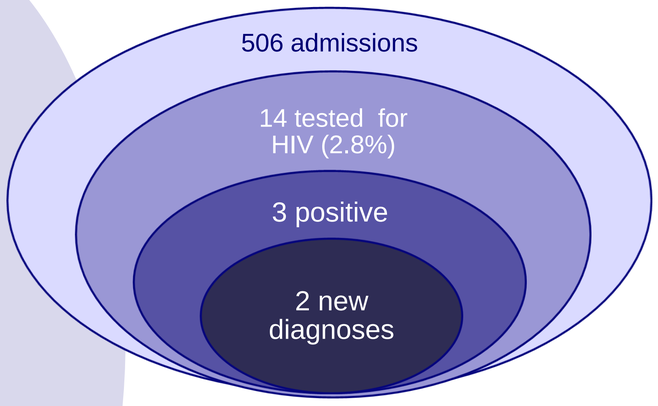
contact stephen.kegg@nhs.net

audit results

Graph 2. Ethnicity of combined audit sample – 554 (57%) of which were under 75 years, and 350 (36%) were under 60

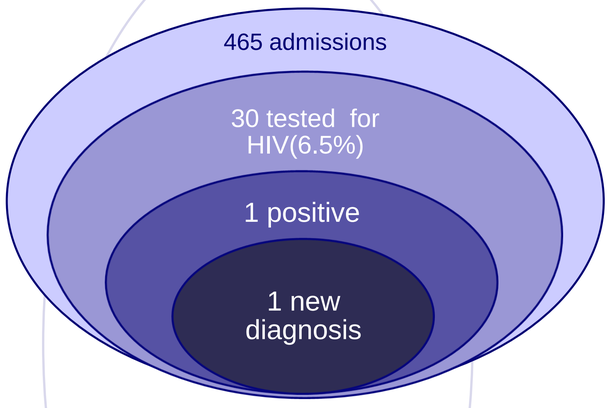


Cycle 1 (June 1st-14th 2011)



Number tested within first 48hrs: 1 (0.20%)
(Median day 5; range 0-40)

Cycle 2 (November 1st-14th 2011)



Number tested within first 48hrs: 16 (3.4%)
(Median day 3; range 0-29)

Table 1. Presence of clinical indicators and proportion tested for HIV in first cycle (number tested / patients with indicator)

Suspected TB	3 / 3
HIV-associated illnesses	1 / 1
STI	1 / 1
Meningitis	4 / 10
Weight loss	2 / 4
Flu-like symptoms	2 / 4
Cytopenia	3 / 21
Associated malignancy	1 / 7
Pneumonia	0 /21
PUO	0 / 6
IVDU	0 / 4
Gastroenteritis	0 / 13
SOL	0 / 1

Table 2. HIV tests performed during first cycle, stratified by cumulative presence of clinical indicators (no. tested / no. patients)

3 indicators	1 / 3	(33.3%)
2 indicators	2 / 7	(28.6%)
1 indicator	12 / 82	(14.6%)
Nil	9 / 414	(2.2%)
TOTAL	24 / 506	(4.7%)

discussion

In our initial assessment, clinicians of all grades working in acute medical admissions demonstrated variable levels of knowledge regarding HIV and the circumstances when testing is indicated. Awareness of national guidelines was poor and the offering of HIV testing in the acute medical setting was therefore low. We identified other barriers to improved rates of HIV testing, including confusion about the level of pre-test discussion required, the movement of patients between different teams and the anxieties of the phlebotomists around testing without additional "consent".

In response, we have developed a programme to improve HIV awareness and support HIV testing among medical staff and other healthcare workers based on the acute medical unit, and have included a prompt for HIV testing on the medical admissions pro forma.

Furthermore, we have resolved some of the anxieties around HIV testing by developing a clear pathway for immediate involvement of the HIV team in the event of a positive result, as well as set out a protocol for patients discharged with a result pending. Early indications suggest a modest improvement in testing rates, but as importantly evidence that HIV testing is being considered and performed earlier in that admission. We plan to continue these interventions until HIV testing is embedded into standard care for all adult medical admissions.