## P121 DO GUIDELINES HELP PROMOTE SEXUAL HEALTH SCREENING (SHS) AND DETECT SEXUALLY TRANSMITTED INFECTIONS (STIS) IN OLDER ADULTS WITH HIV?

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**Background** Adults over 50 with HIV comprise 20% of the national cohort. BASHH/BHIVA guidelines recommend all patients have a sexual health assessment documented at presentation and 6-monthly, with a full SHS offer annually and outcome documented.
**Aims** We audited practice against these guidelines, to establish any difference in services offered to over-50s. We also examined rate of STI detection.
**Methods** 80 case notes were retrospectively audited—40 aged over 50 and 40 aged under 50.
**Results** Abstract P121 Table 1 Shows the demographics of the groups. Only 75% of over-50s had sexual history documented at presentation compared to 86% of under-50s. 45% of >50s had SHS documented at presentation (Chlamydia, GC and Syphilis), with a further 15% having Syphilis test only. 77% of over-50s had full SHS at baseline. In 24 baseline SHS performed in the over-50s we found 8 STIs: 2 Syphilis, 1 HSV, 1 Hepatitis B, 1 Chlamydia and 3 Gonorrhoea. In the 34 SHS performed in under-50s we found 11 STIs: 1 HPV, 2 Syphilis, 2 HSV, 1 Hepatitis B, 3 Chlamydia and 2 GC. Sexual history documentation in 2010/11 was poor in both groups. In the >50s, only 28% had a documented sexual history. In the under-50s, 35% had documented sexual history. SHS in 2010/11 was offered to 20% of over-50s with 1 declining and in 35% of under-50s with 2 declining. Positivity was low; 1 case of Syphilis in each group.

Abstract P121 Table 1 Demographics of HIV cohort

| | <50 years | >50 years |
|---|---|---|
| Mean age | 82% | 62% |
| Male gender | 69 | 36 |
| MSM | 40% | 35% |
| White ethnicity | 55% | 68% |

**Conclusion** In our sample, fewer over-50s had a sexual history and SHS offer documented at presentation. Screening at presentation identified STIs in both groups. Few patients declined SHS, suggesting patients find it acceptable. There were more STIs in the under-50s group at presentation, correlating to national trends. However, we tested more young patients, possibly explaining this difference. STI rate in 2010/11 was low but didn't differ with age—it is important to perform a sexual history in all patients and offer SHS, so we are developing a proforma to prompt clinicians.

## P122 MANAGEMENT OF SEXUAL ASSAULT IN THE EAST KENT COMMUNITY

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**Background** Kent community health NHS Trust provides sexual health services (SHS) in East Kent serving an approximate population of 750 000 based in eight clinical sites. SHS see a significant number of sexual assault (SA) case referrals in this region as there is no designated Sexual Assault Referral Centre.
**Aim** This audit was conducted to determine if the management of SA cases in the services is in accordance to the standards outlined by British Sexual Health and HIV(BASHH) SA auditable outcome measures.
**Method** Case notes coded as SA based on a local code audited from the period of October 2010 to October 2011. Data were collected from the local SA proforma and case note documentation which identified information regarding victim's and assailant's profile and documentation of essential historical elements of SA. Other auditable outcomes measured included injury documentation, HIV risk assessment and post exposure prophylaxis (PEP) offer, police referral for crime and forensic examination (FME), self harm and child protection assessment. Data regarding emergency contraception, prophylactic antibiotics and hepatitis vaccination offered, testing for STIs and referral to EKRL were also collected.
**Results**

| | |
|---|---|
| Total no SA codes | 92:7 notes missing: total 85 cases |
| Source of referrals | Self: 59 (69.4%) Other: 26 (30.6%) |
| Time since SA | 54 (63.5%) seen within 6 weeks |
| Assailant details | Known: 51 (60.0%) Unknown: 34 (40.0%) |
| | HIV risk assessment: 100% |
| | Vaginal: 68 (81.9%) N=83 |
| | Oral: 11 (12.9%) N=85 |
| | Anal: 13 (15.3%) N=85 |
| | High risk: 13—2 eligible for PEP. Offered but declined |
| Referral for FME | Yes 19 (22.3%) No 66 (77.7%) 10 (11.7%) had FME prior attendance |
| Referral to A and E | None |
| Emergency contraception | Yes 6 (7.0%) No 79 (93.0%) |
| Prophylaxis antibiotics for STDs | Yes 6 (7.0%) No 79 (93.0%) |
| Hepatitis B vaccination | 59 (69.4%) indicated 43 (72.9%) vaccinated |
| First visit test | Yes 64 (75.3%) No 21 (24.7%) |
| Repeat test | Yes 33 (38.8%) No 52 (61.2%) |
| Child protection assessment under 16 | 18 (94.7%) N=19 |
| Referral to police | 55 (64.7%) offered 5 (0.09%) declined |
| Referral to EKR line | Yes 48 (56.4%) No 37 (43.6%) |
| Follow-ups offered | 59 (69.4%) |
| Total follow-ups seen | 40 (47.0%) |

**Conclusions** This audit highlighted the importance of clear documentation of treatment and care offered and provided to victims of SA. Poor documentation of management is likely to underestimate the overall outcome of care offered, but when a treatment is indicated and initiated there is a good clear documentation. The local SA proforma is concise and user friendly for any trained and qualified healthcare individuals and covers all aspects of care as recommended by BASHH except for the self harm assessment which will be included upon revision. A close working partnership with local police, SHS and EKRL is essential to ensure the management of SA within the community is in accordance with national standards.

## P123 NON-MEDICAL PRESCRIBING BY NURSE PRACTITIONERS IN A WALK-IN SEXUAL HEALTH CLINIC

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**Background** Non-medical prescribing legislation in the UK provides suitably qualified nurses with prescribing powers comparable with doctors. This facilitates autonomous practice and allows independent completion of care episodes. There is however limited evidence regarding the application and safety of nurse prescribing.
**Aim** Investigate the application of non-medical prescribing in sexual health.