

Competency and Skills framework For Dietitians working with people living with HIV 2023

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# Introduction

## The role of the HIV dietitian

Dietitians are a key part of the multi-disciplinary team working to care for people living with HIV (PLHIV). Since the advent of effective anti-retroviral (ARV) treatment for HIV, the role of the dietitian has changed from one primarily focused on nutritional support of acutely unwell patients, to one supporting healthy lifestyle choices and therapeutic dietary interventions to enable and facilitate long and healthy lives for PLHIV.

The skill set and competency of dietitians working in HIV care has had to change accordingly, with dietary intervention required in a range of conditions and co-morbidities from malnutrition and cancer through to obesity and diabetes. The HIV client group is also a diverse and challenging one, encompassing many who do not always engage well with health services and those who are economically and socially on the margins. A dietitian working in this area needs therefore to have a flexible and patient-centred approach to care, learning about the cultures and groups represented in their caseload in order to provide appropriately tailored interventions. They also need to work closely with their multidisciplinary team (MDT) colleagues, supportive charities and outside agencies to provide holistic and effective care for individuals who are vulnerable. HIV and AIDS-related stigma and prejudice is still a significant barrier to PLHIV seeking care and making decisions about their health. Dietitians integrated with the HIV team are in a strong position to provide care in a safe environment where PLHIV can be assured of confidentiality and understanding.

Given the complexity and breadth of the role of the HIV Dietitian, dietitians working in this area should continue to develop their knowledge, skills and expertise to provide the best possible care for PLHIV. The British HIV Association (BHIVA) Standards of Care for People living with HIV 2018 (1) acknowledge the need for skilled dietitians in the care of PLHIV and reference this document as a method of ensuring their competency.

## The Purpose of the Competency and Skills Framework

The purpose of this document is to set out the standard required by dietitians to competently undertake their role in delivering evidence-based, effective dietetic care to PLHIV. It sets out both the knowledge and skills expected of dietitians working with PLHIV. It does not aim to provide a complete overview of a dietitian’s knowledge and skills but rather lists the HIV specific skills and topics that a dietitian would be required to become familiar with through further reading, learning and clinical practice in order to achieve full competence and to work effectively with PLHIV.

This framework is not intended to be used as a standalone document. It is complementary to, and should be used in conjunction with, the British Dietetic Association (BDA) “Post Registration Development Framework” 2021(2). The BDA document outlines competency and career development pathways for dietitians and details the core skills and activities required of dietitians at various levels from entry level through to consultant level regardless of the dietetic specialty. Both documents should therefore be used together for the purpose of personal professional development and managing or commissioning dietetic services in HIV.

The primary use of the HIV competency framework will be in the personal development of dietitians working in HIV care. It can be used to identify learning needs as part of an induction to a new role, as a proforma to collect evidence of competence in areas of practice, or as part of clinical supervision to ensure dietitians are working at an appropriate level. Given that many dietitians working in HIV work independently, without direct clinical supervision or peer support within their individual organisations, this framework aims to provide expert guidance on required knowledge and skills to help close that gap. The BDA HIV Care Specialist Group(3) in addition to developing and keeping this competency framework up to date, also exists to provide a network for peer support and professional development opportunities for dietitians working in HIV.

## Significant updates

The first competency framework for dietitians working in HIV care was published in 2014(4). The updated document is based on the original framework however is an extensive re-structuring and re-writing with the aim to create a more user-friendly and streamlined document.

**Removal of competency levels (NHS band 4-8)**

The 2014 document specified level of competency for HIV dietitians and dietetic assistants across different capability levels from NHS band 4 through to band 8. This re-write has removed the different levels. The authors agreed that the BDA’s “Post Registration Professional Development Framework” (2) provides a clear outline of expectation of skill and knowledge at different levels and that this did not need to be duplicated in this HIV specific framework.

The BDA framework is an important document for dietitians looking to advance to more specialist levels in their practice, and those involved in commissioning dietetic services. It provides a clear framework for career development, outlining required dietetic competencies across four different pillars of practice (clinical practice, evidence-based practice and research, facilitated learning, and leadership) and at four different levels of capability (entry, enhanced, advanced and consultant level)

To enable the two documents to be easily used in conjunction with one another we have provided a quick reference table which summarises the BDA document (Table 1). This enables the user to understand the expectations of dietitians at each of the different levels of capability and help this HIV competency framework to be a practical and workable document outlining specific areas of expertise needed to progress a role in HIV care.

**Removal of competencies not specific to HIV care**

We have also removed competency tables on communication and behavioural approaches, teaching and learning, evaluation, audit and research and leadership which are not specific to the speciality of HIV. They remain of great importance to the role of the HIV dietitian and are covered in detail in the BDA framework(2).

**The Dietetic Care Process**

Additions to this document include the incorporation of the model and process of dietetic practice(5). Since 2014, the dietetic care process has become the mainstay of pre-registration education and clinical practice and we have reflected this by creating a section on Nutritional Assessment and Care planning to demonstrate its application in HIV dietetic care.

**Changes in HIV Care**

Recent changes in HIV care have been reflected in the current document as best as possible, with a particular emphasis on obesity management and the role of certain ARVs in causing weight gain. Due to recent advances in the treatment of Hepatitis C then dietitians are seeing far fewer Hep C/ HIV co-infected patients therefore this was removed from the liver disease section

**Dietetic assistants**

While the document is intended to be a guide for all those working in dietetic care in HIV, in the interest of keeping it concise, it does not specify competencies or skills for dietetic assistants. There is a separate BDA framework(6) for career development and knowledge and skills for dietetic assistants which can be used in the training and supervision of dietetic assistants working in the area of HIV.

## How to use this document

This document is designed to be used as part of a supervision process to identify the dietitian’s knowledge and skills and highlight learning and development needs. It should be used alongside local appraisal paperwork and the ‘BDA Post Registration Professional Development Framework’ to provide a structure against which to measure progress. At a minimum, annual review of achievement of competencies should be assessed by the dietitian’s line manager or clinical supervisor, although it is recommended that more frequent review is conducted.

Due to the diverse nature of PLHIV including diversity of population groups and co-morbidities, not all sections will be relevant to all HIV dietitians. It is therefore up to the individual to decide which sections will be most relevant to their post and prioritise which specific skills and knowledge areas to focus on.

The document is divided into five competency tables covering different areas of dietetic practice in HIV care. For each knowledge point or skill there is space to document evidence collected. Evidence can take a variety of forms (Appendix 1) and should demonstrate the skill or knowledge competency has been met. This ensures a structured process allowing the dietitian to carefully work through the document and the supervisor to sign off each competency. A list of suggested sources of evidence has been outlined at the end of the document and a variety of sources is recommended to ensure diversity in the dietitian’s professional development portfolio.

## Advancing Level of Capability: Entry, Enhanced, Advanced, Consultant

It is expected that for each competency, depth of knowledge and level of skill will increase according to the level of the post and the practitioner’s experience. For example, a new graduate working with PLHIV would be expected to develop a basic level of knowledge around anti-retroviral (ARV) medications to practice safely at an entry level, whereas a dietitian working at an advanced level would be expected to have much greater depth of knowledge including being able to educate others about their mode of action, side effects and drug-nutrient interactions. The BDA framework(2) should be used as a guide to understand the scope of practice of the dietitian at each level and we would expect dietitians and their supervisors to familiarise themselves with that document. As a quick reference, we have provided a brief summary of the key expectations across the different levels in the table below.

 Table 1. Summary of scope of practice at four levels of dietetic capability(2)

|  | **Practice: Knowledge, Skills, Communication** | **Evidence-based practice & Research****Facilitated Learning** **Leadership** |
| --- | --- | --- |
| **Entry level** | * Basic knowledge
* Works with support & supervision especially in complex and unfamiliar situations
* Develops skills
* Able to plan & prioritise work
* Able to understand and identify risks
* Supports service users to participate in decision making
* Well-developed communication skills and confidently works with complex groups
 | * Able to locate and appraise robust sources of evidence and apply best available evidence to practice
* Incorporates a range of outcome and quality measures into practice
* Contributes to service evaluation and audit work
* Able to deliver a teaching session to peers, students and service users
* Actively seeks development opportunities
* Demonstrates knowledge of relevant policies and practices within practice area
* Accepts responsibility for the quality of the service provided and identifies areas for improvement
 |
| **Enhanced**(Dietitians are specialists at this level of practice) | * In-depth knowledge and specialist skills
* Works autonomously and able to identify own development needs
* Routinely delivers a high standard of practice and able to manage more complex situations confidently and holistically
* Understands wider risks associated with practice and ensures systems in place to proactively manage risks
* Confidently communicates complex information to a variety of stakeholders to influence decisions and actions
 | * Promotes a culture of evidence-based practice and produces resources to reflect this
* Actively challenges poor practice that undermines service quality
* Designs and undertakes local service evaluation and audit projects
* Actively participates in projects which will improve the quality of the service and leads on aspects of the project as appropriate
* Accepts leadership roles to promote dietetics, nutrition and the profession
* Contributes to the development of local strategy and policies
 |
| **Advanced** | * Expert, authoritative knowledge and highly refined skills
* Able to see the ‘big picture’, providing a holistic, efficient and evidence-based approach
* Able to show an intuitive grasp of highly complex situations and proactively manage risks
* Creates and evaluates new developments and innovations and involves service users in the design
* Communication skills applied in challenging situations and beyond the service to influence policy beyond local level
 | * Demonstrates in-depth understanding of evidence from related fields and integrates into practice
* Leads or contributes to the local, regional or national evidence-based guidance, strategy and policy development
* Co-ordinates larger-scale service evaluation and audit projects relevant to multi-professional services
* Provides supervision or mentoring for colleagues
* Actively develops a learning culture in the team
* Promotes and facilitates a culture of clinical effectiveness
 |
| **Consultant** | * Highly developed specialist knowledge and skills
* Highly proficient
* Maintains a deep understanding of situations relevant to area of expertise and makes informed judgments on complex issues
* Proactive in sharing expert knowledge and experience nationally and internationally
* Embeds successful innovative practice, leading this area of expertise
* Communicates complex knowledge to affect improvement in relevant sphere of expertise including to international audiences, often requiring high level diplomacy and negotiation
 | * Establishes pathways and processes at a local and national level
* Leads on national or international service evaluations and audit projects
* Leads on evidence-based guidance and national/international standards
* Leads in education to all staff and supports local and international institutions in the delivery of education programmes, conferences and symposia
* Inspires others to deliver above and beyond in terms of quality of service
* Mentors senior colleagues across organisation boundaries and professional groups
* Is recognised as a national and international opinion leader in their area
* Plays a pivotal role in guiding the service and leads change within the organisation
 |

# Competency Framework Tables

## HIV pathophysiology, epidemiology & clinical guidelines

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of: | **Evidence**  |
| * The importance of nutrition in HIV and reasons for referral to dietetic services
 |  |
| * HIV transmission routes and behaviours putting people at higher risk of HIV infection
 |  |
| * The importance of antiretroviral therapy in relation to CD4 count and viral load (VL) and significance of an undetectable VL for transmission
 |  |
| * The different phases of HIV infection (e.g. acute, chronic latent, advanced HIV)
 |  |
| * The impact of HIV on immune function and risks of illness at different phases of infection
 |  |
| * The signs and symptoms of acute and chronic HIV-related conditions and comorbidities
 |  |
| * The BHIVA standards of care for PLHIV(1)
 |  |
| * Key clinical guidelines for the care of PLHIV e.g. European AIDS Clinical Society Guidelines 2021(9)
 |  |
| * Where to access local and national HIV epidemiology data (e.g. HPA, UNAIDS / WHO annual report)
 |  |

## Social, economic and psychological needs of PLHIV

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of: | **Evidence** |
| * Populations and user groups represented in HIV clinic population and ways in which backgrounds, lifestyles and culture may influence nutritional needs and engagement with care
 |  |
| * HIV-related stigma, the need to respect confidentiality and the impact this may have on compliance with dietary and lifestyle advice
 |  |
| * Process of referral to local and national charities, support groups and voluntary organisations (including food provision services) who support PLHIV and/ or those from vulnerable groups represented in clinic populations
 |  |
| * Increased prevalence of anxiety, depression and other mental health difficulties in PLHIV compared to the general population
 |  |
| * Overlap of HIV-related stigma with other issues including racism, homophobia, weight stigma and social isolation
 |  |
| * Psychosocial and economic impact of living with HIV and relevance to treatment adherence and dietary / lifestyle goals (considering low income, lack of cooking facilities and lack of social support)
 |  |

|  |  |
| --- | --- |
| SKILLS Be able to (appropriate to level and experience): | **Evidence** |
| * Take into account cultural, psychosocial and economic factors when making dietetic assessments and giving advice
 |  |
| * Communicate effectively with PLHIV across communication, language and cultural barriers, including via interpreters.
 |  |
| * Communicate sensitive and/or complex information to PLHIV
 |  |
| * Make appropriate referrals and /or liaise with other members of the MDT to support PLHIV with social, economic and psychological issues
 |  |
| * Build and maintain relationships and contacts with charities, support groups and voluntary organisations working locally, coordinating to support individual clients.
 |  |
| * Provide education and training on the nutritional needs of vulnerable groups to MDT and/or outside agencies e.g. GPs, alcohol and drug services, charities and voluntary organisations
 |  |

## Key population groups

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| *African and Other Ethnic Minority Groups* |  |
| * Ethnic groups represented in respective HIV clinic and relevant dietary practices, cultural and religious beliefs
 |  |
| *Asylum Seekers, Refugees and victims of trafficking* |  |
| * Different immigration statuses, the asylum system and entitlements for those claiming asylum, commonly used terminology e.g., refugee, asylum seeker, leave to remain
 |  |
| * Social, economic and psychological impact of being an asylum seeker/refugee or victim of trafficking and relevance to nutritional assessments and nutritional / lifestyle advice
 |  |
| *People who use drugs or are alcohol dependent* |  |
| * The relevance of nature/ status of substance misuse in making nutritional assessments and tailoring dietary advice
 |  |
| * Side effects of recreational drugs/alcohol dependency and impact on appetite, dietary intake, bowel habit and nutritional status
 |  |
| * ARV and recreational drug interactions and influence of substance misuse on ARV adherence
 |  |
| *MSMs (Men who have sex with men)* |  |
| * The diversity of the population of MSM and how they may identify themselves
 |  |
| * Aspects of behaviour associated with “gay culture” including chemsex, and how these may impact on ARV adherence, dietary habits and nutritional status
 |  |
| * Issue of body dysmorphia amongst some MSMs
 |  |
| * Sports nutrition and supplements and implications of steroid use
 |  |
| *Older Adults* |  |
| * Social and economic impacts of aging in PLHIV
 |  |
| * Potential for wide-ranging multimorbidity and frailty(9) in older adults living with HIV (bone-related disorders, chronic kidney disease, dementia, dyslipidaemia, cardiovascular disease, pulmonary disease, cancer and chronic nervous system conditions) and implications for nutritional management
 |  |
| * Impact of physical and psychological effects of aging on nutritional needs and relevance for tailoring dietary advice
 |  |
| *Children and Adolescents/ transition clinics* |  |
| * Nutrition and food requirements in children and adolescents with HIV according to age
 |  |
| * Growth monitoring and anthropometrics in children and adolescents
 |  |
| * Prevention/ treatment of low bone mineral density and lipid abnormalities(10) in children/ adolescents
 |  |
| * Social and psychological impacts of being a young person living with HIV and implications for nutritional/lifestyle interventions
 |  |

## Comorbidities

### Obesity

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence**  |
| * The relationship between ARV and weight gain including the ‘return to health effect’, and the classes and combinations of ARVs associated with weight gain in certain groups of PLHIV(9, 11)
 |  |
| * The increased risk of weight gain in PLHIV due to other factors such as social and psychological issues and medications prescribed for mental health conditions typically associated with weight gain
 |  |
| * HIV specific barriers to lifestyle change
 |  |
| * The impact of weight stigma in an already vulnerable group, and the importance of non-weight related health goals for PLHIV with a higher BMI
 |  |
| * Specific medications used to manage obesity and associated adverse effects as well as drug-drug interactions
 |  |
| SKILLS Be able to (appropriate to level and experience): |  |
| * Carry out appropriate anthropometry and/or assessments to identify obesity, and distinguish visceral fat from subcutaneous fat and lipodystrophy
 |  |
| * Refer to local initiatives both HIV and non-HIV that can support PLHIV with weight management
 |  |
| * Effectively utilise advanced communication skills such as active listening, motivational interviewing, counselling and cognitive behaviour therapy skills to facilitate behaviour change
 |  |
| * Carry out dietetic assessment and monitoring in PLHIV to help decipher key causes of weight gain, including extent of contribution of ARVs.
 |  |
| * Communicate with the MDT where ARV changes should be considered to help with weight management
 |  |
| * Provide evidence-based dietary and lifestyle advice to manage obesity (drawing upon UK Obesity Care Competency framework (7))
 |  |

### Lipodystrophy

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence**  |
| * Lipodystrophy, lipoatrophy and lipohypertrophy and older classes of ARVs linked to body fat distribution changes(9)
 |  |
| SKILLS Be able to (appropriate to level and experience): |  |
| * Carry out a full anthropometric assessment to identify lipodystrophy and distinguish lipohypertrophy from obesity, and lipoatrophy from malnutrition (skin fold thickness, limb circumferences, waist to hip ratio, bio-electrical impedance)
 |  |
| * Encourage non-weight related health goals for the management of lipodystrophy where weight change is deemed unrealistic
 |  |

### Impaired glucose tolerance, Diabetes mellitus and metabolic syndrome

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| * The multifactorial reasons for the increased risk of impaired glucose tolerance, diabetes and metabolic syndrome amongst PLHIV(9)
 |  |
| * The influence diabetes medications can have on weight and fat redistribution in PLHIV
 |  |
| SKILLS Be able to (appropriate to level and experience):  |  |
| * Work within own limitations and appropriately refer to specialist diabetes dietitians as needed (e.g. for carbohydrate counting)
 |  |
| * Meet entry level competencies for dietitians working in diabetes(8)
 |  |
| * Co-manage the care of complex patients with specialist diabetes dietitians
 |  |
| * Reiterate advice for safe disposal of lancets, glucose strips, insulin syringes, pens and needles to prevent HIV transmission
 |  |

### Cardiovascular Disease (CVD)

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| * The multifactorial reasons for the increased risk of CVD amongst PLHIV
 |  |
| * The tools available to estimate cardiovascular risk (e.g. QRISK, Framingham) and their limitations of use in PLHIV
 |  |
| * Potential interactions between certain lipid lowering medications and ARVs
 |  |
| SKILLS Be able to (appropriate to level and experience):  |  |
| * Carry out CVD risk assessment using most appropriate tool or according to local guidelines
 |  |
| * Interpret lipid profiles in the context of overall CVD risk in PLHIV
 |  |
| * Develop patient centred dietetic care plans to modify CVD risk taking into account HIV specific factors e.g. underweight with dyslipidaemia
 |  |
| * Provide evidence-based advice and holistic care for those with raised CVD risk considering all modifiable lifestyle factors and referring on to other services e.g. exercise, smoking cessation, psychology
 |  |
| * Liaise with clinicians regarding medication changes to reduce CVD risk, for example, initiation of lipid lowering therapy or changes to ARVs to more lipid friendly combinations(9)
 |  |

### Liver Disease

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| * The multifactorial reasons for the increased risk of non-alcoholic fatty liver disease (NAFLD), non-alcoholic steatohepatitis (NASH) and cirrhosis amongst PLHIV
 |  |
| * The significance of waist circumference in addition to use of BMI in detecting risk for NAFLD and situations where limitations in use apply
 |  |
| * The diagnostic tools for NAFLD (9)
 |  |
| * Nutritional, lifestyle and medical strategies for management of NAFLD
 |  |

### Malnutrition

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| * The causes of malnutrition in PLHIV and specific factors which may contribute to reduced nutritional intake or vitamin and mineral deficiencies
 |  |
| * Nutritional requirements in PLHIV and effect opportunistic infections (OIs) and low CD4 count can have on these
 |  |
| * Absorption requirements for certain ARVs e.g. spacing from nutritional supplements/ enteral feeds or taking with sufficient caloric/fat intake
 |  |
| * HIV and OI associated effects on the gut, its absorptive capacity and relevance for preferred routes of nutritional support
 |  |
| SKILLS Be able to (appropriate to level and experience): |  |
| * Use Subjective Global Assessment to identify cases of malnutrition in PLHIV
 |  |
| * Tailor nutritional support to relevant symptoms e.g. nausea, GI disturbance, anorexia
 |  |
| * Work with the MDT to identify HIV associated gastrointestinal malabsorption, requesting appropriate testing where relevant
 |  |

### Bone Health

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| * The multifactorial reasons for increased risk of low Bone Mineral Density (BMD) in PLHIV
 |  |
| * Guidelines for screening and management of bone health in PLHIV9
 |  |
| SKILLS Be able to (appropriate to level and experience): |  |
| * Give tailored dietary and lifestyle advice to optimise bone health taking into account patient specific factors e.g. lactose intolerance, veganism
 |  |
| * Make recommendations on the supplementation of calcium and vitamin D according to local and national guidelines
 |  |

### Pancreatic Insufficiency

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| * The multifactorial reasons for increased risk of pancreatic insufficiency in PLHIV
 |  |
| * The testing and diagnostic criteria for pancreatic insufficiency
 |  |
| * Pancreatic Enzyme Replacement Therapy (PERT) and its use in PLHIV
 |  |
| SKILLS Be able to (appropriate to level and experience): |  |
| * Give evidence-based advice on the appropriate use of PERT, including dosage, to manage symptoms
 |  |
| * Identify PLHIV that may have pancreatic insufficiency and request appropriate testing as needed
 |  |

### Cancer

|  |  |
| --- | --- |
| KNOWLEDGE Demonstrate good working and background knowledge (to appropriate level) of:  | **Evidence** |
| * The increased prevalence of certain types of cancers in PLHIV, including AIDS-defining and non-AIDS defining cancers(9)
 |  |
| * Consider food/ARV interactions for PLHIV and cancer when planning nutritional intervention
 |  |
| * Side effects of common cancer treatments and appropriate dietary interventions
 |  |

## Nutritional and Dietetic Assessment and Care Planning

| **SKILLS Be able to (appropriate to level and experience):** | **Evidence** |
| --- | --- |
| **OVERVIEW** |  |
| Undertake clinical assessment of nutritional risk and nutritional needs in PLHIV and interpret to make appropriate clinical decisions |  |
| Lead in the development of local / regional / national guidelines and policies / protocols for nutritional assessment and screening for nutritional and metabolic issues in PLHIV (Advanced and Consultant only) |  |
| **ANTHROPOMETRY** |
| Measure and interpret weight, height, BMI, weight loss %, waist circumference, waist: hip ratio, and MUAC in PLHIV |  |
| Measure and interpret skinfold thickness and identify the need for more advanced body composition analysis (e.g. DEXA scan)  |  |
| Use and interpret results of nutritionally relevant screening tools used in PLHIV e.g. QRISK, DM Risk, FRAX |  |
| **BIOCHEMISTRY** |
| Interpret results of relevant biochemical and haematological tests related to nutritional care of PLHIV, including CD4 and Viral Load (VL) |  |
| Interpret investigations pertaining to bone disease, lipids and diabetes risk in PLHIV |  |
| Understand and interpret all HIV specific laboratory tests (CD4, CD4 %, nadir VL, VL) and more complex laboratory investigations in an HIV context (e.g. related to bone health or opportunistic infections) |  |
| **CLINICAL ASSESSMENT** |
| Collect and understand relevant information on past medical history in PLHIV including knowledge of conditions that often co-exist with HIV (see comorbidity section for more details) |  |
| Identify clinical conditions, GI symptoms or side effects to treatment in PLHIV which may impact on nutritional status in PLHIV  |  |
| Demonstrate understanding of the aetiology, manifestation, management, and treatment of the main causes of acute illness in PLHIV  |  |
| **MEDICATION** |
| Show awareness of the occurrence of drug-nutrient interactions and know how to access advice about these |  |
| Demonstrate an understanding of how ARVs work (mechanisms of action), drug classes and combinations(11), administration, timings and dietary requirements |  |
| Demonstrate a good knowledge and understanding of other medications commonly prescribed for PLHIV and their common side effects, including anti-microbials, anti-depressants and anti-psychotics |  |
| Recognise common side-effects of ARVs particularly those requiring urgent attention, and demonstrate ability to address the nutritional aspects of long-term side-effects of ARV  |  |
| Know how to access help and advice on HIV treatments, their outcomes and side-effects and direct patients to these resources or MDT members for help |  |
| Recognise and take action when situations are detrimental to the correct administration of ARV (e.g. patients with chronic nausea and vomiting)  |  |
| Demonstrate understanding of the nature of the interactions and risks posed by some complementary/alternative medicine (CAM) and advise patients accordingly. Know where to seek more in-depth advice when needed  |  |
| **DIETARY ASSESSMENT** |
| Complete detailed diet histories relevant to the clinical situation for PLHIV |  |
| Be sensitive to cultural, religious, ethnic, or personal dietary preferences of PLHIV |  |
| Calculate energy, protein, and micronutrient requirements in PLHIV using appropriate predictive equations and evidence base |  |
| Collect detailed information on CAM, vitamins mineral supplementation and identify dietary beliefs and misconceptions  |  |
| **ENVIRONMENTAL/ PSYCHOSOCIAL/ BEHAVIOURAL ASSESSEMENT** |
| Gather and interpret psychosocial information e.g. mental health conditions, sleep patterns, living arrangements, support systems, employment status, immigration status for PLHIV (see social, psychological and economic needs section for more details) |  |
| Gather and interpret information on recent or longstanding lifestyle habits, behavioural patterns, motivating factors and barriers to change  |  |
| **FUNCTIONAL – SERVICE USER GOALS / ASSESSMENT OF CAPACITY** |
| Provide a person-centred approach in assessment taking into account the service user’s goals and functional status |  |
| Demonstrate knowledge of common HIV-related neurological disorders and take capacity into account when making assessments or promoting diet and lifestyle changes  |  |
| Work in collaboration with the service user and other MDT members to assess functional status and tailor assessment and intervention to the patients’ capacity |  |
| **NUTRITION AND DIETETIC DIAGNOSIS** |
| Independently devise appropriate dietetic diagnoses for PLHIV  |  |
| Critique dietetic diagnoses in PLHIV and measure the effectiveness of dietetic intervention |  |
| **DIETETIC CARE PLANNING** |
| Interpret assessments and collaborate with the service user to set aims for nutritional care and implement a nutritional care plan in co-operation with the MDT  |  |
| Use supporting diet sheets, written information and electronic resources pitched at an appropriate level for the PLHIV |  |
| Collaborate with PLHIV to develop a realistic and achievable patient-centred dietetic care plan which takes into consideration all aspects of their social and clinical status |  |
| Plan the appropriate level of review and observation, in conjunction with the MDT, to ensure early detection of any changes to nutritional status |  |

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# Appendix 1: Examples of Evidence

To demonstrate competency in the skills and knowledge described in the above document, evidence should be obtained from a variety of sources. Examples of evidence have been categorised according to the 4 pillars of practice in the BDA Framework(2). The same piece of evidence may be used to demonstrate a large number of individual competencies but overall, the dietitian should seek to use a variety of forms of evidence to demonstrate skills, knowledge and professional practice. This list is not exhaustive but aims to provide ideas of where to start.

### Evidence for Practice (Clinical Practice, Service User Focus, and Communication)

* Peer or supervisor observation of clinic
* 360⁰ feedback / Feedback from MDT colleagues
* Service user feedback
* Case reflections and Case reviews
* Anonymised patient records
* Completion of relevant study days e.g. Introduction to HIV study day, run by dietitians in the BDA HIV Care Specialist Group
* Attendance at communication skills or behaviour change training
* Resources developed e.g., screening tools, referral guidelines, protocols, diet sheets

### Evidence for Evidence Based Practice and Research

* Reading record
* Participation in journal review
* Developing outcome measures to show effectiveness of practice
* Critical appraisal of a research journal article
* Evidence of audit participation
* Audit proposals and reports
* Research Proposals
* Abstracts/posters presented to conferences
* Published research papers

### Evidence for Facilitated Learning

* Supervision records and personal development plans
* Reflections on student supervision
* Feedback from students or supervisees
* Examples of teaching and training sessions with participant feedback
* Active membership of a BDA specialist group
* Teaching and training patient groups
* Teaching and training of colleagues

### Evidence for Leadership

* Colleague Feedback on participation in MDT meetings
* Examples of service evaluation and improvement work
* Participation in and/or chairing of working groups
* Development of referral guidance or care pathways
* Promotion of the role of the dietitian within the MDT
* Promotion of dietetics and nutrition within workplace, regionally and nationally
* Business development cases to develop dietetic service