of telecare of Rheumatology Nursing (CTCER) of our hospital and health care activity generated by this.
Methods: Design: Observational study cross.
Patients: 301 patients for follow-up were derived to CTCER in a hospital of third level of January - November 2016. Our hospital serves a population of 600,000 people.
Protocol: We have a specific document for referral to CTCER where the rheumatologist specifies the reason for referral, the nurse review period and diagnosis. Nurse appointment the patient in its agenda for the telephone follow-up on the date indicated and recorded in the history of the patient efforts made the day of the appointment. The most common medical efforts making the nurse are preset by consensus with rheumatologists. Coming out than expected are reviewed with responsible for the patient's rheumatologist.
Variables analyzed: diagnosis, reason shunt type of FAME, adverse events, appearance of Comorbidities, nurse management, new problems after telephone consultation.
Statistical analysis: descriptive analysis of the main variables.
Results: Of the 301 patients, 68.4% were women. The diagnoses were: rheumatoid arthritis (RA) 116 (38.5%), spondyloarthropathy (SpA) 34 (11.3%), psoriatic arthritis (PsA) 45 (15%), systemic lupus erythematosus (SLE) (18.9%), vasculitis 1 (0.3%), arthritis juvenile idiopathic (AJI) 5 (1.7%), Still's disease adult 3 (1%), osteoporosis 4 (1.3%), 4 undifferentiated arthritis (1.3%). Them reasons of referral were: control to the month of home of FAME synthetic 120 (39.9%), Control to the home of FAME biological 28 (9.3%), review consultations 110 (36.5%), control toxicity hepatic 17 (5.6%), control alteration hematologic 7 (2.3%), control alteration renal 1 (0.3%), control of security of treatment Mycophenolate 4 (1.3%), control of safety of Teriparatide 6 (2%), wish gestational 1 (0.3%), analytical control not performed in consultation 13 (4.3%) (Table1). The most derived synthetic FAME was methotrexate 174 (57.5%) and the most derived biological FAME was etanercept 16 (5.3%) (table2). Nurse managed bypass autonomously 298 (99%) referrals, need help of the rheumatologist in 2 (0.7%) referrals and having only 1 shunt derived to 2017. 17 (5.6%) leads new problems with the call appeared: intolerance digestive 11 (3.7%), headache 3 (1%), worsening 1 (0.3%), moderate 1 infection (0.3%), poor adhesion 3 (1%), new comorbidity 3 (1%).
Conclusions: The inquiry of telecare is a form of collaborative work rheumatologist-nurse. The nurse can manage leads independently without having to go to your rheumatologist. This type of nurse call brings improvements in patient care, prevents displacement, decreased on-site visits and improves the safety of patients.
Disclosure of Interest: None declared
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THU0767-HPR ADVANCED PRACTICE MUSCULOSKELETAL PHYSIOTHERAPY SERVICES: A NATIONAL EVALUATION

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Background: Patients with musculoskeletal (MSK) disorders may remain on lengthy hospital outpatient waiting lists to be reviewed by a consultant doctor, although medical or surgical intervention may not be required (1,2). In 2012, a waiting list initiative saw the introduction of Advanced Practice Physiotherapists (APPs) across 16 hospitals in Ireland. APPs triage and manage patients awaiting a consultant doctor appointment, who are deemed non-urgent or unlikely to require surgery on screening of referral letters. APP scope of practice generally involves some traditionally medical-controlled acts such as: administering injections, ordering investigations/imaging, surgical listing and onward referral to hospital specialities; and depending on consultant doctor availability, their input may be sought on clinical decisions if required.
Objectives:
- Profile the national APP patient caseload
- Establish the clinical outcomes of APP consultations

Methods: A national database was established with all APPs (n=22) submitting patient data for 2014. These data were analysed using descriptive statistics.

Table 1. Outcomes of APP Consultations

Clinical Outcome	Service Users (n=16,577) n (%)
Physiotherapy*	6,715 (41)
Clinical Investigations	4,833 (29)
Clinical Imaging[a]	1,865 (27)
Orthopaedic/Rheumatology Services[†]	2,818 (18)
Other Hospital Speciality[†]	563 (4)
MSK Injection	685 (4)
Surgical listing	404 (2)

Note: Other clinical outcomes included discharge. Clinical Imaging was added to the database from August to December inclusive. Valid data: [a]n=7,009, *n=16,194, [†]n=15,557.

Results: Data showed that APPs assessed 13,981 new patients, who presented most commonly with MSK disorders of the knee (n=3,096), lumbar spine (n=2,926) and shoulder (n=1,945) (Fig. 1) and the median wait time was 167 days (IQR 91–316). Including an additional 2,596 return appointments, the most common clinical outcomes were physiotherapy and/or clinical investigations (Table 1), and clinical decisions were made independently by the APP in 77% (n=11,728) of recorded cases (n=15,189).

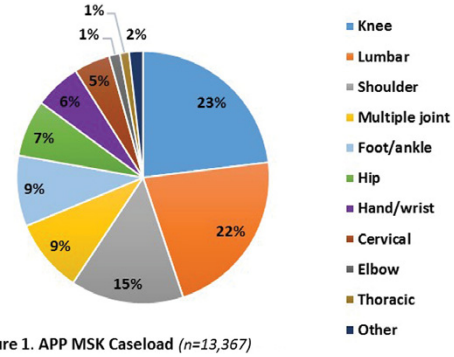

Figure 1. APP MSK Caseload *(n=13,367)*

Conclusions: APP services provide a more efficient MSK clinical pathway and reduce demands on the Consultant Doctor services. Collection of National Data enables ongoing service evaluation and monitoring of key performance indicators.
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THU0768-HPR PHONE FOLLOW-UP PROGRAM ENHANCES TREATMENT SAFETY AND DRUG CONCORDANCE ON DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) THERAPY FOR RHEUMATOLOGY PATIENTS

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Background: DMARDs are beneficial for a number of rheumatic conditions. However, treatment effect may take a few weeks. On the other hand, patients may experience adverse effects (AEs) early on and they may not be able to follow complicated dosage titration regimen. In order to enhance treatment safety and empower self-management, rheumatic disease patients requiring initiation or change of DMARDs were recruited to a rheumatology nurse phone follow-up program.
Objectives: (1) To evaluate the service outcomes of Rheumatology Nurse Phone follow-up Program and (2) explore the factors that may influence treatment adherence
Methods: Upon initiation of DMARDs therapy at out-patient clinic or before hospital discharge, patients and/or their caregivers will be counseled for the new treatment plan and self-management knowledge by rheumatology nurse. A telephone follow-up by rheumatology nurse will be arranged within 4 weeks to monitor patients' condition. Treatment responses, AEs, drug concordance of patients and advice given in each phone consultation (PC) were recorded. Retrospective case review was performed.
Results: There were 1230 episodes of PC performed by rheumatology nurse in 2015. 180 episodes of PC involved 76 patients (56 female) were randomly selected. The average number of PC was 2.4 times per case. The mean age of patient was 58 (24–85) years. Disease categories mainly involved rheumatoid arthritis (60.5%), systemic lupus erythematosus (7.9%), spondyloarthritis (5.3%) and gout (3.9%). The most common DMARDs prescribed were methotrexate (40.8%), hydroxychloroquine (27.6%), sulphasalazine (22.4%) and 39.5% of the study cases have received steroid courses. Among the 76 patients, 8 (10.5%) have taken wrong dosage and another 4 (5.3%) patients have not started therapy due to worries about potential AEs. Altogether 40 patients (52.6%) reported AEs after starting DMARDs. The most common AEs were rash, itchiness, dizziness, alopecia and oral ulcers. For non-adherence behaviour, 8 patients (10.5%) have self-stopped their medication and another 7 patients (9.2%) have self-adjusted the medication respectively. Eventually 90% of the cases were able to continue therapy with or without adjustment of regimes. Only 7 cases (9.2%) required interruption of current treatment or switching to other DMARDs due to AEs within the study period.