Results: The guide is written in English and will be translated into the 23 different languages of the EU.

With information about:

- The definitions of biological and biosimilar medicines.
 - Switching and substitution.
 - The benefits of biosimilars
 - The nurses role in managing the exchange between similar biological medicine.
- The document also includes flow charts for switch implementation, follow up and support.

Conclusions: Switching between similar biologicals opened new chapter in which nurses play a crucial role in communicating with patients and providing support and reassurance, before, during and particularly after the switch. This is build on nurses' many years of education, and their experience with patients in different situations. It is a process that requires time, patience and care.

Patients may be concerned about changes in biologic medicines, and will have a lot of questions. Positive language is important in answering these questions, to provide confidence and reassurance. Patients need to know that their healthcare professionals understand the reasoning behind the change and are confident that it is the right thing to do. To avoid confusion, the team of nurses and other healthcare professionals should have a consistent explanation that is used by all.

REFERENCES:

1. European Commission. What I need to know about biosimilar medicines: Information for patients 2016.
2. European Medicines Agency and European Commission. Biosimilars in the EU: Information guide for healthcare professionals 2017.
3. Read C. Specialist nurses support cost effective drugs for treatment. HSJ 2017.

Disclosure of Interest: J. Voorneveld-Nieuwenhuis: None declared, L. Moortgat: None declared, M. Pavic Nikolic: None declared, P. Crombez: None declared, B. Oomen Grant/research support from: This document has been created with funding from Medicines for Europe and EFPIA.

DOI: 10.1136/annrheumdis-2018-eular.2376

FRI0732-HPR RHEUMATOLOGY NURSE SPECIALISTS AND CORTICOSTEROID PRESCRIBING – DOES IT CONFORM TO EULAR GUIDELINES

J. Begum¹, M.K. Nisar¹. ¹Rheumatology, Luton & Dunstable University Hospital, Luton, United Kingdom

Background: The rheumatology nurse specialist (RNS) plays a central role in the multi-professional rheumatology team. Delivering corticosteroid (CS) therapy to patients is an area where there is little understanding of RNSs confidence in managing them.

Objectives: Considering CSs are a cornerstone of treating rheumatic diseases where RNSs are invariably involved, we undertook a pilot survey to understand the present climate of RNSs prescribing of corticosteroids in their practice.

Methods: A focus group discussion was held at South West regional meeting to ascertain the minimum level of understanding required to successfully deliver CS therapy to patients. It was centred on EULAR recommendations. Nine items were identified based on three main themes – safe prescribing, optimal dosing and prevention of complications. A questionnaire was created based on this discussion and all participants of the meeting were surveyed.

Results: There are 21 centres providing rheumatology services in the South West England. All were represented in 30 participants of the survey. Median age of the nursing establishment was 48 years (mean 47 year, range 27–60 years). Only 6/30 (20%) were nurse prescribers.

14 (47%) did not feel comfortable advising patients on adjusting their CS dose. Only four (13%) had any patient group directive in place at their trust to enable them to amend CS dose for non-medical prescribers. 11 (36%) considered CS to be disease modifying therapy in inflammatory arthritis. 17 (56%) employed CS therapy as part of early arthritis management protocol. 4/30 (13%) considered prednisolone equivalent dose of ≥ 10 mg/day safe in long term and seven (23%) would be happy to utilise 120 mg IM depomedrone monthly as necessary. 10 (33%) were unaware of therapeutic co-intervention for CS related osteoporosis risk and 21 (70%) were not employing any fracture risk stratification tools.

Conclusions: This pioneering initiative highlights a wide variation in the prescription standards of a key job provision. Very few units have independent nurse prescribers. Others lack patient group directive to at least enable non-medical

prescribers i.e. RNSs to safely amend CS therapy prescribed by a rheumatologist. Less than a quarter of those surveyed actually consider CSs to have any disease-modifying role. Rather worryingly, some do not even recognise the safe long-term CS dose and willing to offer high doses periodically. Though most know the concomitant therapeutic options to mitigate against osteoporosis, few are actually assessing fracture risk thereby unlikely to offer the appropriate interventions.

In conclusion, there is wide variation in the service provision of RNSs. This can potentially have a negative impact on effort to promote safer use of CSs in the management of inflammatory rheumatic diseases. There is a need for improving training standards to help deliver good quality rheumatology professionals of the future and ensure safe and effective drug interventions.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.1299

FRI0733-HPR AN INTERACTIVE COURSE ON EXERCISE THERAPY FOR KNEE OSTEOARTHRITIS AND COMORBIDITY: A FEASIBILITY STUDY

M. De Rooij¹, M. van der Leeden², M. van der Esch¹, W.F. Lems³, J. Meesters⁴, W. F. Peter¹, L.D. Roorda¹, M. Terbraak⁵, T. Vredevelde⁵, T.P. Vliet Vlieland⁴, J. Dekker². ¹Department of Rehabilitation, Reade, center of rehabilitation and rheumatology; ²Department of Rehabilitation; ³Department of Rheumatology, VU Medical Centre, Amsterdam; ⁴Department of Orthopedics, Leiden University Medical Center (LUMC), Leiden; ⁵Faculty of Health, ACHIEVE Centre of Expertise, Amsterdam University of Applied Sciences, Amsterdam, Netherlands

Background: A structured, tailored exercise therapy strategy was found to significantly improve physical functioning, reduce pain and was safe for patients with knee OA and severe comorbidity. The intervention was performed in a specialized, secondary care center. Before the intervention can be implemented in primary care, appropriate education of physiotherapists (PTs) as well as insight into barriers and facilitators for using the protocol in primary care is needed.

Objectives: This study aimed to 1) evaluate the effect of an interactive course on the exercise therapy strategy for patients with OA and comorbidity for PTs working in primary care; and 2) map facilitators and barriers for applying the protocol in primary care.

Methods: A pre-posttest study was performed among PTs who were working in primary care. PTs were offered a postgraduate blended educational course consisting of an e-learning lecture (7 hours study load) and two interactive workshops (each 3 hours study load). Measures of effectiveness included a questionnaire on knowledge (60 multiple choice questions) before (T0) and two weeks after the course (T1) and a patient vignette to measure clinical reasoning (nine open questions) before the course (T0) and six months after the course (T2). Facilitators and barriers for using the protocol were measured at T2 by means of a 27 item questionnaire (each item was scored on a 5-point Likert scale, ranging from 0 totally agree to 4 totally disagree).

Results: Thirty-four PTs were included. Fourteen out of 34 PTs had treated at least one patient with knee OA and comorbidity according to the protocol. Statistically significant improvements were found, both for knowledge levels between baseline and T1 (N=34) (p<0.00), and for clinical reasoning between baseline and T2 (N=34) (p<0.00). With regard to facilitators to implement the protocol, the majority of PTs found the protocol feasible in daily practice (68%) and to be supportive regarding clinical reasoning and clinical decision making (77%). Perceived barriers for implementation included the small number of patients with OA and severe comorbidity being referred or referring themselves. Of the therapist who actually treated patients according to the protocol, 86% indicated that the protocol was applicable in their daily clinical practice and that they perceived to have sufficient knowledge (71%) and skills (64%) to apply the protocol. Other barriers indicated by PTs were the limited number of treatment reimbursement by the insurance companies (65%) and a suboptimal collaboration with general practitioners and physicians (65%).

Conclusions: An interactive educational course on exercise therapy for knee OA patients with comorbidity proved to be effective in improving knowledge and clinical reasoning skills of primary care PTs. Main barriers for protocol use included limited referrals of patients with knee OA and severe comorbidity to PTs, and limited number of treatment reimbursement by insurance companies. For larger scale implementation these barriers should be solved.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.5144