Figure 1. Themes of nurse-led care from the perspective of people with RA

Providing knowledge and skill. This theme delineated rheumatology nursing as providing professional expertise in the planning and delivery of care. The rheumatology nurse-led service included easy access via telephone helpline, consultations with the clinical nurse specialist for assessment of disease activity and care needs, planning of care, disease information and education, supporting self-management, and referral to rheumatologist and the multi-disciplinary team. People with RA highly valued the nurse expertise and specialist knowledge provided at nurse-led clinics. *'She was very good at informing me, so I have only praise for this ... because I have never had it like this before'.* (Person with early RA).

Using a person-centred approach. This theme showed nurse-led care using a person-centred approach combined with empathy and good communication skills, which created a good therapeutic environment. People with RA appreciated the person-centeredness, empathy and involvement of the nurse. *'She is very sensitive. She can see if I am feeling bad and comes straight to me and asks: "How are you today?" ... You are treated and taken seriously'.* (Person with early RA).

Meeting patients' care needs. This theme presented nurse-led care as creating a sense of being empowered and psychologically supported in the management of RA and its impact. Nurse-led care made people with RA feel cared for, secure and confident. It added value to rheumatology care and made care complete. *'The thought of sticking a needle into my own stomach... it felt a bit like I would never manage to do that. However, they have been absolutely wonderful here ... and now I can do it myself'.* (Person with early RA).

Conclusion: Nurse-led care for people with RA is characterised by provision of rheumatology expertise using a person-centred approach, and patients' holistic care needs are being met. This study found a dearth of literature on perceptions of nurse-led care in people with early RA, which highlights the need for further research in this population.

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SAT0644-HPR COMPLIANCE OF BIOLOGIC DISEASES MODIFYING ANTI-RHEUMATIC DRUGS (BDMARDS) WITH SYSTEMIC IMMUNO-INFLAMMATORY RHEUMATIC DISEASES (SIRDS). AN ASSESSMENT OF PATIENTS' ADHERENCE AND NON-ADHERENCE CONCERNS.

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Background: Patients with systemic immunoinflammatory rheumatic diseases (SIRDS) are often treated with bDMARDs when the response to conventional disease-modifying antirheumatic drugs (csDMARDs) is inadequate. There are, however, concerns about non-adherence to bDMARDs among patient. The non-adherence to bDMARDs may be caused by the various factors.

Objectives: 1. The main objective of present study was to find out the cause of discontinuation of bDMARDs

2. To find out the adherence and non-adherence rate for bDMARDs.

3. To identify the factors that are modifiable.

Methods: 800 patients with SIRDS prescribed bDMARDs were interviewed to find out the demographic information, their socioeconomic status, and the disease duration. Additional information gathered included the comorbidities, the time for starting bDMARDs, the route of administration of bDMARDs, beliefs and perceptions about treatment efficacy and side effects if any. This was followed by looking at the adherence of bDMARDs; if they had discontinued then efforts were made to find out the reasons for the same.

Based on these findings the patients were classified into adherent and non-adherent categories. The data were analyzed further for

1. Factors that associated with persistence of bDMARDs.

2. Factors that were associated with discontinuation of bDMARDs.

Results: A total of 800 patients were interviewed that included patients with ankylosing spondylitis 430 (52.4%), rheumatoid arthritis 300 (37.7%), psoriatic arthritis 45 (5.2%), and others 25 (0.7%). On analysis 610 (76%) patient were compliant but 190 (24%) patient had discontinued the bDMARDs on their own. On comparison of both groups

Factors that were significantly related to self-discontinuation were:

- Negative beliefs about biologics (37%)
- Cost (33%)
- Reading side-effect profile on Google search (25%)
- Other co-morbidities (6%)

Factors that were significantly related to persistence of biologic treatment were:

- Good counseling by rheumatologist and rheumatology nurse (60%)
- Faith in the treating rheumatologist (25%)
- Fear of deformities and pain (15%)

On analysis it was found that a good counseling and clarifying the doubts of the patients regarding bDMARDs before starting the treatment encourages the patient to continue the biologic treatment, especially it allays their doubts about the drug adverse effects.

Conclusion: Despite negative beliefs and misconceptions about bDMARDs, patient non-adherence at our center is not alarming. A positive reinforcement counseling appears to be the most significant factor to overcome the negative belief of patients. The affordability of the biologic treatment however remains a limiting factor in our centre as in other parts of India.

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SAT0645-HPR MYTHS AND MISCONCEPTION ABOUT THE ILLNESS AND CONVENTIONAL SYNTHETIC DMARDS (CSDMARDS) IN PATIENTS WITH SYSTEMIC IMMUNO-INFLAMMATORY RHEUMATIC DISEASES (SIRDS): A STUDY BY RHEUMATOLOGY NURSE COUNSELOR

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Background: Myths and misconceptions about illness and conventional disease modifying anti-rheumatic drugs directly influence adherence to the prescribed treatment. It is estimated that 30–50% of patients do not adhere to their prescribed treatment due to various reasons where the beliefs of the patients play a crucial role. At our centre we the specialist rheumatology nurse counsel the patients at every visit and try to remove their myths and negative beliefs about the disease as well as the medications.

Objectives: • To explore the common myths and misconceptions of regarding their disease and regarding the csDMARDs.

• To assess the efficacy of counseling in allaying their unfounded fear.

Methods: A total of 450 patients with SIRDS at least 3 times attended the rheumatology out-patient clinic on csDMARDs were enrolled to complete a questionnaire that, besides demographic information, socio-economic status, and co-morbidities, had the following questions:

1. Self reported adherence to medication
2. Misbelieves regarding food items
3. What kind of health-provider was consulted at the onset of the symptoms
4. Their belief/knowledge regarding:
 - A. The need for physiotherapy.
 - B. Life style modification requirement
 - C. About osteoarthritis
 - D. Medication requirement during remission
 - E. Pregnancy and DMARDs
 - F. The need of vaccination