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.

References:

Disclosure of Interests: None declared.

Methods: 800 patients with SIRDs prescribed bDMARDs were interviewed to find out the demographic information, their socioeconomic status, and 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 was made to find out the reasons for the same.

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.

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%)

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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