Conclusion: The study identified that PTs used only a limited number of BCTs. BCTs considered less effective such as providing information were widely used, whereas BCTs that are considered effective, such as specific aims or coping with barriers were much less or not at all used. This study provides an insight in real clinical practice and may help to develop counselling training for PTs. There is a need to translate theoretical BCTs into effective measures that are easy to use in clinical practice.

REFERENCES:

Disclosure of Interests: None declared

HPR Interdisciplinary research...

POS1560-HPR

"MY GUT FEELING IS...": IDENTIFYING HOW HEALTHCARE PROFESSIONALS COMMUNICATE ABOUT PAIN IN PAEDIATRIC RHEUMATOLOGY MULTI-DISCIPLINARY TEAM MEETINGS

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Background: Multi-disciplinary teams (MDTs) are common in paediatric rheumatology where UK standards of care state that all children/young people should have access to a paediatric rheumatologist, nurse, physiotherapist, occupational therapist and a psychologist. MDTs in paediatric rheumatology regularly meet for the broader purpose of discussing the assessment of and future management plans for children/young people with a range of complex conditions in which chronic pain may feature. The content of these discussions has not been previously researched. Little is known about healthcare professional to healthcare professional communication about children/young people with chronic pain.

Objectives: The objective of the current study was to investigate healthcare professionals communication about children and young people with chronic musculoskeletal pain during MDT meetings in paediatric rheumatology.

Methods: This study was a non-participant ethnographic observation of virtual and face-to-face MDT meetings in three paediatric rheumatology centres in the UK. A structured observation checklist was used to capture and organise field notes which were analysed using an inductive thematic approach amongst research team members. Interpretation of field notes was guided by discussions with healthcare professionals from each of the three teams involved.

Results: Forty-two healthcare professionals from across the three teams participated. Ten meetings from each team (n=30) were observed, with meetings ranging from 1-2 hours. Analysis was organised into three themes; 1)Describing the child/young person with pain; Healthcare professionals’ perceptions about personality characteristics (e.g. “He is mature”, “She is sensitive”) were frequently used to introduce a child/young person to the team. A child/young person description was always accompanied by a description of parents and perceptions about their behaviour (e.g. “Dad is very disengaged”; “Mom can shout”). 2)Interpreting the pain of the child/young person: A core component of interpretations was professional’s familiarity with the child/young person and parents (e.g., “I haven’t got a handle on them yet”). Professionals also discussed how their interpretation of pain were influenced by “gut feelings” or “vibes that something else is going on at home”. 3)Managing the child/young person with pain: Healthcare professionals discussed the need for acceptance of pain and treatment from children/young people (e.g., “She wasn’t buying into that”; “He needs to get used to it”). Setting boundaries for children/young people and parents for accessing the team also featured in discussions (e.g., “We need to re-assure them but not always be available”).

Conclusion: This study highlights a range of healthcare professional approaches and processes to communicating about and discussing children/young people with pain at paediatric rheumatology MDT meetings. Findings suggest that healthcare professionals in paediatric rheumatology describe, interpret and manage the child/young person presenting with pain alongside the broader psycho-social (and less frequently the biological) context. These findings will inform the content and methods of a behaviour change intervention to improve pain communication in consultations with children/young people, parents and amongst the paediatric rheumatology team of healthcare professionals in the UK.

Acknowledgements: The authors would like to thank the healthcare professionals for kindly taking the time to take part in this study. The views expressed herein are those of the authors and not necessarily those of the National Health Service, the National Institute for Health Research, or the UK Department of Health. This work was supported by a Foundation Fellowship award from Versus Arthritis (Grant 22433). Aspects of this work were also supported by funding from the Centre for Epidemiology Versus Arthritis (Grant 20380) and the NIHR Manchester Biomedical Research Centre.

Disclosure of Interests: None declared

POS1561-HPR

HEALTH CARE PROVIDERS' PERSPECTIVE ON CONTINUATION VERSUS TEMPORARY INTERRUPTION OF IMMUNOMODULATORY AGENTS IN CASE OF AN INFECTION: AN INTERVIEW STUDY

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Background: Immunomodulatory agents (IA) are often used in the treatment of immune mediated inflammatory diseases (IMIDs). The use of some of these IA is associated with a slightly increased infection risk (1), which raises concerns especially during the current COVID-19 pandemic. It is however unknown whether it is best to continue or temporary interrupt IA in case of an infection, and what the views of health care providers are on this subject.

Objectives: To obtain insight in the health care providers’ perspective regarding continuation and temporary interruption in case of an infection and to assess barriers and facilitators for both treatment strategies.

Methods: Health care providers, involved in the pharmacological treatment of different IMID patients, were interviewed by phone or face-to-face using semi-structured interviews. Recruitment was done using purposive sampling based on age, gender, function, specialty and affinity with the topic. Interviews were conducted until data saturation and analyzed by two researchers using inductive thematic analysis.

Results: Ten health care providers with three different functions (medical specialist, physician assistant, resident in training) from three different medical specialties (rheumatology, gastroenterology and dermatology) were interviewed. Mean age was 49 years (range 34 to 66) and the majority was female (69%). Ten main themes were constructed, yielding 77 barriers and facilitators across the two treatment strategies (see Table 1 for themes and a selection of barriers/ facilitators). Health care providers mentioned that the choice between continuation and temporary interruption is often about balancing infection severity, IMID severity (e.g. risk of flare) and patient characteristics (comorbidities/vulnerability). They struggled with the lack of evidence on these two treatment strategies, which leads to choices being made based on previous experiences or intuition.

Table 1. Identified themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example of barrier/facilitator</th>
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<tbody>
<tr>
<td>1. IMID characteristics</td>
<td>Low disease activity (facilitator for interruption)</td>
</tr>
<tr>
<td>2. IA characteristics</td>
<td>Large administration intervals: interruption not possible (barrier for interruption)</td>
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<tr>
<td>3. Effects of IA on infection</td>
<td>Belief on positive effect (facilitator for continuation)</td>
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<tr>
<td>/ immune system</td>
<td></td>
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<tr>
<td>4. Patient characteristics</td>
<td>Patients with comorbidities / history of previous infections (facilitator for interruption)</td>
</tr>
<tr>
<td>5. Infection characteristics</td>
<td>Mild infection (facilitator for continuation)</td>
</tr>
<tr>
<td>6. IA – current practice</td>
<td>Current IA – interruption of IA during infection (barrier for continuation)</td>
</tr>
<tr>
<td>7. Health care provider characteristics</td>
<td>Peer influence (facilitator for interruption; health care providers state that they would interrupt IA if for example an infectious diseases specialist would recommend so)</td>
</tr>
<tr>
<td>8. Financial</td>
<td>Higher costs (barrier for continuation)</td>
</tr>
<tr>
<td>9. Stopping IA in general</td>
<td>Chance to stop/taper IA (facilitator for interruption)</td>
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<tr>
<td>10. Interruption characteristics</td>
<td>Short duration had no impact on disease activity (facilitator for interruption)</td>
</tr>
</tbody>
</table>

Acknowledgements: The authors would like to thank the healthcare professionals for kindly taking the time to take part in this study. The views expressed herein are those of the authors and not necessarily those of the National Health Service, the National Institute for Health Research, or the UK Department of Health. This work was supported by a Foundation Fellowship award from Versus Arthritis (Grant 22433). Aspects of this work were also supported by funding from the Centre for Epidemiology Versus Arthritis (Grant 20380) and the NIHR Manchester Biomedical Research Centre.

Disclosure of Interests: None declared

Healthcare providers' perspective on continuation versus temporary interruption of immunomodulatory agents in case of an infection: an interview study