From motivated and compliant to empowered: Do we need an IBD nurse led self management programme?

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Background: To ascertain service users level of knowledge regarding use of enema therapy and to investigate the need for the provision of a structured self management program.

Methods: Patients were identified at the Inflammatory Bowel Disease (IBD) clinic in a tertiary referral centre and asked to participate in a confidential questionnaire. The purpose was twofold to assess patient knowledge and to identify barriers to compliance/adherence. Data were gathered prospectively over a 28 day study period and statistically analyzed. P values <0.05 were deemed significant.

Results: Thirty-five completed questionnaires were received; 65.7% had Ulcerative Colitis; median age was 36; median time since diagnosis was 7 years; 94.2% had previously been prescribed topical therapy.

There was no significant preference for use of liquid, foam or suppository preparations. The most widely used preparation was Salofalk enema (30.3%), followed by Predfoam (26.8%). 73% chose evening as the best time to take enemas (p < 0.0001).

A large minority administered their topical treatment incorrectly, while standing (35%), with 43% adopting a left sided position. The majority (71.44%) stayed lying ten minutes or longer after administration rather than moving straight away or within 1 minute (p < 0.0017). Most patients (67.7%), did not change position once the enema had been administered (p = 0.0105).

Compliance was good with 94% always or sometimes completing their full course of treatment as prescribed.

Less than 1/3 participants took treatment for 1 week post symptom resolution, with 42% taking their prescribed course and 30% until they felt better. In addition, 70% of patients never started treatment without consulting a medical professional (p < 0.0028), indicating a potential need for greater autonomy in decision-making around treatment for IBD patients.

The majority (59.5%) chose to contact the IBD nurse when having a flare. Also promisingly, when asked if interested in learning how better to manage flares independently 100% of participants agreed that this would be a desirable option.

Conclusions: While acknowledging the small sample size in our study, gaps in both knowledge and confidence have been identified in this cohort. The service users have a good compliance record and a positive interaction with health professionals (mainly the IBD Nurse). Empowering patients through an IBD Nurse Led Self Management Programme would be beneficial for patients well being and would on the long term reduce the burden on the service.

N002 Nurse specialist prescribing practice in inflammatory bowel disease: A single centre experience

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Background: Nurse prescribing improves the quality of patient care, with timely access to drugs and reduction in physician dependence(1). Role descriptives for IBD nurse specialists (IBDNS) encourage nurse prescribing to enhance patient based services(2).

Methods: To determine the current prescribing practice of IBDNS in a single centre. All prescribing events (PxE) were recorded by 2 IBDNS prospectively for 3 months. APxE included: new drug, repeat prescription or dose change. Decision-making was recorded as independent initiation by IBDNS +/- physician discussion, consensus decision, initiation by physician. Drugs were classified as anti-TNF therapies, immunomodulators (IM) (thiopurines, methotrexate), oral corticosteroids (CS), oral5ASA and topical therapies (TT).

Results: Of 231 patients studied, 279 PxE were recorded (118 ulcerative colitis; 107 Crohn’s disease; 3 indeterminate and 3 lymphocytic colitis). Median age was 42 years (range 18-89); 102 (44.2%) male. There was a mean of 1.5 events/day/IBDNS. One hundred and fifty (65%) patients had a PxE at contact specific to IBDNS; 108 (47%) phone; 42 (18%) at scheduled IM or biological therapy. In 81 (35%), this occurred at a scheduled outpatient visit.

The majority, 135 (58%) had active disease at PxE. In these, 178 PxE occurred: TT 46 (26%); CS 39 (22%); IM 26 (15%); anti TNF 24 (13%); oral5ASA 23 (13%), and non-IBD drugs 20 (11%). In those with inactive disease (n = 96), there were significantly fewer PxE for TT (p < 0.001), and CS (p < 0.001). There were