confident giving advice on vaccinations. Results support the need for further travel specific research and better education in both groups.

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PTU-093 AN EVALUATION OF AN IBD ADVICE SERVICE: IS IT MEETING ITS SERVICE AIMS?

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Introduction The provision of a dedicated and accessible IBD advice service (AS) is a key element of IBD management and, often, the responsibility of the Advanced, or specialist, IBD Nurse according to the N-ECCO Consensus statements. UK IBD Standards require IBD patients to have rapid access to specialist advice before the end of the next working day (EONWD). Our AS aims to provide timely access to clinical advice, support and acts as a point of contact to co-ordinate the patient journey. We evaluated if our advice service was meeting these goals.

Methods Over a 5 week period (23 working days) during October and November 2013, all contacts to the AS of a central London tertiary IBD service were recorded. Patients either called and left a message on an answering machine, or emailed a dedicated email address. Two experienced IBD CNS' collected data during each encounter. This included demographics of gender, age, and diagnosis; the format of contact (phone/email); if a medical opinion (IBD specialist or IBD registrar/fellow) was sought; time to response, and amount of time spent on each contact. The content of the encounter (administrative, clarification, a new query, or a symptomatic change/flare) was documented along with the response (administrative, information, results, treatment changes, medical decision), and the follow up required for the patient (routine, earlier or urgent outpatient appointment, or hospital admission/presentation to AandE).

Results 262 contacts were made to the AS. 4 could not be re-contacted and 23 had missing data, leaving 235 complete encounters for analysis, of which 3 enquiries were non-IBD related. Those who contacted the AS were predominantly female (148/235, 62.98%), between 26–35 (97/235, 41.28%), with a diagnosis of Crohn's Disease (160/235, 68.09%), the latter reflecting the tertiary nature of our IBD service. 99.15% (233/235) of contacts were replied to by EONWD, with 38.29% (90/235) answered within 12 h. The majority of contacts (85.11%) were for clinical reasons with 14.89% administrative (35/235). 51/235 (21.70%) pertained to flares. 88.94% (209/235) were autonomously handled by the IBD CNS though IBD Consultant/Fellow support was required in 26 cases. AandE presentation was recommended to 2 patients (2/235, 0.85%) and 25(10.64%) had their outpatient appointment brought forward, meaning the vast majority were clinically managed without the need for additional outpatient review.

Conclusion Our IBD advice service provides patients with rapid access to specialist advice, symptom management and disease-specific information, meeting UK national standards. The IBD CNS' expertise means clinical enquiries can be effectively managed whilst avoiding additional, unnecessary burden to the patient and to outpatient clinics.

Disclosure of Interest None Declared.

PTU-094 DO WE NEED POST INFLIXIMAB INFUSION MONITORING?

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Introduction Infliximab is used in the treatment of inflammatory bowel disease. It is administered as an intravenous infusion over 2 h with a 2 h monitoring period. Accelerated infusions have been shown to be safe and well tolerated,[1] reducing nursing time and increasing patient satisfaction.[2] It has been suggested that post infusion monitoring may not be necessary,[3] and it was our aim to establish this.

Methods 310 infusions were administered to 103 patients over 6 months (January to July 2013). Infusions 1–4 were administered over 2 h with 2 h monitoring, 5–9 over 1 h with 1 h monitoring, and 10 onwards over 30 mins with no monitoring.

A reaction was classified as mild if no action was required and severe if symptoms required immediate action or treatment withdrawal. A drop in systolic BP of ≥20 mm/Hg was recorded. Treatment of reaction and outcome were documented, including occurrence during or post infusion. Details of any delayed reactions post discharge were obtained from patient notes.

Results Of 41 patients receiving infusions 1–4, 2 patients (4.87%) had an infusion reaction. One mild, and one severe. Both occurred during the first infusion. Both had previously been treated with infliximab.

In 35 patients receiving infusions 5–9, 1 patient (2.86%) experienced a mild reaction during infusion 7, then a severe reaction during infusion 9.

No infusion reactions were observed during infusions 10+ (122 infusions in 37 patients). 11 patients had infusions 10+ over 1–2 h due to side effects with accelerated infusions or 10 mg/kg dose. These patients were not monitored post infusion.

One patient was hospitalised due to a delayed reaction one week after infusion 1 (previous infliximab treatment 108m). No side effects were observed during the infusion or monitoring period.

No reactions were recorded during the monitoring period in any of the treatment groups. One patient had a drop in systolic BP (22 mg/Hg) during the monitoring period of their 5th infusion. No action was taken and the patient was discharged.

Conclusion This audit has demonstrated that post infliximab monitoring is not necessary. We estimate that this would save 494 h of patient and nurse time per annum at our centre.

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