significant relationships with hydration status, symptoms and survival in advanced cancer. However, further work is needed to study these associations in the dying.

Aim This feasibility study aimed to develop the necessary methodology to evaluate hydration and its relationship with clinical symptoms and quality-of-life in dying cancer patients.

Methodology An observational study of thirty patients with advanced cancer in a hospice and hospital-based specialist palliative care inpatient unit. An advanced consent methodology was used to conduct assessments in the dying phase. Assessments involved hydration (BIVA), symptoms, physical signs, quality of life, myoclonus and survival. Family-caregivers experiences of hydration were evaluated via questionnaire.

Results The feasibility aspect of the study was successful in recruiting patients and caregivers across the research sites. The overall recruitment rate for patients was 60% (30 out of 48 approached agreeing to participate) with six (20%) of those recruited receiving a further hydration assessment in the dying phase of their illness. Eighteen caregivers completed questionnaires.

Conclusion It is feasible to use BIVA to assess hydration in the dying. This study will support the next phase of the study which include recruitment from additional palliative care units. The outcomes from this work will help to identify hydration-associated variables to support development of a clinical hydration assessment tool. Ultimately, this will help to develop a framework to clinically assess and manage hydration states patients with cancer.

35 PRINCIPLES OF CARE FOR THE DYING PATIENT- AUDIT OF USE IN A TERTIARY REFERRAL CANCER CENTRE

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Background The Leadership Alliance for the Care of Dying People set out an approach with focus on achieving the five priorities of care. Our trust developed an electronic version of the London Cancer Alliance document, The Principles of Care for Dying Patients. This audit set out to determine the number of expected deaths who had a document in place and if completed, adherence to the NICE Quality Standards for care of adults in the last days of life (NG31).

Methods Prior to the National Care at the end of life Audit, the hospital palliative care team undertook an audit of care of patients in the last days of life for deaths from 1st April 2017 to 31st March 2018. There were 230 deaths across the trust. Deaths in critical care and paediatric deaths were excluded. 177 case record reviews were undertaken by the palliative care team.

Results 65% of patients who were recognised as dying had a principles of care document initiated.

NICE Quality Standard 1: 100% of patients had daily review to assess for changes in dying phase, i.e. nearing death, stabilising or recovering.

NICE Quality Standard 2: 53% of patients had capacity to be able to discuss, and review an individualised care plan (ICP). 97% of cases showed documented evidence of a family discussion to ensure communication of recognition of dying and development of ICP.

NICE Quality Standard 3: – 94% of patients had appropriate anticipatory medications prescribed.

NICE Quality Standard 4%–68% of patients had documented evidence of discussion of hydration status.

Conclusion The Principles of Care Document when used adheres to the Nice Quality Standard. The regular education of the multi-disciplinary team in caring for dying patients continues to focus on use of the document to direct excellent care of the dying.

36 DESCRIBING DEPRESCRIBING – WHEN ARE WE STOPPING MEDICATIONS IN PALLIATIVE CARE?

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Introduction Deprescribing is the process of withdrawal of medication with the goal of improving patient care. Research currently is within the context of polypharmacy and geriatrics, however despite its ubiquity within palliative care it has not been studied significantly. Anecdotally, deprescribing is performed adhoc and using 'common sense' but there appears no clear data on rational and benefit.

Aim To gather data on current deprescribing practice within palliative care, with the aim to inform our own specialty and others.

Methodology Prospectively palliative in-patient hospice and community patients had medications which were deprescribed recorded and the rational. This gained a timeline of medication stops respective to date of discharge and/or death.

Results Data collected from 13/3/18 to 30/06/18 with 647 medication stops of 197 differing medications. 56%(361) medication stops were due to approaching end-of-life. 15%(93) due to swallowing difficulties, 17%(109) due to 'rationalising' medications.

The median number of days of palliative care deprescribing any medication before death is 4, with 1st quartile (25%) being 1 day and quartile 3 (75%) being 9 days before death. Groups identified and measured, included statins (median 5 days), beta-blockers (median 2 days), ACEi (median 5 days), anti-platelets (median 9 days), and Warfarin/NOACS (median 5 days).

Conclusion/discussion By describing deprescribing we outline the short timespan between medication stopping and death for arguably minimal patient benefit at this point of life. The rational for stopping correlates with this postulation, outlining we are stopping the vast majority of medications due to the dying phase rather than preemptively. Arguably, gathering data alone might inform practice but does not in itself bring about change. We suggest therefore that this study should therefore be seen as a positive step into identifying the need for change in current practice, leading to future studies to outline how change is achieved and measured.

37 THE USE OF PERSONALISED END OF LIFE CARE PATHWAY AT THE ROYAL SURREY COUNTY HOSPITAL

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Introduction National guidance has recommended locally developed personalised care plans to ensure needs are met as patients are approaching end of life. The Royal Surrey County