Methodology Prospective palliative in-patient hospice and community patients had medications deprescribed recorded and the rational. This was prospectively gaining a timeline of medication stops respective to date of 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 25% being 1 day and 75% being 9 days before death. Groups were identified and individually measured, including statins (median 5 days), Beta-blockers (median 2), ACEi (median 5), anti-platelets (median 9), Warfarin/NOACS (median 5).

Conclusion/discussion By describing deprescribing current practice we outline the short timespan between deprescribing and death for medications arguably of minimal patient benefit at this point in 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.

**COMMUNICATION WITH PALLIATIVE CARE PATIENTS ABOUT DRIVING AND OPIOIDS**

Emma Collins, Andrew Jones. Cwcn Taf University Health Board

Background Recent changes in the law regarding liability and driving offences whilst on opioids, highlighted by the MHRA, reinforces the importance of communication about driving whilst taking medication and the law. A robust approach to communicating and documenting this information is required.

Methods The audit standard was NICE CG140: ‘Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults’. Patients seen in January 2015 in outpatients, day unit, inpatients and the community initiated on opioids or had dose titration, were reviewed. Cases were excluded if had an ECOG of 3–4. The data was analysed and presented at our clinical governance meeting. This triggered a redesign of our inpatient admission proformas. The method of documenting driving status on electronic patient records was changed and promoted. Driving safety leaflets were made available. The audit cycle was completed in June 2017.

Results Pre-implementation, 33 cases were included in analysis. 9% of cases had their driving status documented. 0% had documentation of discussion of side effects and 9% documented that the patient was informed about the consequences of driving on opioids. On re-audit, 20 cases were analysed. Driving status was documented in 50% of cases, 30% showed discussion of side effects, and 30% documented consequences of driving on opioids.

Conclusions It is the clinician’s responsibility to appropriately counsel patients on risks of driving whilst taking medications, to provide ‘medical defence’. Although conversations often occur, they are seldom documented and can therefore not be evidenced. Having written information to offer can provide evidence, but is no substitute for thorough conversation and eliciting comprehension. In our department, more needs to be done to educate the SPCT to ensure this is done routinely as part of the first assessment, and reviewed frequently, with changes to medications being a prompt.
Furthermore, qualitative evidence suggests PLFU patients felt empowered. Within palliative medicine, focus has shifted towards Phase of Illness to determine follow-up frequency, with stable patients being moved towards PLFU.

**Methods** A cross-sectional cohort of PLFU patients is being followed for six months. Data being collected includes Phase, Karnofsky Performance Score (KPS), diagnosis, Integrated Palliative care Outcome Scale (IPOS) and outcome.

**Results** The project is ongoing but preliminary findings include identifying two cohorts frequently assigned to PLFU; nursing home patients, and breast cancer patients. Breast follow-up appears to be leading the way in PLFU, therefore patients transitioning from oncology follow-up to palliative care may be more amenable to a PLFU approach.

**Conclusions** The literature has demonstrated PLFU as a safe, cost-effective alternative to traditional follow-up and a way of ensuring a reactive service with resources to respond to crises whilst encouraging self-management and patient empowerment. Our study aims to demonstrate how PLFU translates to palliative care, and how we might identify those patients who would be candidates for this approach. It also aims to gain qualitative feedback from focus groups of both patients and relatives of deceased patients who can reflect on the transition to PLFU.