



Conclusion: The importance of VTE risk assessment in acute inpatient wards can never be overemphasized. Studies show that psychiatric inpatients are likely to be at an increased risk of VTE due to – use of psychotropic agents, reduced mobility, dehydration as a result of self-neglect or suicidal attempts, prolonged restraints, sedation, co-morbid physical health problems etc.

There are still lapses in our patient management that need to be considered in order to provide an outstanding patient care and safety.

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Evaluating the Anticholinergic Burden (ACB) of Patients Referred to Rotherham Memory Clinic

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doi: [10.1192/bjo.2025.10651](https://doi.org/10.1192/bjo.2025.10651)

Aims: To evaluate if documentation of Anticholinergic burden (ACB) score is in accordance with the NICE guidelines.

To calculate the Anticholinergic burden (ACB) score for patients referred to memory clinic if not documented.

Methods: I conducted retrospective analysis using a systematic sampling method and a proforma on patient's electronic medical record to ascertain if the ACBs of patients were documented when being reviewed.

Information was obtained from both SystmOne tabbed journals, SystmOne medications list, and referral letters (to determine ACB score documentation and calculation).

Two scoring systems were used to calculate ACB: ACB calculator (<https://www.acbcalc.com/>) and POMH data collection tool.

Results: Of the 92 patients referred to memory service, 30 patients were analysed and only 3 had documented ACB burden score (10%). Using the ACB scale. 13 individuals had ACB score of ≥ 2 which was 43% of patients analysed. Using POMH, 9 individuals had ACB score of ≥ 2 which was 30% of patients analysed.

Most common medication involved in individuals with ACB ≥ 3 was amitriptyline (67% using the POMH calculator and 37% using the ACB calculator) and all were commenced in primary care. If documented, this score would be classified as high risk and necessitate a medical review in line with the guidelines.

Conclusion: To regularly document Anticholinergic burden score for elderly patients referred to service.

Patients with high burden score may require a medication review with documented evidence of either: Discussion about reducing the dose; or stopping or switching the anticholinergic medicine.

Currently, no scoring system is recommended, to use an agreed system.

Reducing drugs with high ACB can also lead to less polypharmacy.

In addition, concomitant use with anticholinesterase inhibitors may reduce the effectiveness.

Reaudit second cycle in 6 months.

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Use of Antidepressant for the Treatment of Depression in CAMHS Outpatient

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doi: [10.1192/bjo.2025.10652](https://doi.org/10.1192/bjo.2025.10652)

Aims: According to NICE guidelines children and young people with depression should be treated on an outpatient basis. Antidepressants should not be offered routinely to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy.

When an antidepressant is prescribed to a child or young person with a depressive disorder, it should be fluoxetine as this is the only antidepressant for which evidence shows that benefits outweigh the risks. There should be monitoring and review of mental state in the course of treatment.

The aim of the audit was to evaluate the use of antidepressants for the treatment of depression in children and young people and the monitoring in place for the duration of treatment at West Lancashire CAMHS outpatient clinic in keeping with NICE guidelines.

Methods: Cohort: Outpatients (young persons) at CAMHS outpatient clinic (Westgate House) prescribed antidepressants for the treatment of depression.

Sample size: 15–20 patients (randomly selected).

Data collection: Retrospective data collection looking through patient's record (RIO) for documented diagnosis of depression, medication initiation process, choice of medication, psychological therapy offered and evidence of monitoring – side effects, review of mental state etc.

Results: All the young persons had a documented diagnosis of depressive disorder on their records following psychiatrist review. Medication and side effect profile were discussed with the young person and family prior to initiation.

85% of the young persons were prescribed fluoxetine as the first-line medication whilst sertraline was given to the remaining.

The range of offered psychological interventions together with pharmacological treatment include: distraction techniques, use of bedside box, psychoeducation, coping strategies, art/play therapy, behavioural activation, problem solving group, DBT, CBT, IPT and family therapy.

Monitoring was done by the prescriber and case managers weekly (60%), two weekly (25%) and monthly (10%).

Conclusion: The range of psychological interventions offered to the young persons were compared with NICE guidelines. Though DBT is not recommended by the guidelines, it was used as a psychological therapy in a background of trauma and emotional dysregulation.

Sertraline was used as first line in one of the young persons with co-morbid PTSD.

Recommendations made to improve the monitoring using the side effect checklist – before prescribing as stated in NICE guidelines and also to liaise with the case managers in the monitoring process after treatment initiation.

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