

**Geriatrics · Educational evidence summary**

Transitions of care and anticholinergic exposure

This geriatric evidence summary examines transitions of care and anticholinergic exposure.

UnifiedACB · Published October 3, 2026 · Updated October 4, 2026

[Read the current article](#)

<https://unifiedacb.com/articles/032-transitions-of-care-and-anticholinergic-exposure/>

A handoff needs to carry meaning

A medication list can arrive at the next care setting without explaining why a medicine was added, which symptom prompted concern or who is expected to reassess it. An anticholinergic score alone carries even less context. The receiving team needs to know what decision or uncertainty the result represents.

The [WHO report on medication safety in transitions of care](#) provides the broader safety context. This article applies that principle to source-based anticholinergic review: preserve the intended exposure, the evidence basis and the follow-up question as care moves between clinicians, facilities or home support.

Describe the transition itself

An admission, transfer, discharge and return to community care can each change the information available. The same medicine may be documented under a different name or formulation. A temporary order may be mistaken for a continuing treatment, or a continuing treatment may be omitted from a summary.

The first task is to distinguish an intended clinical change from a documentation discrepancy. A burden category cannot make that determination. The [AHRO reconciliation toolkit](#) emphasizes a structured comparison of medication information, which is necessary before an exposure change can be interpreted reliably.

Carry four pieces of information together

The first is the intended regimen: exact ingredients, product details, route, schedule and actual-use information where relevant. The second is the reason for a change or continuing treatment. The third is the specific concern being assessed, such as a symptom, functional change or source-qualified prescribing issue. The fourth is responsibility for follow-up.



These elements answer different questions. A list says what is intended. A rationale says why. A clinical concern says what should be observed. An owner says who will act on the information. Leaving one out can make the handoff appear complete while the next step remains undefined.

Preserve the distinction between evidence and action

The [UnifiedACB source table](#) can support a statement that a medicine has a particular published classification. It does not establish that a medication change has been ordered or that the receiving clinician should implement one automatically. The clinical plan should be recorded separately from the educational evidence.

Similarly, a [geriatric criterion](#) should travel with its qualification. A note that says only “Beers medication” may omit the dose, route, indication or condition that determines the relevant concern. The next clinician should not have to reconstruct that meaning from a badge.

If the criterion’s applicability remains uncertain, state the missing detail. A targeted question is more useful than forwarding an unqualified warning that appears to have already been adjudicated.

Make comparison over time reproducible

If the handoff includes an earlier and later burden result, identify the same source version and the medication sets used. A difference caused by a new scale version is not necessarily a change in exposure. A difference caused by a newly documented nonprescription product is not necessarily a new medication start.

Report unmatched or unavailable source entries. Otherwise, a lower total can be mistaken for improvement when it reflects reduced coverage. The receiving team needs to know whether the assessment described the entire reconciled list or only the medicines with verified source values.

Use symptoms and goals to define follow-up

Specify what the team is watching and how it relates to the person’s priorities. “Review daytime alertness after the documented regimen change” is more actionable than “monitor burden.” The outcome should remain a clinical observation, not merely a recalculated category.

The plan also needs to retain the medicine’s benefit. If a change is being evaluated, follow-up should consider both the concern that motivated review and the condition originally treated. The website cannot determine that balance from the source table.

When several aspects of care change together, the handoff should avoid promising that one medication decision will explain the entire course. The receiving team can assess the trajectory while preserving uncertainty about attribution.

Close the loop rather than forwarding a label

A completed handoff makes clear which questions were resolved, which remain open and who will reassess them. The person receiving care and any care partner should understand the intended



regimen and where to seek clarification. Conflicting instructions should be resolved clinically, not by choosing whichever list produces the lowest score.

Anticholinergic evidence is most useful during a transition when it carries a precise question across the boundary. The source classification remains traceable, and the clinical responsibility remains explicit.

References

1. Vennard O, Stewart C, Tolia M, Soiza RL, Myint PK. Anticholinergic Medication Burden Scales: A Systematic Review. *J Am Geriatr Soc*. 2026;74(6):1771-1784. [Source](#)
2. American Geriatrics Society 2023 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc*. 2023;71:2052-2081. [Source](#)
3. American Geriatrics Society Beers Criteria Alternatives Panel. Alternative Treatments to Selected Medications in the 2023 AGS Beers Criteria. *J Am Geriatr Soc*. 2025;73:2657-2677. [Source](#)
4. Fox C, et al. Effect of medications with anti-cholinergic properties on cognitive function, delirium, physical function and mortality: a systematic review. *Age Ageing*. 2014;43:604-615. [Source](#)
5. Ruxton K, Woodman RJ, Mangoni AA. Drugs with anticholinergic effects and cognitive impairment, falls and all-cause mortality in older adults: a systematic review and meta-analysis. *Br J Clin Pharmacol*. 2015;80(2):209-220. doi:10.1111/bcp.12617. [Source](#)
6. Egberts A, et al. Anticholinergic Drug Burden and Delirium: A Systematic Review. *J Am Med Dir Assoc*. 2021;22:65-73.e4. [Source](#)
7. Braithwaite E, et al. Interventions for reducing anticholinergic medication burden in older adults: a systematic review and meta-analysis. *Age Ageing*. 2023;52:afad176. [Source](#)
8. Taylor-Rowan M, Alharthi AA, Noel-Storr AH, et al. Anticholinergic deprescribing interventions for reducing risk of cognitive decline or dementia in older adults with and without prior cognitive impairment. *Cochrane Database Syst Rev*. 2023;12:CD015405. doi:10.1002/14651858.CD015405.pub2. [Source](#)
9. World Health Organization. Medication safety in transitions of care. 2019. WHO/UHC/SDS/2019.9. [Source](#)
10. Agency for Healthcare Research and Quality. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. [Source](#)
11. UnifiedACB. Preserved public source-observation dataset, v3.0 RC12 final; inspected for this editorial revision. [Source](#)

Explore the evidence

[Ask UnifiedACB](#) about a medication or source, browse the [Medication Library](#), or read the [methodology](#).

Disclosure

Funding: None. Conflict of interest: None declared for the UnifiedACB educational project.

Educational evidence summary. This content does not provide patient-specific medical advice and does not replace clinical judgment, medication reconciliation, or prescribing guidance.