

**Geriatrics · Educational evidence summary**

Anticholinergic burden in long-term care

This geriatric evidence summary examines anticholinergic burden in long-term care.

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

[Read the current article](#)

<https://unifiedacb.com/articles/036-anticholinergic-burden-in-long-term-care/>

Use the information available across the care team

A long-term care medication review can draw on orders, administration records, nursing observations, pharmacy review and the resident's or care partner's experience. Each describes a different part of treatment. A source-scale table becomes more useful when those parts are connected rather than replaced by a single total.

The review should begin with the resident's priorities and the concern being assessed. Comfort, alertness, bowel function, transfers, continence and participation can lead to different questions. A category does not choose the goal or determine whether a medicine is providing a meaningful benefit.

Read administration, not just authorization

An as-needed order describes permission to administer a medicine under specified circumstances. It does not establish how often the resident received it. The administration pattern may be more informative for a symptom review than the order's presence on a printed list.

Separate scheduled use, occasional use and unused orders. Record the period being examined and relevant timing. If a symptom changes, distinguish exposure before the change from treatment given in response to it. This avoids assigning causation to a medicine that was added after the problem began.

The [AHRQ reconciliation framework](#) supports accurate medication information across settings. It is especially useful when a resident returns from hospital with new instructions that need to be aligned with the facility record.

Make observations concrete and comparable

Staff observations become more useful when they name the behavior or function and its timing. "Needed additional help at breakfast after the recent regimen change" identifies a question more clearly than "worse cognition." The observation should also be compared with the resident's usual baseline and the course of any illness.



The resident's experience remains essential. A medicine may improve a distressing symptom even while contributing to another concern. A review that records only adverse-effect possibilities can miss why treatment has been continued.

When several clinicians are involved, identify who will interpret the observations and revisit the plan. The value of collecting information depends on a clear route from observation to clinical review.

Keep product details intact

Formulation and route can be important in long-term care, particularly when administration needs change. A source observation that names an ingredient does not automatically establish equivalent exposure for every product form. Product-specific administration questions should be resolved using the relevant prescribing information and clinical guidance.

UnifiedACB's [source labels and formulation notes](#) preserve the available distinctions. A preferred name is a navigation aid, not a license to erase the original wording. If the source is nonspecific, the limitation should remain visible.

Interpret geriatric criteria in the resident's context

The [AGS criteria](#) can help identify medication, condition and interaction concerns. The relevant qualification should be named rather than reduced to "on the list." A criterion involving a particular condition does not apply solely because the person lives in a care facility.

The selected geriatric overlay also does not cover every prescribing issue. Absence from it is not reassurance, and a source-scale zero does not exclude medication-related problems through other mechanisms. The full review remains broader than the anticholinergic classification.

Judge an intervention by resident outcomes

The [randomized trial of reducing anticholinergic burden in frail older adults](#) illustrates why exposure reduction and cognitive improvement are separate outcomes. A facility should not infer that a lower score proves improved care without assessing the relevant clinical result.

If the treating team changes a regimen, monitor the specific concern and the original treatment benefit. Document symptom recurrence, comfort and function as appropriate to the plan. A numerical target should not displace the resident's priorities or create an incentive to minimize useful treatment simply to improve a dashboard.

Care observations should also identify the relevant interval. A symptom recorded during an acute illness and a later routine observation are not automatically comparable. Retaining that context helps the team interpret the course without treating every difference as a medication effect.

A review summary that supports continuity

Record the actual administration pattern, the symptom or functional goal, the source-specific evidence and any unresolved product or clinical question. Distinguish recommendations from orders



and completed actions from proposed ones. After a hospital transfer, reconcile the intended regimen before comparing burden over time.

Long-term care offers repeated observations that can make medication review more informative. Their value lies in a careful timeline and resident-centered interpretation. The burden table supports that work by making the exposure evidence traceable, while the care team determines what the evidence means for the resident.

References

1. Carnahan RM, et al. The Anticholinergic Drug Scale as a measure of drug-related anticholinergic burden: associations with serum anticholinergic activity. *J Clin Pharmacol*. 2006;46:1481-1486. [Source](#)
2. 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](#)
3. 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](#)
4. 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](#)
5. 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](#)
6. 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](#)
7. Agency for Healthcare Research and Quality. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. [Source](#)
8. UnifiedACB. Preserved public source-observation dataset, v3.0 RC12 final; inspected for this editorial revision. [Source](#)
9. Kersten H, et al. Cognitive effects of reducing anticholinergic drug burden in a frail elderly population: a randomized controlled trial. *J Gerontol A Biol Sci Med Sci*. 2013;68:271-278. doi:10.1093/gerona/gls176. [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.