

**Geriatrics · Educational evidence summary**

Documenting anticholinergic burden without overclaiming causality

This geriatric evidence summary examines documenting anticholinergic burden without overclaiming causality.

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Use a note that shows how the conclusion was reached

A medication-review note should allow another clinician to distinguish what was observed from what was inferred. “High anticholinergic burden caused confusion” compresses several unproven steps unless the exposure, syndrome and causal assessment have actually been established. A clearer note keeps those steps separate.

The goal is not cautious wording for its own sake. It is a record that can be reviewed, updated and followed over time without losing the source evidence or the clinical uncertainty. That makes the note useful for both current care and later interpretation.

State the exposure as a fact with a time boundary

Identify the ingredient, formulation, route, schedule and actual use relevant to the concern. Distinguish an active order from a dose that was administered. Record recent changes and the period being assessed. The [medication-reconciliation framework](#) supports establishing an accurate input before interpreting a score.

If use remains uncertain, say so. “Listed on the discharge summary; current use not yet confirmed” is a different fact from “taken daily.” The uncertainty should not disappear when the medicine is entered into a source-based review.

Quote the classification with its provenance

Name the source and version beside the value. The [UnifiedACB observation record](#) provides the original label, evidence state and locator needed to make the finding traceable. If sources disagree, document that disagreement rather than creating a consensus value.

An unavailable source entry should be described as unavailable. An explicit zero should be identified as a published zero. These statements prevent a later reader from assuming that a blank cell was evaluated and found inactive.

For a supplemental [geriatric criterion](#), name the relevant context and qualification separately. A source-scale value and a Beers concern are different findings, even when both support reviewing the same medicine.



Describe the clinical concern independently

Record the symptom or functional change, its onset and the baseline comparison. An observed change in attention, bowel function or mobility should not be defined solely by the medication list. The clinical outcome needs its own description and assessment.

Include relevant competing explanations and the sequence of events. A medicine started after symptoms began may be a response to the problem rather than its initiating cause. If illness and several treatments changed together, the note should preserve that ambiguity.

Match the verb to the evidence

“Classified” describes a source-scale finding. “Associated with” describes a relationship examined in a study. “Possible contributor” describes a clinical hypothesis. “Caused” is a stronger conclusion that requires a supported assessment of the individual event. These verbs should not be exchanged merely to make the note sound more decisive.

The [diphenhydramine cohort study](#) and [cumulative-exposure dementia study](#) illustrate why study context must accompany association language. A published relationship does not automatically confirm an adverse reaction in the person being reviewed.

An educational wording pattern

One useful structure is: the confirmed medication exposure is stated first; the named source classification is stated second; the clinical concern and its timing are described third; and the medication is identified as a possible contributor only if that interpretation is supported. The note then identifies the unresolved questions and the treating team’s plan.

This is a documentation pattern, not a real patient example or a validated causality assessment. It deliberately avoids invented clinical details or numerical risk estimates. The clinician supplies the actual findings and the appropriate degree of certainty.

Separate the plan from the outcome

“Review requested,” “change proposed,” “change ordered” and “change completed” describe different stages. The note should make clear which has occurred and who is responsible for follow-up. The [WHO transition-safety report](#) reinforces the importance of carrying medication information and responsibility across care boundaries.

After a change, document what was observed rather than assuming that a lower burden measure means improvement. The [burden-reduction trial](#) highlights the broader distinction between changing exposure and demonstrating a clinical benefit. The outcome that motivated the review should be assessed directly.

If several interventions occurred, acknowledge that the contribution of any single change may remain uncertain. Improvement is still worth documenting accurately; it need not be assigned a stronger causal explanation than the evidence allows.

A note another clinician can use

The finished record should contain the exposure, source evidence, clinical timeline, interpretation, unresolved issues and follow-up responsibility. It should preserve the medicine’s treatment purpose



as well as the concern. This allows the next reviewer to understand both why the medicine matters and why the decision requires clinical judgment.

Careful documentation turns a burden finding into a reviewable clinical question. It avoids making the score appear to diagnose an adverse effect, prove causation or justify a treatment change that has not been assessed.

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Explore the evidence

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

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