

**Psychiatry · Educational evidence summary**

Anticholinergic burden in inpatient psychiatry

This psychiatry article focuses on anticholinergic burden in inpatient psychiatry.

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The order list is not the exposure timeline

In inpatient psychiatry, a medication may be ordered, available, administered once, used repeatedly, or discontinued before use. A burden summary that treats all of these states as daily exposure can misrepresent the clinical course. The first task is to define the period being reviewed and identify which record establishes actual administration.

This guide focuses on that data problem and its clinical interpretation. It does not propose a ward prescribing target or an acute treatment algorithm. An anticholinergic review should support the assessment of the current concern without delaying necessary care or replacing evaluation of the patient's condition.

Define the unit of review

A review of the admission regimen differs from a review of medicines given during a particular day, the discharge plan, or anticipated home use. State which unit is being described. If several units are compared, preserve the differences rather than merge them into one total.

For example, an as-needed order may belong on the discharge prescription but have no administration during a selected inpatient interval. That is not an inconsistency to “correct” by assuming use. It is a difference between availability and observed exposure, and it should remain explicit.

Map the medication timeline

Record the exact product, route, preparation, and relevant administration information. Identify additions, discontinuations, and changed instructions. Keep the reason for an acute adjunct with the order when known. If the reason is unclear, the record should flag a clinical reconciliation question rather than invent a justification.

This timeline helps distinguish a symptom that preceded treatment from one observed afterward. It also makes it possible to identify whether several medicines changed together. Without that



information, a later association between a burden category and a clinical observation can be difficult to interpret.

Preserve the source evidence as a separate layer

Once identities are clear, retrieve each source-native observation in UnifiedACB. Keep the version and any route or formulation note. A source classification should not be recalculated to imitate administration intensity unless the original method explicitly provides such a calculation.

If a source has no public observation for a medicine, report the gap. Do not borrow a value from another source to complete the first source's column. If values disagree, retain that disagreement. These rules remain necessary even when the immediate task is operational and the medication list is changing quickly.

Name the concern that triggered review

An acute change in attention, a movement complaint, a bowel concern, or another symptom requires a clinical assessment appropriate to that problem. The burden table cannot determine acuity or causality. It should not be used as a substitute for examining the patient or reviewing other plausible explanations.

The note should state the concern and its timing, then describe how the medication history may be relevant. Avoid broad statements such as "symptoms due to high burden" when the exposure and alternatives have not been assessed. A precise description is more useful to the next shift and less likely to harden an untested hypothesis into a diagnosis.

Review the transition to discharge

The discharge regimen should reflect the actual plan, not simply the union of every order used during the admission. Identify which medicines continue, the documented reason for each, and which questions remain for follow-up. The clinical team determines those decisions; the evidence tool should record them accurately.

NICE medicines-optimisation guidance emphasizes communicating relevant medication information across transfers of care. [NICE NG5](#) In this setting, that includes preserving the difference between a transient inpatient intervention and continuing home treatment. A source summary without the underlying list and instructions is an incomplete handoff.

A focused ward-review checklist

- What time interval and medication state does the summary describe?
- Which occasional products were actually administered in that interval?
- Are there duplicate, obsolete, or unresolved product identities?
- What concern is being assessed, and what is its timing?



- Which decisions are completed, which are proposed, and who will follow them?

Research and quality-improvement limits

A change in ward prescribing patterns may be worth measuring, but it is not automatically a clinical benefit. If a service studies an intervention, it should define the population, exposure window, outcomes, and missing-data approach prospectively. A lower average source total alone cannot establish fewer adverse events or better recovery.

For individual care, the useful endpoint is a reliable medication timeline and a clear clinical question. The original source observations can inform that question while administration records and clinical assessment determine what exposure and outcome are actually being considered.

References

1. Georgiou R, et al. Anticholinergic Burden and Cognitive Performance in Patients With Schizophrenia: A Systematic Literature Review. *Front Psychiatry*. 2021;12:779607. [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. Mancini V, et al. Anticholinergic Burden and Cognitive Function in Psychosis: A Systematic Review and Meta-Analysis. *Am J Psychiatry*. 2025;182:349-359. [Source](#)
4. National Institute for Health and Care Excellence. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NG5. Recommendations. [Source](#)

Explore the evidence

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

Disclosure

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