REDUCING FALL RISK FOR PATIENTS ON SEDATING MEDICATIONS

INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS

Some medications can increase a person's **risk of falling**, these include **psychotropics (antipsychotics, antidepressants, sedatives/hypnotics) and opioids.** Taking multiple medications is associated with an increased fall risk, as a result of adverse reactions to one or more of the medications, drug interactions, or incorrect use of some or all of the medications.[1]

Quality use of medicines for minimising falls in older people in the hospital setting

- Avoid initiating psychotropic medication in an older person while in hospital.
- Prescribe the lowest effective dosage of a medication specific to the symptoms and consider cumulative drug burden.
- Provide the patient and their family/carer with an explanation of newly prescribed medications and their possible adverse effects or changes to prescriptions, including written information where appropriate.
- Consider alternate approaches (e.g. behavioural, environmental and psychosocial treatments) to manage sleep disorders, anxiety and depression. These should be tried before pharmacological treatment and may avoid long term problems associated with drug adverse effects and difficulties with withdrawal.
- Consider risk versus benefit of gradual withdrawal of psychotropics.
- Educate the multidisciplinary team, patients and their family/carers to improve their awareness of the medications associated with an increased fall risk.
- Document all recommendations and rationale when reviewing and adjusting patient's medication use.[1]

Medications are a common contributing risk factor to falls.

Conducting routine medication review for minimising falls in older people in the hospital setting

The routine review of appropriateness of medication should be a core part of the assessment of an older person while in hospital. It is effective in reducing falls when combined with other risk-reducing interventions. The review should include the following:

- Ensuring a best possible medication history is conducted as soon as possible after admission
- Conducting medication reconciliation between the patient's medication history and what is charted for them on this admission
- Reviewing the patient's medications on admission, regularly during the patient's stay and on discharge
- Ensuring all medication changes made are communicated to the General Practitioner on transfer of care
- Ongoing monitoring and review where substantial changes have been made to medications or where there are concerns about adherence following discharge.[1]

SEDATING MEDICATIONS ASSOCIATED WITH INCREASED FALL RISK

	Common examples	Side effects increasing fall risk	Other points to consider	Cease abruptly versus taper slowly
Anti psychotics	haloperidol olanzapine risperidone	orthostatic hypotension, confusion, sedation, extra-pyramidal side effects, blurred vision	• If prescribed for non-psychotic illnesses (e.g. acute behavioural disturbances) use the lowest possible dose for the shortest possible time	• Withdraw slowly to avoid relapse and withdrawal symptoms (tachycardia, sweating and insomnia)
Anti depressants	amitriptyline duloxetine sertraline	orthostatic hypotension, dizziness, weakness, drowsiness, confusion	• Weigh up risks to patient (e.g. falls) against benefit to patient's quality of life	• Do not cease abruptly. Taper over several weeks and monitor patient closely to minimise the risk of relapse and withdrawal
Sedatives / hypnotics	oxazepam temazepam zolpidem	dependence, confusion, ataxia, impaired alertness, oversedation, blurred vision, light-headedness	• Avoid where possible. If indicated, limit to short-term, intermittent use due to risk of physical and psychological dependence • Benefits of benzodiazepines are short-lived; hypnotic effect is lost after 14 consecutive nights, however side effects persist, thus increasing fall risk • Consider why it has been prescribed, i.e. if for anxiety, consider an alternative • Where such medications are prescribed, consider whether the medication should continue after discharge, and cease before discharge if possible • Should not be initiated during a hospital admission **For additional information** see CEC *'Reducing the Use of Night Sedation'* information sheet	• Do not cease abruptly due to risk of withdrawal (insomnia, anxiety, irritability, sweating and GI symptoms) • Taper slowly to avoid rebound effects. When tapering: - ensure effective communication with GP for monitoring and review of patient - address concerns by providing information on the benefits of stopping the medication, such as improved cognition, alertness and sleep quality
Opioids	oxycodone morphine fentanyl	orthostatic hypotension, sedation, cognitive impairment, dizziness	• If commenced during admission for acute pain or post-surgery, give clear direction about expected duration of therapy • **If newly prescribed, consider possible drug-drug interactions with patient's pre-existing medications** • Review the patient's needs for opioids regularly, consider reducing the dose and/or tapering, particularly if initiated for acute pain or post-surgery • If required long-term, discuss with GP and consider referral to pain team or specialist	• Physical dependence is common; if taken long-term, opioids should not be ceased abruptly due to the risk of withdrawal symptoms occurring (nausea, vomiting, sweating, anxiety).[2]

References

1. The Australian Commission on Safety and Quality in Health Care, (2009). Best Practice Guidelines for Australian Hospitals, Community Care and Residential Aged Care Facilities.
2. Australian Medicines Handbook (AMH) electronic version, accessed via CIAP 17/8/17

About the NSW Falls Prevention Program

The CEC's Falls Prevention program aims to reduce the incidence and severity of falls among older people and reduce the social, psychological and economic impact of falls on individuals, families and the community.

For further information, please visit **www.cec.health.nsw.gov.au**

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