Fall Injury Prevention

Site Applicability

St. Paul's Hospital, Mount St. Joseph Hospital (Acute Care Only), and Holy Family Hospital-Rehabilitation
Emergency Departments, ambulatory and inpatient areas.

Practice Level: Basic

Nursing, Physiotherapy, Occupational Therapy – see profession specific guidelines

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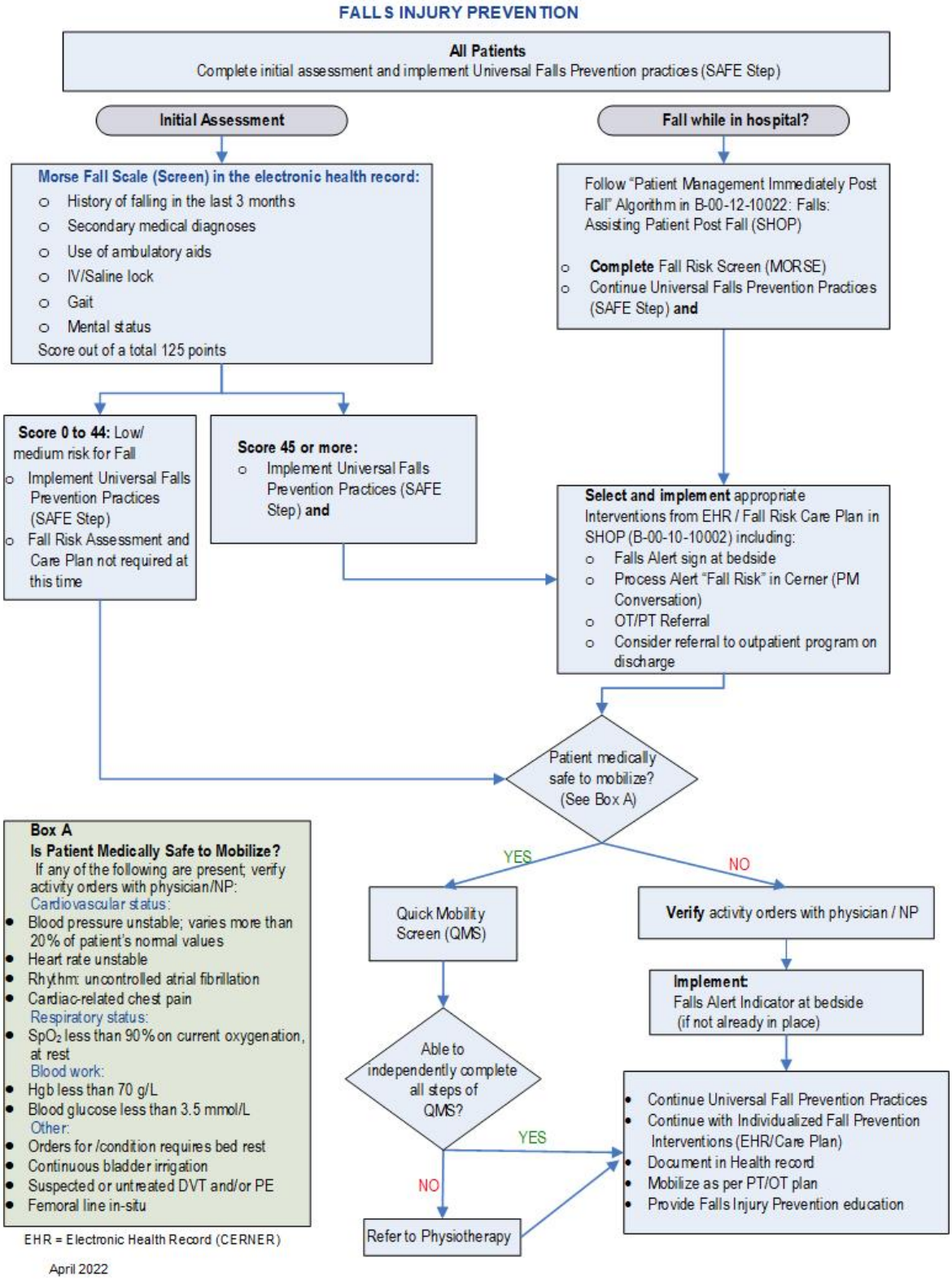
Requirements

1. Universal Falls Prevention Practices (SAFE Step) are implemented throughout PHC.
2. All patients in the Emergency Department will be considered high risk for falls.
3. In any ambulatory setting where procedural sedation or general anesthesia is used, all patients will be deemed high risk for falls.

Algorithm



Need to Know

1. The implementation of a documented and coordinated approach to prevent falls and fall-related injuries is essential to meet Accreditation Canada standards.
2. The interdisciplinary team supports the rights of all patients to move freely and make autonomous decisions that may result in living at risk. These rights are reinforced by the Charter of Rights & Freedoms and the Adult Guardianship Legislation of British Columbia.
3. Preventing falls and minimizing fall-related injuries has the potential to increase the quality of life for patients and reduce significant healthcare costs
4. The desire to prevent falls and fall-related injuries frequently triggers restraint use. Refer to the Least Restraint Care of the Patient at Risk for or Requiring Restraint protocol for appropriate restraint indications.
5. The interdisciplinary team conducts initial and ongoing patient assessments, implements interventions, and evaluates patient specific care plans to prevent falls and fall-related injuries.
6. Universal Falls Prevention Practices (Appendix A) are implemented in all care areas.
7. Patients at risk for falls are identified (see assessment):
    a. In the acute areas of ED at St. Paul's Hospital and Mount St. Joseph Hospital
    b. On admission to an inpatient unit
    c. When assessed by a nurse in an outpatient clinic
8. In any ambulatory setting where procedural or general sedation is used, all patients will be deemed high risk for falls and will have additional interventions initiated.
9. ED patients and inpatients who are identified as being at high risk for falls will have interventions initiated and documented (Appendix C) to prevent falls and fall-related injuries.
10. ED Acute patients and admitted in-patients will be assessed prior to any mobilization, if they are medically safe to mobilize. See the **Quick Mobility Screen** (Appendix D). Whenever possible the goal of mobilizing a patient should be a priority, as loss of muscle strength is a major cause of falls in the elderly and may contribute to falls that occur in hospital.
11. Communication between members of the interdisciplinary team and between patients and families is essential for the prevention of falls and fall-related injuries. Signage may be a useful tool to promote patient and family partnership in fall reduction and safety plans (Appendix E and Appendix F)

Universal Falls Prevention Practices

Universal Falls Prevention Practices are the minimum standards of care implemented into the plan of care for **all patients in all areas**, regardless of their risk for falling. SAFE Step is method of identifying the universal practices.

1) All patients will have Universal Fall Prevention **(Safe STEP)** implemented into their care plan:

Stop

- Scan for safety (e.g. clutter, spills, etc.)

Think Toileting

- Remind patient to ask for help
- Regular toileting prevents falls

Equipment

- Chair, commode, and mobility aids should be positioned close to the patient with the brakes on

Patient

- Non-slip footwear should be worn
- Frequently used items are close by
- Visual and hearing aides are in place
- Provide education to ask for help and sit for at least 20 seconds before standing

PRACTICE GUIDELINES – Nursing

Practice Level:

Basic RN, RPN and LPN

Assessment:

1. **Admission Screening:**

   All patients admitted to acute care or an ambulatory care setting will be evaluated for their risk for falling, e.g. (admission assessments)

   - Inpatients & ED Acute areas – Complete the Morse Fall Scale on admission
     - Maternity – patients are assessed each shift
   - Ambulatory Care Patients – Complete the Morse Fall Scale **or** the STEADI Fall Risk Screen as per unit workflow. Patients complete the Staying Independent Checklist (Available on FormFast) to inform this screen.

Interventions

1. All Patients - Universal Falls Prevention Practices (SAFE Step)

- Implement Universal Falls Prevention Practices (SAFE step) for **all** patients (Appendix A)
- Admitted inpatients - Hourly Rounding/Intentional Rounding: Every hour, while the patient is awake, assess the Four Ps (Appendix G)

2. Patients Identified as high risk for falls

Initiate **Fall Risk Alert:**

- Place Process Alert in patient record in CERNER
- Place **HIGH RISK FOR FALLS ALERT** (Appendix F) indicator close to the patient and/or bedside in a clearly visible location
- Provide **RED** non-slip socks as a visible risk indicator (for in-patients). Explain their purpose to the patient and family.
- Implement appropriate individualized falls prevention interventions (CERNER/paper care plan) and document
- Consider appropriate falls-related outpatient services on discharge (Appendix H)

3. Individualized Fall Prevention Care Plan

For inpatients who are identified as being at high risk for falls a **care plan** will be:

- Implemented within 24 hours of admission / transfer or with a significant change in the patient's status
- Evaluated daily, when there is a significant change in the patient's status; or after a fall. Interventions are added or discontinued as appropriate for the patient (e.g. discontinue red socks if patient assessed as no longer high risk for fall)
- Inclusive of interventions that are appropriate based on the fall risk factors identified in the multi-factorial assessment
- Developed in collaboration with the patient, family/ caregiver(s), and interdisciplinary team

For Ambulatory Care:

- Provide "Staying Independent" brochure (available on the PHEM web site), document in the health record and recommend follow up with family physician for patients identified as at risk for falling.
- For areas with recurring visits (e.g. Hemodialysis), a care plan will be developed on admission and reassessed with any significant change in status or report of a fall.

4. Safe Mobilization/Activation:

All patients should be mobilized to the greatest extent possible, unless contraindicated by illness or condition. If any of the following conditions are present (see below), verify activity orders with the physician:

Medical Factors Influencing the Safe Mobilization/Activation of Patients	
Cardiovascular Status	• Blood pressure unstable; varies more than 20% of patient's normal values • Heart rate unstable; 50% greater than predicted maximum heart rate (220 minus age) • Rhythm: Uncontrolled atrial fibrillation • Cardiac-related chest pain
Respiratory Status	• SpO_2 less than 90% on current oxygenation at rest
Bloodwork	• Hgb less than 70 g/L • Blood glucose less than 3.5 mmol/L
Other	• Orders for/condition requires bed rest • Continuous bladder irrigation • Suspected or untreated DVT and/or PE • Femoral line in-situ

5. Quick Mobility Screen

After assessment that the patient is medically stable, before mobilizing the patient, complete a **Quick Mobility Screen** (Appendix C)

- If patient unable to perform any step, do not proceed. Refer to Physiotherapy for further assessment.

6. Medication Review

Various medications can increase the risk of falling or outcomes associated with fall-related injuries (Appendix G)

- Consider referral of patient to Pharmacist, Geriatrician or Most Responsible Physician for medication review and evaluation

PRACTICE GUIDELINES – Occupational Therapy (OT)

Practice /Competency Level:

Entry-level graduate

Response time: (PIC = Priority Intervention Criteria; found on Occupational Therapy intranet site)

If patient is identified as at risk in the **Fall Risk Screening** (Appendix B) and a referral to OT is sent, the patient will be seen by OT within one working day from receipt of referral (PIC 1). The most responsible OT for the patient will determine the PIC according to OT guidelines.

If an OT referral is made for fall prevention interventions, the patient will be seen as caseload permits (PIC 3)

Screening

As per nursing guideline, see the **adult systems assessment** Fall Risk Screening (Appendix B) for all patients.

Assessment

Based on nursing guideline, referrals may be made to OT under suggested fall prevention interventions from the Fall Risk Assessment & Interventions.

As per standard OT practice guidelines, use Occupational Therapy Services Assessment and Intervention Plan (PHC-PM105) and standardized assessments as appropriate. Recommend functional and environmental interventions based on assessment results.

Intervention/ Discharge Plans

- Standard OT interventions as appropriate based on assessment results
- Communicate with unit staff as appropriate, the potential falls risks in hospital and necessary adaptations/assistance needed to increase patient safety.
    - Consider referral to Community OT (Referral Form AOA2: TST Community Health Services Referral)
    - Consider referral to other appropriate community resources (e.g. Grocery delivery services, activity programs such as Tai Chi or stroke fitness classes).
    - Consider interventions including referral to ophthalmologist or CNIB if appropriate
- Consider appropriate falls-related outpatient services on discharge (Appendix H)

Criteria for SPH Falls Clinic:

Patients who are over age 65 with a history of falls or gait/balance deficit and have no significant cognitive impairment.

PRACTICE GUIDELINES – Physiotherapy (PT)

Practice/Competency Level:

Entry level graduate

Screening

As per nursing guideline, see the Fall Risk Screening assessment for all patients.

Assessment

Based on nursing guideline, referrals may be made to PT under suggested fall prevention interventions from the Fall Risk Assessment (Appendix B) or the Quick Mobility Screen (Appendix D).

- Response time for initial PT involvement should be within 24 hours of referral on weekdays, or over a weekend and holidays, the next regular working day
- Assess as per the usual unit practice, with emphasis on functional mobility, safety in transfers, ambulation and balance
- Consider obtaining a Timed Up and Go (TUG) score and a Berg Balance Score (FormFast)
- Communicate with other unit staff or document (via Care Guide/Plan, ADL wall chart, care map and/or health record) as to level of assistance and mobility aid required for safe mobilization

Interventions

- Mobilize with appropriate mobility aid to the greatest extent possible, depending on the patient's medical condition (see nursing guideline)
- Consider exercise sessions in the physiotherapy treatment room as appropriate
- Consider transfer of function to Rehab Assistant for ambulation or balance exercises as appropriate

Discharge Plans

- Consider giving home exercise program with emphasis on balance and gait re-education (see PT Balance Exercise sheet from FormFast)
- Consider referring to homecare or physiotherapy (public or private) as appropriate
- Consider giving information for Osteofit, SteadyFeet, Get Up and Go, or similar exercise programs in community for high functioning individuals (TUG 20 seconds or less)
- Consider giving Patient Health Education Materials as appropriate
- Consider appropriate falls-related outpatient services on discharge (Appendix H)

Criteria for SPH Falls Clinic:

Patients who are over age 65 with a history of falls or gait/balance deficit and have no significant cognitive impairment.

All Disciplines

Documentation

According to site/program and profession specific documentation practices, document the following using applicable tools (CERNER-EHR, paper):

- Initial Assessment and Screening tools (admission documentation)
- Assessment results of the Fall Risk Screening Tool
- Fall prevention interventions implemented
- Patient and family education provided

Note: In the Maternity Centre the related documentation is located in PowerChart in the *OB Postpartum* and *OB Special Assessment* bands.

Patient/Family Education

- Educate patients, families, and caregiver(s) about Universal Falls Prevention Practices to prevent falls and fall-related injuries. Engage patient and family in care planning and discussion of risks/benefits of interventions intended to minimize risk
- Provide patients (including caregiver(s) and families) who are identified as being at high risk for falls with specific falls prevention education tailored to the patients' individualized care plan
- Educate patients, families, and caregiver(s) about the least restraint protocol at PHC where appropriate

Patient Health Education Materials (available in English, Chinese, Farsi & Punjabi):

- Vancouver Coastal Health. (2013). Family and Visitors Help Keep Your Loved One Safe from Falls (JB.206.F35),http://vch.eduhealth.ca
- Vancouver Coastal Health. (2012). Prevent Falls: Stay in the Game (BE250.P928), http://vch.eduhealth.ca
- Vancouver Coastal Health. (2012). Prevent Falls: Stay on Your Feet (BE.250.S798), http://vch.eduhealth.ca
- Vancouver Coastal Health. (2012). Stay on Your Feet: What to Do If You Fall (EB.470.G48), http://vch.eduhealth.ca
- Vancouver Coastal Health. (2011). Stay on Your Feet: Understanding and Reducing the Risk of Falling for People with Parkinson's (FM.495.S73),http://vch.eduhealth.ca
- Staying Independent (BC Ministry of Seniors) https://phc.eduhealth.ca

Expected Outcomes

- Patients who are at high risk for falls will be identified by using the Morse Fall Risk Screening tool or STEADI tool
- Patients will experience a decreased risk of falls and fall-related injuries

- All patients, families, and caregivers will be informed about risk factors for falls and how to reduce falls and fall-related injuries

Related Documents and Resources:

1. B-00-12-10022 – Falls – Assisting Patient Up from the Floor Post Fall
2. B-00-13-10059 – Least Restraint: Care of the Patient at Risk for or Requiring Restraint
3. B-00-13-10013 – Alcohol Withdrawal: Screening and Management using the Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-ar)
4. B-00-13-10065 – Delirium: Assessment and Care (Acute Care)
5. B-00-13-10081 - Close or Constant Care: Decision Making Process
6. B-00-13-10082 – Close and Constant Care: Implementing
7. B-00-07-10042 – Fall Prevention for Newborns

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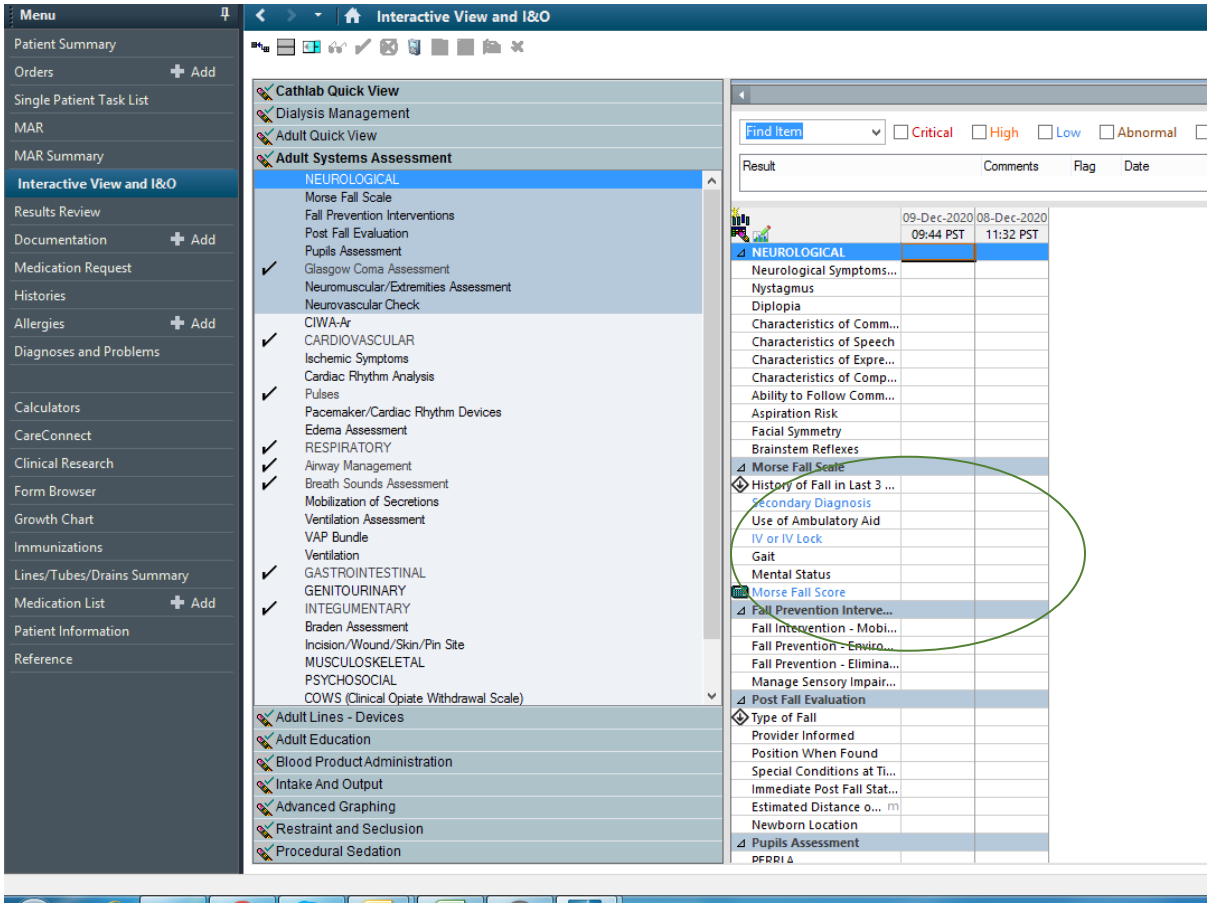
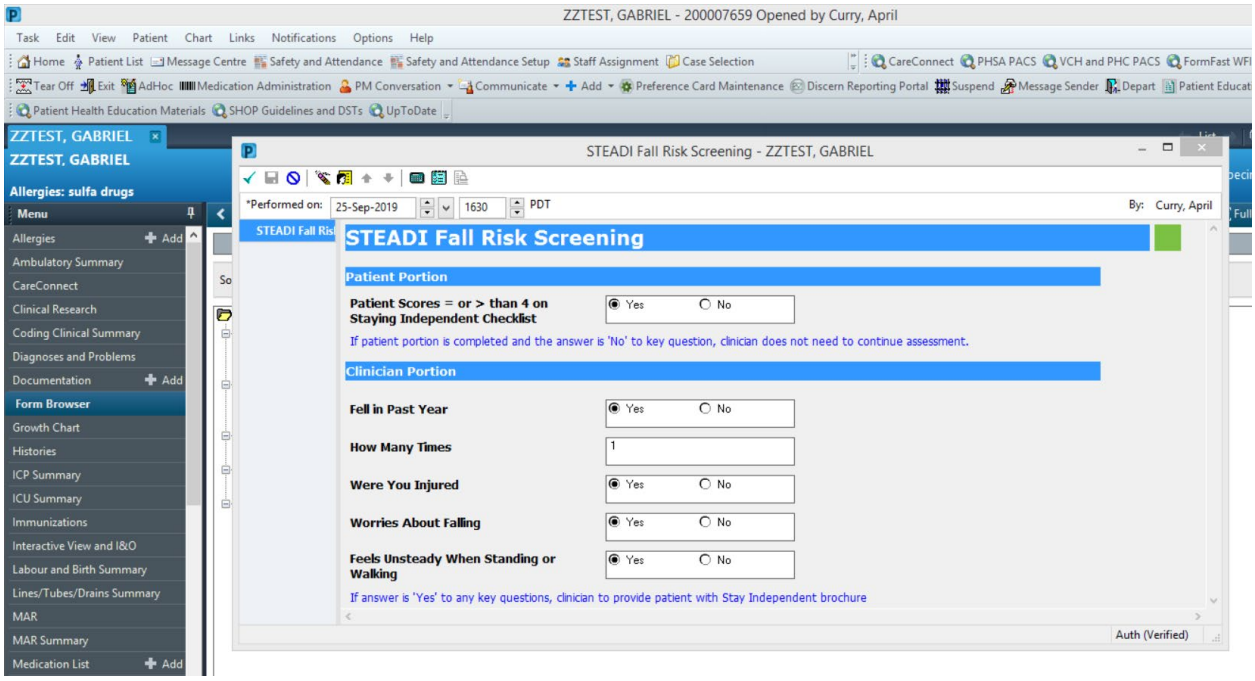
Appendix A

Appendix B Fall Risk Assessment (MORSE and STEADI)

Inpatient Screening



Ambulatory Care Screening: STEADI



NOTE: Patients complete the Staying Independent Checklist (Available on FormFast) to inform this screen

Appendix C Falls Risk Care Plan for Patients

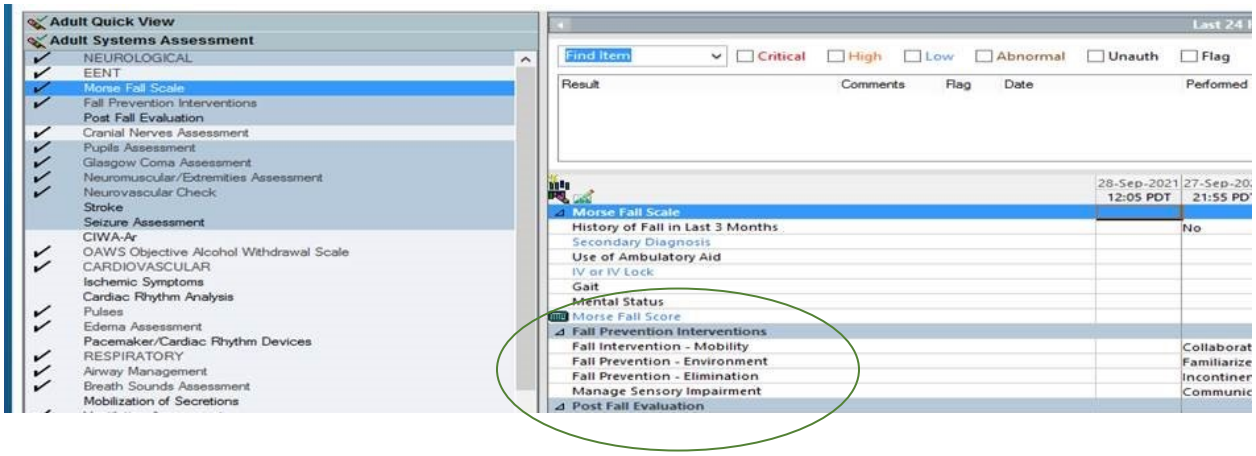
Refer to B-00-10-10002 for full document

- Morse Fall Risk Assessment score 45 or more indicates the patient is at risk for falling
- Universal Fall Prevention Strategies are in place for all patients

Falls Risk – Prevention Interventions (as in Cerner Documentation)			
Mobility	**Environment**	**Elimination**	**Sensory**
☐ Collaborate with OT/PT	☐ Alarms on	☐ Incontinence product(s)	☐ Communication board or device
☐ Encourage handrail /safety bar use	☐ Familiarize with surroundings	☐ Bathroom	☐ Glasses
☐ Encourage personal mobility support item use	☐ Family with patient	☐ Bedpan/urinal	☐ Hearing aids or amplification device
☐ Protective barriers for side rail gaps **use with caution**	☐ Hourly or more frequent monitoring	☐ Toileting at regular intervals	☐ Large print reading materials provided
☐ Mobilize	☐ Traffic path in room free of clutter	☐ Bedside commode	☐ Other
☐ Use gait belt	☐ Sensory aids within reach	☐ Collaborate with continence advisor	
☐ Accompanied ambulation	☐ Personal items within reach	☐ Diapered **Use briefs, only use diapers if all other interventions unsuccessful**	
☐ Non-slip footwear or socks (Red Socks)	☐ Call device within reach	☐ Increased toileting as indicated	
☐ Appropriate pain management	☐ Minimize distractions during ambulation	☐ Supervision with toileting	
☐ Wheels locked for transfers	☐ Move close to the nurses station	☐ Appropriate elimination drainage bag	
☐ Bed at patient knee height (mobile patients)	☐ One to one observation	☐ Other	
☐ Bed in low position (if immobile/high risk of fall)	☐ Keep door open at all times		
☐ Mobility device safety harness	☐ Provide visual cues or reminders		
☐ Developmentally appropriate bed	☐ Fall mat		
☐ Pediatric crib or stretcher side rails up	☐ Adequate room lighting		
☐ Upper or half-length side rails up	☐ Organize lines, tubes and drains		
☐ Lower length side rails down	☐ Other		

PHC Considerations

Cerner Documentation of Fall Prevention Care Planning



Appendix D Quick Mobility Screen

Providence HEALTH CARE
How you want to be treated.

Quick Mobility Screen

If patient unable to perform any step, do not proceed. Refer to physiotherapy.

1. Alternate Hip and Knee Flexion

Can the patient move knees (one at a time) upwards off the bed towards chest without assistance? Indication of range of movement (ROM) and strength of legs.

2. Bridging

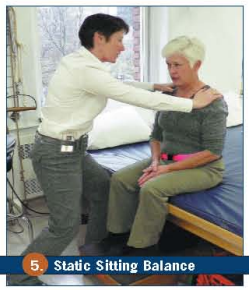
Can the patient lift buttocks off the bed without assistance? Indication of ability to bear weight while standing (strength). **Contraindicated if possible hip/pelvis/lumbar spine fracture.**

3. Rolling

Can the patient bend knees up, reach across body with the uppermost arm and roll over onto one side without assistance?

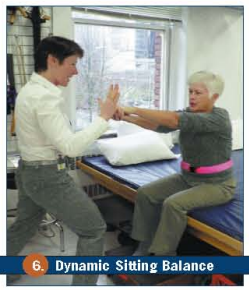
4. Lying - Sitting

Can the patient move from lying to sitting without assistance? If assistance is required do not proceed to standing without obtaining assistance from another team member and/or referring to physiotherapy.



5. Static Sitting Balance

Apply transfer belt for safety. Ensure bed is in its lowest position and patient's feet are flat on the floor. When sitting without back support can the patient keep balance? Can the patient maintain this position if you gently nudge chest? Indicates safety for independent sitting. If the patient cannot maintain balance, do not proceed to standing without obtaining assistance from another team member and/or referring to physiotherapy.



6. Dynamic Sitting Balance

Ensure transfer belt is on. Ensure bed is in its lowest position and patient's feet are flat on the floor. Ask the patient to reach forward to touch your hand. Alternatively, you can ask the patient to try putting on their shoes, but this may be too difficult for some elderly patients. The patient who fails the sitting balance test will likely need 1 or 2 assist to stand up, transfer and ambulate. Do not proceed to standing without obtaining assistance from another team member and/or referring to physiotherapy.

7. Sit to Stand

Ensure transfer belt is on. Ensure bed is in its lowest position and patient's feet are flat on the floor. Place a walker or large heavy chair in front of patient to use for assisting balance if necessary. Can the patient move from sitting to standing without any assistance? Pause in standing – can the patient maintain balance? If the patient cannot maintain balance in stationary standing, do not proceed to walking.

***Mobilization is everyone's responsibility.**

Screening for mobility contributes to safe, early patient ambulation, and protects patients and staff from injury.

8. Static Standing Balance

Ensure transfer belt is on. Place a walker or large heavy chair in front of patient to use for assisting balance if necessary. Can the patient maintain balance if you gently apply pressure to the trunk? Indicates sufficient balance for walking without a walker. Do not proceed to walking if unable do this safely.

9. Dynamic Standing Balance

Ensure transfer belt is on. Can the patient maintain balance if you ask them to reach forward with hands to touch your hand? Do not proceed to walking if unable to do this safely.

10. Walk

Ensure transfer belt is on. Can the patient march on the spot safely? If so, proceed with walking. Use a walker only if the patient reports using a walker at home - use the same type (wheeled or non-wheeled) as the patient uses at home.

Form No. PHC-PM160A (May-07)

Appendix E **Signage For Ambulatory Care Areas (Available from PHEM)**

Appendix F Falls Risk Sign

PHC-PM177 (Oct-15)

Appendix G Intentional/Hourly Rounding

Four Ps for Hourly Rounding/Intentional Rounding	
Pain	How is your pain?
Personal Needs	Do you need to use the toilet?
Proximity	Do you have everything you need close by? (e.g. water, mobility aide, call bell, etc.)
Positioning	Are you comfortable?
Always inform your patient when you will return	

Appendix H **Referral for Fall-Related Outpatient Services**
(Elder Care Ambulatory Clinic – SPH 604-806-8029 or MSJ 604-877-8371/604-877-8181)

Patient Characteristics	Age	**Midlife**	**Well Seniors**	**Frail Seniors – Cognitively Intact**	**Frail Seniors – Cognitive Impairment**
	Cognitive Status		Intact	Intact MMSE greater than 24	Impaired MMSE less than 24
	Morbidities & Comorbidities	Low BMD	High risk for falls/fracture	Atraumatic fracture, complex medical conditions	Falls and complex medical conditions, usually frail with functional impairment
Intake		**Contact Elder Care Ambulatory Clinic at SPH or MSJ**			
Referral	Inpatient	Screening	Screening	Geriatric Emergency Nurse	Geriatric Emergency Nurse
	Outpatient	Screening	GEN	BCWHC OP Clinic	Geriatric Emergency Nurse
	Community	Family Physician	Family Physician, PT, OT	Family Physician	Family Physician
Services	Physician	Endocrinologist	Community based Geriatricians	Geriatricians with expertise in bone health	Geriatricians
		Obstetrician/Gynecology	Dr. Margaret MacGregor		
		Rheumatology	Family Physicians (Dr. Roderick Ma)		
		Nephrology			
		Physiatry			
	Nursing	Nurse with specialized skills			
	Allied Health	Occupational Therapy/Physiotherapy			

			Nutrition Pharmacy				
	Clinic		SPH- Endocrine Clinic		BCWHC Osteoporosis Program	SPH Falls Clinic MSJ Geriatric Ambulatory Clinic	SPH General
			BCWHC Osteoporosis Program		SPH Geriatrics	BCWHC Osteoporosis Program	SPH/MSJ Geriatric Ambulatory Clinic
			BCWHC Endocrine Clinic		VGH STAT Clinic	VGH Falls Clinic	
Focus	Prevention		Primary and Secondary osteoporosis including nutrition strategies		Primary prevention of falls and fractures Primary and Secondary osteoporosis including nutrition strategies	Secondary prevention of falls and fractures	Fall and fracture risk reduction; optimization of function and community supports, placement
	Treatment		Underlying bone disease		Underlying bone disease	Comorbidities	
			Nutritional interventions		Nutritional interventions	Nutritional interventions	
			Pain management (e.g. vertebroplasty)				
	Research		Clinical trials (e.g. bone building pharmaceuticals)		Clinical Trials (KT)	Clinical Trials (KT)	

Appendix I Medications and the Risk of Falling

Medications and the Risk of Falling

Which drugs can increase the risk of falls?

In theory ANY drug that causes one of the following effects can increase the risk of falling:

- Drowsiness
- Dizziness
- Hypotension
- Parkinsonian effects
- Ataxia/gait disturbance
- Vision disturbance

As well, theoretically ANY drug that causes the following effects can increase the risk of a serious outcome if an individual falls:

- Osteoporosis or reduced bone mineral density: Increased risk of fracture if a fall occurs
- Bleeding risk: Increased risk of a cerebral hemorrhage if a fall occurs

What can be done if you are taking a drug that can increase the falls risk?

Individualize treatment. Drugs are just one of many factors that can increase the risk of falling.

Assessment: Are you at high risk?

- ☐ **Have you had a slip, trip, near fall or fall in the last 6 months?**
- ☐ Are you **taking a drug that can cause the effects listed above** (see attached list of drugs)
- ☐ Are you taking a **high dose of the drug?**
- ☐ Are you **displaying any of the adverse effects listed above**, such as drowsiness?
- ☐ Are you over the age of 65? Elderly patients may be more sensitive to adverse drug effects because of alterations in the way that the body absorbs, distributes or eliminates the drug.
- ☐ Are you **taking more than one drug that increases the falls risk**?
- ☐ Are you at **high risk of falling for other, non-drug reasons**?
- ☐ Is it **difficult for you or your doctor to monitor** for an adverse drug effect?

Consider intervention, especially if you have assessed the patient as high risk:

- Consider risk/benefit ratio: Does the benefit of the drug outweigh a possible risk of falling?
- Is there a safer drug or non-drug alternative?
- Is it possible to minimize the dose without losing the benefit of the drug?

Medications and the Risk of Falling

Examples of drugs that can increase the risk of falling, or of a serious outcome if a fall occurs (and possible mechanisms)

ACE Inhibitors (3)
Benazepril
Captopril
Cilazapril
Enalapril/enalaprilat
Fosinopril
Lisinopril
Perindopril
Quinapril
Ramipril
Trandolapril

Alcohol (1,5)

Alpha Receptor Blockers
(2,3, especially initial doses)
Alfuzosin
Doxazosin
Prazosin
Tamsulosin
Terazosin

Anticoagulants (8)
Dalteparin
Danaparoid
Enoxaparin
Heparin
Nadroparin
Nicoumalone
Tinzaparin
Warfarin

Anticonvulsants
(1,2,5,6,7)
Carbamazepine (1,2,6)
Ethosuximide (1,2,5)
Fosphenytoin (1,2,5,7)
Gabapentin (1,2,5,6)
Lamotrigine (1,2,6)
Levetiracetam (1,2,5)
Methsuximide (1,2,5)
Oxcarbazepine (1,2,5,6)
Phenobarbital (1,2)
Phenytoin (1,2,5,7)
Primidone (1,2)
Topiramate (1,2)
Valproic acid (1,2,5)
Vigabatrin (1,2)

Antidepressants (1,2,3,6)
Amitriptyine
Bupropion
Citalopram
Clomipramine
Desipramine
Doxepin
Escitalopram
Fluoxetine
Fluvoxamine
Imipramine
Maprotiline
Mirtazapine
Moclobemide
Nortriptyline
Paroxetine
Phenelzine 1,2,3
Sertraline
Tranylcypromine 2,3
Trazodone
Trimipramine
Venlafaxine

Antihistamines, sedating (1)
Cold Medications that contain sedating antihistamines (1)
Azatadine
Brompheniramine
Cetirizine
Chlorpheniramine
Clemastine
Cyproheptadine
Diphenhydramine
Hydroxyzine
Meclizine
Promethazine
Trimeprazine

Antipsychotics (1,3,4)
Chlorpromazine
Clozapine
Flupenthixol
Fluphenazine
Haloperidol
Loxapine
Methotrimeprazine
Olanzapine
Paliperidone
Perphenazine
Pimozide
Pipotiazine
Prochlorperazine
Quetiapine
Risperidone
Thioproperazine
Thiothixene
Trifluoperazine
Zuclopenthixol

Corticosteroids, oral (7)
Corticosteroids, inhaled, high-dose (7)
Beclomethasone
Betamethasone
Budesonide
Cortisone
Dexamethasone
Fludrocortisone
Fluticasone
Hydrocortisone
Methylprednisolone
Prednisolone
Prednisone
Triamcinolone

Digoxin (mechanism unknown)

Eye drops (6)

Herbal and Natural health products
Natural sleep aids
Natural products for sexual enhancement
(possible adulteration with undeclared drugs)

Metoclopramide (1,2,4)

Muscle Relaxants (1,2)
Baclofen
Carisoprodol
Chlorzoxazone
Cyclobenzaprine
Dantrolene
Methocarbamol
Orphenadrine
Tizanidine

Nitrates (2,3)
Isosorbide dinitrate
Isosorbide mononitrate
Nitroglycerin

NSAIDs
ASA/acetylsalicylic acid (8)

Opiates/narcotics (1,2,3)
Alfentanil
Butorphanol
Codeine
Fentanyl
Hydromorphone
Meperidine
Methadone
Morphine
Oxycodone
Oxymorphone
Nalbuphine
Pentazocine
Propoxyphene
Sufentanil

Proton Pump Inhibitors (9)
Esomeprazole
Lansoprazole
Omeprazole
Pantoprazole
Rabeprazole

Sedative/ hypnotics
Benzodiazepines
Barbiturates (1,2,5)
Alprazolam
Bromazepam
Chloral hydrate
Clorazepate
Diazepam
Diphenhydramine
Doxylamine
Flurazepam
Lorazepam
Midazolam
Nitrazepam
Oxazepam
Pentobarbital
Phenobarbital
Temazepam
Triazolam
Zopiclone

Thiazolidinediones (7)
Pioglitazone
Rosiglit

Possible mechanisms (often unclear): (1) Drowsiness; (2) Dizziness; (3) Hypotension; (4) Parkinsonian effects; (5) Ataxia/gait disturbance; (6) Vision disturbance; (7) Osteoporosis or reduced bone mineral density increases the fracture risk if a fall occurs; (8) Risk of serious bleeding if a fall occurs. Drugs are listed by generic (chemical) name under each drug group. For Brand (manufacturer's) names, check in the CPS to find the generic name. This list includes only those drugs for which there is evidence of increased risk of falls or their consequences. There may be other drugs that increase this risk in certain patients.

Barbara Cadario and BC Falls and Injury Prevention Coalition. Drugs and the Risk of Falling: Guidance Document. Revised August 2011.