

## Care homes - Medication and falls

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.<sup>1</sup>

The impact of falls may include:

- Fractures of the hip, femur, humerus, wrist and rib
- Soft tissue injuries
- Haematoma
- Transient confusion
- Social/psychological consequences (loss of independence, loss of confidence, limited social and physical activity)
- Sudden ageing
- Hospitalisation and immobilisation
- Disability
- Death.

This resource pack has been produced to raise awareness amongst healthcare professionals of the medicines that can increase the risk of falls in older people. The aim is that they are taken into consideration when conducting medication reviews and also when deciding whether to initiate medicines if the patient is a known faller or at risk of falls.

The information is divided into:

- A medicines and falls risk classification document and key information sheet for GPs (attachments 1& 2).
- An information sheet for care home staff (attachment 3).
- A falls risk questionnaire which is intended to gather valuable information that should be shared with a healthcare professional with appropriate skills and experience in falls risk assessment. It can be adapted to reflect the local referral process (attachment 4).

### Points to note

- Falls are multifactorial and a fall should not be looked at in isolation.
- All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.
- Falls assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service.

## How medicines can cause falls

In theory any medicine that causes one of the following effects can increase the risk of falling.



**Sedation, drowsiness**



**Impaired postural stability**



**Hypoglycaemia**



**Hypothermia**



**Confusion**



**Dehydration**



**Vestibular damage (tinnitus, deafness)**



**Visual impairment (blurred vision, dry eyes)**



**Orthostatic hypotension**



**Drug induced Parkinsonism**

There are two classes of drugs that have the highest propensity to cause falls, those acting on the brain and those acting on the heart and circulation.

### Drugs acting on the brain (psychotropic drugs)

There is good evidence that stopping psychotropic drugs can reduce falls.<sup>2</sup>

Taking a psychotropic medicine approximately doubles the risk of falling. There is no data on the effect of taking two or more psychotropic medicines at the same time.<sup>3</sup>

Sedatives, antipsychotics and sedating antidepressants cause drowsiness and slow reaction times. Some antidepressants and antipsychotics also cause orthostatic hypotension.

### Drugs acting on the heart and circulation

Maintaining consciousness and an upright posture requires adequate blood flow to the brain. This requires an adequate pulse and blood pressure. In older people a systolic blood pressure of 110mmHg or below is associated with an increased risk of falls. Any drug that reduces the blood pressure or slows the heart can cause falls (or feeling faint or loss of consciousness or “legs giving way”).<sup>4</sup> In some patients the cause is clear – they may be hypotensive, or have a systolic drop on standing. Others may have a normal blood pressure lying and standing, but have syncope or pre-syncope from carotid sinus hypersensitivity or vasovagal syndrome. Stopping cardiovascular medication reduces syncope and falls by 50%, and reduces the prevalence of these four syndromes.<sup>5,6</sup>

**Falls may be due to recent medication changes, but are usually caused by medicines that have been given for a long time without appropriate review. Attachment 1 is a falls risk classification document which grades psychotropic drugs and drugs acting on the circulation according to their effects on falls risk. it can be used by GPs and pharmacists to support medication review.**

## References

1. Falls: assessment and prevention of falls in older people. NICE Clinical Guideline 161. June 2013. Available at <http://www.nice.org.uk/Guidance/CG161>.
2. Campbell AJ, Robertson MC, Gardner MM, et al. Psychotropic medication withdrawal and a home-based exercise program to prevent falls: a randomized, controlled trial. *J Am Geriatr Soc* 1999; 47: 850–3.
3. Darowski A, Chambers SCF and Chambers DJ. Antidepressants and falls. *Drugs and Aging* 2009; 26 (5): 381-394.

4. Darowski A and Whiting R. Cardiovascular drugs and falls. Reviews in Clinical Gerontology 2011; 21 (2): 170-179.
5. Van der Velde N, van den Meiracker AH, Pols HA, et al.. Withdrawal of fall-risk-increasing drugs in older persons: effect on tilt-table test outcomes. J Am Geriatr Soc 2007;55: 734–739.
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## Additional PrescQIPP resources



Risk classification guide, guide to medication and falls for GPS/care home staff, falls risk questionnaire

Available here: <http://www.prescqipp.info/resources/viewcategory/307-care-homes-medication-and-falls>

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**Contact [help@prescqipp.info](mailto:help@prescqipp.info) with any queries or comments related to the content of this document.**

This document represents the view of PrescQIPP CIC at the time of publication, which was arrived at after careful consideration of the referenced evidence, and in accordance with PrescQIPP's quality assurance framework.

The use and application of this guidance does not override the individual responsibility of health and social care professionals to make decisions appropriate to local need and the circumstances of individual patients (in consultation with the patient and/or guardian or carer). [Terms and conditions](#)

## Attachment 1: Medication and falls risk classification guide

The tables below have been adapted from the Medicines and Falls in hospital: Guidance Sheet produced by John Radcliffe Hospital, Oxford, March 2011.

This is available as a separate document (attachment 1). Visit:

<http://www.prescqiip.info/resources/viewcategory/307-care-homes-medication-and-falls>

### Drugs acting on the brain (psychotropic drugs)

HIGH RISK OF FALLS EITHER ALONE OR IN COMBINATION		
MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Sedatives: Benzodiazepines	Temazepam, nitrazepam, diazepam, lorazepam, clonazepam, flurazepam, lorazepam, oxazepam, clonazepam	<ul style="list-style-type: none"> <li>• Drowsiness, slow reactions, impaired balance.</li> <li>• Caution in patients who have been taking them long term.</li> </ul>
Sedatives: "Zs"	Zopiclone, zolpidem	<ul style="list-style-type: none"> <li>• Drowsiness, slow reactions, impaired balance.</li> </ul>
Sedating antidepressants (tricyclics and related drugs)	Amitriptyline, dosulepin, imipramine, doxepin, clomipramine, lofepramine, nortriptyline, trimipramine, mirtazapine, mianserin, trazodone	<ul style="list-style-type: none"> <li>• All have some alpha blocking activity and can cause orthostatic hypotension.</li> <li>• Antidepressants can cause drowsiness, impaired balance and slow reaction times.</li> <li>• Doubles the rate of falling.</li> </ul>
Monoamine oxidase inhibitors (MAOIs)	Phenelzine, isocarboxazid, tranylcypromine	<ul style="list-style-type: none"> <li>• MAOIs are now rarely used; all (except moclobemide) cause severe orthostatic hypotension.</li> </ul>
Drugs for psychosis and agitation	Chlorpromazine, haloperidol, fluphenazine, risperidone, quetiapine, olanzapine	<ul style="list-style-type: none"> <li>• All have some alpha - receptor blocking activity and can cause orthostatic hypotension.</li> <li>• Sedation, slow reflexes, loss of balance.</li> </ul>
Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants	Venlafaxine, duloxetine	<ul style="list-style-type: none"> <li>• As for selective serotonin reuptake inhibitor (SSRI) antidepressants (see table on page 5) but also commonly cause orthostatic hypotension (through noradrenaline re-uptake blockade).</li> </ul>
Opiate analgesics	All opiate and related analgesics, e.g. codeine, morphine, tramadol	<ul style="list-style-type: none"> <li>• Sedation, slow reactions, impair balance, cause delirium.</li> </ul>
Anti-epileptics	Phenytoin	<ul style="list-style-type: none"> <li>• Phenytoin may cause permanent cerebellar damage and unsteadiness in long term use at therapeutic dose.</li> <li>• Excess blood levels cause unsteadiness and ataxia.</li> </ul>
	Carbamazepine, phenobarbitone	<ul style="list-style-type: none"> <li>• Sedation, slow reactions. Excess blood levels cause unsteadiness and ataxia.</li> </ul>
Parkinson's disease (PD): Dopamine agonists	Ropinirole, pramipexole	<ul style="list-style-type: none"> <li>• May cause delirium and orthostatic hypotension.</li> </ul>

## HIGH RISK OF FALLS EITHER ALONE OR IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Parkinson's disease (PD): MAOI-B inhibitors	Selegiline	<ul style="list-style-type: none"> <li>Causes orthostatic hypotension. The subject of drugs and falls in PD is difficult, as falls are so common, and orthostatic hypotension is part of the disease. In general only definite drug related orthostatic hypotension would lead to a change in medication.</li> </ul>

## MEDIUM RISK OF FALLS ESPECIALLY IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Selective serotonin reuptake inhibitor (SSRI) antidepressants	Sertraline, citalopram, paroxetine, fluoxetine	<ul style="list-style-type: none"> <li>Cause falls as much as other antidepressants in population studies.</li> <li>Several population studies have shown that SSRIs are consistently associated with an increased rate of falls and fractures, but there are no prospective trials. The mechanism of such an effect is unknown. They cause orthostatic hypotension and bradycardia only rarely as an idiosyncratic side effect. They do not normally sedate. They impair sleep quality.</li> </ul>
Muscle relaxants	Baclofen, dantrolene	<ul style="list-style-type: none"> <li>Sedative. Reduced muscle tone. No falls data on muscle relaxants. Tend to be used in conditions associated with falls.</li> </ul>
Anti-epileptics	Sodium valproate, gabapentin	<ul style="list-style-type: none"> <li>Some data on falls association.</li> </ul>

## POSSIBLE RISK OF FALLS PARTICULARLY IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Anti-epileptics	Lamotrigine, pregabalin, levetiracetam, topiramate	<ul style="list-style-type: none"> <li>Insufficient data to know if these newer agents cause falls.</li> </ul>
Vestibular sedatives Phenothiazines	Prochlorperazine	<ul style="list-style-type: none"> <li>Dopamine antagonist – may cause movement disorder in long term use. Also acts as an alpha receptor blocker and antihistamine.</li> </ul>
Vestibular sedatives Antihistamines	Cinnarazine, betahistine	<ul style="list-style-type: none"> <li>Sedating. No evidence of benefit in long term use.</li> </ul>

## POSSIBLE RISK OF FALLS PARTICULARLY IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Sedating antihistamines for allergy	Chlorphenamine, hydroxyzine, promethazine, trimeprazine	<ul style="list-style-type: none"> <li>No data, but sedation likely to contribute to falls. Long half-lives.</li> </ul>
Anticholinergics acting on the bladder	Oxybutinin, tolterodine, solifenacin	<ul style="list-style-type: none"> <li>No data, but have known Central Nervous System (CNS) effects.</li> </ul>

### Drugs acting on the heart and circulation

## HIGH RISK OF FALLS EITHER ALONE OR IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Alpha receptor blockers	Doxazosin, indoramin, prazosin, tamsulosin, terazosin, alfuzosin	<ul style="list-style-type: none"> <li>Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.</li> </ul>
	Sedating antidepressants	<ul style="list-style-type: none"> <li>See 'sedating antidepressants' in the 'drugs acting on the brain' table (page 4).</li> <li>Orthostatic hypotension.</li> </ul>
	Drugs for psychosis and agitation	<ul style="list-style-type: none"> <li>See 'drugs for psychosis and agitation' in the 'drugs acting on the brain' table (page 4).</li> <li>Orthostatic hypotension.</li> </ul>
Centrally acting alpha 2 receptor agonists	Clonidine, moxonidine	<ul style="list-style-type: none"> <li>May cause severe orthostatic hypotension.</li> <li>Sedating.</li> </ul>
Thiazide diuretics	Bendroflumethiazide, chlorthalidone, metolazone	<ul style="list-style-type: none"> <li>Cause orthostatic hypotension, weakness (muscle and general) due to low potassium.</li> <li>Hyponatraemia.</li> </ul>
Angiotensin converting enzyme inhibitors (ACEIs)	Lisinopril, ramipril, enalapril, captopril, perindopril	<ul style="list-style-type: none"> <li>These drugs rely almost entirely on the kidney for their elimination and can accumulate in dehydration or renal failure.</li> </ul>
	Fosinopril, trandolapril, quinapril	<ul style="list-style-type: none"> <li>Excreted by liver and kidney.</li> </ul>

## HIGH RISK OF FALLS EITHER ALONE OR IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Beta blockers	Atenolol, sotalol (renally excreted, may accumulate)	<ul style="list-style-type: none"> <li>• Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.</li> </ul>
	Bisoprolol, metoprolol, propranolol, carvedilol, timolol eye drops	<ul style="list-style-type: none"> <li>• Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.</li> </ul>
Antianginals	Glyceryl trinitrate (GTN)	<ul style="list-style-type: none"> <li>• A common cause of syncope due to sudden drop in blood pressure.</li> </ul>
	Isosorbide mononitrate, nicorandil	<ul style="list-style-type: none"> <li>• Cause hypotension and paroxysmal hypotension.</li> </ul>

## MEDIUM RISK OF FALLS ESPECIALLY IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Loop diuretics	Furosemide, bumetanide	<ul style="list-style-type: none"> <li>• Dehydration causes hypotension. Low potassium (which can cause fainting and general weakness) and low sodium (which can cause sluggishness and confusion).</li> </ul>
Angiotensin receptor blockers (ARBs)	Losartan, candesartan, valsartan, irbesartan, olmesartan, telmisartan, eprosartan	<ul style="list-style-type: none"> <li>• May cause less orthostatic hypotension than ACEIs.</li> <li>• Excreted by liver and kidney.</li> </ul>
Calcium channel blockers that only reduce blood pressure	Amlodipine, felodipine, nifedipine, lercanidipine	<ul style="list-style-type: none"> <li>• Cause hypotension and paroxysmal hypotension.</li> </ul>
Calcium channel blockers which slow the pulse and reduce blood pressure	Diltiazem, verapamil	<ul style="list-style-type: none"> <li>• May cause hypotension or bradycardia.</li> </ul>
Other antidysrhythmics	Digoxin, amiodarone, flecainide	<ul style="list-style-type: none"> <li>• May cause bradycardia and other arrhythmias.</li> <li>• Data on digoxin and falls probably spurious due to confounding by indication.</li> </ul>

## POSSIBLE RISK OF FALLS PARTICULARLY IN COMBINATION

MEDICATION GROUP	COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Acetylcholinesterase inhibitors (for dementia)	Donepezil, rivastigmine, galantamine	<ul style="list-style-type: none"> <li>• Cause symptomatic bradycardia and syncope.</li> </ul>

### Note

The list is not meant to be fully comprehensive but intended to raise awareness of the types of drugs that can contribute to falls. There may be other drugs that increase the risk of falls in certain patients.



## Attachment 2: Key information for GPs

This is available as a separate document. Visit:

<http://www.prescgipp.info/resources/viewcategory/307-care-homes-medication-and-falls>

### Medication review: Reducing the risk of falls

In patients taking medicines known to contribute to falls, medication review can play an important part in falls prevention. The aim of the review should be to modify or withdraw the drug, if this is not possible, close monitoring is required.

#### Key points

- Patients who have fallen are at high risk for a repeat fall. The mortality risk from a fall at age 85 is about 1% per fall.<sup>1</sup>
- Older people (≥ 65 years of age) have altered pharmacokinetics and may be more “sensitive” to medications.
- Renal function impairment may result in accumulation of medication and increased risk of adverse reactions.
- Patients taking ≥ 4 prescription drugs, regardless of pharmacologic classification, are at an increased risk for falls.<sup>2</sup>
- There are two classes of drugs that have the highest propensity to cause falls, those acting on the brain and those acting on the heart and circulation. See attachment 1 for more information on individual drugs.
- Orthostatic hypotension is often caused by medication and leads to falls in older adults.<sup>3</sup>
- 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, e.g. long term use of steroids: Increased risk of fracture if a fall occurs.
  - » Bleeding risk e.g. anticoagulants: Increased risk of a cerebral haemorrhage if a fall occurs.

#### Symptomatic hypotension in systolic cardiac failure<sup>2</sup>

- Liaise with the consultant for patients with symptomatic hypotension in systolic cardiac failure and review all medicines the patient is taking.
- ACEIs and beta blocker have a survival benefit in systolic cardiac failure and should be maintained whenever possible.
- Most cardiac failure in older people is diastolic (preserved left ventricular function). ACEIs and beta blockers have little survival benefit in diastolic failure.

#### Key actions

- 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?
- To screen for postural hypotension lying and standing blood pressures should be performed. (Remember to keep the instrument at the level of the patient’s heart both when they are lying and when they are standing). Orthostatic hypotension is defined as a drop in BP (usually >20/10 mm

Hg) within three minutes of standing.<sup>4</sup>

- Symptomatic orthostatic hypotension can be reversed by non-pharmacological interventions. These include advice on avoiding:<sup>3</sup>
  - » Sudden head-up postural change (especially first thing in the morning)
  - » Hunger
  - » Dehydration
  - » Excessive heat
  - » Large meals especially with alcohol
  - » Straining (when passing stool)

The use of compression hosiery to increase venous return is an option for low blood pressure (in the absence of any signs of arterial disease, e.g. intermittent claudication).

If non-pharmacological interventions fail, pharmacological interventions may be required. These include use of blood pressure elevating drugs such as fludrocortisone, corrective measures such as use of slow sodium 2g-10g/day or laxatives to prevent straining.

## REMEMBER

Medicines are just one of many factors that can increase the risk of falling. Others include:

- Motor problems
- Physical problems
- Environmental problems
- Cognitive problems
- Behavioural problems
- Cardiovascular problems
- Neurological problems.

## References

1. Darowski A, et al. Medicines and Falls in hospital: Guidance Sheet produced by John Radcliffe Hospital, Oxford, March 2011.
2. Freeland KN, Thompson AN et al. Medication Use and Associated Risk of Falling in a Geriatric Outpatient Population. *The Annals of Pharmacotherapy* 2012; 46 (9):1188-1192. Available at [http://www.medscape.com/viewarticle/770401\\_4](http://www.medscape.com/viewarticle/770401_4)
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[http://www.eaneurology.org/fileadmin/user\\_upload/guidline\\_papers/EFNS\\_guideline\\_2011\\_Orthostatic\\_hypotension.pdf](http://www.eaneurology.org/fileadmin/user_upload/guidline_papers/EFNS_guideline_2011_Orthostatic_hypotension.pdf)

## Attachment 3: Key information for care home staff

This is available as a separate document. Visit:

<http://www.prescgipp.info/resources/viewcategory/307-care-homes-medication-and-falls>

### Medication and falls: Key information for care home staff

In patients taking medicines known to contribute to falls, medication review can play an important part in falls prevention. The aim of the review should be to modify or withdraw the drug, if this is not possible close monitoring is required.

#### Key points

- Residents who have fallen are at high risk for a repeat fall. The mortality risk from a fall at age 85 is about 1% per fall.<sup>1</sup>
- Older people ( $\geq 65$  years of age) may be more “sensitive” to medications.
- Residents taking  $\geq 4$  prescription drugs, regardless of type of drug, are at an increased risk for falls.<sup>2</sup>
- Falls may be due to recent medication changes, but are usually caused by medicines that have been given for a long time without appropriate review
- Orthostatic hypotension (sudden drop in blood pressure when they move from a lying down or sitting position to sitting or standing) is often caused by medication and leads to falls in older adults.<sup>3</sup>
- Residents at high risk of falling (e.g. with recurrent, unexplained or injurious falls) should be considered for specialist referral and multidisciplinary intervention.

**In theory any medicine that causes one of the following effects can increase the risk of falling**



**Sedation, drowsiness**



**Impaired postural stability**



**Hypoglycaemia**



**Hypothermia**



**Confusion**



**Dehydration**



**Vestibular damage (tinnitus, deafness)**



**Visual impairment (blurred vision, dry eyes)**



**Orthostatic hypotension**



**Drug induced Parkinsonism**

#### Remember

The more risk factors a resident has, the more likely they are to fall. Medication is only one risk factor; others include:

- Motor problems
- Physical problems, e.g. not using mobility aids correctly
- Environmental problems, e.g. poor footwear
- Cognitive problems, e.g. poor memory resulting in trying to walk unaided

- Behavioural problems
- Cardiovascular problems
- Neurological problems.

## Key actions

- Prompt medication review for any resident who has an acute fall, to identify and review any medicines that may be contributing to their risk of falls.
- If there are any changes to a resident's mobility, balance, coordination or alertness inform the GP as this increases their risk of falls.
- To avoid orthostatic hypotension encourage the resident to:<sup>3</sup>
  - » Avoid sudden postural change, especially when getting up in the morning.
  - » Increase their non-caffeinated fluid intake to > 2 litres a day (about 3 litres if they weigh more than 75kg) where appropriate, some residents may be on a fluid restricted diet.
  - » Eat several small meals a day.
  - » Drink caffeine on rising and after meals.
  - » Lie propped up at night with a head up tilt of 15° – 20° (pillow height 20cm - 30cm).

## References

1. Darowski A, et al. Medicines and Falls in hospital: Guidance Sheet produced by John Radcliffe Hospital, Oxford, March 2011.
2. Freeland KN, Thompson AN et al. Medication Use and Associated Risk of Falling in a Geriatric Outpatient Population. The Annals of Pharmacotherapy 2012; 46 (9):1188-1192. Available at [http://www.medscape.com/viewarticle/770401\\_4](http://www.medscape.com/viewarticle/770401_4)
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## Attachment 4: Falls risk questionnaire

This is available as an adaptable Word document, attachment 4. Visit:

<http://www.prescipp.info/resources/viewcategory/307-care-homes-medication-and-falls>

### FALLS RISK QUESTIONNAIRE

The questions below are intended to gather valuable information that should be shared with a healthcare professional with appropriate skills and experience in falls risk assessment.

<b>Name of resident</b>	
<b>Date of birth</b>	
<b>Care home</b>	
<b>Name of person completing form</b>	
<b>Date form completed</b>	

<b>Has the resident had a fall in the last year?</b>	<b>Yes</b>		<b>No</b>	
<b>If yes, how many times?</b>				
<b>Has this impacted on their mobility or daily activities?</b>	<b>Yes</b>		<b>No</b>	
<b>Does the resident have any difficulties with mobility or impaired balance?</b>	<b>Yes</b>		<b>No</b>	
<b>Does the resident have a fear of falling?</b>	<b>Yes</b>		<b>No</b>	
<b>Does the resident have any visual problems?</b>	<b>Yes</b>		<b>No</b>	
<b>Is the resident cognitively impaired?</b>	<b>Yes</b>		<b>No</b>	
<b>Does the resident have behavioural problems?</b>	<b>Yes</b>		<b>No</b>	
<b>Does the resident have any health problems that can increase their risk of falling*?</b>	<b>Yes</b>		<b>No</b>	
<b>If yes, please list the health problems</b>				
<b>Please list all the medicines the resident is currently prescribed, both regular and when required (it would be useful to provide a copy of their MAR chart).</b>				

\* Health problems such as orthostatic hypotension (sudden drop in blood pressure when they move from a lying down or sitting position to sitting or standing), Parkinson's disease, diabetes.