

# Conquering the Occurrence of Falls in the Ambulatory Setting

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## Introduction

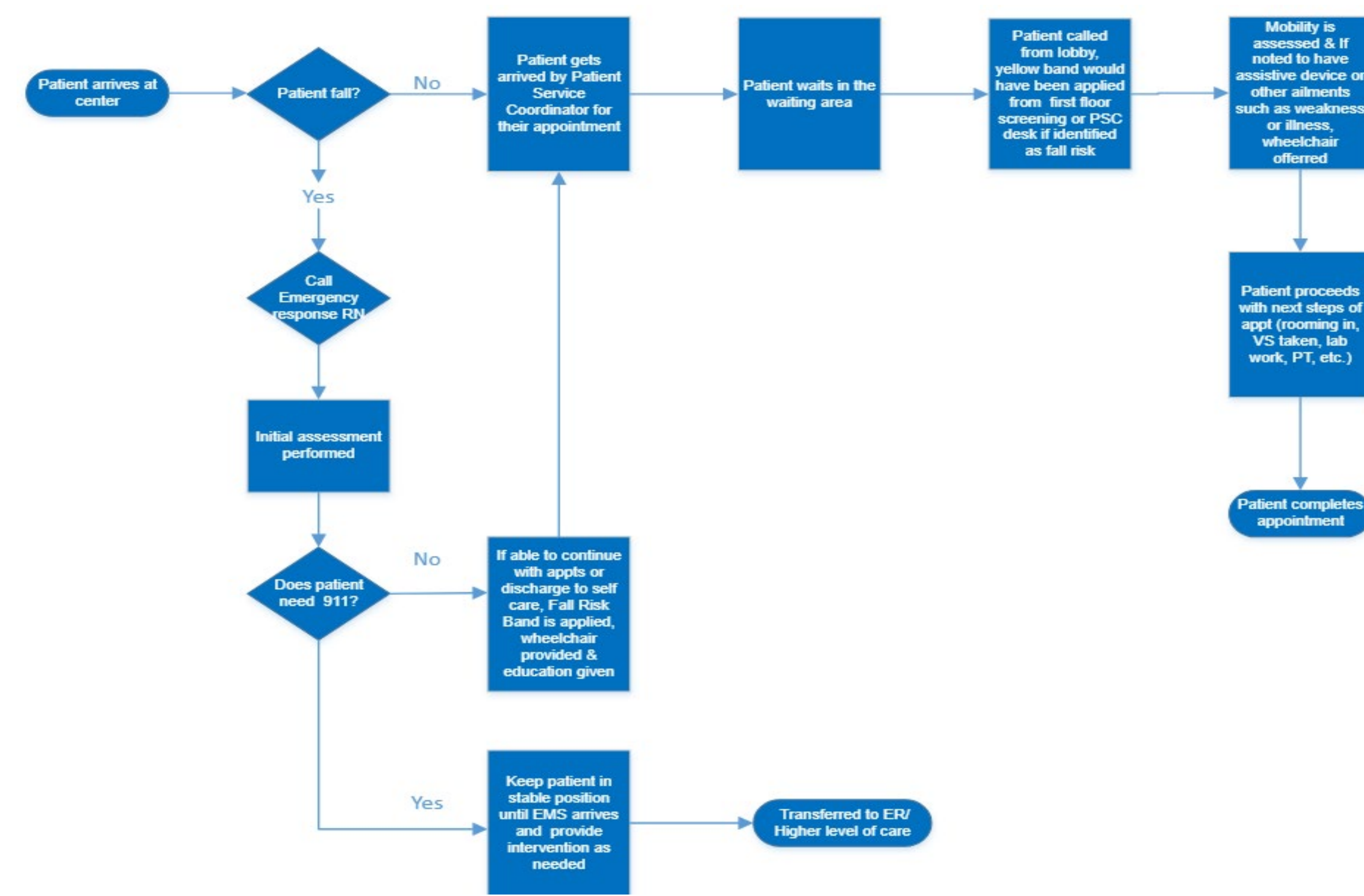
Patient fall events are a persistent and costly safety concern in both inpatient and outpatient healthcare settings. As ambulatory services expand and patient care complexity increases, all ambulatory staff must proactively develop and implement evidence-based solutions to address fall prevention opportunities in these settings.

## AIM

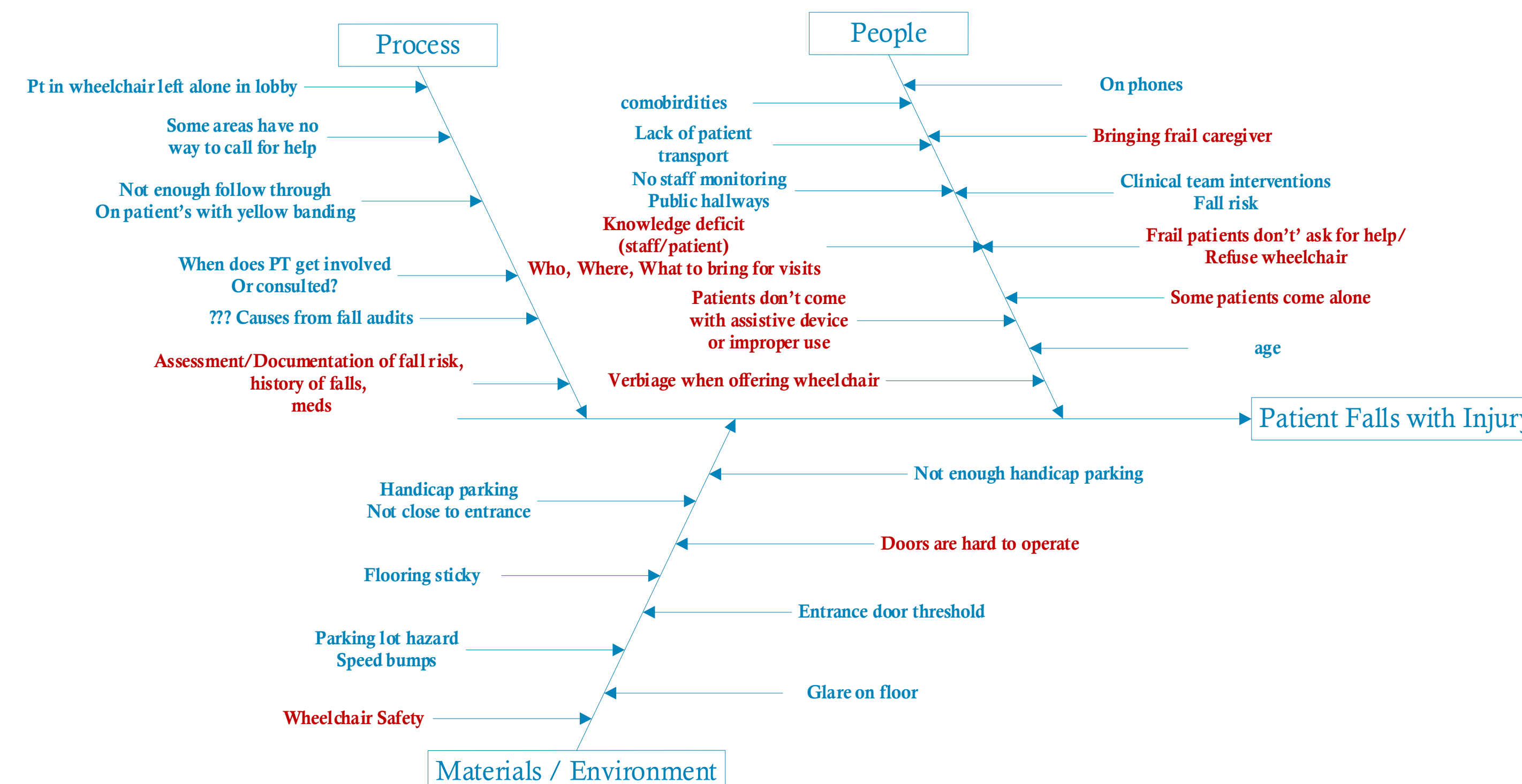
The ambulatory center recorded a higher-than-expected fall rate. The primary objective of this project was to reduce fall incidents by 30% over a 12-month period.

## Baseline Data

MD Anderson The Woodlands observed patient fall events in the ambulatory setting with many resulting in minimal to moderate injuries. This highlighted the importance of efforts to reduce fall events, ensuring patient safety and alignment to NDNQI benchmarks. The initial focus was to implement preventive measures, such as staff education and training, fall risk assessments, patient education, and environmental modifications, to further decrease the risk and severity of fall events in the future.



**Decrease Fall with Injury by 30%**



## Plan

Through process and factor analysis, a bundle of interventions would be implemented to prevent fall events. Our focus group researched evidence-based support for the action plan. The following interventions emerged:

- Patient Ambassador staff at building entry to observe patient mobility and initiate fall prevention strategies with patient transportation services and wheelchair safety education
- Fall Prevention Committee to provide both patient and staff education events.
- Interdepartmental collaboration through open communication and feedback to identify high interventions needed.
- Leveraged electronic health systems for fall risk documentation and initiated interventions. Added automated appointment reminders built into system for reminders about mobility devices.

## Do (Implementation)

The focus group measured fall events as reported through our safety event reporting website. The following interventions were utilized to meet success:

1. Environment Assessment  
Reviewed safety events and collaborated with all departments regarding fall prevention strategies.
2. Communication and Feedback  
Frequent meetings and communications for momentum and feedback regarding the project to all stakeholders.
3. Education/Training
  - Patient ambassador staff training for quick look at patient mobility, application of fall risk wristbands, and patient wheelchair safety
  - Utilization of The Woodlands Fall Prevention Committee for onsite patient and staff education
  - Improved detailed documentation of safety events
4. Electronic Health Record  
Collaboration with strategic communication teams to configure portal notifications reminding patients to bring mobility aids to appointments.
5. Patient Transportation Services  
The implantation of patient transportation services at MD Anderson The Woodlands further reduced fall risk.

## Study (Results)

Following a year of strategic planning and the implementation of targeted fall prevention protocols, the focus group realized a significant and sustained reduction in patient falls. This initiative successfully met its primary objectives, demonstrating that specialized strategies in an ambulatory oncology setting directly enhance patient safety and the overall care experience. The results highlight a multi-faceted benefit: improved clinical stewardship, a reduction in financial burden associated with fall-related complications, and a decrease reliance on community emergency resources. Ultimately, these findings validate the effectiveness of a proactive, coordinated approach to patient mobility.

## Act (Maintain Improvement)

The fall prevention strategies have been implemented starting with staff training and environmental adjustments. Ongoing monitoring includes review of safety events to sustain improvements. Routine patient fall risk assessments and interventions will support success. Strategies shared through the institutional Fall Prevention Committee and implemented at other MD Anderson locations to enhance safety across sites. Future strategies include enhancing environmental factors like installation of automatic doors in high-volume patient areas. Sustainable practices, such as continuous staff education and regular reassessments, will ensure long-term effectiveness. All strategies will ultimately reduce fall events and improve patient care system-wide.

## References

1. Hammontree, S., Potts, M., Neiberger, A., Olds, D., English, D., & Myers, J. S. (2023, August 24). *Outpatient Oncology Fall Risk: A Quality Improvement Project*. The University of Kansas Health System
2. Saberi, N., Darvishpoor Kakhka, A., Ilkhani, M., & Khan, H. T. A. (2022). Falls in older ambulatory care patients with cancer in Iran: Implications for clinical practice. *Journal of Evaluation in Clinical Practice*, 28, 624–630.
3. Schoberer, D., Breimaier, H. E., Zuschnegg, J., Finding, T., Schaffer, S., & Archan, T. (2022). Clinical practice guideline. *Worldviews on Evidence-Based Nursing*, 19, 86–93.
4. Vaishya, R., & Vaish, A. (2020). Falls in Older Adults are Serious. *Indian Journal of Orthopaedics*, 54, 69–74.

ASPAN 2026  
45<sup>th</sup> National Conference  
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