BMAT: FAQs

1: How often is the RN required to do the BMAT?
A: Should be completed and documented in MC with admission assessment, every shift, upon transfer.

2: Is it ok to perform BMAT from chair if patient already up?
A: YES—if patient maintaining balance in chair, start with handshake and go from there.

3: If patient uses a cane or walker, can they use for the assessment?
A: YES, please have this equipment at bedside to insure safety.

4: What is best way to tell patient what I am going to do?
A: Script—Now I am going to assess your mobility level to determine how much assistance you will need when ambulating and equipment I will need to use so we can keep you safe.

5: Where can I find SPHM technology in my area?
A: There is a designated location for every unit/department. The Duke MOVES Champion/Coaches can tell you the specific equipment on your unit/department and location.

6: Who is responsible for marking Mobility/Fall sign?
A: The RN performing the assessment each shift must insure that the correct BMAT score is circled and YES or NO for fall risk is circled. It is discharging nurse’s responsibility to erase.

7: Why do we need to place signage outside room?
A: The Mobility score communicates much needed info to ALL. Knowing the patient’s mobility level is often needed prior to entering the room—as leaders round, as staff care for unfamiliar pts during coworker’s break, as staff answer call lights, and as ancillary departments participate in care. Knowing the level allows staff to enter the room prepared to care for patient, resulting in efficiency, improved response time, and consistent use of SPHM technology.

8: What if patient has ability to stand or walk but needs assistance to get to a sitting position?
A: There are some conditions, i.e., sternotomy, abdominal surgery with large incision, orthopedic conditions that precludes the patient from coming to a sitting position temporarily (or until recovered and is not a permanent impairment) or requires additional support of an affected extremity to get to the edge of bed. Staff may need to use a blue liner, sling, or lift to help patient move self to seated position on edge of bed. Refer to tips below for performing Level 1 Assessment.
Assessment Level One- Sit and Shake

The purpose of the assessment level one is to test the patient’s ability to come to a sitting position and their sitting balance. If your patient is unable to achieve a sitting position independently and you desire to continue the assessment, the options below will safely assist the patient to an edge of bed sitting position.

**OPTION 1- EDGE OF BED**

Utilize the ceiling lift or floor based total lift and sling. Secure the sling to the sling bar and lift the patient to a bedside sitting position, at the edge of bed as seen here.

Once the patient is positioned safely at the edge of bed, lower the tension on the lift and if the patient is able to maintain sitting, proceed with the assessment.

**OPTION 2- EDGE OF BED**

If available, utilize the full chair feature on the bed. Remove the footboard and ensure that foot of the bed is touching the floor.

Encourage patient to move to the edge of the bed and assess his ability to support himself in a sitting position, proceed with assessment.

*Continue the next levels of the BMAT to determine patient’s mobility level.*