# Adult Bedside Mobility Assessment Tool (BMAT) for Nurses

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<th>ASSESSMENT</th>
<th>TEST</th>
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<td>Safety Screen Assessment:</td>
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<td><strong>FAIL</strong></td>
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<tr>
<td>M: Myocardial</td>
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<td>• Initiate falls bundle, if indicated</td>
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<td>O: Oxygenation</td>
<td></td>
<td>• Use equipment for repositioning in bed</td>
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<tr>
<td>V: Vasoactive</td>
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<td>• ROM exercises, minimum 5 repetitions</td>
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<td>E: Engaged</td>
<td></td>
<td><strong>PASS</strong></td>
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<td>S: Special Considerations</td>
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<td>Continue with Sit and Shake Assessment</td>
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| Sit and Shake Assessment (trunk strength and seated balance) |           | **FAIL** | Mobility Level 1 – Bedfast/Dependent |
|                                                             | Instructions: (Obtain necessary assistive device, cane or walker.) |         | • Initiate falls bundle, if indicated |
|                                                             | 1. From a semi-reclined position, ask patient to sit at the side of the bed. May use bed rail. |         | • ICU: consider PT/OT consult for RASS score -2 to +2 |
|                                                             | 2. Note patient’s ability to sit for > 2 minutes without caregiver assistance. |         | • Use equipment for repositioning in bed |
|                                                             | 3. Ask patient to reach out and grab your hand and shake making sure patient reaches across midline. |         | • Use chair position in bed or sit in chair for meals and/or ADLs |
|                                                             | **PASS** |         | Use equipment for transfers OOB |
|                                                             |         |         | Initiate Level 1 ROM exercises* |
|                                                             |         |         | **FAIL** | Mobility Level 2 - Chairfast |
|                                                             | Continue to Sit and Shake Assessment | Mobility Level 2 - Chairfast | Implement Level 2 activities as above |

| Stretch and Point Assessment (lower extremity strength and stability) |           | **FAIL** | Mobility Level 3 – Stand |
|                                                                      | Instructions: |         | • Initiate falls bundle |
|                                                                      | 1. With patient seated, have patient place both feet on floor with knees no higher than hips. |         | • Sit on the edge of the bed or chair for meals and/or ADLs |
|                                                                      | 2. Ask patient to stretch one leg and straighten knee, then bend the ankle/flex and point toes. If appropriate, repeat with other leg. May test with only one leg (e.g. ankle cast, stroke). |         | • Use equipment for transfers OOB |
|                                                                      | **PASS** |         | • Initiate Level 3 ROM exercises* |
|                                                                      |         |         | Continue to Stand Assessment |

| Stand Assessment (lower extremity strength for standing) |           | **FAIL** | Mobility Level 3 – Stand |
|                                                           | Instructions: (Consider patient’s cognitive ability, orientation, & presence of delirium.) |         | • Initiate falls bundle |
|                                                           | 1. Ask patient to elevate off the bed or chair (seated to standing). May use assistive device (cane, bedrail). |         | • Sit on the edge of the bed or chair for meals and/or ADLs |
|                                                           | 2. Patient should be able to raise buttocks off bed and hold for count of 5. May repeat once. May test with only one leg (e.g. ankle cast, stroke). |         | • Use equipment for transfers OOB and standing |
|                                                           | **PASS** |         | • Initiate Level 3 ROM exercises* |
|                                                           |         |         | Continue to Walk Assessment |

| Walk Assessment (standing balance and gait) |           | **FAIL** | Mobility Level 4 – Walk |
|                                            | Instructions: (Use assistive device if needed.) |         | • Initiate falls bundle, if indicated |
|                                            | 1. Ask patient to march in place at bedside. |         | • Walking in room and in hallway as able |
|                                            | 2. Then ask patient to advance step and return each foot. |         | • Use assistive devices as needed |
|                                            | 3. Assess patient’s balance, stability, and safety awareness. |         | • Encourage out of bed for meals and/or ADLs |
|                                            | **PASS** |         | • Initiate Level 4 ROM exercises* |

Always default to the safest patient handling equipment if there is any doubt in patient’s ability to perform task.

*Consider notifying provider to place PT/OT consult for patient not at baseline or who demonstrates declining mobility/ADL.
### Safety Screen Assessment: M.O.V.E.S

| M: Myocardial | • New MI by EKG or elevated cardiac enzymes (May progress activity level 24 hours after cardiac enzymes peak)  
| • New antiarrhythmic infusion added within last 12 hours  
| • New unstable dysrhythmia within last 12 hours  
| • Changes to Flolan (epoprostenol sodium) or Veletri dosing within last 30 minutes |

| O: Oxygenation | • Sustained desaturation <88% or patient specific goal  
| • Increases in ventilator support within last 4 hours  
| • Current ventilator settings FiO2 >80%, PEEP >16, and plateau pressures >30  
| • Oxygenation requirements of FiO2 100% in non-ventilated patients |

| V: Vasoactive | • Increase in vasoactive requirements over the last 2 hours  
| • New vasoactive added in last 2 hours |

| E: Engaged | • Any new undetermined/undiagnosed change in neuro status  
| • Cervical or spinal injury without clearance from Neurology/Neurosurgery and/or Orthopedics |

| S: Special Considerations | • Hemi-cranial that does not have a helmet  
| • Neuromuscular blockade agents, epidurals, nerve blocks, special lines  
| • Combative or violent behavior (RASS +3 - +5) |

### Equipment and Assistive Device Options for Mobility Interventions and Fall Prevention

| Strict Bedrest | X | X | X |
| Mobility Level 1 | X | X | X | X |
| Mobility Level 2 | X | X | X | X | X |
| Mobility Level 3 | X | X | X | X | X | X |
| Mobility Level 4 | Canes | Rollator | Crutches | Walker | Ultramove or Quickmove with footplate removed | RoWalker |

Always default to the safest patient handling equipment if there is any doubt in patient’s ability to perform task.

Updated: October 2018