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An Educational Intervention to Increase Nurses' Knowledge and Confidence of Patient Mobility

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Walden University

College of Nursing

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Debbie Pytak

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Walden University

2026

Executive Summary: Staff Education Project
An Educational Intervention to Increase Nurses' Knowledge and Confidence of
Patient Mobility

by

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Summary

Immobility is a significant concern given that nearly half of all hospitalized adults are immobile during their hospitalization, placing them at increased risk for adverse outcomes. As a result, it is critical for nurses to implement strategies that promote safe, structured patient mobility. Thus, the purpose of this Doctor of Nursing Practice (DNP) project was to determine if an educational intervention focused on patient mobility and standardized mobility tool utilization increased knowledge and confidence among nursing staff in an acute care setting. Ten participants volunteered to attend the educational intervention. The average age of the participants was 44.30 years ($SD = 7.27$) with 70% identifying as female. All 10 participants indicated they worked as a registered nurse in the organization. The mean pretest score for knowledge was 8.50 ($SD = 1.08$), and the mean posttest score was 10.00 ($SD = 0.00$). A Wilcoxon signed-rank test used to analyze the data showed statistically significant differences between pre- and posttest knowledge scores ($z = -2.55, p < .05$), demonstrating an increase in knowledge among the participants. Additionally, participants were asked to rate their confidence in four specific content areas using a Likert scale. Results from the Wilcoxon signed-rank test indicated a statistically significant increase in pre- to posttest scores across all four confidence items. ($p < .05$). Given the importance of patient mobility, it is recommended that the project findings be disseminated among leadership and staff with anticipation that the increased knowledge and confidence translate into practice, resulting in positive patient, provider, and organizational outcomes and, ultimately, positive social change.

Background

Immobility is a significant concern among hospitalized adults, particularly those recovering from trauma or surgical procedures, and is associated with preventable complications, such as venous thromboembolism, pneumonia, pressure injuries, delirium, muscle atrophy, and functional decline (Svensson-Raskh et al., 2024). Nearly half of all hospitalized adults remain largely inactive during their admission, placing them at increased risk for these adverse outcomes (Piper et al., 2024). Early mobilization has been consistently identified as a critical component of recovery, with evidence linking it to shorter hospital stays, improved functional outcomes, and reduced readmission rates (Lakshmi et al., 2024).

Despite strong evidence supporting early mobility, several barriers continue to impede implementation of early mobility. Nurses frequently reported limited time, inadequate staffing, and lack of confidence as major obstacles to consistent mobility practices (Silcox & Doucette, 2023). The evidence suggests that standardized mobility tools, such as the Bedside Mobility Assessment Tool (BMAT) and the Johns Hopkins – Activity and Mobility Promotion (JH-AMP) framework, improved documentation, mobility goal achievement, and interdisciplinary communication when used consistently among hospitalized patients (Hoyer et al., 2023; Jones et al., 2020). However, variability in tool adoption and uncertainty about roles and responsibilities continues to hinder widespread use (Svensson-Raskh et al., 2024). These persistent barriers highlight the importance of targeted education to support reliable mobility assessment and intervention.

Within the local organization, leadership identified similar challenges among nursing staff. Specifically, staff expressed uncertainty about when to initiate mobilization, who is responsible for progressing mobility, and whether a physician's order is required. These inconsistencies can contribute to delays in ambulation and hinder the organization's ability to standardize care. Given the strong evidence supporting early mobility and the need for consistent practice, an educational intervention was identified as a feasible strategy to improve staff knowledge and confidence, ultimately supporting a culture of evidence-based care (Wells, 2024). Thus, the purpose of this DNP project was to determine if an educational intervention focused on patient mobility and standardized mobility tool utilization increased knowledge and confidence among nursing staff in an acute care setting.

Staff Education Project Development

As part of the organizational evaluation, I conducted an organizational readiness assessment and a strengths, weaknesses, opportunities, and threats analysis. The *Organizational Readiness for Implementing Change* assessment demonstrated strong commitment and motivation among staff and leadership, with high levels of agreement across items related to confidence, coordination, and determination to implement the change. The strengths, weaknesses, opportunities, and threats analysis further highlighted the importance of the educational intervention. Several strengths that positioned the organization for successful implementation included strong nurse leadership support and established interdisciplinary collaboration with physical and occupational therapy. Opportunities identified included alignment with national emphasis on early mobility and

robust evidence base supporting mobility intervention. However, despite these strengths and opportunities, several weaknesses and threats were identified that required consideration. Weaknesses included inconsistent use of standardized mobility tools and limited staff confidence in applying mobility assessments. Threats, such as staffing shortages and burnout, were also noted. These challenges highlighted the need for a structured, evidence-based educational intervention to increase knowledge and confidence in mobility practices.

Following the assessment of the organization and approval of the project by leadership, I conducted a review of the literature and using the available evidence, created an educational intervention (Appendix A), a pretest (Appendix B), and a posttest (Appendix C). After the materials were developed, I organized a panel of experts to evaluate the educational intervention, pretest, and posttest to determine the content validity of each item. The Item-Content Validity Index (I-CVI) and Scale Content Validity Index (S-CVI) were employed to assess the content validity of the three components (Polit & Beck, 2006). The I-CVI and S-CVI for the educational intervention were 1.0 and 1.0, respectively, and the I-CVI and the S-CVI for the pre- and posttest were 1.0 and 1.0, respectively, which met and exceeded the acceptable level of 0.80 (Polit & Beck, 2006).

Procedures

I invited a convenience sample of nursing staff working on the trauma and surgical acute care unit to participate in the educational intervention. Participation was voluntary and no incentives or compensation were provided to the participants. Prior to

beginning the session, each participant was asked to create a unique identifier known only to them. I used this identifier to match pre- and posttest responses while ensuring that no identifying information was collected. Using the unique identifier, participants first completed the pretest, which included six demographic questions, 10 multiple-choice knowledge questions, and four Likert-scale confidence items. After completing the pretest, the educational intervention was delivered. A recorded version of the presentation was made available for staff unable to attend the live sessions. Following the educational intervention, participants were asked to complete the posttest using the same unique identifier. The posttest consisted of the same 10 knowledge questions and four confidence items as the pretest. Once the posttest was completed, participants were free to leave the session.

All pretests and posttests were then matched using the unique identifiers, reviewed, and scored for the number of correctly answered knowledge questions. I entered the demographic data, pretest scores, and posttest scores into a Microsoft Excel spreadsheet and uploaded them into SPSS for analysis. Descriptive statistics were used to describe the sample and inferential statistics were employed to determine if there was a difference in pre- and posttest scores.

Results

Demographic Results

I invited a total of 15 individuals to participate in the educational intervention. With the support of leadership, 10 individuals were able to attend the education intervention over the course of 12 days. The average age of the participants was 44.30

years ($SD = 7.27$) with a range of 32 to 52 years old. Seventy percent ($n = 7$) of the participants identified as female, with the remaining 30% ($n = 3$) being male. All 10 participants (100%) indicated they worked as registered nurses in the organization. Nine of the participants (90%) indicated they had a Bachelors in Nursing and one participant (10%) indicated they had an Associate's degree in Nursing. The mean number of years working in nursing was 15.10 years ($SD = 5.70$) with a range of 7 to 27 years, and the mean number of years working in the participant's current position was 8.75 years ($SD = 6.95$) with a range of 1 to 19 years (Table 1).

Statistical Analysis

Knowledge

The mean pretest score for knowledge was 8.50 ($SD = 1.08$) with a range of 7 to 10, and the mean posttest score was 10.00 ($SD = 0.00$) with a range of 10. Using a Wilcoxon signed-rank test to estimate the data, the results showed that there was a statistically significant difference between the pre- and posttest scores ($z = -2.55, p < 0.05$), indicating that there was an increase in knowledge among the participants.

Confidence in Assessing a Patient's Mobility Level

The mean pretest score for confidence in assessing a patient's mobility level was 4.60 ($SD = 1.51$) with a range of 3 to 7. The mean posttest score for confidence in assessing a patient's mobility level was 6.90 ($SD = 0.32$) with a range of 6 to 7. Using a Wilcoxon signed-rank test to estimate the data, the results showed that there was a statistically significant difference between the pre- and posttest scores ($z = -2.55, p < 0.05$), indicating an increase in confidence in assessing a patient's mobility level.

Confidence in Using the BMAT to Guide Mobility Decisions

The mean pretest score for confidence in using the BMAT to guide mobility decisions was 3.00 ($SD = 1.63$) with a range of 1 to 6. The mean posttest score for confidence in using the BMAT to guide mobility decisions was 6.60 ($SD = 0.52$), with a range of 6 to 7. Using a Wilcoxon signed-rank test to estimate the data, the results showed that there was a statistically significant difference between the pre- and posttest scores ($z = -2.82, p < 0.01$), indicating an increase in confidence in using the BMAT to guide mobility decisions.

Confidence in Applying the JH-AMP Framework

The mean pretest score for confidence in applying the JH-AMP framework was 2.80 ($SD = 1.32$) with a range of 1 to 4. The mean posttest score for confidence in applying the JH-AMP framework was 6.70 ($SD = 0.48$) with a range of 6 to 7. Using a Wilcoxon signed-rank test to estimate the data, the results showed that there was a statistically significant difference between the pre- and posttest scores ($z = -2.87, p < 0.01$), indicating an increase in confidence in applying the JH-AMP framework.

Confidence in Selecting Safe and Appropriate Mobility Interventions

The mean pretest score for confidence in selecting safe and appropriate mobility interventions for patients was 4.50 ($SD = 1.08$) with a range of 4 to 7. The mean posttest score for confidence in selecting safe and appropriate mobility interventions for patients was 6.90 ($SD = 0.32$) with a range of 6 to 7. Using a Wilcoxon signed-rank test to estimate the data, the results showed that there was a statistically significant difference

between the pre- and posttest scores ($z = -2.81, p < 0.01$), indicating an increase in selecting safe and appropriate mobility interventions for patients.

Table 2

Pretest vs. Posttest Knowledge and Confidence (N = 10)

Variable	<i>M (SD)</i>	Range
Knowledge*		
Pretest	8.50 (1.08)	7 to 10
Posttest	10.00 (0.00)	10
Confidence in Assessing Mobility Levels*		
Pretest	4.60 (1.51)	3 to 7
Posttest	6.90 (0.32)	6 to 7
Confidence in Using BMAT to Guide Decisions**		
Pretest	3.00 (1.63)	1 to 6
Posttest	6.60 (0.52)	6 to 7
Confidence in Applying JH-AMP Framework**		
Pretest	2.80 (1.32)	1 to 4
Posttest	6.70 (0.48)	6 to 7
Confidence in Selecting Mobility Interventions**		
Pretest	4.50 (1.08)	4 to 7
Posttest	6.90 (0.32)	6 to 7

* $p < 0.05$.

** $p < 0.01$.

Implications

As demonstrated by the results, the educational intervention increased participants' knowledge and confidence related to early mobility practices and standardized mobility tool utilization. This has important implications for the organization. The project underscores the importance of using the best available evidence to develop educational tools that support nursing practice and promote safe, effective patient care. By grounding the intervention in valid tools and frameworks, the project reinforces the role of evidence-based practice in improving clinical decision-making.

Additionally, the project demonstrated the importance of staff education as a strategy to address practice variability and enhance nursing competency. The increase in knowledge and confidence suggest that nurses are better equipped to assess mobility levels, apply standardized tools, and select safe and appropriate interventions. I hope that these improvements will translate into consistent practice changes that promote earlier mobilization and reduce immobility-related complications. These changes have the potential to improve patient, provider, and organizational outcomes by supporting safer and more efficient care processes.

Implications Beyond Organization

The outcomes of this project also have implications beyond the project site. The project offers a replicable model that other units and organizations can adopt to improve mobility practices and reduce immobility-related complications. The structured approach of the project provides a scalable framework for implementation and can be adapted across departments, service lines, and institutions seeking to strengthen mobility practices. As a result, the project contributes to broader efforts to standardize mobility assessment and promote safe patient care.

The project also adds to the growing body of evidence supporting staff education as a mechanism for improving clinical outcomes and advancing evidence-based practice. By demonstrating that targeted education can significantly increase knowledge and confidence, the project reinforces the importance of ongoing professional development in promoting safe, high-quality patient care. Sharing these findings through presentations,

posters, or professional forums may encourage other organizations to adopt similar interventions.

Finally, the project aligns with national priorities related to patient safety, enhanced recovery pathways, and reduction of hospital-acquired complications. As healthcare systems continue to emphasize value-based care, interventions that reduce complications, shorten length of stay, and improve functional outcomes are increasingly important. By contributing to these goals, the project supports positive social change by promoting safer, more effective, and more equitable care for hospitalized patients. The emphasis on early mobility also aligns with national initiatives aimed at improving patient experience and functional recovery. In this way, the project has the potential to influence practice beyond the local setting and contribute to system-wide improvements in patient care.

Recommendations

I developed several recommendations from the results of this DNP project. The findings highlight the value of ongoing, targeted education for nursing staff, particularly in high-acuity environments where competing priorities may limit consistent application of evidence-based practices. Additionally, to maintain and strengthen staff knowledge and confidence, the organization should incorporate the mobility education intervention into onboarding for new staff. Given the importance of early and safe mobility in preventing complications and improving patient outcomes, safe mobilization practices should be included in orientation. Embedding this content into onboarding will help promote consistency across the unit and support long-term practice change.

Finally, given the organization's commitment to continuous quality improvement, it is important that the results of this project be shared with leadership and frontline staff. Disseminating the findings through internal presentations, quality meetings, or professional forums may encourage broader adoption of standardized mobility practices. Sharing outcomes reinforces the value of the intervention and highlights its impact on clinical practice. This transparency supports organizational learning and promotes a culture of evidence-based care. Ultimately, these recommendations aim to strengthen mobility practices and improve patient, provider, and organizational outcomes.

Strengths and Limitations

The project demonstrated several important strengths that contributed to its success. One of the most significant strengths was the strong support received from organizational leadership, including the nurse manager and clinical nurse leader, which ensured visible sponsorship and alignment with unit priorities. Despite these strengths, the project had several limitations. The sample size of 10 participants limits the generalizability of the findings to other units or organizations. Additionally, given that the sample was drawn from a single trauma and surgical acute care unit, the results may not reflect the experiences or needs of staff in other clinical settings. Finally, in the project I measured immediate changes in participants' knowledge and confidence but did not include long-term follow up to determine whether these improvements translated into sustained practice changes or improved patient outcomes.

Conclusions

Staff education is a critical strategy for improving clinical practice and promoting positive patient outcomes. This project demonstrated that an educational intervention focused on early mobility and standardized mobility tool utilization significantly increased knowledge and confidence among acute care nurses. These findings align with evidence showing that structured training improves nurse knowledge and confidence in patient mobility practices (Chen et al., 2022; Jones et al., 2020). Ultimately, this project contributes to positive social change by promoting safer care for hospitalized patients and supporting the ongoing professional development of nursing staff.

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Appendix A: Outline of Educational Intervention

1. Introduction
2. Review of Patient Mobility in the Acute Care Setting
3. Importance of Early and Safe Patient Mobility
4. Review of Standardized Mobility Tools
 - a. Bedside Mobility Assessment Tool (BMAT)
 - b. Johns Hopkins Activity and Mobility Promotion (JH-AMP) Tool
5. Review of Mobility Assessment and Mobilization Techniques
 - a. Determining mobility level
 - b. Selecting appropriate interventions
 - c. Safe mobilization practices
6. Questions and Answers
7. Conclusion

Appendix B: Pretest

Thank you for agreeing to participate in this educational intervention. Please create a unique ID that is only known to you. You will not be asked to share this ID with anyone, nor should you share your ID with anyone. The ID will only be used to match your pretest with your posttest. No identifying information will be asked for and please do not provide any additional information outside of the questions being asked. All information collected will be reported in the aggregate. Thank you again for agreeing to participate in this educational intervention.

My Unique ID: _____

Demographic Information

Age (in years): _____

Gender:

_____ Male

_____ Female

_____ Non-Binary

Role in Organization:

_____ Nursing Assistant (NA)

_____ Licensed Practical Nurse (LPN)

_____ Registered Nurse (RN)

Highest Level of Education:

_____ Certification

_____ Associate Degree

_____ Bachelor's (BS or BSN)

_____ Master's (MS or MSN)

_____ Doctoral (DNP or PhD)

Years of Experience: _____

Years in Current Position: _____

Knowledge Questions

Please select the best answer for each question.

1. Early and safe patient mobility is associated with which of the following outcomes?
 - a. Increased length of stay
 - b. Increased risk of complications
 - c. Improved patient outcomes and reduced complications
 - d. No measurable impact on patient recovery

2. The Bedside Mobility Assessment Tool (BMAT) is used to:
 - a. Diagnose musculoskeletal disorders
 - b. Determine a patient's mobility level and guide interventions
 - c. Replace physical therapy assessments
 - d. Evaluate only upper-extremity strength

3. The Johns Hopkins Activity and Mobility Promotion (JH-AMP) tool focuses on:
 - a. Physical therapy–only mobility activities
 - b. Nurse-led and interdisciplinary mobility promotion
 - c. Mobility activities for outpatient settings only
 - d. Assessing cognitive status exclusively

4. A patient is considered safe to mobilize independently if they demonstrate which of the following?
 - a. Ability to follow commands but cannot sit unsupported.
 - b. Ability to stand but cannot maintain balance.
 - c. Ability to sit unsupported, stand with minimal assistance, follow commands, and maintain balance.
 - d. Ability to walk short distances with two-person assistance.
5. Mobility assessments should be completed:
 - a. Only once during admission
 - b. Once per shift or when the patient's condition changes
 - c. Only when physical therapy requests it
 - d. Only when the patient reports pain
6. Early mobility can help prevent which of the following hospital-acquired complications?
 - a. Deconditioning, pressure injuries, and delirium
 - b. Hypertension and diabetes
 - c. Chronic kidney disease
 - d. Seasonal allergies
7. The BMAT includes how many progressive levels to determine safe mobility activities?
 - a. Two (2)
 - b. Three (3)

- c. Four (4)
 - d. Five (5)
8. A patient who is unable to lift their hips off the bed during the BMAT Sit & Shake assessment should be classified as:
- a. The highest mobility level
 - b. A lower mobility level requiring additional support
 - c. Ready for independent ambulation
 - d. Safe for stair climbing
9. Consistent documentation of mobility assessments and interventions is essential because it:
- a. Is optional and not needed for patient care
 - b. Helps with communication, continuity of care, and monitoring progress
 - c. Is only required for physical therapy
 - d. Replaces the need for reassessment
10. If a patient demonstrates a lower mobility level on reassessment, the nurse should:
- a. Ignore the change unless the patient complain
 - b. Continue the previous mobility plan
 - c. Adjust the mobility plan and notify appropriate team member
 - d. Discontinue all mobility activities

Confidence Questions

Please rate your confidence of the following statements using the indicated scale of 1 to 7 where 1 = “no confidence” and 7 = “full confidence”.

I feel confident assessing a patient’s mobility level.	1	2	3	4	5	6	7
I feel confident using the BMAT to guide mobility decisions.	1	2	3	4	5	6	7
I feel confident applying the JH-AMP mobility framework.	1	2	3	4	5	6	7
I feel confident selecting safe and appropriate mobility interventions.	1	2	3	4	5	6	7

Appendix C: Posttest

Thank you again for agreeing to participate in this educational intervention. Please do not provide any additional information outside of the questions being asked. All information collected is anonymous and will be reported in the aggregate. Please complete this posttest using the ID that you created for your pretest. The ID will be used to match your pretest with your posttest.

My Unique ID: _____

Knowledge Questions

Please select the best answer for each question.

1. Early and safe patient mobility is associated with which of the following outcomes?
 - a. Increased length of stay
 - b. Increased risk of complications
 - c. Improved patient outcomes and reduced complications
 - d. No measurable impact on patient recovery
2. The Bedside Mobility Assessment Tool (BMAT) is used to:
 - a. Diagnose musculoskeletal disorders
 - b. Determine a patient's mobility level and guide interventions
 - c. Replace physical therapy assessments
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4. A patient is considered safe to mobilize independently if they demonstrate which of the following?
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 - c. Ability to sit unsupported, stand with minimal assistance, follow commands, and maintain balance.
 - d. Ability to walk short distances with two-person assistance.
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- a. Deconditioning, pressure injuries, and delirium
 - b. Hypertension and diabetes
 - c. Chronic kidney disease
 - d. Seasonal allergies
7. The BMAT includes how many progressive levels to determine safe mobility activities?
- a. Two (2)

- b. Three (3)
 - c. Four (4)
 - d. Five (5)
8. A patient who is unable to lift their hips off the bed during the BMAT Sit & Shake assessment should be classified as:
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10. If a patient demonstrates a lower mobility level on reassessment, the nurse should:
- a. Ignore the change unless the patient complain
 - b. Continue the previous mobility plan
 - c. Adjust the mobility plan and notify appropriate team member
 - d. Discontinue all mobility activities

Confidence Questions

Please rate your confidence of the following statements using the indicated scale of 1 to 7 where 1 = “no confidence” and 7 = “full confidence”.

I feel confident assessing a patient’s mobility level.	1	2	3	4	5	6	7
I feel confident using the BMAT to guide mobility decisions.	1	2	3	4	5	6	7
I feel confident applying the JH-AMP mobility framework.	1	2	3	4	5	6	7
I feel confident selecting safe and appropriate mobility interventions.	1	2	3	4	5	6	7