Salinas Valley HEALTH

# Transitioning to a Mobility Committee: An Initial Step in Improving Mobility Rates and Patient Outcomes

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## Background

Patient falls in healthcare settings are a significant safety concern, leading to patient injury, increased length of stay, and higher healthcare costs (Gonzales et al., 2024). Traditional fall prevention strategies, such as bed alarms and fall-risk wristbands are often managed by a dedicated falls committee and may overlook the modifiable risk factors of immobility and deconditioning during hospitalization (Turner et al., 2020). Shifting from a fall prevention focus to a mobility-centered model may improve patient outcomes. Patient deconditioning related to a lack of mobility for Salinas Valley Health Medical Center patients had been observed, a finding documented in the literature (Buckner & Sump, 2025). Historically, the medical center's Falls Committee had overseen fall prevention efforts. Considering the importance of mobility for preventing falls, committee members decided to transition to a Mobility Committee.

## Purpose Statement

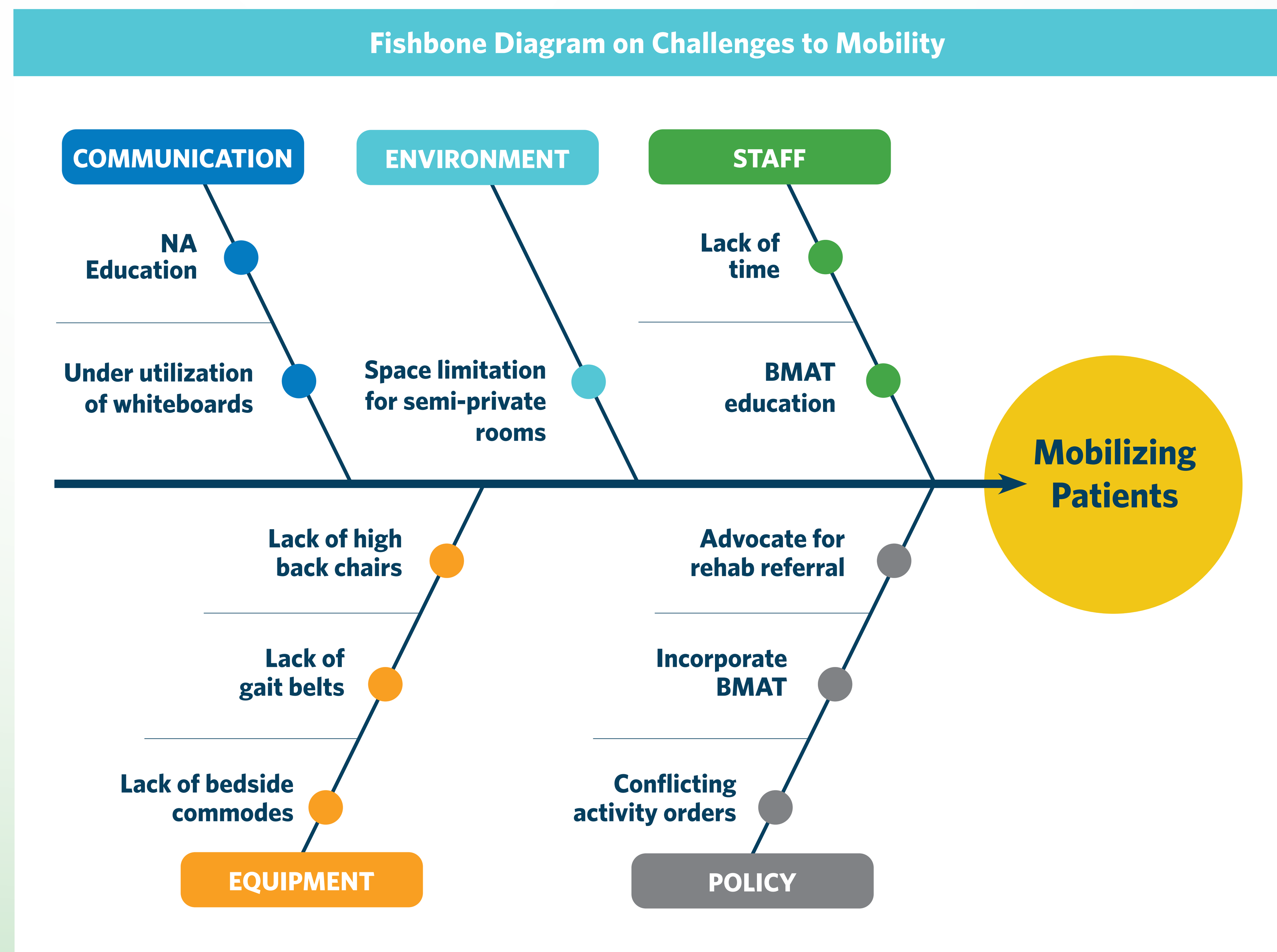
The purpose of this quality improvement initiative was to transition an existing Falls Committee to a Mobility Committee to shift its focus from falls to mobility.

## Methods

In November 2024, one of the project leads (EMD) used a fishbone diagram to brainstorm barriers to mobilizing patients in inpatient units. She brought this to the Falls Committee to initiate discussions about improving mobility rates (see Figure 1). These discussions indicated a need for the committee to have a broader scope from falls to mobility. Thus, the Falls Committee formally changed to the Mobility Committee in December 2024, maintaining its interprofessional membership that includes clinical registered nurses (RNs), rehabilitation professionals, pharmacists, patient care assistants, and nurse leaders.

**Figure 1**

**Fishbone Diagram on Challenges to Mobility**




*Note.* Diagram completed in November 2024. NA = nurse aide; BMAT = Bedside Mobility Assessment Tool.

The committee used a quality improvement (QI) framework, the Plan-Do-Study-Act (PDSA) cycle, to guide this transition. The following timeline outlines the committee's key interventions in 2025 associated with its transition:

- January 2025: Established its charter and identified a framework (see Figure 2) to guide its initiatives to encourage safe mobilization: a mobility program, fall prevention, and safe patient handling.
- February to April 2025: A standardized Bedside Mobility Assessment Tool (BMAT) to evaluate a patient's mobility level and setting clear, daily goals were implemented house-wide (see Figure 3). A comprehensive education program was launched to train nursing staff on the importance of mobility, use of the BMAT, and techniques for safe patient handling and ambulation. In collaboration with Employee Health and Materials Management, training videos on safe patient handling equipment were developed and embedded in various sites in STARnet (the organization's intranet). This education was integrated into the annual competency camps and new hire orientation.
- April 2025: The committee created and trialed a tool to conduct mobility audits. After the trial, the audits were revised to focus on patients with a BMAT score of 3 or 4 and were implemented in ten inpatient units.
- June to September 2025: Conducted monthly audits using the mobility audit tool and analyzed data. Committee members calculated the percentage of patients with a BMAT score of 3 or 4 (i.e., those who can ambulate independently or with minimal/standby assistance) who ambulated within 24 hours of the audit. The committee shared results with nursing leadership and the Practice Council. The Mobility Committee and Practice Council agreed on the goal to reach 80% mobility rates for all patients with a BMAT score of 3 or 4.
- September 2025: The Mobility Algorithm went live. A multidisciplinary taskforce had been convened to develop the algorithm for RNs to use to determine how to mobilize patients safely (see Figure 3). Copies of the algorithm were distributed to the units and uploaded to the committee's page in STARnet to promote its use.

To evaluate the effect of the committee's transition from falls to a mobility focus, the committee analyzed monthly audit data, inpatient total patient falls and inpatient injury falls rates, and education rates. The goal for the falls rates was to remain below the National Database of Nursing Quality Indicators (NDNQI) benchmark and not increase as this would indicate that patients were being safely mobilized. We analyzed both monthly and quarterly falls data.

**Figure 2**

**Mobility Committee Framework for Mobility Success**

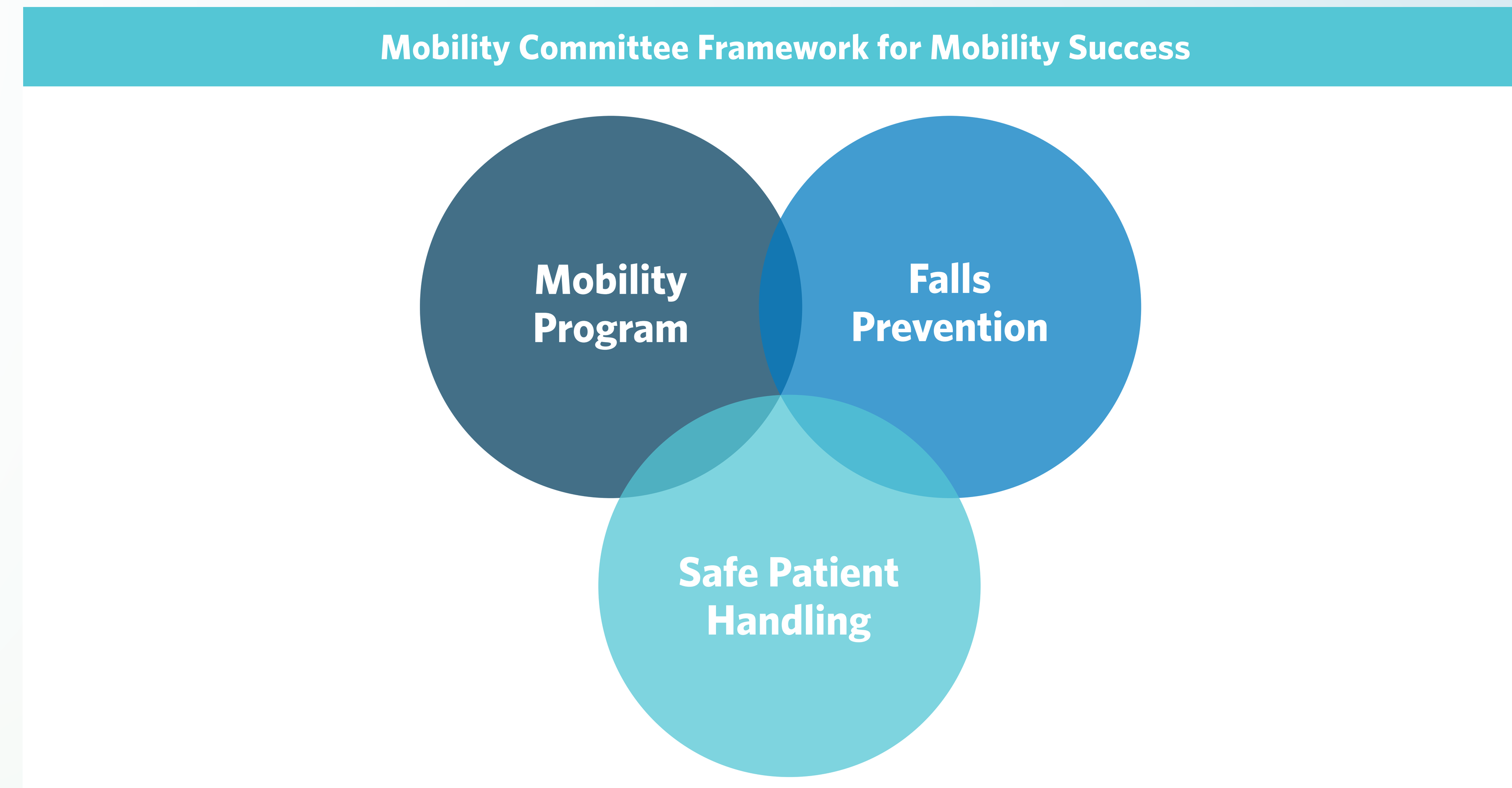



**Figure 3**

**Mobility Algorithm**

Salinas Valley HEALTH — Mobility & Safe Patient Handling Algorithm

| Start Here | Considerations | BMAT score | | | |
|---|---|---|---|---|---|
| | **Exclusion Criteria** *Always use clinical judgement based on individual patient's clinical presentation and moods* | **Level 1** *Dependent* | **Level 2** *Moderately Dependent* | **Level 3** *Minimal Assistance Required* | **Level 4** *Independent* |
| | | **Mobility Goals:** | | | |
| Perform *initial* mobility screen w/in 8 hrs. of admission – | • Unstable vital signs (positive orthostatic vitals, consult PT) • Specific weight-bearing restrictions • Agitated, aggressive or impulsive behavior • ICU placement • Bed Rest Orders • New or increasing vasopressor infusion • New onset cardiac arrhythmias or ischemia • Sedated patients – consider if pt. is drowsy, nauseated etc. | Willing to participate in PT/OT activities Other grooming activities | If deemed SAFE, OOB for all meals, repositioning with little to no assist | OOB for all meals, utilizing BSC/bathroom | OOB for all meals, ambulating to bathroom (with supervision as needed) |
| | | **Mobility Device Recommendations:** | | | |
| | | • Cardiac chair position • SimPull (lateral transfer device) • Tenor/Golvo • Repositioning devices – such as slides/sheets | • Tenor/Golvo • Sara-Steady (if pt. can stand with minimal assist.) • Encore • Sitting support device • Gait belt as appropriate | • Utilize mobility devices (canes, crutches, walkers) • Sara-Steady (if pt. can sit to stand with minimal assist.) • Gait belt as appropriate | N/A |
| | | **JH - ADL Guide & Highest Level of Mobility Scale** | | | |
| *Reassess* mobility level every shift | *Report* Workplace Violence (*WPV*) *incidents to leader & Nursing Supervisor x 5771/5772* *Stay alert and look for bear signs* | Wash face, comb hair, or brush teeth in bed | Wash face, comb hair, brush teeth, or shave sitting at edge of bed | Wash face, comb hair, brush teeth, or shave while standing, wash and dress upper body in chair/toilet on bedside commode | Utilizing bathroom, All ADL in bathroom after gathering supplies |
| | **Report Fall incidents ASAP through the Occurrence Reporting Link:** STARNet > RL6-WeCare Safety Reporting | | Sit at edge of bed, Transfer to Chair Lying, Turn self/Activity | 1 Minute Stand, 10+ steps (walk) 2x/day with standby assist | 25+ feet walk, 250+ feet walk |
| | | ***Consider patient preference activities**: Creative/Expressive: art/craft, writing, music Entertainment/Leisure: watching tv, reading, puzzles, Social & Communication: family calls, pet therapy etc.* | | | |
| **Refer to OT/PT** | Consider Baseline, Candidate for discharge, Declining BMAT scores, Consult PT/ OT | Consider Baseline Consult PT/ OT | Consider Baseline Consult PT/ OT | This is not their baseline and or decompensating | N/A |

*Note.* PT = physical therapy; OT = occupational therapy; OOB = out of bed; JH-ADL = John Hopkins Activities of Daily Living; BMAT = Bedside Mobility Assessment Tool.

## Results

Audit results from April to September 2025 showed that all units increased their mobility rates. In September 2025, the mobility audits indicated that three of the ten units were above the goal of 80% mobility rates. Inpatient total falls (see Figure 4) and injury falls (see Figure 5) rates remained below the benchmark throughout the intervention (January to September 2025) with the exception of injury falls in August 2025. Lastly, 90% of inpatient clinical RNs received education about mobility and safe patient handling as of Q4 2025.4).

**Figure 4**

**Total Patient Falls - Inpatient**

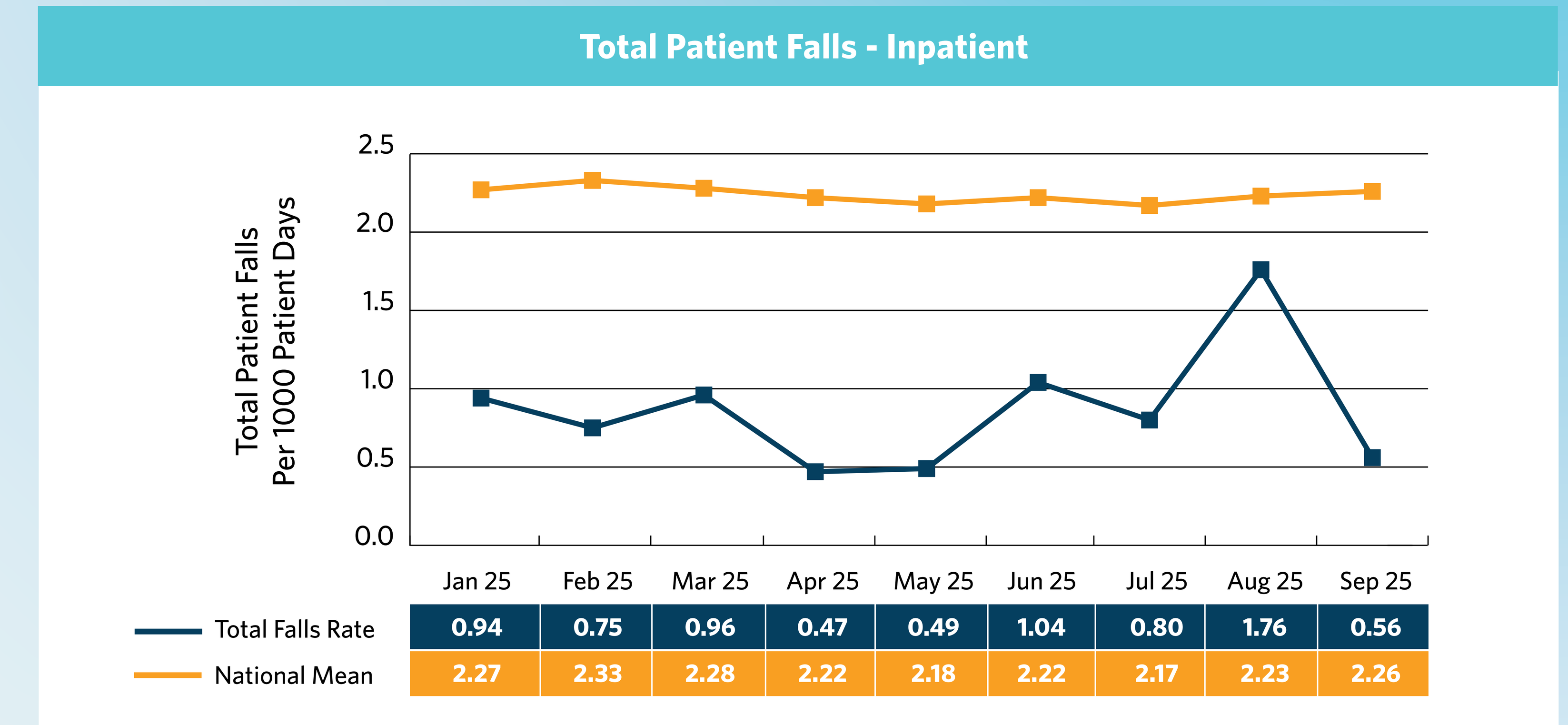
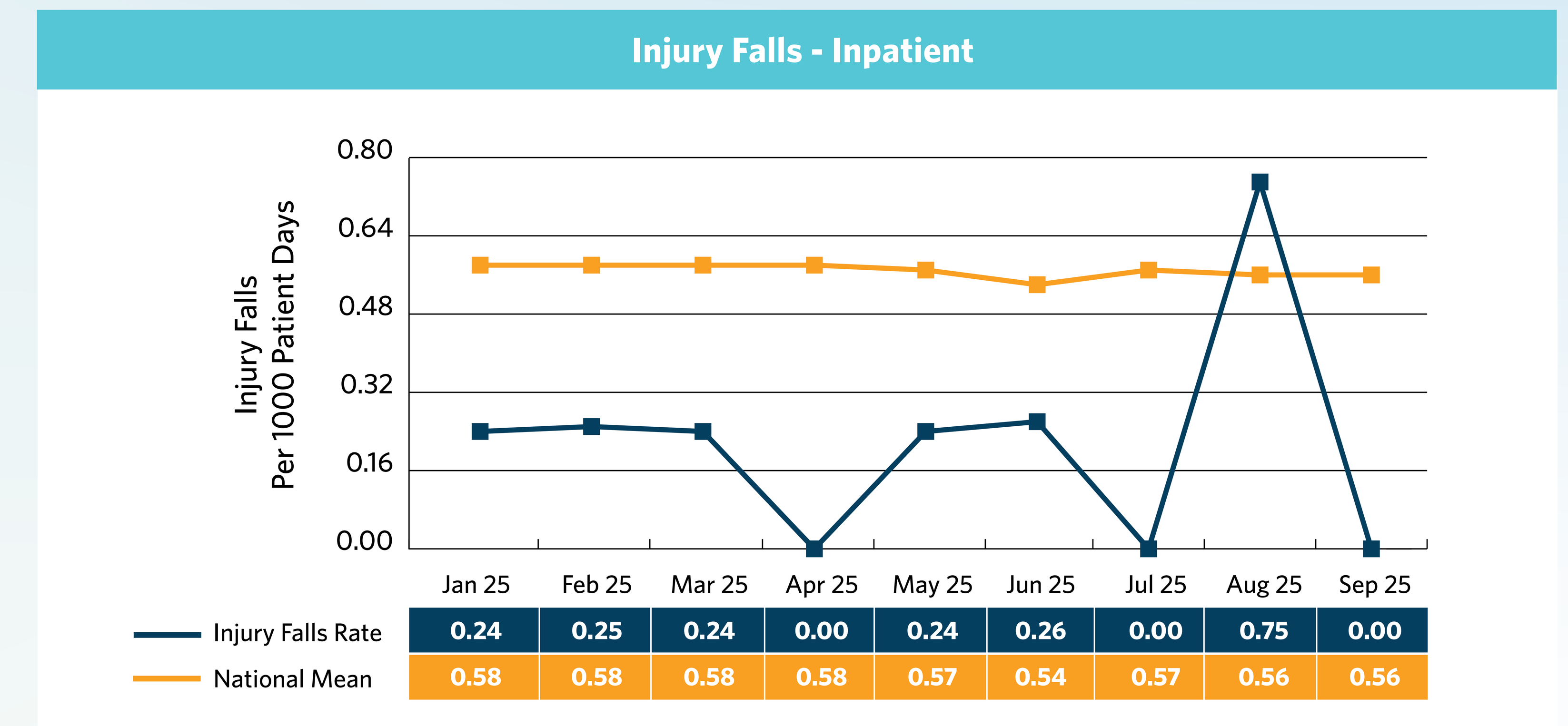



**Figure 5**

**Injury Falls - Inpatient**




## Conclusions

The transition to a Mobility Committee demonstrated a positive impact through increasing units' mobility rates and maintaining falls rates below the national benchmark. The committee's change from a fall prevention model to a proactive mobility-focused approach supports a safer patient environment. Next steps include increasing the use of the Mobility Algorithm, continued work to achieve 80% mobility rates in all inpatient units, adopting safe patient handling equipment, promoting the enculturation of patient mobility, and exploring mobility's impact on outcome measures like hospital-acquired pressure injuries.

## References

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