

QUALITATIVE RESEARCH REPORT



Patient as active partner – clue to successful early mobilization in intensive care

Annika Söderberg MSc, RPT ^{a,b}, Veronika Karlsson PhD, RN ^c, Monika Fagevik Olsén PhD, RPT ^a,
Anneli Thelandersson PhD, RPT^d, and Anita Johansson PhD, RN ^e

^aDepartment of Health and Rehabilitation, Institute of Neuroscience and Physiology, Arvid Wallgrens Backe, University of Gothenburg, Gothenburg, SE, Sweden; ^bDepartment of Physiotherapy, Skaraborg Hospital, Skövde, SE, Sweden; ^cSchool of Health Sciences, University of Skövde, Skövde, SE, Sweden; ^dSection for Research and Education, Kungälv Hospital, Kungälv, Sweden; ^eResearch and Development Centre, Skaraborg Hospital, Skövde, SE, Sweden

ABSTRACT

Background: The evidence for the benefits of early mobilization in intensive care is growing. Early mobilization differs from most other interventions in intensive care since the patient's participation is requested. What kind of challenges this entails for the intensive care clinicians, and what is crucial in successful early mobilization from their perspective, is sparsely explored and was therefore the purpose of this study.

Methods: Semi-structured interviews were held with 17 intensive care clinicians, seven nurses, five assistant nurses and five physiotherapists. The interviews were analyzed with a phenomenographic methodology.

Findings: Four descriptive categories emerged: 1) Taking responsibility; 2) Taking the patient's perspective; 3) Time or not time to mobilize; and 4) The "know-how" of early mobilization. Early mobilization was perceived as an important and crucial part of intensive care. It includes positioning and sensory stimulation, which could be used to re-orientate the patient and prevent delirium. The patients' experiences were considered individual with a mix of strong emotions. Despite the stated significance of early mobilization, different conceptions were expressed about the right time, some of them based on concerns for the patient, and some due to safety concerns. In the optimal active mobilization to upright positions there was an emphasis on careful preparation and patient involvement, including negotiation and active participation.

Conclusions: The importance of early mobilization is indisputable. Successful early mobilization is achieved by applying a person-centered approach, involving the patient as an active partner. Early mobilization comprises positioning and sensory stimulation and should be included in the daily planning of patient care.

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Background

The number of survivors after critical illness are increasing due to technical advancements in intensive care. Many of them have persistent complications such as muscle weakness, concentration and memory difficulties, post-traumatic stress disorder, anxiety, and depression (Bein, Bienvenu, and Hopkins, 2019; Dirkes and Kozlowski, 2019; Girard, Dittus, and Ely, 2016). The use of early mobilization (EM) in the intensive care unit (ICU) has been shown to prevent not only physical, but also cognitive and mental complications (Nydahl et al., 2017). Early mobilization research indicates that it is feasible and safe to mobilize several patient groups early (Fuest and Schaller, 2019; Nydahl et al., 2017) and that this leads to improved function such as: earlier independence (Burtin et al., 2009; Schweickert et al., 2009); fewer

days on mechanical ventilation, in ICU and in hospital (Fuest and Schaller, 2018); reduced anxiety and depression and improved cognitive function (Hopkins, Suchyta, Farrer, and Needham, 2012); increased quality of life (Arias-Fernandez, Romero-Martin, Gomez-Salgado, and Fernandez-Garcia, 2018); and fewer days with delirium (Schaller et al., 2016; Schweickert et al., 2009). Delirium in the ICU is associated with increased mortality, significant morbidity, longer hospital stays and a prolonged cognitive impairment (Fiest et al., 2021; Kresevic et al., 2020). An agreed definition of what constitutes EM is still missing (Clarissa, Salisbury, Rodgers, and Kean, 2019). In this study "early" is defined as soon as the patient is respiratory and circulatory stable and "mobilization" refers to an increasing range of physical exercises starting with passive movements in bed, then active movements,

CONTACT Annika Söderberg  annika.soderberg@gu.se  Department of Health and Rehabilitation/Physiotherapy, Institute of Neuroscience and Physiology University of Gothenburg, Sahlgrenska Academy, Gothenburg, SE 405 30, Sweden

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followed by sitting on the edge of the bed, standing and walking (Stiller, 2013).

A patient in ICU is completely dependent on technology and the clinicians. Previous research shows that this loss of control, and dependence for the most basic needs, can be a very unpleasant experience for patients in intensive care (Karlsson, Bergbom, and Forsberg, 2012; Lykkegaard and Delmar, 2015). Other difficult experiences such as pain, anxiety, fear, nightmares and difficulty communicating have been described (Bergbom-Engberg and Haljamae, 1989) but also that these can be reduced if the patients are involved in their own treatment and treated as part of the team (Berntzen, Bjørk, and Wøien, 2018; Laerkner, Egerod, Olesen, and Hansen, 2017; Tingsvik, Hammarskjöld, Mårtensson, and Henricson, 2018). Being involved in one's own treatment also applies to EM, which differs from most other measures in intensive care, since the patient's participation is requested. In a recent study where patients were interviewed about their experiences of EM in ICU, it was found that clinicians had a significant function in making the patients' experience of EM predominantly positive (Söderberg et al., 2022). Moreover, one of the conclusions in the review of Lang, Paykel, Haines, and Hodgson (2020) is that both the family and patient should be involved in EM. However, how the intensive care clinicians should involve the patient in EM and what is crucial for successful EM from this perspective, is to the authors' knowledge sparsely explored. In the beginning of this study, it was assumed that the clinicians' conceptions of patients' experiences could influence both conceptions of EM in general, and how the patient should be involved. Therefore, the twofold aim of this study was to explore and describe the clinicians' conceptions of EM, as well as their conceptions of the patients' experiences of EM.

Methods

Design

In this qualitative study a phenomenographic approach developed by Marton (1981) and described by Sjöström and Dahlgren (2002) and Stenfors-Hayes, Hult, and Dahlgren (2013) was applied. Phenomenography belongs to the interpretivist paradigm which acknowledges that there are many ways of interpreting reality (Stenfors-Hayes, Hult, and Dahlgren, 2013). A fundamental distinction is made between two perspectives; the first-order perspective, in which the researcher is interested in how something "really is" and the second-order perspective, where the focus is how the experienced phenomena are conceived,

understood, and conceptualized (Marton, 1981; Sjöström and Dahlgren, 2002). Phenomenographic research is primarily interested in studying the second-order perspective, and it is the conceptions that guide the individual's actions you want to derive (Marton and Booth, 2013). Other epistemological assumptions are to study the qualitatively different ways in which people perceive the same phenomenon (Marton, 1981; Sjöström and Dahlgren, 2002), and that the relationships between the different categories of conceptions should be described (Marton and Booth, 2013; Stenfors-Hayes, Hult, and Dahlgren, 2013). The study was reported according to Standards for Reporting Qualitative Research Guidelines, SRQR (O'Brien et al., 2014).

Settings and sample

Purposive sampling was used to recruit 17 participants from six ICUs of different sizes and specializations from the south of Sweden. They were recruited through a request to the head of each ICU. The sample consisted of seven nurses, five assistant nurses and five physiotherapists, the three professions that carry out EM. Among them three were male and 14 females, they ranged in age from 28 to 62 years and their professional experience of intensive care varied between 1 to 35 years (median = 10). Three of the participants were briefly known to the interviewer, who had been working in the same unit, however five years earlier. All interviews took place at the hospital where the participants worked. All participants received verbal and written information about the study, their rights, and their freedom to withdraw at any time, assured that the data would be handled confidentially and were asked to sign a written form to give their consent. The study was approved by the Swedish Ethical Review Authority (Dnr 409–15, T1162–18).

Data collection

Data were generated through semi-structured interviews (Appendix). The semi-structured interview provides flexibility and allows participants to freely describe their experiences and for the interviewer to ask additional questions, confirm data and avoid misunderstandings (Sjöström and Dahlgren, 2002). An interview guide, covering the areas of interests, was constructed using the framework described by Kallio, Pietilä, Johnson, and Kangasniemi (2016). All interviews were conducted over six months during 2019, and lasted 28–79 minutes, (median = 45). To enhance dependability, they were recorded and transcribed

Table 1. Seven steps of analysis.

| | |
|--------------------|--|
| 1. Familiarization | Reading through the interview transcripts to get a fresh impression of how the interview proceeded |
| 2. Condensation | Identifying meaning units in the dialogue and marking these for further scrutiny |
| 3. Comparison | Comparing the meaning units regarding similarities and differences |
| 4. Grouping | Allocating answers expressing similar ways of understanding the phenomenon to the same category |
| 5. Articulating | Capturing the essential meaning of a certain category |
| 6. Labelling | Expressing the core meaning of the category |
| 7. Contrasting | Comparing the categories through a contrastive procedure, whereby the categories are described in term of their individual meanings as well as in terms of what they do not comprise |

verbatim by the first author. The last three interviews added no additional variation, and since the number of interviewees in a phenomenographic study usually ranges between 10 and 30 (Stenfors-Hayes, Hult, and Dahlgren, 2013) the authors decided to stop data collection.

Data analysis

The phenomenographic analysis described by Stenfors-Hayes, Hult, and Dahlgren (2013) was used in the analysis. The transcribed interviews were first read several times to get an impression of the whole. Then the structured analysis described in Table 1 followed (Stenfors-Hayes, Hult, and Dahlgren, 2013). Meaning units were identified, compared regarding similarities and differences, coded, and grouped into categories. This process was repeated several times and the categories were constantly compared with the research question. During the whole process, reflections regarding codes and categories were noted and discussed among all the authors.

To enhance dependability, the first author, a practicing intensive care physiotherapist, conducted and transcribed the interviews. The procedure of listening to the recorded interviews was repeated. To ensure credibility, the analysis was performed in close collaboration and reflective, continuous discussion with primarily the second and last author. When the results emerged the two other authors also participated in the discussion that continued throughout the analysis process. To manage pre-understanding, notes and reflections were taken by the first author, mainly in the beginning of the analysis process, and discussed with the coauthors, who have extensive experience of intensive care and post-graduate

training. To further strengthen the credibility, the study findings is illustrated by representative quotations.

Findings

The analysis yielded four descriptive categories, each comprising two subcategories, that describe the participants conceptions of EM (Table 2). All participants unanimously expressed the position that EM is important to prevent complications. Various views of what counts as EM and why were described. The conceptions of the patient's reactions were commonly expressed as a lot of mixed experiences and strong emotions that could also differ depending on the kind of mobilization. These variations were reflected in the different conceptions about the right time to mobilize. Based on all other conceptions, the optimal active, and upright mobilization was described, with a strong emphasis on the importance of involving the patient.

The descriptive categories reflect the conceptions of all participants, regardless of profession. However, some statements were associated with specific professional roles, and this has been highlighted. The number appearing after the quotations refers to the individual participant, in the order of the interviews.

Taking responsibility

This descriptive category has two subcategories: 1) "Preventing complications" which addresses the reasons for using EM; and 2) "Various views – What counts as early mobilization?" which describes the different ways in which this prevention of complications is carried out. There was a common view that EM is a significant issue in ICU and could be performed in several ways.

Table 2. The descriptive categories and subcategories, with perceptions of early mobilization among intensive caregivers.

| Descriptive categories | Taking responsibility | Taking the patient's perspective | Time or not time to mobilize | The 'know-how' of EM |
|------------------------|---|---|---|--|
| Subcategories | Preventing complication Various views – what counts as early mobilization? | Giving the patient a sense of reality Giving the patient a sense of action | Considerate clinicians Coordinating clinicians | Timing the teamwork Collaboration in action |

Preventing complications

All participants considered EM to be a crucial part of intensive care. The main reasons given were findings from recent research indicating decreased mortality rates and reduced complications, enabling patients to recover more quickly. Some of the other reasons were that ICUs must take responsibility for the state of immobilization and the subsequent deterioration. One participant said that it is not ethical from the patient's or a healthcare-cost perspective to refrain from EM.

Yes, what I'm thinking about is this, when talking about EM and which patients should get up, but it's more about which patients should not get up and sit, what makes these particular patients not being mobilized . . . it goes without saying, we all know the positive benefits of getting up. (4)

Further, some participants said it could be the best way to prevent pneumonia, constipation, and thrombosis. It could also be used to calm an uneasy patient, who is tossing and turning in bed, in a more natural way than giving sedatives.

It probably gives more to mobilize, I think, it does. In the past, you had to lie down for a long time, and I've heard that you got myocardial infarction from lying in bed. It seems life-threatening! So, most things indicate that the patient should be more awake, should not be put to sleep as hard anymore and should be mobilized. They must be involved. Everything points on this nowadays. (12)

Various views – what counts as early mobilization?

The preventive measures of EM could be carried out in several ways, such as bed-cycling; using the new modern beds for rocking or sitting reclined; sitting at the edge of the bed, in a chair, or in an ICU chair (i.e. a mobile chair which allows the patient to sit in different positions without transfers). All participants considered active and upright kinds of mobilization to be the best, if possible. This was considered to provide more exercise, better alertness, and a better body awareness. Another common thought was that caring touch, passive range of motion and positioning the patient in different ways also should count as early forms of EM, since this was said to provide an important sensory and mental stimulation.

I think that's an important part of, like, body image, that you actually get to feel the arm move. . . and that you feel every body part. That this is an important thing, to feel, to be able to find your body again. (9)

Taking the patient's perspective

This descriptive category consists of two subcategories: 1) "Giving the patient a sense of reality"; and 2)

"Giving the patient a sense of action", that present the participants' conceptions about the patient reaction and experience. The participants emphasized that patient experience is individual. The different kinds of EM were perceived to elicit various reactions. It was commented that a patient could be difficult to read, and the conceptions should be understood in this context. What patients had told participants after their ICU stay was sometimes considered.

Giving the patient a sense of reality

Supplying a patient with sensory input and mental stimulation was emphasized as important. This was accomplished by bringing a patient to a more upright and interactive position; taking them away from their bed; and providing more normal and varied stimuli. The main reasons for this were the intention to re-orientate the patient, to elicit a better body awareness and to restore a sense of normal life again. Some of the participants favored the new modern beds instead of the ICU chair, since the ICU chair is hard and uncomfortable and means that the patient must be restrained by belts, hampering any movement. On the other hand, some said that the harder surface in this chair contributes to a better body awareness. It is easier to find a good sitting position than in bed and to move your arms, you see yourself better, and this too could facilitate body awareness. In the ICU chair the patient also could be moved away from their bed, perhaps even outdoors. This can provide a much-needed change and can sometimes calm an anxious patient. It could also give the patient some hope for the future and encourage their fighting spirit.

Sometimes, even if they are very tired, we can walk a little bit . . . then we can get out of bed and out into the corridor. Yes, I think it can be a good thing, that something happens. And if they are a little more awake, we even go outside, outside the ward and into the fresh air if possible. (5)

Above all, I think in order to eliminate the risk of delirium and the patients who have it, . . . that you try to orient them back to the present in some way, and that this getting out and feeling the wind in your face can be part of that. (10)

Giving the patient a sense of action

All participants regarded the upright positions to be the kind of EM that elicited a lot of mixed experiences and strong emotions in the patient, especially the first few times. Difficult experiences such as exertion,

exceptional fatigue, dizziness, nausea, pain, and fear were commonly observed. Fear may be due to the patient not believing they can handle it; are stuck in lots of medical devices; do not trust the staff; and have fear of pain and a sense of no control.

In general, I think that the patient can feel some anxiety, maybe be a little worried that it will hurt, that he is not in control of his body. And he doesn't know us, doesn't know if he can trust us, that we help. I can imagine that there are many question marks for the patient based on insecurity, that they do not know what will happen, that they do not have control over their own body. (7)

Fear can be seen more often if the patient has experienced a trauma or is poorly prepared for what is going to happen. It tends to decrease if the patient is made more involved in the mobilization. The personality of the patient and the reason for admission to intensive care were also said by many of the participants to influence the patient's experience.

It's very different I think, a bit depending on how they are basically, their personality. Some of us are a bit more anxious than others, easily worried and such. Others do not give up, but resist. (17)

The first mobilizations could be a surprise for patients, giving them a better understanding of their limited ability, but the experience could also be pleasant and a relief. The experience of exertion and other discomfort was usually seen to decrease gradually, and the pleasant feelings increased. The patient was perceived to experience a greater freedom, to not be tied to bed, to be able to do something, to be about to recover. This could result in the patient gaining a better self-confidence, regaining their integrity as a person, being strengthened, and spurred on to continue to fight to get better.

I think he thinks it's very nice. If you explain calmly and he agrees. And that you don't mess up too much, but rather try to take it a bit gently, then I think the patient finds it very nice to get up. (15)

In this context, bed-cycling and exercise programs were put forward by some of the participants as good alternatives when lying down, when there is lack of staff resources or time. Participants described how both patients and sometimes their relatives considered the bed bike as an active and healthy form of mobilization. This seemed to give some hope that the situation was not hopeless after all.

Time or not time to mobilize

The agreement on the importance of EM was substantial. However, several different conceptions about the

right time to mobilize were expressed, here in the two subcategories: 1) "Considerate clinicians" which describe patient-related barriers to EM; and "Coordinating clinicians" in which the provider-related barriers to EM are delineated.

Considerate clinicians

Some participants said that having too high ambitions for mobilization could lead to a physical deterioration and cause an unnecessarily bad experience for the patient. It is better to start cautiously, until the patient is more prepared, both physically and mentally. In contrast, another participant thought that it was better to try, and then stop if it doesn't go well. Further, one participant said that it is common to want too much, it is better to focus on a few steps or even a single step in EM.

I think I've seen on several occasions that the patient starts to wake up and then the mobilization starts adamantly, maybe three times a day - and then the patient backs down and gets worse! It becomes too much, physically it can also become too much and then you have to start all over again. Otherwise, I do not say no to mobilization, absolutely not! (11)

I'm like that, I like to try and push on. Because I think you have to try, until proven otherwise. As long as you haven't tried, you don't know, and as long as the patient agrees to it. (16)

There were also different views regarding the confused and unsettled patient. Some of the participants suggested that EM should be performed because they assumed that patient anxiety derived from lack of variety in their environment and stimuli. Others said, however, that there could be risks of mobilizing in this case, since the patient is too confused and could try to walk away or start hitting at all directions.

I think, when I sometimes see that the legs are almost outside the bed - they want to go somewhere. Wherever they are in their mind-set, they want to go away, therefore they need to get up. (2)

Then I think you must be a bit cautious about mobilization because it could probably make things worse, I think, depending on how they feel and behave. I mean . . . help up a patient who is writhing and wriggling and hits, then we don't have a chance . . . it's hard for them to understand that they are stuck in the technical equipment. (8)

Coordinating clinicians

Several differences in conceptions that depend on the personality or insufficient knowledge were described.

Some clinicians seem to feel uncomfortable or a little afraid to mobilize early. Possible explanations given for this were not wanting to give the patient a negative experience or having concerns for patient safety and being afraid that something serious will happen.

It's not just the patient's fear, I think it's just as much the providers' fear, and that this is an area that you don't know much about, and the lack of knowledge means that you don't really know what to do. (3)

According to the physiotherapists, medical and nursing measures were sometimes prioritized before EM. This conception was in part confirmed by some of the assistant nurses who appreciated when the physiotherapist reminded them about EM. Nurses and assistant nurses considered to a greater extent than physiotherapists that nursing in itself meant EM, such as turning in bed or letting patients brush their own teeth. While the physiotherapists emphasized the importance of achieving more of the active and upright forms of EM, such as sitting on the edge of their bed. However, despite these differing views on appropriate timing, the shared responsibility was emphasized and that all professions were equally important for ensuring EM.

The 'know-how' of early mobilization

In this descriptive category, the optimal mobilization is presented, with emphasis on an active, participating patient. Necessary careful preparation of both patients and the team, and implementation is described in the two subcategories: 1) "Timing the teamwork;" and 2) "Collaboration in action."

Timing the teamwork

There was an unequivocal agreement that mobilization should be well prepared. Ideally, it should be included in daily planning, so as not to be forgotten or not prioritized. It requires a detailed plan of who does what, since uncertainty or disagreement can otherwise have negative influence on the patient. Providing information to and motivating the patient are necessary parts of the preparation. The patient needs to know what is going to happen and, if possible, understand what the benefits and the goal of EM are. Taking time for this was considered to be well spent time.

They themselves do not have the insight that it is easy to lose fitness and strength. So, most people experience fear. But if we talk to them for a long time beforehand, then it works better. (14)

The doubtful and skeptical patient was said to be very common. The participants faced this with

a combination of reassuring, motivating, and negotiation. One participant mentioned that the patient has the right to refuse treatment and thus also EM. The prevailing view, however, was that you must take responsibility for the impaired rational decision-making that is often a consequence of the medication given to patients in intensive care. You must cautiously take over the decision-making for the patient and help them over the stumbling block that EM can entail. Some participants were not comfortable with this but found support in research and from previous patients who had realized the benefits and afterward thanked for the push they had received. On rare occasions, you must respect the patient's wish and refrain from mobilization.

You can also understand from the way some patients behave, that they are not really themselves. . . we destroy them with our medicines and other such things, that's why we must decide. (1)

Most patients, however, allow themselves to be reassured and convinced. The negotiation often means that the patient is not allowed to decide whether the EM should take place, but when and sometimes what kind. The participants described that you should find out if there is anything that can be helpful for the patient, such as getting dressed. The patient may also be helped by some extra pain relief, sedatives, or extra oxygen. It should also be kept in mind that some patients may feel that they are a nuisance due to all the preparation needed for EM and may not be used to having so many strangers close by.

There is sometimes a negotiation about how to do and what to do. The patient can choose certain things but cannot opt out of the mobilization. (4)

Collaboration in action

The mobilization should be adapted to the individual patient. A calm and safe atmosphere around the patient should be created, and, if possible, let the patient determine the pace. There should be a reward when the patient gets up (e.g. something more interesting to look at than straight into a wall) by getting their hot back cooled by a wet washcloth or having a sip of water.

In addition to continuously informing the patient what the next step will be, "chit-chat" about everyday things, life outside, both with the patient and with each other can be useful. It can relieve stress and lighten the mood. If possible, using humor can be useful, but you need to know the patient well enough to know that they will appreciate it. However, one participant thought that you should not talk about irrelevant things, it can get too

messy. The same participant also expressed that doing too many things at once should be avoided, such as exercise and nursing at the same time.

Lightening the mood, that's really important! Also in combination with the mobilization. That you feel that it is not as hard and dangerous as you might feel when you are lying there as a patient. You can relieve anxiety, both with humor and social talk... then you let go of this illness and the hospital. (11)

During the mobilization, being sensitive to any sign of inconvenience to the patient and ready to adjust the position in several ways is important. One participant emphasized that it is important to keep your promises. If you have said that the patient should be allowed to lay down whenever they want, this must actually happen. If a patient wants to stop the mobilization quickly, the cause should be established, so that things can be adjusted before the next time. After the mobilization, it should be evaluated together with patient and all progress should be underscored, however small.

Has it been said that we interrupt if it becomes too difficult, then we have to do it. We gain trust, the patients feel that they are being listened to and become involved. That's the most important thing. (6)

It is important to give positive feedback. Although sometimes it's not that much, there is always something good to take note of. (13)

Discussion

This study explored the clinicians' conceptions of EM in intensive care. EM was perceived as an important and crucial part of intensive care to prevent complications. To actively involve the patient in EM was another paramount finding, that was regarded to be of utmost importance. The concept of person-centredness described by McCormack et al. (2015) and Ekman et al. (2011) is applicable in this situation. This concept emphasizes that the focus should be on the patient as a person, rather than the medical diagnosis (McCormack, Karlsson, Dewing, and Lerdal, 2010). The patient is not just a passive recipient of care, but an active partner (Ekman et al., 2011). Communication in this partnership is essential (Olsson, Jakobsson Ung, Swedberg, and Ekman, 2013) which could be a major challenge in ICU, where normal conversation often is hindered by a ventilator and fatigue. Still, the participants in this study stressed that the patients should be as actively involved as possible and took time to reassure, motivate and negotiate EM. At the same time, the participants sometimes found it necessary to cautiously take over the decision-making. This is similar to the

review of Clarissa, Salisbury, Rodgers, and Kean (2019) where informed consent was sought in some cases, and not in others, since EM was regarded as part of routine care. The same situation from the patients' perspective is described in the qualitative study by Corner, Murray, and Brett (2019) where one of the findings was that the patients craved a paternalized approach, due to their loss of autonomy. Thus, before EM, time should be taken to reassure, motivate and, if necessary, negotiate EM.

Lightening the mood and encouragement were also considered important. Likewise, Corner, Murray, and Brett (2019) found that "humanized care" was important that meant a positive – patient interaction. A professor of psychiatry, Cullberg (2006) used the idea that clinicians should be a "stand-in hope," as an important part of dealing with a person who has suffered something very difficult. Similarly, in an interview-study by Karlsson and Bergbom (2015) nurses derived greater satisfaction from caring for conscious patients in ICU, since then they could inspire hope. Laerkner et al. (2019) studied negotiated mobilization, and one main theme was "inducing hope through mobilization." This is in line with this study, where EM were assumed to give the patient hope and strength to continue to fight toward recovery. Therefore, the clinicians in intensive care should be aware of their opportunity to induce hope.

Although the upright positions were perceived to be the best, variety of EM was considered an asset. The participants also included sensory input and mental stimulation in EM. Although this phenomenon may seem to be distinct from EM, physiotherapists frequently use sensory stimulation and proprioception as facilitators to elicit a neuromuscular response. In a current review EM is considered one of the non-pharmacological measures to prevent delirium (Sahawneh and Boss, 2021) and in a randomized controlled trial by Brummel et al. (2013) a combined cognitive and functional rehabilitation strategy is suggested. Hence, positioning, and sensory stimulation ought to be regarded as parts of EM.

There were several different conceptions on the right time to initiate EM. One common reason to wait was concern about safety, that sometimes were explained by insufficient knowledge. These safety-concerns have been described by Lago et al. (2022) and in a review by Potter, Miller, and Newman (2021). The question about insufficient knowledge has been studied by Anekwe et al. (2020) and Chaplin and McLuskey (2019) and is in these studies described as a main barrier to EM. Differing conceptions were also present when discussing how to assess and handle the restless and unsettled

patient. This kind of uncooperative behavior was also described and calculated by Cooper, Gasperini, and Parkosewich (2021) as the main patient-related barrier and, similarly, in the cohort-study by Watanabe et al. (2021) levels of consciousness were one of two significant barriers to EM. This study contributes with the idea that a restless patient might need variety and therefore should be mobilized. Thus, there is a need to further enhance and implement knowledge about safety and about the unsettled patient.

Competing priorities of care were sometimes mentioned as a challenge, mainly by the physiotherapists in this study. This issue is also addressed in the review by Potter, Miller, and Newman (2021). However, the question of who is responsible for EM, investigated in a survey by Nydahl et al. (2016), and also found by Chaplin and McLuskey (2019) didn't seem to be a problem in this study. The participants considered each other to be complementary, all equally important in the EM teamwork. Such complementary view was also found in a qualitative study by Liew, Mordiffi, Ong, and Lopez (2021). In a study (Linke et al., 2020) and in the review of Nydahl et al. (2016) the question of a mobility protocol is crucial for increasing the mobility in the ICU. However, in this study, this question was rarely addressed since EM was considered part of routine care and was included in daily planning. Lack of time and sufficient staffing, another common problem, described in a survey by Anekwe et al. (2019) and in the review of Dubb et al. (2016) was sometimes solved with exercise programs in bed, and bed-cycling. The bed bike was assumed to give hope for recovery, which is in line with the result in a study by Ringdal et al. (2018). The study by Thelander, Nellgård, Ricksten, and Å (2016) indicates that it also could be used in neurocritical care. Thus, EM should be considered as part of routine care and included in the daily planning of patient care.

Strengths and limitations

This study illuminates the clinicians' conceptions of EM. Phenomenography was an appropriate approach to the purpose of this study since the aim was to describe the conceptions of EM, from the second-order perspective and variations in these, but also describing the patients' perspective through the clinicians. The assumption that clinicians' conceptions of patients' experiences would influence their conceptions of EM in general was confirmed. However, conceptions of a phenomena are culturally and socially dependent. Consequently, not everything could be said in a research conversation. There are both explicit and implicit norms governing

what could be communicated in an interview and how (Friberg, Dahlberg, Petersson, and Öhlen, 2000). The first author's profession as a physiotherapist could have had an influence on the answers. The participants might have answered according to what is expected to be a physiotherapist's view. On the other hand, the first author's profession and experience facilitated the additional and probing questions. To enhance dependability, the interviewer also transcribed the interviews, and the procedure of listening to the recorded interviews was repeated. To further ensure credibility and manage pre-understanding the analysis was performed in close collaboration and reflective, continuous discussion with the coauthors, who have extensive research experience and all but one have broad experience of intensive care. The coauthor who had no intensive care experience contributed valuable understanding from a different perspective. The participants were aware that patient could be difficult to read and often used the words "think" and "assume" when describing the patients' experiences. Notably, there still was a considerable agreement between participants.

The purposive sample of participants showed the desired diversity regarding professions, experience, and age. The distribution men – women was similar to the distribution in hospital staff in general. Six different ICUs, with different orientations, were also represented. The authors therefore believe that the results ought to be transferable to similar contexts, i.e. ICU of several different kinds.

Conclusion

The importance of EM is indisputable. Successful EM is achieved by applying a person-centered approach, involving the patient as an active partner. Thereby, it is important to give enough time to reassure, motivate and sometimes negotiate EM. The possibility of raising hope through EM should be considered. Positioning and sensory stimulation are included in EM. It should be considered as part of routine care and included in the daily planning of patient care. Further studies are needed about mobilization of the unsettled patient.

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ORCID

Annika Söderberg MSc, RPT  <http://orcid.org/0000-0001-8904-2415>

Veronika Karlsson PhD, RN  <http://orcid.org/0000-0001-9423-9378>

Monika Fagevik Olsén PhD, RPT  <http://orcid.org/0000-0002-0207-4105>

Anita Johansson PhD, RN  <http://orcid.org/0000-0001-9019-2402>

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Appendix. Interview guide

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- How is EM usually carried out in this unit? Do you follow an early mobilization protocol?
 - Can you describe how you perceive that a patient, who is being mobilized for the first time, experiences this?
 - Is there any difference when the patient has been mobilized before, during this admission?
 - What different experiences have you observed in the patient?
 - What do you think may be the cause of the patient's experience?
 - What is the most important thing in a good mobilization?
 - Is there anything important that I have not asked about?
- Follow – up/probing questions:
- Can you tell me more about ...?
 - Have I understood you correctly ...?
-

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