



## The Role of Awareness and Training Perceptions in Shaping Respiratory Therapists' Involvement in Intensive Care Unit Early Mobilization Efforts in a Tertiary Hospital

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### **Abstract:-**

**Background:** Early mobilization in the Intensive Care Unit is a critical intervention associated with improved patient outcomes, including reduced length of stay and enhanced functional recovery. Respiratory therapists, with their expertise in ventilator management and patient airway care, are integral to facilitating EM, particularly in mechanically ventilated patients. Despite these benefits, EM implementation remains inconsistent, often due to perceived barriers such as limited staff awareness and training. This study aimed to investigate the perceptions of awareness and adequacy of training among respiratory therapists at a tertiary hospital regarding their involvement in EM initiatives within the ICU.

**Methodology:** A quantitative, cross-sectional design was employed using an electronically distributed, validated questionnaire adapted from Cabana et al.. The study was conducted at tertiary across all adult ICU departments. The target population included all respiratory therapists currently practicing in the ICU with a minimum of six months' experience. The instrument comprised three main sections: awareness and training, attitudes toward EM, and behavioral/institutional factors influencing EM engagement. Participants responded using Likert scales. Data were analyzed using SPSS v22, employing descriptive statistics (mean, SD, frequencies, percentages), Chi-square tests, and independent sample t-tests, with significance set at  $p < 0.05$ .

**Results:** The majority of participating respiratory therapists were male (67.5%), with the largest proportion aged 20-29 (40.4%). Most held a Bachelor's degree (78.1%), and a significant segment had 4-6 years of ICU experience (40.4%). Key findings indicated a high level of agreement among RTs regarding the adequacy of their training in safely mobilizing mechanically ventilated ICU patients (mean score  $4.21 \pm 0.68$ ) and confidence in their ability to mobilize patients (mean score  $1.75 \pm 0.75$ , reverse-scored). There was also a strong consensus on the benefits of intensive mobilization strategies (mean score  $4.40 \pm 0.65$ ). However, variability was observed in documentation practices of patient physical functioning (mean score  $3.10 \pm 1.00$ ), and a notable proportion of participants perceived time constraints as a barrier to active participation in patient mobilization (mean score  $3.30 \pm 1.00$ ).



**Conclusion:** Respiratory therapists at this tertiary hospital demonstrate strong awareness, adequate training, and confidence in their role in early mobilization. While they are crucial for successful EM, inconsistencies in documentation and perceived time constraints represent ongoing challenges. Addressing these specific barriers through standardized protocols and optimized workflow management is essential to further enhance EM implementation and improve patient outcomes in the ICU.

**Keywords:** *Intensive Care Unit, Early Mobilization, Respiratory Care.*

## 1. Introduction

Early mobilization (EM) in the Intensive Care Unit is a critical intervention defined as the initiation of rehabilitation within 48 to 72 hours of admission, provided there are no contraindications (Deitos et al., 2021). This proactive approach has been increasingly recognized as a foundation in critical care, moving beyond the traditional emphasis on rest to embrace dynamic recovery (Morimoto et al., 2022). This paradigm shift is driven by compelling evidence demonstrating that early mobilization significantly reduces the duration of mechanical ventilation and shortens the overall length of ICU stay (Privitera et al., 2022). Furthermore, it has been shown to mitigate common ICU-acquired weaknesses, such as delirium and muscle atrophy, thereby improving functional outcomes for critically ill patients (Sato et al., 2017). Despite these recognized benefits, the consistent implementation of early mobilization strategies in ICUs worldwide faces considerable challenges due to various patient, structural, and process-related barriers (Dubb et al., 2016). These barriers often include a lack of specialized training for healthcare professionals, insufficient staffing, equipment limitations, and a prevailing culture that prioritizes sedation over movement (Cuello-García et al., 2018). The role of respiratory therapists (RTs) in this context is particularly relevant, given their direct involvement in ventilator management and patient airway care, placing them at a unique intersection for facilitating early mobilization efforts. Their expertise in pulmonary mechanics and gas exchange positions them as key contributors to assessing patient readiness for mobilization, managing respiratory support during mobilization, and implementing breathing strategies that support physical activity. and patient stability makes their awareness and perceptions of training crucial for successful integration into early mobilization protocols. This study aims to investigate the current perceptions of awareness and the perceived adequacy of training among respiratory therapists at a tertiary hospital regarding their involvement in early mobilization initiatives within the Intensive Care Unit, thereby identifying potential gaps and opportunities for enhancing their contribution to patient recovery. Specifically, it will explore how these perceptions influence their engagement and the overall effectiveness of early mobilization programs, ultimately contributing to improved patient outcomes and reduced healthcare errors. This research will also outline the specific barriers and facilitators encountered by respiratory therapists in their daily practice concerning early mobilization.



providing actionable insights for targeted interventions. This includes evaluating the impact of educational interventions and institutional policies on their active participation in these crucial rehabilitation efforts.

## **2. Objectives**

Early mobilization (EM) of mechanically ventilated patients in the intensive care unit (ICU) is associated with improved patient outcomes, including reduced ICU length of stay, decreased duration of mechanical ventilation, and enhanced functional recovery. Despite these benefits, the implementation of EM protocols remains inconsistent, often due to barriers such as limited staff awareness and training. Respiratory therapists, with their specialized expertise in mechanical ventilation and cardiopulmonary physiology, are integral to the successful execution of EM strategies. However, their awareness and understanding of their role in EM vary significantly across healthcare settings. A pilot study conducted in Saudi Arabia surveyed 156 respiratory care professionals to assess their knowledge of EM practices. The study revealed that while RTs recognized the importance of EM, there were notable gaps in their knowledge and application of EM protocols. Factors such as age, gender, nationality, and years of ICU experience influenced their understanding of EM. Notably, those who had treated more patients using EM demonstrated higher knowledge levels, indicating that practical experience enhances awareness (Qutub et al., 2018). Further emphasizing the need for increased awareness, a study by Jolley et al. (2014) explored the attitudes and perceived barriers among ICU clinicians, including RTs, towards EM. The findings indicated that while clinicians acknowledged the benefits of EM, barriers such as staffing constraints, time limitations, and concerns about patient safety impeded its implementation. These challenges underscore the necessity for targeted education and institutional support to empower RTs in their EM roles. Moreover, a qualitative study by Kayambu et al. (2013) highlighted that multidisciplinary collaboration is essential for successful EM implementation, with RTs playing a key role in managing ventilatory support during mobilization. However, lack of clarity regarding RT responsibilities and insufficient training were identified as factors limiting their involvement, pointing to the need for improving RT awareness and role definition. In a more recent mixed-methods study, Tipping et al. (2017) found that ICU staff, including RTs, who received dedicated EM training exhibited higher confidence and greater participation in mobilization activities. The study also reported that enhanced awareness of the clinical benefits of EM positively influenced staff engagement, demonstrating the impact of knowledge on practice.

Additionally, barriers faced by RTs in EM implementation include institutional culture and protocol absence, which contribute to inconsistent awareness levels. Addressing these challenges requires increased awareness and education, development of multidisciplinary EM teams, and formalized protocols, as identified in studies focusing on RT perspectives (Schweickert & Kress, 2011). Furthermore, while the benefits of EM in mechanically



ventilated ICU patients are well-documented, the need to assess the awareness and understanding of RTs regarding their role in EM require enhancement. This research hypothesizes that enhancing respiratory therapists' awareness and providing structured educational training on early mobilization protocols will significantly improve clinical outcomes for critically ill patients and reinforce the active role of RTs in the implementation of EM practices within intensive care units.

### 3. Methods

A quantitative, cross-sectional design questionnaire conducted at tertiary hospital across all adult ICU departments. The target population included all respiratory therapists currently practicing in the ICU with a minimum of six months' experience. Those in non-clinical roles or working exclusively outside the ICU were excluded. A validated questionnaire adapted from Cabana et al. (1999) was distributed electronically to RTs. The instrument comprised three main sections: awareness and training, attitudes toward EM, and behavioral/institutional factors influencing EM engagement. Participants responded using Likert scales. The sample size was calculated based on a 95% confidence interval and 5% margin of error, yielding a requirement of 114 participants from a total population of 160.

Data were entered into Microsoft Excel and analyzed using SPSS v22. Descriptive statistics (mean, SD, frequencies, and percentages) summarize the variables. Chi-square tests and independent sample t-tests were used to explore associations, with significance set at  $p < 0.05$ .

### 4. Results

The results show that the majority of the participating respiratory therapists are male (67.5%) compared to female (32.5%). The largest proportion falls within the 20-29 age (40.4%), followed closely by those aged 30-39 (34.2%), then age group 40-49 (19.3%), which indicates a relatively young to middle-aged workforce. (78.1%) participants hold a Bachelor's degree, followed by master 16 (14%) then 9 (7.9%) diploma holders. Lastly, regarding ICU experience, the largest segment has between 4-6 years of experience (40.4%), with a substantial number also in the 1-3 years range (28.1%), suggesting a mix of relatively new and moderately experienced professionals working in critical care.

For the statement (I have received training on how to safely mobilize mechanically ventilated ICU patients) The mean score of  $4.21 \pm 0.68$  (SD) for this statement suggests a generally high level of agreement among respiratory therapists regarding their training in safely mobilizing mechanically ventilated ICU patients. The relatively low standard deviation indicates that responses were clustered closely around the mean, implying a consistent perception of adequate training across the participant group. This finding suggests that a substantial proportion of the participants feel well-prepared in this critical aspect of patient care. Moreover, the statement (I understand which ICU patients are appropriate to refer to physical therapy) reveals a mean





score of  $3.95 \pm 0.72$ , participants generally agreed that they understand appropriate referral criteria for physical therapy in the ICU setting. While still indicating strong agreement, the slightly larger standard deviation compared to the training statement might suggest a slightly broader range of understanding, with some participants perhaps less confident in their knowledge of referral guidelines. This highlights a generally good, though not universally consistent, understanding of interdisciplinary referral processes. Furthermore, (I understand which ICU patients are appropriate to refer to occupational therapy) this statement yielded a mean score of  $3.78 \pm 0.85$ , which is slightly lower than the understanding of physical therapy referrals and training. The higher standard deviation suggests greater variability in responses, indicating that while many participants understand occupational therapy referral criteria, a notable segment may feel less certain or have differing levels of awareness. This could point to a potential area for targeted education or clarification regarding the distinct roles of occupational therapy in the ICU. Additionally, the statement (Unless contraindicated, I educate my ICU patients about the importance of physical activity and mobilization) showed the mean score of  $4.05 \pm 0.65$  indicates that respiratory therapists generally engage in educating their ICU patients about physical activity and mobilization. The relatively low standard deviation suggests this is a consistent practice among the participants. This finding highlights a strong commitment to patient education as part of the mobilization process, underscoring the perceived importance of patient involvement in their recovery and rehabilitation within the ICU.

## Section 2: Attitudes Toward Early Mobilization:

The statement (My ICU patients are usually too sick to be mobilized) shows a mean score of  $1.90 \pm 0.85$  indicates a strong disagreement with the statement that ICU patients are usually too sick to be mobilized. This suggests a prevalent positive attitude among respiratory therapists, recognizing the potential for early mobilization even in critically ill patients, challenging a common barrier to practice. The relatively low standard deviation reflects a consistent viewpoint across the group. Moreover, (Increasing mobilization of ICU patients may cause harm) With a mean of  $2.15 \pm 0.70$ , participants generally disagreed that increasing patient mobilization may cause harm. This indicates a favorable attitude towards the safety of mobilization, suggesting that RTs perceive the benefits to outweigh potential risks when performed appropriately. The low standard deviation implies broad agreement on the safety aspect. Furthermore, (Mobilization should primarily be handled by physical or occupational therapists, not RTs) the mean score of  $2.40 \pm 0.92$  suggests a general disagreement with the idea that mobilization should only be handled by physical or occupational therapists. This indicates that respiratory therapists see themselves as having a role in patient mobilization, promoting a multidisciplinary approach rather than limiting it to specific professions. The slightly higher standard deviation suggests some variability in this perception. Additionally,



this statement (Increasing patient mobilization would create more work for nurses) showed a mean score of  $2.80 \pm 0.95$  indicates that participants are somewhat neutral to slightly disagreeing with the notion that increased mobilization would create significantly more work for nurses. This suggests a nuanced understanding of workload, possibly indicating a belief that while it might add tasks, the overall benefits or existing collaborative structures might mitigate the perception of excessive burden. The higher standard deviation reflects diverse opinions on this workload impact. For this statement (Increasing patient mobilization would create more work for physical/occupational therapists). The mean of  $3.10 \pm 0.88$  suggests a slight agreement or neutrality on whether increasing mobilization would create more work for physical/occupational therapists. This could reflect a realistic understanding that increased activity demands more from these specialized roles, or a perception that their current capacity might be strained by a significant increase in mobilization efforts. A high mean score of  $4.50 \pm 0.55$  for (ICU patients mobilized at least three times daily are likely to have better outcomes) demonstrates strong agreement among participants that frequent mobilization (three times daily) leads to better patient outcomes. This reflects a positive, evidence-based belief in the benefits of intensive mobilization strategies, aligning with contemporary best practices in critical care. The very low standard deviation signifies strong consensus. Also, (I am unsure when it is safe to mobilize ICU patients) With a mean of  $2.00 \pm 0.80$ , participants largely disagreed with being unsure about when it is safe to mobilize ICU patients. This suggests a high level of perceived competence and clarity regarding patient selection and safety criteria for mobilization. The mean score of  $1.75 \pm 0.75$  for the statement (I do not feel confident in my ability to mobilize ICU patients) indicates a strong disagreement with feeling unconfident in their ability to mobilize ICU patients. This suggests that respiratory therapists generally feel competent and assured in their practical skills related to patient mobilization. The low standard deviation points to a widespread feeling of confidence. Finally. A mean of  $3.60 \pm 1.05$  indicates a moderate level of agreement that ICU patients have enough time for three daily mobilization sessions. The higher standard deviation here suggests a wider range of perspectives, possibly reflecting varying clinical realities, workload pressures, or differing patient needs across units. This could indicate a perceived logistical barrier despite a belief in the benefits of frequent mobilization for the statement (My ICU patients have time during their day to be mobilized at least three times).

### Section 3: Behaviors and Institutional Factors:

Participants' perceptions and self-reported practices concerning the safe mobilization of mechanically ventilated ICU patients, along with their attitudes, perceived barriers, facilitators, and existing team practices, were comprehensively assessed through a series of statements.

The reverse-scored statement, "My ICU lacks the necessary equipment or furnishings to support safe patient mobilization," yielded a mean score of  $2.10 \pm 0.90$ . This indicates a general



disagreement among participants, suggesting that inadequate equipment or furnishings are not widely perceived as significant barriers to safe patient mobilization within their respective ICUs. The relatively low standard deviation implies a consistent perception across the participant group regarding the availability of necessary resources. For the statement, "The physical functioning of ICU patients is regularly discussed among RTs, nurses, physicians, and therapists," a mean of  $3.95 \pm 0.85$  was observed. This high mean indicates that interdisciplinary discussion concerning patients' physical functioning occurs regularly, suggesting the presence of robust communication channels crucial for effective and coordinated mobilization efforts. The standard deviation, while modest, points to some variability, potentially reflecting differing communication norms or frequency across various units. The statement, "Nurse-to-patient staffing is adequate to support mobilization efforts in my ICU," recorded a mean of  $2.70 \pm 1.05$ . This score suggests a neutral to slightly disagreeing stance on the adequacy of nurse staffing for supporting mobilization initiatives. The notably higher standard deviation indicates a diverse range of opinions, with some participants likely perceiving staffing levels as a significant barrier, while others find them sufficient, highlighting staffing as a potential area of concern. The reverse-scored statement, "Most ICU patients have contraindications that prevent mobilization," had a mean of  $1.80 \pm 0.70$ . This strong disagreement indicates that participants do not widely perceive medical contraindications as a prevalent barrier to mobilization, suggesting a recognition that a substantial proportion of ICU patients are, in fact, medically suitable for early mobilization. A high mean of  $4.15 \pm 0.75$  for the statement, "Unless contraindicated, ICU patients are mobilized at least once daily by the care team," signifies strong agreement that the care team consistently engages in daily patient mobilization, underscoring a perceived commitment to routine mobilization practices. The statement, "My department leadership actively supports ICU patient mobilization," obtained a mean of  $4.25 \pm 0.60$ . This strong agreement suggests that leadership actively champions early mobility initiatives, fostering a positive organizational culture conducive to these practices. The reverse-scored statement, "Mobilizing patients more frequently increases my personal risk of injury," yielded a mean of  $2.30 \pm 0.80$ . This general disagreement indicates that participants do not widely perceive frequent patient mobilization as increasing their personal risk of injury, potentially reflecting effective training in safe patient handling techniques and equipment use. The statement, "ICU patients who can be mobilized usually have physician orders in place," had a mean of  $3.80 \pm 0.95$ . This indicates a general agreement that physician orders for mobilization are typically established, suggesting that physician support and proper documentation processes facilitate the implementation of mobilization efforts. The reverse-scored statement, "ICU patients often resist being mobilized," presented a mean of  $2.90 \pm 1.10$ . This score reflects a neutral to slightly disagreeing stance, coupled with a high standard deviation, indicating varied experiences among participants; while some patients may exhibit resistance, it is not universally perceived as a major or consistent barrier. For the statement,



"Family members are usually interested in helping mobilize ICU patients," a mean of  $3.40 \pm 0.90$  was observed. This moderate agreement suggests that while family involvement is recognized as potentially beneficial, it may not be consistently perceived as a strong facilitating factor in all clinical situations, possibly due to varying family availability, capacity, or comfort levels.

Continuing the analysis, the statement, "I document the physical functioning status of my patients during my shift," registered a mean of  $3.10 \pm 1.00$ . This score reflects a neutral to slightly agreeing response, with a notable standard deviation. This suggests variability in documentation practices among respiratory therapists, indicating an area where consistency in recording patient physical functioning could be improved. For the reverse-scored statement, "I do not have enough time during my shift to participate in mobilizing ICU patients," a mean of  $3.30 \pm 1.00$  was observed. This score, with its high standard deviation, indicates a slight agreement to neutrality regarding time constraints as a barrier. This suggests that for a notable proportion of participants, perceived lack of time during their shift presents a challenge to active participation in patient mobilization, highlighting a common logistical and workload-related barrier within the busy ICU environment.

Participants' documentation practices and personal involvement in patient mobilization were also assessed. The statement, "I document the physical functioning status of my patients during my shift," registered a mean of  $3.10 \pm 1.00$ . This score reflects a neutral to slightly agreeing response, with a notable standard deviation. This suggests variability in documentation practices among respiratory therapists, indicating an area where consistency in recording patient physical functioning could be improved. For the reverse-scored statement, "I do not have enough time during my shift to participate in mobilizing ICU patients," a mean of  $3.30 \pm 1.00$  was observed. This score, with its high standard deviation, indicates a slight agreement to neutrality regarding time constraints as a barrier. This suggests that for a notable proportion of participants, perceived lack of time during their shift presents a challenge to active participation in patient mobilization, highlighting a common logistical and workload-related barrier within the busy ICU environment.

## 5. Discussion

The comprehensive assessment of participants' perceptions, attitudes, and reported practices concerning early mobilization in the intensive care unit offers valuable insights into the current landscape of rehabilitation efforts for critically ill patients. This discussion will delve deeper into the implications of these findings, comparing them with existing literature to provide a broader context and identify potential areas for improvement and future research.

The mean score of  $3.10 \pm 1.00$  for the statement, "I document the physical functioning status of my patients during my shift," reflects a neutral to slightly agreeing response among





participants, accompanied by a notable standard deviation. This variability suggests inconsistencies in documentation practices, highlighting an area where standardization could significantly enhance continuity of care and interdisciplinary communication. Effective documentation of physical functioning is crucial for tracking patient progress, identifying barriers, and tailoring individualized mobilization plans (Aglawe et al., 2022). Tools like the Perme ICU Mobility Score have been developed to standardize the assessment and measurement of mobility status in critically ill patients, thereby facilitating more consistent documentation and tracking of functional recovery (Perme et al., 2014). However, as indicated by other studies, documentation can be a significant burden, particularly in relation to nursing flowsheets, where detailed data entry is time-consuming (Collins et al., 2018). Manual documentation processes are prone to errors and can hinder the timely capture of real-time information (Haas et al., 2021; Sowen et al., 2019). The observed variability in documentation practices within this study aligns with broader challenges reported in the literature regarding data quality and trending in early mobility monitoring, emphasizing the need for standardized tools and protocols to improve consistency (Fazio et al., 2020). Without clear and consistent documentation, it becomes difficult to assess the impact of interventions of mobilization and to provide evidence-based care.

The perceived barrier of time constraints is evident in the mean score of  $3.30 \pm 1.00$  for the reverse-scored statement, "I do not have enough time during my shift to participate in mobilizing ICU patients." The high standard deviation indicates a wide range of experiences, suggesting that for a significant portion of participants, insufficient time is a considerable impediment to active involvement in patient mobilization. This finding resonates strongly with extensive research identifying inadequate staffing and time as pervasive barriers to implementing early mobilization programs across various healthcare disciplines in the ICU (Dubb et al., 2016). Healthcare professionals frequently report that lack of time due to high workload and inadequate staffing is a significant impediment to initiating or increasing patient mobility (Barber et al., 2014; Parker et al., 2021). For instance, nurses have identified insufficient staffing as a barrier to early mobilization (Babazadeh et al., 2021), and studies suggest that increasing staffing may be required to improve mobility outcomes (Dafoe et al., 2015). The relationship between nurse-patient ratios and mobility levels also indicates that higher patient loads can hinder active mobilization (Raurell-Torredà et al., 2021). Competing priorities, such as managing complex medical devices, administering medications, and responding to acute patient changes, often relegate mobilization to a lower priority, despite its known benefits (Barber et al., 2014). Addressing this barrier often necessitates a systemic approach, including adequate staffing models, dedicated mobility teams, and efficient scheduling that integrates mobilization into routine care workflows (Dafoe et al., 2015; Hunter et al., 2017). Without addressing these systemic issues, individual commitment to mobilization,



while high, may be undermined by practical constraints, leading to less frequent mobilization than desired (Barber et al., 2014).

Despite these challenges, the mean score of  $3.75 \pm 0.80$  for the statement, "Unless contraindicated, I personally assist in mobilizing ICU patients at least once per shift," demonstrates a general agreement among participants to actively contribute to patient mobilization (Zaccagnini et al., 2024). This finding reflects a hands-on approach and a strong personal commitment to patient mobility, reinforcing the integral role of respiratory therapists within the multidisciplinary early mobilization team. This active involvement is consistent with the growing emphasis on a collaborative, interprofessional approach to early mobilization, where various healthcare team members, including physical therapists, nurses, and physicians, contribute their combined skills to achieve safe and effective patient outcomes (Deitos et al., 2021; Green et al., 2016; Harris & Shahid, 2014; Linke et al., 2020). Respiratory therapists are indispensable in the evaluation, treatment, and management of cardiopulmonary diseases and collaborate closely with multidisciplinary teams to deliver comprehensive respiratory care, including facilitating early weaning from mechanical ventilation, which is crucial for early mobility (Xu et al., 2024). Their expertise in ventilator settings and managing respiratory stability during movement makes them crucial for safely mobilizing intubated or mechanically ventilated patients (González-Seguel et al., 2021). This direct participation underscores the understanding that early mobilization is a shared responsibility, requiring the integrated efforts of all team members (Hickmann et al., 2016). The consistently high mean score suggests that despite the perceived time constraints, respiratory therapists prioritize and actively engage in patient mobilization, reflecting a strong professional commitment to patient recovery and functional independence.

Expanding on other key findings, the high mean score of  $4.21 \pm 0.68$  for "I have received training on how to safely mobilize mechanically ventilated ICU patients" and the strong disagreement ( $1.75 \pm 0.75$ , reverse-scored) with "I do not feel confident in my ability to mobilize ICU patients" collectively underscores the positive impact of training on self-perceived competence and confidence. Effective training programs are crucial for equipping healthcare professionals with the necessary knowledge and skills for safe early mobilization (Hunter et al., 2017; Joseph & McCauley, 2019). Research indicates that comprehensive education can significantly improve clinicians' attitudes and reduce perceived barriers related to knowledge and safety (Akhtar & Deshmukh, 2021; Jiang et al., 2022; Messer et al., 2015). This is vital, as a lack of knowledge or confidence can be a significant barrier to implementation (Zhang et al., 2021). The consistency in perceived adequate training suggests that educational initiatives are reaching the participant group effectively, fostering a foundation of confidence necessary for proactive engagement in mobilization.



Furthermore, the general agreement ( $3.95 \pm 0.85$ ) with "The physical functioning of ICU patients is regularly discussed among RTs, nurses, physicians, and therapists" highlights the presence of robust interdisciplinary communication channels (Jootun & Pryde, 2012). This is a critical facilitator for coordinated mobilization efforts, as effective communication ensures that all team members are aware of the patient's mobility status, goals, and any contraindications, thereby enhancing patient safety and optimizing outcomes (Deitos et al., 2021; Ntinga & Aswegen, 2020). Studies by Dubb et al. identified interprofessional meetings and shared clinical responsibilities as key strategies to overcome process-related barriers to early mobilization (Dubb et al., 2016a, 2016b). The implementation of electronic health record tools to promote interprofessional communication has also been shown to improve collaboration and patient outcomes in early mobility programs (Anderson et al., 2018). While some variability was noted, the overall positive perception of interdisciplinary discussion suggests a foundational strength within the units that can be leveraged for further improvements in mobility practices.

Finally, the strong agreement ( $4.25 \pm 0.60$ ) that "My department leadership actively supports ICU patient mobilization" indicates a positive organizational culture that promotes early mobility initiatives (Chiscano-Camón et al., 2022). Leadership support is consistently cited as a critical facilitator for successful implementation of early mobilization programs, as it influences resource allocation, policy development, and staff prioritization (Barber et al., 2014; Hodgson et al., 2021). When leadership champions mobility, it fosters an environment where staff feel empowered and supported in their efforts (Boehm et al., 2022). This organizational endorsement can mitigate some of the perceived barriers, such as lack of resources or conflicting priorities, by ensuring that early mobilization is recognized as a core component of patient care (Barber et al., 2014). The role of a dedicated mobility champion, supported by leadership, has also been found to be successful in improving early mobility program effectiveness (Bruce & Forry, 2018). The low disagreement  $2.10 \pm 0.90$ , regarding the lack of necessary equipment or furnishings further supports the notion of an enabling environment, suggesting that physical resources are generally not a significant barrier in the participating ICUs (Katsukawa et al., 2021).

## 6. Conclusion

This study reveals that respiratory therapists are highly trained, confident, and play an integral role in early mobilization efforts within the ICU, supported by strong interdisciplinary communication and active leadership. However, the effectiveness of these efforts is hampered by inconsistent documentation practices and significant time constraints stemming from workload pressures. To enhance early mobilization programs, future strategies should focus on standardizing documentation protocols and implementing systemic changes to staffing and workflow management to alleviate time-related barriers. By addressing these key areas,



healthcare systems can further leverage the expertise of respiratory therapists to achieve more consistent and improved functional outcomes for critically ill patients.

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