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EMPIRICAL RESEARCH QUALITATIVE

Healthcare professionals perspectives on feasibility and acceptability of family engagement in early mobilisation for adult critically ill patients: A descriptive qualitative study

Sasithorn Mukpradab M.N.S., RN, PhD Student[1] | Julie Cussen MN, RN, Nurse Researcher[2] | Kristen Ranse PhD, RN, Senior Lecturer[1,3] | Praneed Songwathana PhD, RN, Associate Professor[4] | Andrea P. Marshall PhD, RN, Professor[1,2,3]

[1]School of Nursing and Midwifery, Griffith University, Southport, Queensland, Australia

[2]Gold Coast University Hospital, Southport, Queensland, Australia

[3]Menzies Health Institute Queensland, Griffith University Parklands Drive, Southport, Queensland, Australia

[4]Faculty of Nursing, Prince of Songkla University, Hat Yai, Thailand

Correspondence
Sasithorn Mukpradab, School of Nursing and Midwifery, Griffith University, Southport, Queensland, Australia.
Email: sasithorn.mukpradab@griffithuni.edu.au

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Abstract

Aims: To explore healthcare professionals' perceptions of the feasibility and acceptability of family engagement in early mobilisation for adult critically ill patients.

Background: Early mobilisation is beneficial to minimise intensive care unit acquired-weakness in critically ill patients and family engagement can help with meeting early mobilisation goals, but it is not widely practiced. Understanding healthcare professionals' perceptions of feasibility and acceptability of family engagement in early mobilisation of adult critically ill patients is required to inform future implementation strategies to promote early mobilisation.

Design: A descriptive qualitative study.

Methods: Face-to-face, individual, semi-structured interviews were conducted between August 2021 and March 2022 with healthcare professionals working in two intensive care units in Australia. The interviews were analysed using the inductive content analysis, and descriptive statistics were used to summarise participant characteristics. The COREQ checklist was followed when reporting this study.

Results: Eleven ICU nurses, five physiotherapists and four physicians participated in the interviews. Three main categories were identified: (i) healthcare professionals' readiness, (ii) mediators of engagement and (iii) foundations for successful implementation. Most participants demonstrated a positive attitude towards an implementation of family engagement in early mobilisation for adult critically ill patients; however, capability and capacity of healthcare professionals, family members' willingness, availability and readiness and the care context were considered factors that could influence the successful implementation.

Conclusion: From the perspectives of healthcare professionals, family engagement in early mobilisation is feasible and acceptable to enact but implementation is influenced by contextual factors including, healthcare professionals' capability and capacity and

family members' willingness, availability and readiness. Collaborative teamwork and preparing family members and healthcare professionals are needed to support this practice.

Relevance to Clinical Practice: The findings provide important information to further identify potential strategies of family engagement in early mobilisation and to help and mitigate factors that impede implementation.

KEYWORDS
acceptability, adult critically ill patients, early mobilisation, family engagement, feasibility, qualitative study

1 | INTRODUCTION

Early mobilisation in critical illness is beneficial to support physical recovery and minimise the development of complications associated with immobilisation such as intensive care unit-acquired weakness (ICUAW) (Anekwe et al., 2020; Wang et al., 2020; Zhang et al., 2019). However, early mobilisation of critically ill adults is not consistently undertaken and decisions to mobilise are influenced by the patients' clinical condition, availability of staff and equipment to support mobilisations (Dubb et al., 2016; Parry et al., 2017). Family engagement is recognised as a strategy to improve the quality of care for adult critically ill patients in a range of areas including promoting early mobilisation (Ely, 2017; van Delft et al., 2021). However, enacting this approach will require support from healthcare professionals and a change in usual practice if family engagement is not well embedded in the clinical setting (Haines, 2018). Optimal strategies to support family engagement in early mobilisation in the context of critical illness are currently unknown (Haines, 2018). Before such strategies can be developed, we first need to understand healthcare professionals' perceptions of the feasibility and acceptability of implementing family engagement in early mobilisation of adult critically ill patients.

Reporting Method

The consolidated criteria for reporting qualitative research (COREQ) was followed when reporting this research.

Patient or Public Contribution

Healthcare professionals were involved in this study and provided the data through participant interviews.

What does this paper contribute to the wider global clinical community?

- From the perspectives of healthcare professionals, the feasibility and acceptability of family engagement in early mobilisation for adult critically ill patients could be influenced by the care context, healthcare professionals' readiness and family members' willingness, readiness and availability.
- Collaboration, teamwork and preparation of healthcare professionals and family members are needed as foundations to support successful implementation of family engagement in early mobilisation for adult critically ill patients.

2 | BACKGROUND

Critically ill patients are at high risk of developing ICUAW because they often have prolonged periods of immobility when receiving life-saving treatment (Yang et al., 2018). Promoting early mobilisation using both in-bed and out-of-bed exercises throughout the intensive care unit (ICU) stay enhances physical function in adult critically ill patients (Clarissa et al., 2019) and can help to minimise the development of ICUAW (Anekwe et al., 2020). Promoting early mobilisation can also help to reduce duration of mechanical ventilation (Zhang et al., 2019), prevent hospital-acquired complications including pressure injuries, deep vein thrombosis and ventilator-associated pneumonia (Wang et al., 2020) and improve physical mobility at hospital discharge (Anekwe et al., 2020; Wang et al., 2020; Zhang et al., 2019). Although promoting early mobilisation may be of benefit to adult critically ill patients, there are some challenges with its implementation. These include determining when it is best to commence early mobilisation, and the frequency, dose and type of exercise to be undertaken (Clarissa et al., 2019; Wang et al., 2020). All these factors may impede the enactment of early mobilisation of critically ill patients (Clarissa et al., 2019; Wang et al., 2020).

Despite the benefits of early mobilisation, several factors, such as the patient's clinical condition, staffing levels and limited equipment in critical care areas, limit the regular and timely implementation of early mobilisation (Dubb et al., 2016; Parry et al., 2017). Strategies to overcome barriers to early mobilisation in critical illness include implementing safety guidelines and mobility protocols, interprofessional training, providing education and identifying local physician champions (Dubb et al., 2016). The use of an interprofessional approach and multiple-targeted strategies to sustainably implement early mobilisation in practice are also recommended (Dubb et al., 2016).

Partnership between healthcare professionals and family members is another strategy suggested to facilitate early mobilisation in adult critically ill patients (Ely, 2017). In an article describing the process of engaging family members in early mobilisation, Rukstele and Gagnon (2013) reported that family engagement can increase compliance with early mobilisation from 66% to 94% in the ICU setting. Furthermore, a systematic review of 18 studies by van Delft et al. (2021) found that more than 85% of family members are willing to engage in physiotherapy-related tasks for adult critically ill patients such as passive and active range of motion exercises, changing a patient's position, mobilisation out of bed and ambulation. Healthcare professionals may also be willing to be partner with family members in early mobilisation activities although further research in this area is needed (van Delft et al., 2021).

Despite the potential benefits of family engagement in early mobilisation, adopting this approach remains challenging and may require a change in practice culture (Haines, 2018) and clear strategies to address safety concerns (Haines, 2018; Hamilton et al., 2020). Support from healthcare professionals is required to facilitate family engagement in early mobilisation yet little is known about the best strategies to support family members, or the challenges that might be experienced by healthcare professionals. Understanding healthcare professionals' perspectives of the feasibility and acceptability of engaging family members in early mobilisation in the ICU can help to identify strategies to successfully implement this practice (Haines, 2018).

3 | METHODS

3.1 | Design

An exploratory-descriptive qualitative study was undertaken to explore healthcare professionals' perceptions of the feasibility and acceptability of family engagement in early mobilisation for adult critically ill patients, which is not well described in the literature (Hunter et al., 2019).

3.2 | Setting and participants

This study was conducted from August 2021 to March 2022 in two ICUs within one health service based in southeast Queensland, Australia. Hospital A had a 28-bed ICU and admitted more than 2000 patients annually; hospital B had a 6-bed ICU and admitted approximately 450 patients annually. Both ICUs employed nurses, physiotherapists, physicians and other allied healthcare professionals who worked together to provide high-level intensive care for adult critically ill patients. There was an open visiting policy throughout day and night with the only restriction being two family members visiting at the bedside at any one time. Early mobilisation was usual practice in both ICUs and healthcare professionals completed mandatory manual handling training annually which provided healthcare professionals with the knowledge and skills required to effectively implement early mobilisation in the ICU. Prompts and reminders regarding early mobilisation were also present in the electronic medical record. Family engagement in early mobilisation was not considered usual practice in either ICU.

Purposive sampling was used to recruit participants from healthcare professionals who were currently working in ICU and were employed as a registered nurse, physiotherapist or physician. Potential participants were provided with a participant information and consent form which outlined the study purpose. Based on previous experience and as suggested by Mason (2010), we anticipated recruiting approximately 20 participants. However, the sample size was not specifically predetermined with participant recruitment to be completed after no new categories or subcategories arose from the interviews (Bengtsson, 2016; Polit & Beck, 2014). At this point, we interviewed an additional three participants from each professional group to confirm data saturation. Overall, 20 participants across three professions participated in this study. No participant withdrew from this study.

3.3 | Data collection

Face-to-face individual semi-structured interviews were guided by an interview schedule (File S1) informed by the theoretical framework of acceptability (TFA) (Sekhon et al., 2017) and previous research undertaken in the area of family engagement in the ICU (Marshall et al., 2017). The interviews were performed by the first author and participant recruitment was facilitated by the second author. All interviews were conducted at a time and place in the hospital that was convenient for the participants. Demographic data, including age, gender, educational level, position and years of clinical experience in ICU were collected at commencement of the interview. All interviews were audio recorded and transcribed verbatim by the first author or a professional transcription agency prior to data analysis. Transcription accuracy was checked by the second author.

3.4 | Data analysis

An inductive content analysis approach was used to interpret and identify coding, subcategories, generic categories, main categories, coding frequency and contents (Elo & Kyngäs, 2008). The first author read and re-read the interview transcriptions to make sense of and identify codes in the raw data. Similar codes were then grouped together, and these codes were grouped into subcategories, generic categories and main categories by the first author. In an iterative fashion, the codes, frequency of codes, subcategories, generic categories and main categories were reviewed and discussed with the second, third and last authors until a consensus was reached (Bengtsson, 2016).

Healthcare professionals' characteristics were analysed using descriptive statistics using IBM SPSS Statistics for Windows Version 20 (IBM Corp). Categorical variables, including gender, education level and position, were analysed using frequency distributions and percentage. Mean and standard deviation were used to analyse continuous variables with normal distributions, including age and years of clinical experience in ICU (Polit & Beck, 2014).

3.5 | Rigour

All authors were female with expertise in qualitative research and critical care nursing practice. Based on previous experience, the researchers expected that wide variability in how healthcare professionals perceived the feasibility and acceptability of family engagement in early mobilisation of adult critically ill patients was likely. The authors did not have any personal or professional relationship with the participants. Trustworthiness and integrity of qualitative data were enhanced using several strategies. The information from the interviews were completed and checked with the participants after each interview. Codes, main categories, generic categories, subcategories, frequency of codes and finding contents were reviewed by comparison and discussion with the research team until reaching a consensus to enhance the credibility, dependability and confirmability of data analysis. The researcher also reported the finding results with a clear description of settings, participants, methods and the process of data analysis to enhance transferability by following the consolidated criteria for reporting qualitative research (COREQ) (File S2) (Tong et al., 2007).

3.6 | Ethical considerations

Ethics approval was received from the Human Research Ethics Committee (HREC) at Griffith University (GU Ref No: 2022/155) and Gold Coast Health (LNR/2021/QGC/73172). Written informed consent was obtained from participants prior to participation in the interviews. Participant codes were used to ensure anonymity and confidentiality.

4 | FINDINGS

Twenty healthcare professionals, comprising of eleven registered nurses, five physiotherapists and four physicians participated in this study. The majority were female, and the mean age was 36.95 ± 2.54 years. The clinical experience of the participants varied, and the participants had experience in critical care settings at a mean of 11.45 ± 2.49 years. Participant characteristics are outlined in Table 1. The interview duration was between 19 and 46 minutes (average 29 minutes) producing a total of 574 minutes of data.

Analysis revealed three main categories describing healthcare professionals' perceptions of implementing family engagement in early mobilisation for adult critically ill patients: (i) healthcare professionals' readiness, (ii) mediators of engagement and (iii) foundations for successful implementation. The main categories and generic categories are demonstrated in Table 2.

TABLE 1 Participant characteristics ($N = 20$).

	n (%)
Gender	
Male	4 (20%)
Female	16 (80%)
Position	
Nurses	11 (55%)
Physiotherapist	5 (25%)
Doctor	4 (20%)
Education	
Bachelor's degree	5 (25%)
Master's degree	5 (25%)
Postgraduate specialty qualification	6 (30%)
Bachelor of Medicine	2 (10%)
Doctor of Medicine	2 (10%)
Experience in critical care settings	
1–5 years	10 (50%)
6–10 years	1 (5%)
More than 10 years	9 (45%)

4.1 | Healthcare professionals' readiness

The readiness of healthcare professionals to engage family members in the process of early mobilisation for adult critically ill patients in ICU settings was influenced by several factors including (i) capability with early mobilisation (ii) capability with family engagement in early mobilisation and (iii) healthcare professionals' capacity.

4.1.1 | Capability with early mobilisation

Being able to facilitate family engagement in early mobilisation required healthcare professionals to feel confident in enacting early mobilisation as part of their usual clinical practice. Some participants described healthcare professionals as lacking experience and capability with supporting early mobilisation independently. For example, a senior nurse described that some junior nurses might not know *'how to do range of motion exercises'* (Nurse #8) and a physiotherapist described that some healthcare professionals did not have the *'experience of knowing how hard to push a patient or not push a patient'* (Physiotherapist #5) when supporting patients with early mobilisation. Hesitancy with undertaking early mobilisation was common for healthcare professionals with less experience in caring for critically ill patients. Physiotherapists commented that some bedside nurses may feel hesitant to encourage critically

TABLE 2 The main categories and generic categories.

Main categories	Generic categories
Healthcare professionals' readiness	• Capability with early mobilisation • Capability with family engagement in early mobilisation • Healthcare professionals' capacity
Mediators of engagement	• Family willingness • Family availability and opportunity • Family readiness
Foundations for successful implementation	• Identified benefits to patients and family members • Patient safety concerns • Preparing healthcare professionals and family members • Collaboration and teamwork

ill patients to perform early mobilisation because they were unsure *'how it is going to go'* and there was the perception that they lacked experience to *'manage the situation'* (Physiotherapist #10) if something inadvertent occurred. Additionally, some healthcare professionals, especially those who were younger or new to the ICU, were not confident in their ability as they lacked experience in promoting early mobilisation for critically ill patients. One nurse commented that:

> *'I don't have as much experience* [promoting early mobilisation]*...I'm a bit more nervous when it comes to the tube and potentially losing the tube or if something goes wrong and they're not in the bed and how am I going to handle it because I don't have the experience'* (Nurse #11)

4.1.2 | Capability with family engagement in early mobilisation

Although it was considered appropriate, most healthcare professionals were hesitant to engage family members in early mobilisation because they felt they lacked capability in this area. As one nurse explained, when healthcare professionals were uncertain and nervous about performing early mobilisation activities, *'they would feel uncomfortable having a family member'* (Nurse #1) help them in early mobilisation sessions. Furthermore, the different levels of knowledge and experience of healthcare professionals may impact their ability in engaging family members in early mobilisation. Most physiotherapists and senior nurses said that they felt confident to engage family members in promoting early mobilisation activities because they knew how to support family members in the aspects of early mobilisation. However, others, especially junior healthcare professionals, did not engage family members in early mobilisation as *'they are not sure of what family members can do'* (Nurse #8) and felt that the single room setting in the ICU made *'...it is very hard for them to learn'* (Nurse #13) from experienced nurses about how to do this. The uncertainty about how to engage families in early mobilisation activities was exemplified by one healthcare professional who commented:

> *'I don't know exactly what I would be asking them to do. I wouldn't really know what to say to them at this point in time. I could probably say, oh we want to get your loved one moving, our physiotherapists are going to help, if you would like to be there and they can show you things you can do to help...I think that would be nice for them to know...But currently I wouldn't know what to say because I don't know how we would be doing it for each patient'* (Physician #20)

4.1.3 | Healthcare professionals' capacity

Priority of care and workloads in ICU settings could impact healthcare professionals' capacity to enact family engagement in early mobilisation. Although family engagement in early mobilisation could be enacted in ICU settings, healthcare professionals were less supportive of this approach because of competing priorities of care and high workloads. One nurse commented that they were not available to *'go through the early exercise with them* [family members]*'* (Nurse #2) because there were other priorities of care at the time, a sentiment that was echoed by others. The responsibility to *'keep the patient alive first'* (Nurse #2) by focusing on *'giving the drugs'* (Nurse #2) and monitoring *'the patient's breathing, heart rate, and blood pressure'* (Nurse #2) was considered a priority. When patients were stable, healthcare professionals shifted their focus to *'discharge'* (Nurse #7) of patients to the wards.

High workloads in ICUs were also identified by healthcare professionals as contributing to lack of time to engage family members in early mobilisation. Some healthcare professionals explained that *'our workload in ICU is quite a lot'* (Physiotherapist #5) and they did not have time to *'teach relatives* [family members] *how to do leg exercises'* (Nurse #2). Healthcare professionals also identified that working with family members in promoting early mobilisation would depend on *'caseload demands'* (Physiotherapist #6) in ICU settings and family

engagement in early mobilisation could only really be done when *'it is not very busy'* (Physiotherapist #6).

4.2 | Mediators of engagement

Mediators of engagement focused on factors from family members who acted as intermediaries with healthcare professionals to support the feasibility and acceptability of implementing family engagement in early mobilisation for adult critically ill patients. Three mediators of engagement were identified in interview transcripts: (i) family willingness, (ii) family availability and opportunity and (iii) family readiness.

4.2.1 | Family willingness

Family willingness was a factor that could influence the feasibility and acceptability of implementing this approach. Healthcare professionals believed that family members wanted to *'help and see their loved one get better'* (Nurse #11) and do what they could to provide *'the best'* (Physiotherapist #4) in patient care was a factor in whether family would be willing to engage in early mobilisation. One physiotherapist reflected on an experience in clinical practice that *'they* [family members] *are happy to be in the room'* (Physiotherapist #16) while healthcare professionals promoted early mobilisation activities, such as active-assisted exercise or in-bed exercises but did not comment on family engagement beyond being present.

Although healthcare professionals believed that most family members were willing to be engaged in early mobilisation, it was recognised that this may not be accepted by all family members. Some might not be willing to partner with healthcare professionals in early mobilisation if they perceived that *'getting better is just resting'* (Physiotherapist #4), while other healthcare professionals felt that family members came to visit the patients and only wanted to *'get an update*, [and] *see and talk with their loved ones'* (Physician #17). Additionally, where poor family relationships existed, healthcare professionals did not consider family engagement in early mobilisation to be an activity likely to be undertaken by family members or desired by the patient. As an example, one nurse described that when there is conflict and *'…clearly not a great dynamic*, *it ends up in people getting frustrated and not being able to listen to us because they are fighting'* (Nurse #11).

4.2.2 | Family availability and opportunity

The lack of family availability and opportunity was also considered to be a factor that could negatively influence the family engagement in early mobilisation. Healthcare professionals commented that *'if the family is not here* [the ICU setting] *when the physio is here then that* [family engagement in early mobilisation] *is not going to happen'* (Physician #17). When family members are not present, healthcare professionals do not have the opportunity to *'chase them* [family members] *up'* (Physiotherapist #6) or *'…coordinate with families'* (Physician #17) to engage them in early mobilisation. Healthcare professionals also elaborated that some family members would not get the opportunity to engage in early mobilisation because of *'the quick turnaround'* (Physiotherapist #6) of critical patients. For example, the opportunity for this type of engagement would be limited for patients who are *'short-term patients'* (Nurse #13) and are discharged from ICU relatively quick.

4.2.3 | Family readiness

Healthcare professionals identified that family members have different levels of readiness which may influence their ability to engage in early mobilisation. A physiotherapist said that *'it depends on the family and how stressed they are and how able they are to engage'* (Physiotherapist #5) in early mobilisation. Some family members were ready to be engaged with the patients and healthcare professionals because they had *'medical background* [or] *an experience in the hospital'* (Nurse #1). On the other hand, some family members did not feel that *'they can touch anything'* (Nurse #1) and the ICU environment was *'quite scary and traumatising'* (Nurse #13). It was considered important to know if *'your family were wanting to be involved*, *some people feel really apprehensive about touching their family member or they know that they are sick*, *so they find it difficult to know what to do'* (Nurse # 8). Moreover, a lack of *'understanding health in ICU'* (Physiotherapist #5) could limit family engagement in early mobilisation. Although healthcare professionals provided the information regarding early mobilisation to family members, some family members were not cooperative due to a *'lack of understanding and just generally being emotionally very overwhelmed'* (Physiotherapist #16) which contributed to them feeling *'uncomfortable'* (Physiotherapist #16). As a result, it was difficult to get family members *'on board with some of these exercises'* (Physiotherapist #16).

Because of the differing levels of readiness in family members, more passive roles were suggested to support family engagement in early mobilisation. Passive roles such as *"emotional support or … motivation"* (Nurse#12) were considered more appropriate for family engagement compared to active roles, such as helping healthcare professionals to *'get a patient out of bed'* (Nurse #13). Healthcare professionals did not think that families had *'…the skills and the knowledge'* (Nurse #13) to engage in early mobilisation when a patient was mechanically ventilated and receiving a high level of monitoring and medical support, including sedation. As a result, passive roles were more highly favoured where families could provide *'…encouragement and also motivation for the patient to perform the exercises'* (Physiotherapist #4). Additionally, family members could undertake passive roles as *'…a consistent voice and advocate'* (Physiotherapist #10) to keep progressing with early mobilisation by prompting healthcare professionals with statements such as *'Oh*, *yesterday I watched the patient walk 10 metres. What are we going to do today?'* (Physiotherapist #10).

Although most healthcare professionals agreed with engaging family members in passive roles, others indicated that family members could undertake more active roles when they were trained and ready for engaging in early mobilisation activities.

> *'They may be offering emotional support and verbal encouragement to try and encourage the patient to participate in whatever exercises are being prescribed to them or they may physically assist as well with certain movements which might be passive movements in the bed or maybe things such as walking, maybe even taking them for a walk down the hallway'* (Physician #20)

4.3 | Foundations for successful implementation

Foundations for successful implementation highlighted the essential components which may enhance successful implementation of family engagement in early mobilisation for adult critically ill patients. Four components were categorised, which consists of (i) identified benefits to patients and family members, (ii) patient safety concerns, (iii) preparing healthcare professionals and family members and (iv) collaboration and teamwork.

4.3.1 | Identified benefits to patients and family members

Healthcare professionals recognised that partnering with family members could potentially benefit patients by motivating them to engage in prescribed exercise activities because they are *'the ones who know the patient, how to encourage them, and also how to reassure them'* (Nurse #1). This nurse also said that when critically ill patients felt uncomfortable to sit and stand, *'we get relatives involved in that sort of thing'* (Nurse #1) to support patients emotionally because *'…they know what sort of mannerisms the patient is comfortable with'* (Nurse #1). Family members were also thought to potentially benefit through partnership with healthcare professional. Healthcare professionals explained that family members may *'feel less anxious…* [and have a] *positive experience* [because]*… they can do something while they are there, and they can see their loved one getting better'* (Physiotherapist #10). Additionally, family engagement in early mobilisation could assist family members to feel *'confident to help the patients'* (Nurse #7) in performing exercise when the patients are transferred to the ward and after they are discharged home.

4.3.2 | Patient safety concerns

Patient safety was also a key consideration which could influence successful implementation of family engagement in early mobilisation. Concerns about patient safety were greater in *'the acute stage where the patient is ventilated and sedated'* (Physiotherapist #6) and appear to diminish somewhat once the patient become more stable and was recovering. Healthcare professionals said that family members should be engaged in early mobilisation when the patients were *'…medically appropriate…'* (Physiotherapist #6) and *'off* [the] *ventilator, and they don't have as many tubes and things* [monitoring equipment]*'* (Nurse #3) as this was considered lower risk. Another safety consideration was that family members worked with healthcare professionals who would be aware of the patient's abilities so that *'they* [family members] *are not over progressing patients too quickly'* (Physiotherapist #6).

4.3.3 | Preparing healthcare professionals and family members

Preparation for healthcare professionals and family members was seen as necessary to effectively implement family participation in early mobilisation. Providing education to family members and healthcare professionals and communicating with family members could facilitate preparation of healthcare professionals and family members. For family members, education about *'…why it is important for the family to be involved in early exercise'* (Nurse #15), *'…what the family are allowed to do'* (Nurse #3), *'…what are the benefits, and what our* [healthcare professionals] *job is'* (Nurse #11) is needed to support a clear understanding about how they could be engaged. For healthcare professionals, providing education on *'the benefits…and* [reasons] *why we are trying to do this* [family engagement in early mobilisation]*'* (Physician #20), and *'…how they* [healthcare professionals] *can get family members involved in early mobilisation'* (Physiotherapist #4) is required to prepare healthcare professionals for this approach. For both healthcare professionals and family members, education could be provided in several ways including via booklets and/or online training, such as *'apps or videos'* (Physiotherapist #10) and displaying a poster may help to *'remind staff'* (Physician #17) about engaging family members in early mobilisation.

Regular communication with family members was considered important as it could help by *'giving the family a bit of an idea of what goes on in here and what is going to happen onwards'* (Nurse #11) and assist family members to gain more understanding of *'the plan and what staff are going to do'* (Nurse #1). One physician commented that conveying the days plans could help with engagement, providing information such as *'we were planning to get the patient up into a chair at 11 o'clock today, are you free and do you want to be involved?'* (Physician #18), and this could help the family members plan and have time to think about how they might like to be involved.

4.3.4 | Collaboration and teamwork

Collaboration and teamwork were considered an essential component required to support family engagement in early mobilisation. A lack of collaboration and teamwork among healthcare

professionals were considered limiting factors and that individual role and how to best support family engagement was not well understood. Healthcare professionals elaborated that family engagement in early mobilisation was rarely enacted in ICU settings because *'they* [healthcare professionals] *separately work in a different capacity'* (Physiotherapist #4) and staff did not know *'what they* [healthcare professionals themselves] *and other staff can do'* (Nurse #8) to support family engagement in early mobilisation. Nurses described family engagement in early mobilisation as being *'a group effort'* (Nurse #14) and not an activity that could be undertaken by any one individual. A team approach to early mobilisation could help nurses, physiotherapists and physicians to better understand their individual roles in early mobilisation and how to best engage family members in early mobilisation. For example, physicians can help the team by providing *'reassurance'* (Nurse #11) that the patient is ready to commence exercise. Whilst physiotherapists were considered *'excellent resources'* (Nurse #11) who work collaboratively with nurses to ensure a consistent plan and support novice healthcare professionals in engaging family members in early mobilisation to *'happen easier'* and *'happen faster'* (Physiotherapist #10).

An identified team leader was seen as a strategy that could enhance the practice of family engagement in early mobilisation in ICU settings. The participants explained that a team leader could facilitate, guide and motivate healthcare professionals to enact family engagement in early mobilisation so that *'it becomes just a normal part of your practice'* (Nurse #15). Both physiotherapists and bedside nurses were suggested as being ideal for the team leader role. Physiotherapists are *'expert in promoting early mobilisation'* (Physician #17) and could assist bedside nurses in teaching and engaging family members in early mobilisation while nurses were always at the bedside and could help the team in *'delivering messages about what each staff role is'* (Physiotherapist #16) for enacting family engagement in early mobilisation.

5 | DISCUSSION

In this study, most healthcare professionals expressed positive perceptions towards family engagement in early mobilisation of adult critically ill patients. While it was considered family engagement during this stage could be done in ICU settings, different levels of readiness among healthcare professionals and family members could impact on the implementation of this approach. Feasibility and acceptability of family engagement in early mobilisation could also be influenced by family members' willingness, readiness, and availability. The patient context could also influence feasibility and acceptability depending on the degree of critical illness. This means that either the patient was too unwell or the stay in ICU too short, both of which could limit opportunities for family engagement. Consequently, the feasibility and acceptability of family engagement in early mobilisation depends on individual family members, healthcare professionals involved and the situation.

Although success in family engagement in the ICU settings has been described in other contexts (Kleinpell et al., 2019; Marshall et al., 2017), it is unclear whether family engagement in early mobilisation may be feasible and acceptable in the ICU. In this study, some healthcare professionals were hesitant to enact this approach because they lacked knowledge and experience in promoting early mobilisation. Others were unclear about what family members could do and how family members could be supported to engage in promoting early mobilisation or assisting with early mobilisation interventions. Previous articles studying the barriers to family engagement in ICU patient care have revealed that family members were more likely to be engaged and received support from staff who had higher education and more experience, especially staff with post graduate degrees and extensive critical care experience (Hetland et al., 2017). Healthcare professionals with less critical care experience may also lack confidence in their abilities to provide optimal care when cooperating with family members (McConnell & Moroney, 2015). Consequently, incorporating family engagement in early mobilisation in the ICU settings will require support for some healthcare professionals to develop these skills which may come from mentorship by knowledgeable and experienced healthcare professionals who can role model how to assist family engagement in early mobilisation.

Family readiness was also perceived to be different and was likely to impact their ability to participate in early mobilisation activities. In this study, most healthcare professionals believed that the ICU environment and family members' understanding of health in the ICU setting may influence their readiness for supporting this approach. The unfamiliarity of the critical care environment may cause stress for some family members and limit their ability to comprehend the information necessary to effectively partner with healthcare professionals in care (Hetland et al., 2018; Marshall et al., 2017; McConnell & Moroney, 2015). Additionally, several studies described health literacy as a factor which might impact family engagement in care because their ability to understand basic health information crucial for decision-making may be limited (Hamilton et al., 2020; Marshall et al., 2017; Riley et al., 2006). However, healthcare professionals did not elaborate on how they assess family members' readiness to be engaged in early mobilisation. Further research may be needed to explore how to best assess family readiness to support the implementation of family engagement in early mobilisation.

Providing education to healthcare professionals can support different levels of their readiness towards family engagement in early mobilisation. Such education is acknowledged as an essential strategy which can facilitate a change in healthcare professionals' perceptions and the ICU culture to promote family engagement in care (Hetland et al., 2018; Kleinpell et al., 2019). Kleinpell et al. (2019) explained that providing education can help healthcare professionals to understand the importance of family engagement in critical

care settings. It can also help healthcare professionals to understand the implementation process, especially how they can safely guide family members to be engaged in care which can make healthcare professionals feel more confident (Hetland et al., 2018; Kleinpell et al., 2019). Consequently, providing education to healthcare professionals could enhance their readiness to adopt family engagement in early mobilisation in ICU settings.

Providing education to, and communicating with, family members are also suggested as ways to prepare family members to engage in early mobilisation activities, and this is an approach emerging in similar studies (Hetland et al., 2018; Marshall et al., 2017). Communication with family members is necessary and can also help them to better understand the plans and goals of family engagement in the care of the patients (Hamilton et al., 2020). Thus, providing education to and communication with family members are important strategies to enhance family readiness and may mitigate variation in their readiness for the engagement in early mobilisation for adult critically ill patients.

In this study, collaboration and teamwork are required to facilitate a better understanding individual healthcare professional. Physiotherapists or bedside nurses can both assume the role of team leaders to initially engage family members in early mobilisation, but teamwork is necessary to support other healthcare professionals develop expertise in family engagement in early mobilisation. Opportunities to communicate with other healthcare professionals and discuss plans, goals and healthcare professionals' roles for engaging family members in care is an important step in this collaboration (Hamilton et al., 2020). Introducing family engagement in patient care, including early mobilisation, may be new to a clinical area. Identification of a local champion for this practice may be necessary to influence policy change or the unit culture so that family engagement in care is embedded in clinical practice (Hamilton et al., 2020; Hetland et al., 2018). Therefore, collaboration and teamwork are necessary which can assist healthcare professionals to understand their roles and implementation process for supporting family engagement in early mobilisation.

5.1 | Limitation

There are several limitations in this study. First, study participants were recruited from two ICUs located in one health service. This may influence transferability, in other words, the application of the findings in other areas, particularly those where family engagement in care is already part of clinical practice. Second, although the participants were healthcare professionals with different levels of experience and there were senior nurses and physiotherapists and this study did not include consultant physicians. Consequently, this study may be limited in its exploration of the feasibility and acceptability of family engagement in early mobilisation from the perspectives of consultant physicians who can influence a change of ICU practice.

6 | CONCLUSION

Implementation of family engagement in early mobilisation of critically ill patients is feasible and acceptable from the perspective of some, but not all healthcare professionals. Enacting this approach requires assessment of family readiness and appropriate support to effectively partner with healthcare professionals. Individual contexts of both family members and healthcare professionals are likely to influence successful implementation. Consequently, preparing healthcare professionals and family members as well as collaboration and teamwork are required for successful implementation of this approach.

7 | RELEVANCE TO CLINICAL PRACTICE

The findings of this study demonstrated the factors which can influence the feasibility and acceptability of family engagement in early mobilisation of adult critically ill patients. To adopt this practice in clinical settings, collaboration, teamwork and preparation of healthcare professionals and family members are required for successful implementation. Furthermore, physiotherapists or bedside nurses are both well-positioned to lead this practice, but individuals require the knowledge, skills and confidence to effectively enact family engagement in early mobilisation of adult critically ill patients. The findings from this study may help healthcare professionals with implementing this practice and developing a culture of family engagement in early mobilisation in their clinical setting. For examples, healthcare professionals should regularly communicate with family members about the plans for early mobilisation and how the family may participate, if they wish. Identifying a local champion is also an important strategy to support a culture of family engagement in early mobilisation. Findings from this study can also inform future research and the identification of strategies which may support successful implementation of family engagement in early mobilisation in the context of critical illness.

AUTHOR CONTRIBUTIONS

Sasithorn Mukpradab contributed to the study conceptualisation and methodology, data collection, data analysis, interpretation and curation of the data, writing–original draft, writing–review and editing, visualisation. Julie Cussen contributed to the study conceptualisation and methodology, data collection, interpretation and curation of the data, writing–review and provided critical reflections. Andrea Marshall, and Kristen Ranse contributed to the study conceptualisation and methodology, data analysis, validation, writing–review and editing and supervision. Praneed Songwathana contributed to writing–review and supervision.

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CONFLICT OF INTEREST STATEMENT

The authors declare that there are no conflicts of interest.

DATA AVAILABILITY STATEMENT

Owing to the conditions under which participant consent was gained and the requirements of the institution providing ethical approval, only named researchers on the ethics application are permitted access to the raw data.

ORCID

Sasithorn Mukpradab https://orcid.org/0000-0002-2815-8673
Andrea P. Marshall https://orcid.org/0000-0001-7692-403X

TWITTER

Sasithorn Mukpradab @SasithornMukpr1
Kristen Ranse @KristenRanse
Andrea P. Marshall @AndreaM_au

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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