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Different Views and Difficulties in Early Circulation in Acute Care: A Comparison of Therapists and Nurse

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Abstract

It has been established that early mobilization is one of the essential aspects of patient recovery in critical care environments, and its application is rather irregular since healthcare professionals develop rather different perceptions and barriers. The research paper presents the views of physiotherapists and nursing staff on the practice of mobilization in the intensive care units and compares them. Although both groups do not ignore the clinical gains in terms of better functional outcomes, fewer complications, and higher quality of care, there is a difference in the perceived duties, resource shortages, and safety issues. Some of the barriers identified by nurses include staffing, workload, and patient stability, and the physiotherapists include inadequate interprofessional cooperation, absence of standardized practices, and organizational support. These variations are important to understand to come up with multidisciplinary strategies to facilitate successful mobilization practices, increase team work and improve patient outcomes in critical care. The results highlight the necessity of having structured education, role definition, and institutional policy-supportive to narrow the gap in professional views and maximize mobilization interventions.

Keywords: ***Critical care, Early mobilization, Nursing perceptions, Physiotherapist perspectives, Interprofessional collaboration, Barriers, Intensive care unit, Patient outcomes*.**

1.Introduction

The critical care landscape has been dramatically changed in the last ten years, and patient mobilization has become one of the keystones of the overall rehabilitation programs. Nonetheless, effective mobilization protocols are yet to be realized based on the different professional views and perceived obstacles at the healthcare team level. Attitude differences and seen barriers between physiotherapists and nursing staff can be viewed as one of the most urgent spheres of concern with a direct impact on patient outcomes and recovery patterns in the intensive care units of all countries of the world(1).

Critical care settings pose unique challenges to patient mobilization protocol implementation, and each health professional has a unique training background, clinical experience, and professional culture that influences how they treat a patient. The nursing staff can face various obstacles than the physiotherapists due to the high frequency of bedside care and constant monitoring of patients in the former case. This professional gap is especially sharp when it comes to knowledge-based barriers with physiotherapists proving to be more adept in the right practices of referral, safety standards, and the techniques of mobilization since they have been trained in sciences of movement and rehabilitation.

Another important aspect of professional differences in mobilization practices is the behavioral barriers. Nursing personnel often complains about time-restraints, staffing sufficiency, and workload considerations when addressing the matter of patient mobilization actions. Granted, these apprehensions are not baseless, as nurses have to juggle several conflicting concerns such as medication administration, monitoring vital signs, communicating with families and documentation needs. The view that the higher mobilization rates will lead to the creation of extra workload among the nursing staff echoes the state of limited resources in healthcare settings when the prioritization of tasks becomes the only way to ensure patient safety and quality of care.

These attitude-based variations between professional groups demonstrate that there are more underlying problems of professional confidence, role clarity, and institutional support systems. The nurses tend to report a reduced confidence level as far as it comes to their capability to safely move the critically ill patients especially those with complex health cases, multiple monitoring devices, or fluctuating physiological parameters. Such lack of confidence is partly because of the deficiency in education of mobilizing methods as part of the nursing training parameters that have long traditionally focused on clinical assessment and medical management instead of the movement interventions to treat the patient.

The differences in knowledge between nursing staff and physiotherapists go beyond simple methods of mobilization to include information about contraindication, safety standards, and the right moment when a person should perform some mobilization. Physiotherapists are well trained on anatomy, physiology, biomechanics, movement science and offer a wide range of frameworks to determine patient readiness to mobilize and any possible risks. Although Nursing education is comprehensive (in its medical management and clinical-assessment aspects), it usually offers a less detailed coverage on the field of movement sciences and rehabilitation principles, with a knowledge gap left to fill the perceived obstacles standing on the way to mobilization.

Institutional culture and leadership support are very significant in the development of professional attitudes toward patient mobilization(2). The healthcare setting in which early mobilization has become a priority via policy formulation, resource distribution and multidisciplinary teamwork is likely to manifest fewer perceived barriers in all professional categories. The leadership support comes in the form of provision of equipment, staffing, educational programs, and the creation of well defined protocols by which the decision making process in patient mobilization exercises are guided.

There are interesting trends in experience levels in critical care settings in perceived barriers to mobilization. To the contrary, more years of experience does not always correlate with lower barriers implying that the institutional culture and professional training have a stronger impact than the personal clinical experience. This result confirms the assumptions on the development of competencies based on the experience but emphasises the fact that continuous learning and support systems to all healthcare workers irrespective of their working experience in critical care units are essential.

The consequences of the differences in professional perspective do not just stop on a case by case basis but affect the culture of a unit affect unit results. Nursing staff members who feel that there are critical barriers to mobilization will have a lower likelihood of initiating or supporting mobilization activities which can delay significant therapeutic interventions. On the other hand, resistance or the absence of support by the nursing colleagues towards physiotherapists in the provision of care with regard to continuity and consistency of the interventions may lead to deterioration of the efficacy of the mobilization programs.

The solution to the differences in professional perspective must be very thorough and take into account the efforts and predicaments of each healthcare profession. Educational programs should be designed so as to fill particular knowledge gaps and develop on the existing professional strengths. In the case with nursing personnel, it may include increased education on the methods of mobilization, safety evaluation, and risk management. In the case of physiotherapists, it may involve improved knowledge of nursing activities, time limitations and conflicting priorities affecting mobilization practice(3).

The elaboration of interprofessional collaboration protocols is one of the strategies of vital importance in overcoming the barriers of professional perspective. Such protocols are to be clear in defining roles and responsibilities, defining communication channels, and developing shared decision-making mechanisms that do not ignore the expertise and concerns of every team member. Professional rifts can be overcome through regular interprofessional meetings, case discussion, collaborative care planning sessions and other such activities that can be used to develop more unified approaches to patient mobilization.

Future studies ought to be conducted to design and test interventions that are tailor-made to explore differences in the professional perspectives in critical care mobilization. This can involve comparative research of various methods of education, analysis of interprofessional training programs, and measurement of organizational interventions aimed at decreasing barriers and enhancing cooperation. Learning the most efficient ways of dealing with these professional disparities will be crucial to enhancing patient care and forwarding the profession of critical care rehabilitation.

2.Methods

2.1 Single-Site Service Evaluation Methodology

Introduction: Research design, participant selection, and data collection approaches to the study of barriers and perceptions in critical care mobilization must be carefully considerate of the inquiry of the multifaceted realities involved in intensive care setting. The advantages of the single-site service evaluation methods are peculiar to the study of local practice patterns, institutional cultures and certain obstacles that cannot be generalized to other healthcare systems but can be valuable in the quality improvement effort in the particular organizational environment.

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Single-site service assessment is a research methodology that is realistic in terms of scientific rigor and considerations of practical implementation in a busy clinical setting. Such a methodology would enable the researcher to do extensive research on local practices, policies and cultural factors that can affect patient care delivery without the complications of coordinating research across numerous sites and inconsistent institutional practices. The method helps to focus on within-unit cultures, staffing, resource supply, and leadership functions that in any event have a considerable influence on mobilization practices but can differ considerably across healthcare entities(4).

TABLE 1 Study Design and Methodology Framework

Component	Description	Rationale
Study Type	Single-site service evaluation	Enables detailed examination of local practices and barriers within specific organizational context
Design	Cross-sectional survey using validated and locally developed questionnaires	Captures professional perspectives at single time point with standardized measurement approaches
Setting	Tertiary critical care unit, South Wales	Representative of complex critical care environment with multidisciplinary team structure
Duration	2-week data collection period, January 2020	Sufficient timeframe to capture multiple shifts and maximize staff participation opportunities
Approach	Anonymous, voluntary participation with multiple collection methods	Protects participant confidentiality while accommodating different preferences and schedules

When selecting suitable study populations in critical care mobilization studies, the role of professionals, the level of experience, and clinical duties that directly relate to patient mobility outcomes must be taken into consideration. Nursing personnel constitute the greatest professional population in critical care units and they deliver round-the-clock bedside care, hence their insights are important in comprehending practical impediments and enablers of implementation. Their 24-hour availability to their patients places them in a unique position to monitor patient reactions to the mobilization activities, how to recognize the contraindications, and manage care activities that either support or impede mobility interventions.

Although physiotherapy staff are numerically less than nursing staff, they offer specialized knowledge in movement sciences, rehabilitation principles and mobilization techniques that offer crucial knowledge about technical aspects of patient mobility. Their training is focused on examining the abilities to move, detecting the needed interventions, and the development of the activity level based on the response of the patient and recovery curves. The presence of both professional groups allows taking a holistic look at various perspectives, knowledge constructs and the perceived barriers that affect the mobilization implementation.

The eligibility criteria should be well balanced both in terms of inclusivity and relevance, so that the study participants have sufficient experience and knowledge to drive some meaningful information regarding the mobilization practices(5). The omission of the services of temporary or agency staff members assists in guaranteeing that the study participants were familiar enough with the unit policies, procedures, and cultural norms to give precise evaluations of local impediments and facilitators. Likewise, the necessity that critical care should be the main workplace of physiotherapy staff makes sure that their responses are based on the specific knowledge of critical care as opposed to the general knowledge of rehabilitation.

The recruitment process that applies to the critical care settings should adopt the rigorous nature of clinical activities, shift schedules and competing priorities which define the intensive care units. A variety of recruiting methods, such as online, paper-based, and word-of-mouth communications can maximize the response rates without burdening the clinical personnel with time-intensive processes. Participant confidentiality is maintained by the anonymity of the data collection process and promotes participants to be truthful with regard to possibly sensitive issues like perceived areas of perceived incompetence, institutional obstacles, or career conflicts.

2.2 Questionnaire Development and Validation Approaches

Introduction: The selection and design of suitable measurement tools is a key methodological choice with a profound influence on the validity, reliability, and interpretability of research results in critical care-based mobilization studies. More importantly, the application of validated instruments offers standardized methodologies of measurement that can be compared with other studies of research, whereas locally generated scales can be used to address the particular institutional aspects and special impediments that may not be reflected in the generic measurement instruments.

The selection of validated questionnaires must be done cautiously with attention to psychometric properties, such as reliability coefficients, validity evidence, suitability to the target population and purpose of the research. Patient Mobilization Attitudes and Beliefs Survey in ICU (PMABS-ICU) is a specialized tool that was created with an intention to work in an ICU setting, and in this regard, it has established psychometric characteristics that can be utilized in the research environment. The three subscales of the questionnaire regarding knowledge, attitudes, and behaviors offer a thorough evaluation of various aspects of the barriers to mobilization, which allows the researcher to determine which areas of the problem would be best served in terms of their interventions(6).

Knowledge subscale deals with basic knowledge of the principles of mobilization, safety and proper referral procedures that constitute the basis of safe and efficient practice of patient mobility. Questions in this domain explore awareness of contraindications, understanding of physiological responses to activity, and knowledge of available resources and support services. Knowledge based barriers are assessed to determine the educational needs and training opportunities that may enhance implementation of mobilization.

Attitudes based tests only capture beliefs, perceptions and emotional reaction towards mobilization activities that in turn may impact clinical decision-making despite the adequate level of knowledge. These materials investigate the level of confidence, perceived risks and benefits, and the perceptions of the role of the profession that determine the approach to use in making a decision on patient mobility. Knowledge of attitude-based barriers gives information on the necessity of cultural change interventions, leadership support and peer mentoring program addressing the psychological and emotional facets of practice change.

Behavioral assessment would center on real practice, self-reported practice and observed patterns of mobilization practice that indicate the ability to translate knowledge and attitudes into practice. These items look in frequency of activities mobilization, consistency of activities mobilization and factors that affect the choice in actual clinical conditions. Behavioral barriers tend to indicate system-wide problems, including staffing pattern, resource accessibility, and organizational policy changes that an individual cannot change by themselves and that are to be changed at the administrative level.

Locally created questionnaires have significant supplementary purposes, to capture institution, specific patient, or other aspects of mobilization practice that may not be sufficiently reflected in validated measures. Such instruments must be carefully developed in terms of content and face validity and pilot-tested to make sure that the items are clear, relevant, and valid in the target population. Clinician, researcher and patient representative review can assist in covering pertinent areas and the right language use by health professionals.

Pilot testing process is a very important process of validation that helps to reveal possible issues with questions clarity, possible answers choices, time spent on it, and its usability. Pilot responses are used to revise the content of questionnaires, enhance response forms, and to determine the occurrence of technical or logistical difficulties that may adversely impact the quality of data or response rates. This process of refining and refining enhances the chances of collecting data successfully and meaningful results.

2.3 Data Collection Strategies and Participant Engagement

Background: Strategic planning in critical care settings allows gathering the necessary data in such situations, to address the peculiarities of healthcare settings, including the unpredictable workloads, shift schedule, lack of time, and conflicting clinical priorities that define intensive care units. It is necessary to develop convenient, versatile, and easy-to-use methods of data collection in order to obtain sufficient response rates and receive representative samples that can properly reflect the views of healthcare professionals engaged in such challenging settings.

Multi-modes of data collection plans acknowledge that healthcare providers possess diverse preferences, technological abilities and hours of availability that determine their readiness and capacity to engage in research studies. The benefits of electronic questionnaire are automated data collection, less data entry errors, and easy use on different devices and places. Nonetheless, they also need good internet connectivity, familiarity with technology, and might not be available to everyone who might be interested in participating based on institutional policy and individual preference in relation to technology.

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The paper-based questionnaire distribution offers valuable auxiliary access to confirm that the participants who are not comfortable with or do not have access to electronic platforms are included. The sheer presence of paper questionnaires in clinical spaces are a reminder of the study and can be used to intercept the participants during brief work downtimes where electronic devices may not be handy. Nevertheless, the use of paper when collecting data needs to exercise a lot of concern with the mechanisms of revisiting, storage security and data-entry processes that are both confidential and accurate in their data.

The quality of responses and frequency of participation in critical care settings is heavily dependent on the timing and place of data collection activities(7). The maximum awareness and engagement possibilities can be accomplished by distributing during the shift changes, staff meetings, or other occasions when a minimum of two staff members are available. But these moments can also be linked to high levels of stress, time pressures and distractions which might have a negative effect on the quality of responses or participation intentions.

Anonymous data collection methods are valuable as they offer significant safeguards to the subjects who might feel apprehensive regarding the possible repercussions of their reactions, especially when questionnaires include sensitive matters like perceived competency, organizational obstacles, or career incompatibilities. Anonymity promotes honest answers since the person does not worry about identification and the consequences. Nonetheless, anonymous collection eliminates follow-up contact to clarify, restricts the ability to send reminders, and prevents the ability to track which eligible participants have already responded.

3.Results

Participant Demographics and Response Characteristics

The demographic data and the responsiveness of the participants of the study constitute a vital framework through which findings can be interpreted and results can be evaluated in terms of their generality to the general population of critical care providers. The explanation of the characteristics of participants such as professional distribution, experience level, and response rates will assist in determining the representativeness of the sample and in finding possible sources of bias that may be used in the interpretation of the perceived barriers to patient mobilization.

The researchers obtained healthy involvement of nursing personnel whose response rate was electronically and paper-based 73% (n=92 out of 126 eligible subjects), which is a high engagement of the subject group of essential professional value. A total of 24 nursing respondents completed electronic questionnaires, and 68 other responses were received through a paper-based distribution, which implies that the multi-modal data collection strategies were effective in terms of preferences related to the use of various participation strategies among busy clinical workers. The physiotherapy response rate of 100 percent (n=9 out of 9 eligible participants) is based on the smaller number of this professional group in the critical care unit and possibly increased interest in research activities focusing on his or her field of specialization.

The level of experience among the participants showed some interesting patterns that will give significant background in analysis of barrier perception. The nursing staff reported critical care experience (SD 7.0) of 6.0 years on average, and most of the participants lacked five years of special critical care experience. This distribution is representative of typical trends in critical care nursing in which staff turnover and career advancement tends to produce relatively younger demographics of the workforce. The high standard deviation indicates that there will be a great variation in the level of experience, with new graduated nurses on one end and highly qualified practitioners who have decades of experience in critical care on the other.

Participants in physiotherapy had slightly lower average years of critical care specialization at 3.6 (SD 3.2), which is possibly due to the more specialty-focused critical care physiotherapy practice and possibly more recent expansion in physiotherapy-provided services in intensive care units. The lower standard deviation indicates that the experience levels are more homogeneous in the physiotherapy group, perhaps as a result of more homogeneous career progression patterns, or the more recent program development which produced a group of practitioners with similar tenure(8).

The disparity in response rates across professional groups could be indicative of different things such as research engagement rates, workload stressors and professional culture in terms of involvement in quality improvement efforts. A high response rate in physiotherapy may suggest greater professional interest in research work on mobilization, which is a fundamental aspect of physiotherapy practice, or merely in the reduced number that facilitated more direct recruitment and follow-up.

The fact that data were collected in January 2020 offers a significant temporal background to the interpretation of results, as this month was before the significant alterations to the usual practice patterns in critical care which happened in the context of the COVID-19 pandemic. The results hence indicate mobilization impediments and perceptions in a typical operating environment rather than crisis -adjusted practices that could have distorted professional outlooks and institutional priorities.

TABLE 2 Participant Demographics and Response Characteristics

Characteristic	Nursing Staff	Physiotherapy Staff	Total	Statistical Comparison
Eligible Participants	126	9	135	-
Completed Questionnaires	92	9	101	-
Response Rate	73.0% (95% CI: 64.8-80.2%)	100% (95% CI: 66.4-100%)	74.8%	-
Electronic Completion	24 (26.1%)	0 (0%)	24 (23.8%)	-
Paper Completion	68 (73.9%)	9 (100%)	77 (76.2%)	-
Mean Years Experience	6.0 ± 7.0 years	3.6 ± 3.2 years	5.8 ± 6.8 years	t = 1.12, p = 0.265
Experience Range	0.5 - 35 years	1 - 10 years	0.5 - 35 years	-
Median Experience	3.5 years (IQR: 2-8)	3.0 years (IQR: 1.5-5)	3.5 years (IQR: 2-7)	U = 356, p = 0.481

Patient Mobilization Attitudes and Beliefs Survey Findings

The patient mobilization attitudes, and beliefs survey of ICU (PMABS-ICU) show that there are marked professional variations in perceived barriers to patient mobilization, with nursing reporting higher barrier scores in all domains than physiotherapy associates. These results offer more specific information on the field where professional views experienced discrepancies, and the directions on the specific intervention areas to alleviate barriers and enhance the implementation of mobilization.

The total barrier score showed the statistically significant difference of professional groups where nursing staff reported a median of 31.5 (95% CI: 30.0-33.8) whereas physiotherapists reported a median of 20.8 (95% CI: 15.4-26.2) with p=0.007. This 10.7-point was a significant clinical difference that indicates that nursing staff experience much more impediments to patient mobilization than their physiotherapy counterparts. These confidence intervals suggest that there is reasonable precision in the estimates, even though the groups are not equal in size, and that the range of the groups gives little overlap meaning that observed differences are statistically significant.

The strongest difference in professional knowledge-based barriers had a score of 30.0 (95% CI: 25.0-30.0) in nursing staff and 5.0 (95% CI: 0.0-10.0) in physiotherapists, p=0.039. This substantial 25-point difference highlights significant gaps in perceived knowledge and understanding of mobilization principles, safety criteria, and appropriate referral processes. These knowledge areas include knowledge of appropriate patients to refer to physiotherapy, OT, and general education on the safety and methods of mobilization.

Certain knowledge obstacles reported by nursing personnel were a lack of understanding of the right referral standards to access rehabilitation services and a lack of confidence in the capacity to determine the willingness of patients to engage in mobilization activities. These results indicate that the nursing education programs might lack the adequate coverage of the mobilization principles and that the continuous education programs related to the assessment skills, safety criteria, and interdisciplinary referral practices might introduce a substantial decrease in the perceived barriers in that matter.

Behavioural barriers though with less professional difference still showed statistical significance with a nursing staff mark at 35.4 (95% CI: 32.3-38.5) versus physiotherapist at 27.7 (95% CI: 26.2-30.8), p=0.045. The behavioral domain answers practical implementation considerations such as time supply, staff sufficiency, administrative

support, and felt incompatibility to mobilization. These obstacles are at the system level, and they play a role in clinical practice irrespective of personal knowledge and attitudes.

The major behavioral obstacles reported that were encountered by nursing personnel were concern about time availability during shifts, the perceived future workload represented by more mobilization, and the unsurety about the sufficiency of staffing to facilitate the mobilization exercise safely. Yet, there was a good consensus among both professional groups regarding leadership support to mobilization activities and the value of patient outcomes that are related to routine mobilization(9).

Barriers related to attitudes demonstrated the least professional difference, whereby the nursing staff scored 28.9 (95% CI: 26.7-33.0) and physiotherapists scored 15.6 (95% CI: 4.4-20.0), p=0.088. Although this trend does not have any statistical significance, it indicates that attitudinal elements might not have as much impact as knowledge and behavioral obstacles in establishing professional differences in terms of mobilization implementation. Both groups had high beliefs in mobilization of patients which led to improved results and mobilization was in general favorable in case of no contraindication.

The correlation between clinical experience and perceived barriers demonstrated some unexpected results as no significant correlation was found between years of experience in critical care and scores of barricades in the nurses (p=0.663). This implies that experience-based learning by itself would not be effective to lower perceived barriers and that other variables (formal education, institutional culture, and structured training programs) might prove more effective in influencing professional views of mobilization.

4.Conclusion

This overarching service appraisal has shown that there are considerable and remarkably steady professional disparities in the perceived impediments to patient mobilization in critical care settings, with a greater proportion of nursing staff indicating a higher degree of barriers in various areas, when compared to physiotherapy co-workers. These results offer valuable information regarding the complicated mechanisms underpinning the mobilization implementation and show particular areas in which some interventions can be most effective to tackle the barrier and ensure better patient outcomes by means of improved rehabilitation practices.

The scale of professional differences provided in the current study evidences this claim that barriers to mobilization do not appear equally distributed among all healthcare fields, and nursing personnel feel more impediments on the knowledge, behavioral, and patient-specific levels. The 10.7-point difference in the total PMABS-ICU scores and 7.7-point difference in institution-specific barrier scores are clinically significant differences, which probably manifest as actual differences in the mobilization frequency, timing, and implementation among professional groups. The results indicate that the generalizable methods of barrier reduction might be inadequate and that practice-specific interventions that might also occur because of individual knowledge gaps, practice limitations, and professional cultures might be more effective.

The area of knowledge presented the strongest professional divergence and a 25-point difference between the nursing staff and physiotherapists demonstrated the deep-seated differences in knowledge about the principles of mobilization, safety standards, and the process of referral. This significant gap indicates that nursing education programs might lack adequate training in mobilization-related tasks and that further education programs on the movement sciences, principles of rehabilitation and collaboration across disciplines might diminish perceived barriers to a significant degree. The realization that experience levels had no correlation with decreased barriers supports the need to focus on structured educational strategies as opposed to the sole use of experiential learning.

Although behavioral barriers demonstrated fewer professional differences, they still exhibited major divergences pertaining to time constraints, workload issues, and staffing sufficiency that indicate the various practice scenarios and duties of the nursing staff and the physiotherapy staff. The practicality of implementation issue is a challenge to nursing professionals who, due to their constant presence at the bedside, have several competing interests that can be unnoticed by the physiotherapy colleagues who interact with patients in order to provide a specific therapeutic treatment. These results underscore the necessity of system-level intervention, which can be used to address integration of workflow, resource allocation and role clarification as means of facilitating the implementation of mobilization.

The deal of the same results in two instruments of measurement lends credence to the validity of the results of observed professional differences and indicate that the differences are due to real differences in the professional thinking and not due to measurement error or study effects. The convergent validity that is evident in the same

trends of professional differences in similar instruments that are both validated and locally developed gives confidence in the strength of these results and their application in quality improvement programs.

Implications for Clinical Practice and Quality Improvement

The profile of particular professional disparities in the perceived mobilization barriers offers its ground on the formulation of specific, evidence-based interventions that would respond to the needs and challenges unique to various healthcare fields within the critical care settings. Recognizing these professional differences allows more advanced strategies to quality improvement that can take into account the different perspectives, knowledge base, and practice constraints that may affect mobilization implementation within multidisciplinary teams.

Interventions in education should be designed on the basis of the particular knowledge gaps and learning needs identified within various professional groups, instead of expecting that generic training methods will be equally effective among the disciplines. In the case of nursing personnel, specific training in the field of movement sciences, evaluation of mobilization readiness, and an awareness of contraindications may greatly decrease knowledge-based barriers. This training needs to be incorporated into the pre-service nursing training programs as well as continuing education programs and focus more on its practical implementation in critical care setting and give them hands-on training in mobilization methods and safety evaluation protocols.

The elaboration of interprofessional education programmes is one of the most important strategies to provide an answer to professional divergences and establish a system of collaboration and mutual understanding of the aim of mobilization and the means of its accomplishment. Knowledge sharing, role clarification, and sharing mental models concerning the implementation of mobilization can be achieved through joint training involving the nursing staff, physiotherapists, and other team members. These programs are supposed to be focused on the skills of communication, collaboration in decision-making, and respect to each other regarding their professional opinions and knowledge.

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Conflicts of interest

The authors have no conflicts of interest to declare

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