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RESEARCH ARTICLE

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Pushing and guiding me towards home; patients' perspectives of person-centred physiotherapy in Intensive Care

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ABSTRACT

Purpose: Person-centred physiotherapy in Intensive Care Units (ICU) supports patients' early rehabilitation. Yet little is known about the activity required to enable person-centred physiotherapy in this setting. This study explores the experiences and interpretations of people who received physiotherapy.

Methods: A qualitative study using Interpretative Phenomenological Analysis was conducted. Eight participants, recruited from a Ventilation Unit in Northwest England, were interviewed. Data were transcribed and managed using NVivo 12 software.

Results: Participants described being "pushed" and guided by physiotherapists. The "emotional" pushing through motivation and encouragement, and "physical" pushing through setting goals, were perceived as person-centred activities, despite physiotherapists initially directing them. Other important aspects of individualised care were feeling safe and understanding how their body had changed.

Conclusions: Patients viewed physiotherapist led rehabilitation in ICU as being person-centred, despite the lack of collaboration during early recovery, because they were too ill. Models of person-centred physiotherapy could be made more applicable to clinical settings by fully integrating the patient perspective.

IMPLICATIONS FOR REHABILITATION

- Patients perceive physiotherapy in Intensive Care Units (ICU) as being person-centred even when they were not involved during early recovery due to being too ill.
- To be person-centred in ICU, physiotherapists must find the right balance when pushing rehabilitation, foster a sense of safety, explain changes in body, and make logical goals in the patients' journey towards recovery.
- For novice physiotherapists working in ICU navigating the balance, between pushing patients too much or too little, is likely to be challenging and should be more fully incorporated into educational curricula.

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Person-centred; rehabilitation; physiotherapy; Intensive Care; qualitative

Introduction

To support patients' progress through the Intensive Care Unit (ICU) and enhance long-term physical functionality, it is recommended to initiate physiotherapy as early as possible [1,2]. The efforts of patients recovering from critical illness in the ICU are often hidden to the healthcare team [3]. Survivors manage their vulnerabilities, confront obstacles and setbacks, and aim for stability by maintaining physical and emotional balance in their recovery towards home [4]. Following mechanical ventilation, patients will often have limb muscle atrophy, impaired functional status, and diaphragm dysfunction [5] alongside emotional work when confronting death and possible futures [3]. The key to their recovery and improvement lies in being appropriately challenged physically and functionally, a task often fulfilled by physiotherapists [6]. Patients' struggle during rehabilitation in ICU as they have been acutely unwell [7] and this hidden rehabilitative work is supported by personalised care where they are recognised and cared for as unique human beings [3]. Person-centred care has improved health outcomes for people with long-term or chronic health conditions [8] suggesting it could be a suitable approach in this setting. Recognising the unique person and forming therapeutic partnerships are important elements of person-centred care (Feldhusen et al. 2022) [9] but this could be challenging in an ICU setting.

Person-centred rehabilitation is a way of thinking about and providing rehabilitation "with" the person [10] and is influenced by theoretical models and frameworks that emphasise the importance of the relationship between the healthcare professional and patient [10–12]. Theoretical attributes of centredness in health care, have been described as "being unique," "being heard" and having a "shared responsibility" [13]. Whilst these models, framework, and attributes are not specific to the ICU setting, they can provide guidance for person-centredness in the rehabilitation of ICU patients. In ICU where the environment has a focus on life at all costs [14] and patients experience communication difficulties because of life saving interventions [15], forging therapeutic relationships will be more challenging. Physiotherapists strive to develop partnerships in

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rehabilitation with patients in ICU but recognise the need to be in control initially before patients are cognitively aware [16]. Physiotherapy has been described as a necessary but challenging aspect for individuals recovering from critical illness, and they report a preference for the physiotherapist to take control [17]. This preference contradicts the collaborative partnership models and frameworks, highlighting the need for further exploration of ICU patients' perceptions of person-centredness in rehabilitation.

It remains unclear how physiotherapists can deliver person-centred rehabilitation in ICU settings, when there are barriers to forming collaborative partnerships as patients are recovering from acute illness. The viewpoints and experiences of people who have undergone physiotherapy in ICU can provide valuable insights to physiotherapists in how they can address person-centred needs when these barriers exist. The aim of this study was to explore the experiences of people who have received invasive ventilation and physiotherapy in ICU and their perceptions of person-centredness.

Methods

Design

A qualitative study using interpretative phenomenological analysis (IPA) methodology [18] was conducted to explore the experiences and perceptions of individuals who had received physiotherapy in ICU. IPA draws on the lived experiences and perspectives of participants to gain new insights and understanding about a particular phenomenon, in this case, the experience of receiving physiotherapy in ICU and their perceptions of person-centred care. This methodology is appropriate to explore the firsthand experiences and perceptions of participants [18] regarding person-centred care and physiotherapy in ICU. We referred to the consolidated criteria for reporting qualitative research (COREQ) when designing and reporting this study [19].

The study design was guided by the theoretical framework of person-centred care, which informed the topic guide and data analysis. A plethora of frameworks, models, and definitions of person-centred care exist, understanding of person-centred care was gathered from existing literature [10–12,20–24] (Feldhusen et al. 2022; The Pickers Institute, 2018). Four areas of important activity repeatedly emerged from the literature that appeared integral: the caring and respectful characteristics and interpersonal skills of the health professional, the patient is recognised as unique and having individual needs, a therapeutic partnership that empowers the patient, and the context of care allows for coordinated and collaborative care with the patient. The ICU setting creates barriers to person-centred physiotherapy due to the context of care and the medical condition of patients; we were therefore interested in the experiences and perceptions of patients regarding the physiotherapy they received on ICU.

Recruitment and participants

Participants were recruited from a unit for people who require difficult and prolonged weaning from invasive ventilation and received referrals from all ICU units across the Northwest region of England. Eligible participants were adults (>18 years of age), who had received mechanical ventilation with prolonged weaning, could remember the physiotherapy received on ICU, willing and cognitively able to share their experiences, and able to speak English as no translation services were available for this study. Patients receiving ongoing psychological intervention following ICU admission were excluded as sharing their experience had the potential to cause them additional distress and was considered unethical. This approach was selected as an efficient method to recruit a purposive sample of people who had undergone an extensive ICU rehabilitative journey and received physiotherapy across several ICU units. All eligible patients receiving care between 2018 and 2022 were contacted with details about the study between October 2022 and March 2023.

Data collection

Semi-structured interviews were selected as the preferred data collection in IPA to gather rich data about participants' experiences and perceptions [18]. Following informed consent, data was collected using semi structured interviews guided by an interview guide (Appendix 1) informed by IPA ideology [18]. As the purpose of the study was to explore perceptions of person-centred care alongside experiences of physiotherapy in ICU, a descriptive question to determine their perceptions was added. If required, a description of person-centred care was provided for participants, based on the theoretical perspective discussed previously. An advisory group, which included a service user and physiotherapist, reviewed the interview guide, following which amendments were made. Interviews were conducted between November 2022 and March 2023, at a location chosen by the participant in order that they would feel comfortable during the interview. One researcher (HC), not known to any participant prior to the study and with experience and training in qualitative data collection, conducted all interviews. All interviews were audio-recorded and fully transcribed using voice recognition software within Microsoft Teams and validated by HC. Field notes on paralinguistic and non-verbal skills were taken during the interview.

Data analysis

Interview data was managed and retrieved using NVivo 12 software and an inductive approach used for data analysis was informed by IPA methodology [18]. Data analysis was completed by the research team which included a physiotherapist and a nurse working in academia, and a physiotherapist working in clinical practice. The research team adopted a reflexive approach, acknowledging their preconceptions and experiences caring for patients in ICU when exploring the experiences of participants. As active contributors to the interpretations of participants' experiences [25] researchers used reflective discussion and notes to justify decisions during data analysis in relation to participants' experience and perceptions, and our interpretations. The findings, therefore, are a co-product from the participants and research team, as they are the result of how the research team made sense of the participants experiences and perceptions [18].

Using the six-step analysis proposed by Smith et al. [18], two researchers (HC and DD), both physiotherapists, independently interrogated each interview transcript line by line alongside memos and impressions of the interaction from field notes. The first transcript was read and re-read to make initial notes and gather emergent themes and interpretations. Linguistic and idiographic interpretations were explored to ensure individual experiences and personal themes were appreciated before repeating the process for other transcripts and look for patterns across all data. Similarities and differences between the participants' experiences and interpretations were compared and debated by the research team to ensure each experience was considered and

Table 1. Approaches used to support trustworthiness of the study.

	Strategy	Description
Credibility	Investigator triangulation	Data was independently analysed by two researchers (HC & DD). Ideas and interpretations were compared to reach a consensus on important themes and concepts. A third researcher (FA) reviewed a random selection of transcripts and compared to the identified themes and concepts. All three researchers met to discuss interpretations and closely examined similarities and differences.
	Peer debriefing	Experienced researchers in qualitative methods (FA and AW who is attributed in the acknowledgements) were consulted during the study for advice on conducting the research in relation to IPA. They provided guidance and feedback to ensure methodological rigour.
	Advisory group	The advisory group, including a physiotherapist and service user representative, were consulted. They informed the data collection methods and commented on the recognisability of results.Top of Form
Transferability	Participant descriptions	Detailed and pertinent descriptions are available in Table 2.
	Description of setting	Information regarding the setting of interviews can be found in the Methods section of the article.
Dependability	Advisory group	The advisory group, including a physiotherapist and service user representative, were consulted. They informed the data collection methods and commented on the recognisability of results.
	Decision trail audit	A decision trail was employed throughout to track decision-making and allow reflection on the process.
Confirmability	Practicing reflexivity	HC employed reflexivity by maintaining a journal throughout the study, with the objective of acknowledging interpretations and thoughts that emerges from both the interview data and their personal experiences as a physiotherapist in the ICU setting. The research team engaged in reflective discussion, considering how their individual backgrounds and prior experiences could potentially influence the analysis of the data.
	Decision trail audit	A decision trail was employed throughout to track decision-making and allow reflection on the process.

included within our interpretations. Ongoing discussions between the research team allowed identification of meanings and concepts which were compared to the initial findings. A third researcher (FA), (a Registered Nurse with ICU experience) independently analysed a random sample of transcripts. Experiential themes that encompassed the descriptions and interpretations across the group of participants were decided between the research team and a visual representation was formed that described the relationship between the themes.

The advisory group ($N = 3$) that guided on the data collection methods were consulted to ensure the findings were recognisable to the phenomenon studied. Findings were presented to participants if requested at the time of study, but member-checking of the findings did not take place because they were interpretative in nature [26]. Table 1 describes approaches used to support the trustworthiness of the study.

Table 2. Participant characteristics.

Participant number	Gender	Age	Ethnicity	Reason for ICU admission (reported by participant)	Number of ICU units admitted to
1	Male	61	Other ethnic	Covid related	3
2	Female	46	Other ethnic	Post-partum complications	2
3	Male	51	White British	Covid related	1
4	Male	46	White British	Influenza, sepsis, ARDS	4
5	Female	58	White British	Pneumonia, sepsis, Covid related	2
6	Female	58	Black British	Covid related	3
7	Male	70	White British	Respiratory failure, myopathy	5
8	Male	47	Asian Indian British	Covid related	2

Ethical considerations

Ethical approval was granted by the Research Ethics Committee; West of Scotland (REC reference – 19/WS/0192) and the University of Salford (Reference number – HSR1819-132). All identifying data was protected during the study and anonymised in reporting. Informed consent was obtained for all participants. Risk assessments were conducted and followed to protect researchers and participants.

Results

Eight participants agreed to take part in the study. This sample size reflects IPA methodology which requires a detailed exploration of rich data gathered from a smaller number of participants [18]. Inductive thematic saturation was achieved [27] as new themes were not discovered in the later interviews. Participant characteristics are shown in Table 2. As recollections and perceptions of their experiences were sought, irrespective of time passed since their ICU stay, data about length of time since discharge was not collected. However, it is interesting to note that most participants had been a patient in several ICUs and reported experiences from between 1 and 5 different ICU's that they had been admitted to (mean = 2.75 ICU's). Six interviews took place in the participants' home, one in a temporary care home, and one in a hospital setting. The eight interviews lasted an average of 63 min (between 43 and 90 min). In one interview (participant 7), the participant's spouse was also present and contributed to the discussions. The purpose of this study was not to collect data from partners, however flexibility was deemed appropriate in this instance to support the participant when recounting potentially traumatic and distressing experiences. The data was included in collection after both had given informed consent, however we recognise the presence of a partner may have affected the data collected about individual experiences [28].

Data was collected in the study following the Covid 19 pandemic, and four of the eight participants were admitted to ICU for Covid related reasons. The experiences of these participants would have been affected by the restrictions in family visits that were in place, but as the focus of the study was to explore their experiences of physiotherapy and perceptions of person-centred care, they were included in the study.

Figure 1 shows a visual representation of the six themes that explain participants' perceptions of person-centred physiotherapy on ICU. Theme 1 "Pushing and guiding me towards home until we can push together" is an overarching theme that describes how participants explained that they needed to be guided and "pushed" by the physiotherapist before they were well enough to contribute to the push towards home themselves. The other five themes describe the integral elements necessary when physiotherapists are pushing and guiding rehabilitation. The other five subthemes describe the contributing elements that cause physiotherapy on ICU to be perceived as person-centred by the patient.

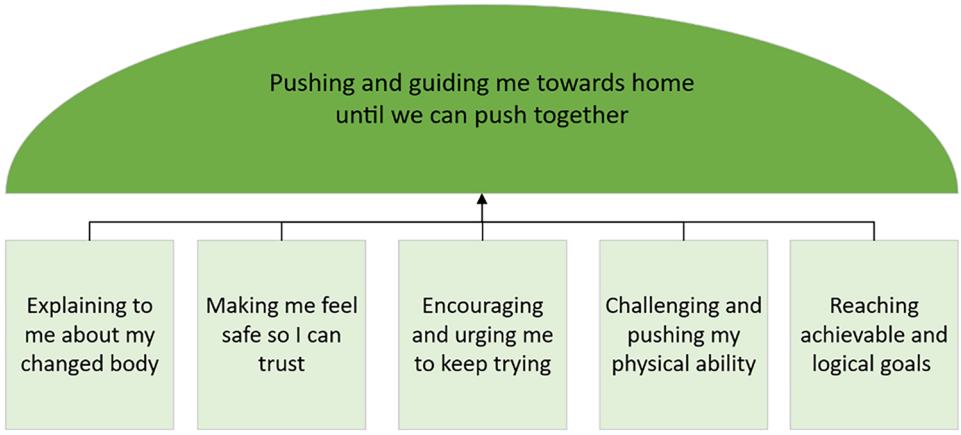

Figure 1. Visual representation of themes.

Pushing and guiding me towards home until we can push together

All participants perceived that physiotherapy was person-centred and focused on them. This was despite some acknowledging that the physiotherapist guided rehabilitation and they were not involved in decisions. It was recognised that physiotherapists initiated the rehabilitation towards home, before participants recognised that there was a need to increase their physical capability.

When recounting experiences of physiotherapy in ICU, participants emphasised how difficult it was and how hard they had to "work." Some participants experienced pain during physiotherapy and needed to "*get past that pain barrier in order to get well and to start moving" (participant 6, 58 year old female)*. From the experiences recounted and the words participants used, it was apparent in initial rehabilitation attempts that the physiotherapist was the driving force behind rehabilitation as participants confronted their body which had changed significantly during their critical illness. One participant discusses that initially, the physiotherapist's determination guided the rehabilitation journey.

> They were determined to… get me back to a level that I was at before I was ill, or at least start me on that journey. (participant 4, 46 year old male)

When reflecting on the guidance and "push" from physiotherapists following their time on ICU, participants perceived it as necessary to their improvement. All participants used the word "push" when describing their physiotherapy and recognised it as vital in their recovery. As the work was so hard, participants recounted needing the push from physiotherapists to begin and valued their guidance concerning the necessary steps towards home.

Some participants reported not recognising the value of this push from physiotherapists whilst in ICU. As physiotherapy was difficult, some participants dreaded and *"hated" (participant 8, 47 year old male)* physiotherapy initially, before they began to see the purpose behind it. When they recognised the purpose of physiotherapy, participants positively anticipated it despite the pain and effort required.

> I just wanted to get better and back to normal, so I was eager to do more. (participant 3, 51 year old male)

However, not all participants engaged with physiotherapy during their ICU stay. One participant who refused initial attempts at rehabilitation went on to recount a turning point in their feelings about their physiotherapy and described a conversation with their physiotherapist.

> What she talked about… 'We are here to help you. Tell us what you want, and we'll work with you, with the therapy team in here. Tell us what you need? If telling you this is what you need, this is what (we) have to do. Tell us what you need, and we will work with you… from that moment on, (we) worked with, not against. [participant 1, 61 year old male]

The conversation shifted the participants perception from working against physiotherapy, which was unpleasant and difficult, to working together in rehabilitation as a team. The participant strongly valued the team approach.

Explaining to me about my changed body

During early recovery, participants recounted frightening thoughts and feelings about their changed body as it felt so very different to before their critical illness. Participants initially had no sense of how much their body had changed and had to adjust expectations about their physical capability.

> You come into ICU, the period just before… you've been walking and normal and then within… a short period you've been put into a coma and come out at the end of that, luckily… but being completely unable to do anything. (participant 3, 51 year old male)

> I'd just presumed… that I could sit up and walk. So, trying to sit up on the edge of the bed, when I tried for the first time and I said to the physio, 'let me go', I just flopped. (participant 4, 46 year old male)

This time was frightening for participants as they were unclear about how much physical ability they would regain through rehabilitation. The fear of an unknown future was exacerbated by a lack of understanding about why their body had changed in the way it looked and the level of strength.

> The first time they got me up (to) walk. That was scary as hell. Why? I couldn't reason… I couldn't explain what was happening to me. So weak that when they sat me on the edge of the bed… My back was literally full [hunched over posture demonstrated]. And right at that moment, all I could see was… Skin, bones and veins… When doing it… all I could think about (was), how will these legs support me… it's too much, I need to lie down. (participant 1, 61 year old male)

Participants felt understood by the physiotherapist through the explanation of their changed body and it gave reassurance

that their physical sensations and experiences were to be expected and not unusual.

> He was like 'are you dizzy?', and I was like 'yeah, a bit'. '(It's) because it's the first time you've been upright for a long time'… he knew everything that I was going to go through. He knew I was going to be dizzy. (participant 5, 58 year old female)

> And my blood pressure just went crazy, and nobody could explain what was happening to me, the doctors (or) the nurses. I told (the physio) next time she helps me out of bed, we sit there, after. It sorted it… I looked at her and said, 'How come the doctors didn't have answers for me and you do?'. (participant 1, 61 year old male)

One participant described a lack of understanding about the physiological changes in their lung capacity and the rationale for using a device that would encourage deep breathing. This lack of understanding negatively influenced the level of engagement with this intervention and how much they pushed themselves when working with the physiotherapist.

> They did eventually bring something, which had three balls and then I had to blow into that and see if you could let the balls rise up. And I used that a few times, but I didn't really have an understanding about what was happening with my lungs. And I think that is crucial. (participant 6, 58 year old female)

Making me feel safe so I can trust

Participants recounted feeling safe during physiotherapy when they understood that the physiotherapist recognised the risks that were unique to them and prevent them coming to harm. Often, they did not trust their changed body to perform a physical activity, and having the instrumental and emotional support from the physiotherapist made them feel safe and enabled them to begin to rehabilitate towards home.

> Safe I would say. Like, you know, I could trust… her. (participant 2, 46 year old female)

> It was frightening, so I think… it was more about just gaining confidence… from them. (participant 2, 46 year old female)

When exploring participants' experiences and the vocabulary they used to describe why they felt safe, the close physical proximity of physiotherapists was important, as was having enough physiotherapists to support their changed body which was weak.

> But what I didn't realise, at that time… I had four physios around me. I had two on the sides. One at the front and one virtually right behind me. And you know, they took every precaution. (participant 8, 47 year old male)

> There was a few of them… there was always three at the beginning… They made sure it was very controlled and I… just felt confident that they were in control with you and knew what they were doing and therefore they helped me. (participant 3, 51 year old male)

The physical presence of physiotherapists around them made participants feel safe and allowed them to push themselves in their rehabilitation. The second quote hinted that the behaviour of the physiotherapist was also important to give them confidence. Other participants developed this further.

> You could just… tell… how they were professional, they (weren't) messing around… and that's how I knew that they were safe. (participant 2, 46 year old female)

> You can tell with the different people that you deal with and the way that they deal with you, how confident you are in them. (participant 7, 70 year old male)

In these quotes, the feelings of safety were enhanced not only by their presence but by the expected professional behaviour of the physiotherapist. All participants gave examples from their experiences which mentioned the trust they had in their physiotherapists. It was vital for them to trust the people around them to allow them to work to improve their physical ability. One participant explained the need to trust.

> You feel so vulnerable. You have to learn to trust people. Whereas before I would have done everything for myself. (participant 7, 70 year old male)

Encouraging and urging me to keep trying

During their rehabilitation on ICU, participants valued the encouragement and coaxing "to do more" that they received from physiotherapists that was made personal to them. As rehabilitation was difficult, these actions helped to motivate them to continue in their struggle. Most participants described instances when the physiotherapist encouraged them to push themselves further in their rehabilitation.

> They're trying to motivate you to do more, but also that they say… 'Go on. You can do it' and push you a bit. (participant 3, 51 year old male)

> They were all good, don't get me wrong, but there was two or three that seemed to give me that bit more, sort of, encouragement. (participant 7, 70 year old male)

Participants perceived that this encouragement was to motivate them in their rehabilitation to improve physical capability. Some participants perceived that the encouragement was sometimes too demanding, and the way this was perceived did differ between participants.

> That is a motivational thing. But, if you're having a bad day, as in you weren't feeling very well, that didn't cut it. (participant 4, 46 year old male)

> There (was) one particular physio… And she pushed. Not only me, she pushed everyone. I felt personally… like I felt it was personal at that time. (participant 8, 47 year old male)

Some participants perceived that on occasions physiotherapists subtly communicated some level of dissatisfaction with their progress. One participant explained this,

> Well, they didn't actually say it in so many words, but there were a couple there that gave me (that) impression… 'you've only done 15 minutes'… 'You're supposed to be doing half an hour' and stuff like that. And without actually coming out with it, word for word. It was like, you're not pushing yourself. And they'd get (annoyed) with you… it wasn't in an encouraging way. (Participant 7, 70 year old male)

The result of these interactions was that participants felt that their effort was undermined which was demotivating. Participants strongly valued encouragements during rehabilitation. When it was perceived as useful it resulted in them feeling that rehabilitation was centred upon them.

Challenging and pushing my physical ability

There was an overwhelming belief from all participants that physiotherapists aimed to further their physical activity and capability. This push was different to the verbal motivation given, rather the physiotherapist through their expectations in rehabilitation, tested and challenged their physical capability. This was perceived as an important step to drive their personal rehabilitative journey.

> She was pushing me all the time to do more, do more and do more, which I was motivated to do anyway. Because I wanted to get out of there as soon as possible. (participant 4, 46 year old male)

> They did push me. But that was more at my request, than them forcing it on me. (participant 5, 58 year old female)

> All the team was pushing me. They said 'look, this is why we were pushing you, because we knew what you could do'. (participant 8, 47 year old male)

All participants recognised the push that came from physiotherapists was instrumental in their physical recovery towards home. However, some participants perceived they were pushed beyond what they could physically achieve. One participant recounted an occasion when their physical capability was challenged too much.

> There was one point where I had enough one day. I think I was just tired, and I think they were asking too much, well I thought that they were. So, I just told everybody to go away. (participant 2, 46 year old female)

In this experience, because the physiotherapist challenged the physical ability too much, the participant did not feel able to push themselves at all and refused physiotherapy. Equally, some participants did not feel they were challenged enough which also affected how they deemed their rehabilitation was centred on them. In contrast, two participants were frustrated when they perceived they were not pushed to their limits.

> I'll be honest with you, I felt 'you're holding me back'. The day before, I would be here. walking with the tracheostomy… walking stick and three or four people around me, just two sometimes. (participant 1, 61 year old male)

> And I wanted to do more, but they (said)… quite rightly, 'you can't do more, you need to take it at the right pace' So yeah, it was a mixed feeling I think, of really glad that I was doing it but also a little bit frustrating because… I didn't feel that I was getting enough. (participant 3, 51 year old male)

In both these instances, participants recognised in retrospect that there may have been reasons they were not challenged more, but they recounted the frustration they felt at the time. The physiotherapist was perceived by them as a barrier towards them pushing themselves and preventing a quicker progression towards home.

Some participants perceived they were understood, and that the physiotherapist knew when to challenge their physical capability and when to stop.

> …and they knew when to stop, you know, they said 'alright, you know we won't… We'll give you a rest now'. (participant 2, 46 year old female)

> They never pushed me too far. If I'd had enough, they would have said, 'oh, that's enough for today.' (participant 4, 46 year old male)

> But I think that we had a good understanding about… they knew that I wanted to get well, and they knew that I would push at all costs to do so. (participant 6, 58 year old female)

Reaching logical and achievable goals

All participants discussed the goals set within their rehabilitation which were discussed with the physiotherapist. These goals were individualised to their capability and centred upon them. One participant explained that their rehabilitation goals originated from their wishes for the future.

> That was my goal. They asked me, what my goals were… and I said, 'to be able to go home and do my garden, and keep my house, and go back to [local community garden], and go back to traveling'. (participant 5, 58 year old female)

This participant had clear goals for the future and could see how physiotherapy would lead to them being achieved. They were the only participant who discussed goals that were driven by future wishes. In other participants' experiences, it was unclear whether they contributed to the goals that were made, and there was a sense that they were driven by the physiotherapists. However, at no point did they disagree with the goals as they were logical steps in their improvement towards home.

> They probably did say to me, 'What we need to do is, this stage to this stage', you know… this is what our target is. (participant 3, 51 year old male)

Participants valued achieving small goals which brought them satisfaction and joy. All participants could recount such positive experiences which marked their physical improvement.

> The best experience was… the first time walking. Because I can remember, I couldn't lift my feet up you know, that mechanism of… Being able to lift (my) feet… That was a really happy moment. (participant 2, 46 year old female)

> Then one day when (the physio) let me go, I could sit up on my own, with holding on for dear life to the edge of the bed. Yeah. But I could sit up… That was an achievement. (participant 4, 46 year old male)

> I remember texting my daughter, 'I've done 6 steps today!'. (participant 5, 58 year old female)

When achieving goals, participants appreciated the forward movement in their journey towards home, which brought happiness. One participant recognised how their physiotherapist used this sense of achievement to push them on their rehabilitation journey.

> They said 'we know you're not going to go very far. Let's see, if we can get to that fire extinguisher' or something. You know a feature that might only be three or four steps further. (participant 7, 70 year old male)

> Because, I'd be saying like 'can I get back into bed'. (They said) 'Well, (we're not available for 10 minutes, so can you just hang on'. And they did it by stealth sometimes [the participant smiled]. Yeah, 'Just give me 10 minutes and there will be two of us, we'll get you back in bed'. And you think later, 'you're conning me there' [laugh]. But you've got to smile. (participant 7, 70 year old male)

In both experiences, the participant recognised that the physiotherapist used smaller staged goals to improve their physical strength and stamina. This participant also recognised that this was necessary for them in the push towards home, and the physiotherapist was working with them to achieve it.

Discussion

For the first time, the patient perspective of the important components of person-centred physiotherapy in ICU has been elaborated. Participants perceived physiotherapy as person-centred when physiotherapists understood their personal rehabilitative journey and guided and supported them. Participants viewed physiotherapy as being particularly person-centred if they were emotionally and physically pushed, with sufficient, but not too much force to achieve the necessary steps for them to improve towards being discharged home. This is an important finding and can be used by physiotherapists when planning interactions with their patients. Although participants perceived there was an

unequal rehabilitation partnership initially, physiotherapy was still deemed to be person-centred as they recognised that they could not be an equal partner as they were too ill.

Previous studies exploring the experiences of patients on ICU, discovered that patients' appreciated physiotherapists taking control of rehabilitation [17] and prefer a more directive, physiotherapist driven, approach to their care during the early recovery in ICU [29]. Physiotherapists' accounts of the progression of physiotherapy in ICU, from being directive and physiotherapist led, to more collaborative [16], support the experiences of patient participants in this study. Models and frameworks guiding person-centred physiotherapy describe the need to empower patients and co-create rehabilitation [10] and create partnerships with patients [11]. The findings from this study do not align with this theory and need for an empowering relationship, and provide an interesting reference point about patients' experiences and perceptions of person-centred rehabilitation in ICU. They preferred a directive approach, which they perceived as being person-centred, until their clinical condition improved. This suggests that physiotherapists can provide, what patients perceive as person-centred rehabilitation, even when barriers exist to forming an equal partnership.

A new and unique discovery from this study is the perceived push that came from physiotherapists that participants perceived as vital to their recovery. Although the word "push" can have negative connotations, in this study, the feelings behind the use of this word were mostly positive as it was the driving force behind recovery and necessary before the participants could contribute towards their rehabilitation themselves. The word "push" is not used as a word to describe a physical force to move something away, rather it is used to describe a necessary persuasion and challenge to drive rehabilitation towards recovery. As the rehabilitative journey through ICU is painful and hard, both parties needed to push together to overcome the difficulties and aim towards home. The "push" was perceived in two separate ways (an "emotional" push and a "physical" push); this term was used by participants when alluding to both types of activity. The "emotional" and "physical" push worked together to progress the patient's rehabilitation towards discharge home. Being challenged and improving physical function is recognised by patients as integral to recovery [6]. This study identifies that the physiotherapist plays a central role in this and the right balance in challenging physical ability was needed for participants to perceive that physiotherapy was centred on them. A motivating and verbal "push" was also perceived that aimed to encourage them to keep trying in their attempts to improve. Importantly, this study highlighted the fine line between pushing the patient "too much" or "too little" and the challenge for physiotherapists working in this setting is to navigate this balance.

From the perspective of physiotherapy education developing the skills to navigate this fragile balance, between pushing too much or too little, is likely to be challenging for novice physiotherapists working in ICU. Patient fatigue is recognised as a limiting factor in the delivery of intensive rehabilitation in ICU settings [30]. Knowledge and skills are required to recognise fatigue and when to stop pushing patients: interpreting changes in patients' physiological parameters, the quality of their movements and other non-verbal signs. Novices could learn this through class-based education [31], but emotional intelligence is also required to understand how patients may be feeling emotionally and when to "push" them verbally. Emotional intelligence is developed during clinical practice when novice practitioners experience daily interactions with vulnerable patients whilst immersed in emotions-based scenarios [32] which has a direct influence on the provision of person-centred care [33]. This study reinforces the need for novice physiotherapists to acquire the knowledge and skills to provide person-centred physiotherapy in ICU settings. A combination of classroom-based learning, clinical practice and guided reflection will raise awareness amongst novices about this important aspect of the physiotherapist's role. This is an important finding as this topic receives little attention in educational programmes for physiotherapists and should be integrated to enhance person-centred care (Sommaruga et al. 2016).

Participants appreciated the explanations physiotherapists gave about the changes in their physical ability and being in an environment in which they felt safe, as they were seen as a unique person with individual needs. When patients are being moved and mobilised in ICU, a sense of re-calibration of their body and ability is required [29] and explanations for unpleasant and alarming physical sensations and symptoms demonstrated the physiotherapist understood them. When participants received explanations that they could understand they felt that physiotherapy was centred on them, and they were seen as unique, because the physiotherapist understood the difficulties they faced. A physiotherapists presence as patients move from a failing body to one that becomes stronger and more independent may provide the steady reassurance that they are safe [34]. This concurs with previous understanding of person-centredness, as being recognised as a unique person and being heard have been identified as important components (Feldhusen et al. 2022).

The explanations that physiotherapists gave to patients about the physiological changes in their body and associated physical sensations also supported the development of trust. Such explanations also helped participants to understand the impact of their critical illness on their body and recognise how far to trust their body and "push" themselves. Clear communication has repeatedly been recognised as important elements in person-centred physiotherapy [12,30]. This study elaborates this further by illustrating how important detailed explanations are to patients. Examples from this study evidence that physiotherapists who invested time and effort in such explanations promoted levels of patient-physiotherapist trust and enhanced engagement with rehabilitation. An important finding is that in doing so, patients are likely to perceive that physiotherapy is person-centred.

The importance of trust has been previously recognised within person-centred physiotherapy [35], and physiotherapy on ICU [3,17,29]. Findings from this study support those from earlier studies as there was an overwhelming sense that participants trusted their physiotherapists which contributed to them perceiving physiotherapy as being person-centred. However, the findings go further and detail how the professionalism of the physiotherapist facilitated this trust and with it a feeling of being physically safe. The trust that participants had in their physiotherapist allowed them to work to the limits of their physical ability and was vital to allow them to begin to push towards home. This trust was nurtured by the physiotherapist understanding the risks caused by the participants' changed bodies and acting to prevent them coming to harm. As this understanding was perceived as being unique and individual to them, this contributed to participants perceiving physiotherapy as person-centred.

The sense of accomplishment patients gained from achieving goals within ICU was highlighted by this study. In analysing patients accounts we found that activity goals did not typically emerge from shared decision-making between physiotherapists and patient which have been previously reported [17]. Although goals were not agreed by the participant, they were common-sense and logical activities which they needed to do in order to get home and were therefore perceived as person-centred. Interestingly,

findings from a study of non-sedated, mechanically ventilated, awake patients reported that patients were involved in negotiating goals about mobilisation with nursing colleagues [36]. This suggests that a more collaborative process, not reported by participants in this study, may be possible. Whether this difference could be explained by experiences being observed rather than reported, or due to the nature of the prolonged engagement of the nurse-patient dyad, compared to the physiotherapist role, is worthy of further investigation. In our findings, the goals that the physiotherapist made were designed to foster physical improvements that would enable patients to progress towards being discharged home, and as such participants agreed with them. Shared decision-making is often impractical and ineffective in the ICU setting because of challenges created by the setting and the capacity of patients [37]. The findings from this study suggest that patients may not need to be involved in decision-making during early recovery, if the physical activity goals are logical and patients can see how they would enable recovery towards home. However, linking the physiotherapy activities to the personal goals set by patients when they go home may be motivating.

Limitations

This qualitative study recruited participants from one centre within Northwest England. The findings emerged from the researchers' interpretations of participants accounts and as all participants had been successfully discharged from ICU this could influence the findings. However, in this in-depth study participants were purposefully sampled and had been admitted to multiple ICUs making the findings potentially transferable to other ICU settings. The length of time since physiotherapy on ICU was received was not used as a criterion to include or exclude participants. It became apparent during the interview, that some participants had been discharged from ICU some years prior to data collection. This could impact upon the accuracy of their recall. However, all participants were able to remember detailed information about their experiences with physiotherapists on ICU and describe their perceptions of rehabilitation and person-centredness.

Conclusion

In this qualitative study exploring ICU patients' experiences and perceptions of physiotherapy, we report that although physiotherapy was invariably controlled by physiotherapists, patients perceived it was person-centred. This contradicts current understanding of person-centred physiotherapy. Patients perceived physiotherapy as being person-centred when explanations encouraged an understanding of body changes (appearance, physical and physiological) and the activities promoted trust, motivation, challenged physical activity, and facilitated the attainment of logical recovery goals. By investing in such activities, physiotherapists can facilitate the patient to begin to guide their own recovery and allow control of rehabilitation to be shared between them.

Despite the small scale of this study, new insights not previously published are presented about the fine balance between activity that is perceived as person-centred by patients versus activity which pushes them beyond their perceived limits. Physiotherapists face challenging decisions in how to motivate and challenge patients' rehabilitation in ICU and this study highlights the importance of focusing upon this educational need in professional programs and curricula. Models of person-centred physiotherapy could be made more applicable to policy, practice, and education by fully integrating the patient perspective.

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