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Multidisciplinary Perceptions of Delirium Management in Neurological Care: A Qualitative Study

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Abstract

Delirium is a common and serious condition among neurological patients, and the overlap between delirium symptoms and neurological disorders complicates both diagnosis and management. Despite its clinical impact, guidance for delirium management in neurological settings remains limited. This qualitative study aimed to investigate healthcare professionals' perceptions of delirium management in a Danish neurological hospital setting. Focus group interviews were conducted with five multidisciplinary healthcare professional groups. Maximum variation sampling was used to capture diverse perspectives, and 24 healthcare professionals from the same neurological department participated. Data were analyzed using reflexive thematic analysis. Three themes were identified: (1) delirium care practices in an acute neurological setting; (2) multidisciplinary collaboration in delirium care; and (3) responsibility for delirium care. The findings highlight challenges related to prioritization, mono-professional practices, and organizational structures that shape how responsibility for delirium management is understood and enacted. Overall, the study illustrates the complexity of delirium management within multidisciplinary neurological teams and suggests the need for context-sensitive approaches that support collaboration and clarify responsibilities in clinical practice.

Keywords: delirium; neurology; neurological patients; multidisciplinary care; delirium management; healthcare professionals; qualitative research

1. Introduction

Delirium is an acute neuropsychiatric syndrome characterized by disturbances in attention, awareness, and cognition, with a typically abrupt onset and fluctuating course [1]. It is prevalent among hospitalized patients, especially older adults and those with pre-existing neurological conditions, and is associated with poor and adverse outcomes, including increased mortality, prolonged hospital stays, functional and cognitive impairment, and increased healthcare costs [2–5]. Despite its significance, delirium remains underrecognized and inadequately managed across clinical settings [6], reflecting broader challenges in implementing evidence-based care in acute hospital environments [7,8]. This underlines the need to strengthen delirium care during hospital admission to support the implementation of evidence-based interventions and reduce the risk of adverse consequences.

Management of delirium is particularly critical in neurology, where patients are frequently at high risk due to factors such as acute brain injury, seizures, or infections [9]. Delirium symptoms are often mistaken for manifestations of the underlying neurological condition, resulting in misdiagnosis and missed opportunities for care [9–11]. Studies have found that delirium occurs in 1.4% to 75.6% of patients with stroke and is associated with poorer patient outcomes [12,13]. This wide variation in reported prevalence is likely due to differences in the assessment tools used to identify delirium

[12,13]. However, delirium assessment is often viewed as a separate task, rather than an integral part of routine care in neurology units [12]. Guidelines for the management of delirium exist; however, they are generally broad and provide limited guidance for implementation in clinical practice [14,15]. Patients with neurological conditions often present complex clinical profiles and receive care from multiple healthcare professionals [16]. This highlights the need for a neuro-specific approach to delirium management [17].

Research on barriers to effective delirium management in neurology remains limited. In critical care, delirium barriers include limited clinician awareness, difficulty differentiating delirium from neurological diagnoses, the absence of specialty-specific screening tools, and a lack of time and staff [18–20]. Bae and Roh (2024) investigated delirium care competencies among intensive care, geriatric, and oncology nurses [21]. They found that delirium care competencies were influenced by barriers to delirium care [21]. The barriers to delirium care were a lack of personal and physical support systems (i.e., availability of delirium screening tools and delirium-nursing manual), emotional burden, lack of knowledge and self-confidence, conflict with physicians and family, heavy workload, lack of motivation and communication skills, and difficulty in delirium assessment [18,19,21].

Delirium is a multidisciplinary challenge that requires collaborative management across professional groups to ensure optimal patient care. Patients with neurological conditions often have complex care needs and are therefore managed by multiple healthcare professionals [16]. However, delirium management in neurology lacks specific clinical guidelines [17]. These factors contribute to the persistent underdiagnosis and suboptimal management of delirium in neurological settings. The presence of pre-existing cognitive impairment is a well-established risk factor for delirium, making this population particularly vulnerable and highlighting the need for further investigation [9,10]. Given the scarcity of research focused specifically on delirium within neurology, a research gap remains in understanding delirium in neurological settings [6]. Multidisciplinary perspectives are central to delirium management, yet remain underexplored, despite evidence suggesting similar assessment outcomes across professions [13]. This gap is particularly evident in acute neurological settings, where the complexity of patients with delirium presents unique challenges. Understanding these perceptions may support the development of tailored interventions, improve clinical practice, and inform policies aimed at enhancing delirium management. Therefore, this study aims to explore multidisciplinary healthcare professionals' perceptions of delirium management in an acute neurological hospital setting, with the potential to improve patient safety and quality of life.

2. Materials and Methods

.2.1. Design

A qualitative, explorative design was chosen to explore the perceptions of multi-disciplinary healthcare professionals regarding delirium management in a neurological hospital setting using focus group interviews [22,23]. A qualitative approach is appropriate for exploring complex and context-dependent phenomena and for gaining insight into participants’ experiences and perspectives [24,25]. Data were collected using focus group interviews, which facilitate discussion and reflection among participants and allow insights to emerge through interaction between professionals from different disciplines [22,23]. The data were analyzed using reflexive thematic analysis informed by a hermeneutic approach [26,27]. The study complied with the Consolidated Criteria for Reporting Qualitative Research [28].

2.2. Setting and Participants

The study was conducted in an acute neurological department at a Danish university hospital in June 2024. The department comprises 52 beds, divided into two wards: a general neurology ward and a neurovascular center, each with 26 beds. In 2024, the department admitted 6961 patients with an average length of stay of 3.8 days in general neurology and 1.6 days in the neurovascular ward.

Multidisciplinary healthcare professionals were recruited to capture a variety of perspectives on delirium management [29]. Our sampling strategy was based on purposive sampling with maximum variation according to three criteria: (1) experience with delirium; (2) employment of ≥ 1 year in the department, and (3) representation of different healthcare professions within the neurological team. In agreement with department management, representatives from junior and senior physicians, nurses, nurse assistants, nurse managers, and affiliated allied healthcare professionals (e.g., occupational and physiotherapists) were invited. The second author invited potential participants via email. Most participants worked rotating shifts, except for the neuropsychiatrist and the therapist group. Patients with delirium often have sleep disturbances, which made it relevant that participants had experience from evening and night shifts.

A total of five focus group discussions with 24 participants were conducted. Participants represented a range of professional groups and varied in age, gender, and clinical experience (aged 26–60 years; 83% female) (Table 1).

Table 1. Participants' characteristics (N=24).

Participants (P#)	Sex	Age (years)	Seniority (years)	Job position	Employment (years)[1]	FGD
P1	Female	39	11	Physician	3	1
P2	Male	52	21	Physician & Professor	10	1
P3	Female	37	11	Physician	3	1
P4	Male	42	15	Physician	3	1
P5	Female	37	9	Physician	1,5	2
P6	Male	28	2	Physician	1,5	2
P7	Male	39	12	Physician	2	2
P8	Female	58	33	Head nurse	34	3
P9	Female	38	13	Head nurse	11	3
P10	Female	42	14	Head nurse	2	3
P11	Female	60	34	Nurse manager	24	3
P12	Female	50	21	Audio speech therapist	7	4
P13	Female	30	2	Neuro-psychologist	3	4
P14	Female	30	1	Physio-therapist	2,5	4
P15	Female	46	4	Occupational therapist	2	4
P16	Female	41	2	Nurse Assistant	3	5
P17	Female	59	25	Nurse assistant	7	5
P18	Female	49	18	Head nurse assistant	7	5
P19	Female	27	2	Nurse	1	5
P20	Female	44	2	Nurse	3	5
P21	Female	32	3	Nurse	3	5
P22	Female	26	1	Nurse	1	5
P23	Female	34	9	Head nurse assistant	7	5
P24	Female	31	2	Nurse	8	5

[1] Age and seniority are presented in years; employment refers to years in the department.

The focus group discussions were conducted to explore healthcare professionals' experiences and perceptions of delirium management, aiming to generate a broad understanding of the topic rather than achieving consensus [22,23]. Each focus group was encouraged to reflect on challenges and barriers related to delirium management within their own profession, enabling the exploration of profession-specific perspectives. The composition of the groups was carefully considered, and participants were grouped based on professional background to facilitate open discussion and highlight shared professional understandings [22,23]. Each focus group comprised a single professional group, except for one multidisciplinary group including neuropsychologists, speech therapists, occupational therapists, and physiotherapists. This grouping was intended to create a safe space for dialogue and to minimize the influence of professional hierarchies during the discussions. For example, combining senior and junior physicians might create a power imbalance that could inhibit junior physicians from contributing their perspectives. By organizing the groups in this way, we sought to promote equal participation, increase spontaneity, and allow participants to speak freely about their experiences. Therapists were grouped as they collaborate closely in daily practice.

2.3. Data Collection

The researchers obtained permission from management to invite participants during their working hours, allowing them to remain in their usual work context and relate directly to the discussion topics. The interviews were conducted in a meeting room at the hospital located outside the wards to avoid interruptions. A semi-structured interview guide was used, covering open-ended questions based on the following topics: (1) perspectives of delirium in general, (2) current delirium practice, (3) barriers and facilitating factors, and (4) recommendations for delirium management. Open-ended questions allowed participants to express their views in their own words and elaborate on their experiences. One author moderated the interviews, while another author served as an observer and took reflection notes. The moderator facilitated the discussions through active listening and fostering a safe and comfortable environment for participants [30]. To minimize potential influence on the participants, the moderator remained aware of the preconceptions throughout the interviews [24–26]. At the end of each interview, the observer was invited to ask supplementary or clarifying questions to address any ambiguities. The moderator and observer then had a debrief following each interview. Field notes were used to support reflection and form the initial stages of analysis. The interviews were audio-recorded and transcribed verbatim.

3.4. Data Analysis

Reflexive thematic analysis, as outlined by Braun and Clarke, was used to analyze and systematically organize data [Braun & Clarke, 2021]. This approach is widely recognized for its flexibility and is well-suited for exploring complex phenomena in healthcare settings, as it allows for the identification and interpretation of patterns across qualitative data. The analysis followed a six-step process, as outlined in Table 2.

Table 2. Execution of the six steps of analysis.

Step	Description of the process
1. Familiarizing yourself with your data	All data were transcribed and thoroughly read by all authors.
2. Generating initial codes	The first and last author met to code text, which was noted on post its. Another member of the research group coded independently, and the codes were then compared in a joint workshop. This process resulted in the merging of initial codes, guided by the study aim.
3. Searching for themes	After coding, all authors met to identify initial themes, which were organized in a table and registered in a joint document.
4. Reviewing themes	Through several rounds of reading both the transcripts and the codes, the research team engaged in an iterative process of reflection and

	comparison. This led to the gradual development, adjustment, and merging of codes into themes, resulting in three final themes that reflected participants´ perceptions of delirium management.
5. Defining and naming themes	The themes were named, highlighting the meaning of the theme.
6. Producing the report	Writing the analysis was a dynamic, iterative process, beginning in phase four and moving back and forth between the last three of the six steps. The focus was on relating the data to the research aim.

The process began with repeated reading of the transcripts to ensure familiarization with the data. Data were then systematically coded, followed by collaborative discussions and iterative refinement of themes. This process involved continuous reflection and resulted in a set of themes capturing participants' perceptions of delirium management.

3.5. Rigor

The research team engaged in continuous critical reflection on their influence during the data collection and analysis process [25,26,31]. Researcher triangulation was applied during the development of the interview guide, as well as during data analysis and interpretation [25,26,31]. This involved discussions of coding, theme development, and the selection of illustrative quotes. Codes and themes were compared across professional groups to identify similarities and differences in perspectives. To enhance transparency and transferability, the processes of sampling, data collection, and analysis were described in detail [25,26,31]. During interviews, reflexivity was supported by probing participants' responses and seeking clarification to ensure shared understanding [25,26,31]. The research team comprised researchers with diverse professional, clinical, and research backgrounds. The researchers were employed in the department but had no clinical responsibilities.

3.6. Ethical Considerations

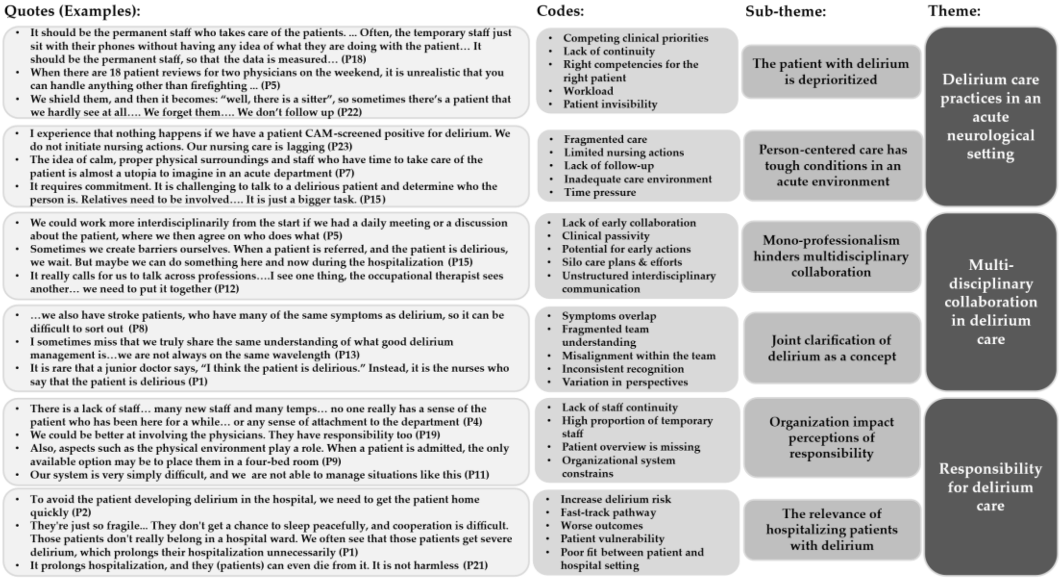
The Danish Data Protection Agency approved this study (J.nr.: P2025-19545). The study was conducted in accordance with the ethical principles of the Declaration of Helsinki [32]. According to the regional ethics committee, the study was not classified as biomedical research and therefore did not require formal ethical approval (J.nr. EMN-2025-05969). The study was approved by department management. Participants received written and verbal information and provided informed consent. Additionally, they were told that participation was voluntary. Data were handled confidentially and anonymized, and participation had no consequences for employment.

3. Findings

3.1. Findings from the Analysis

Analysis of the focus group interviews revealed three interconnected themes reflecting healthcare professionals' perceptions of delirium care in an acute neurological setting. These themes were: (1) delirium care practices in an acute neurological setting, (2) multidisciplinary collaboration in delirium care, and (3) responsibility for delirium care. Each theme covers two sub-themes that capture how organizational pressures, professional boundaries, and cultural norms shape the recognition and management of delirium. Collectively, the themes illustrate how delirium care management is shaped by structural and contextual factors across clinical practices, collaborative processes, and the distribution of responsibility (Figure 1).

[Figure 1 The analytical process]



Quotes (Examples):	Codes:	Sub-theme:	Theme:
• It should be the permanent staff who takes care of the patients. ... Often, the temporary staff just sit with their phones without having any idea of what they are doing with the patient… It should be the permanent staff, so that the data is measured… (P18) • When there are 18 patient reviews for two physicians on the weekend, it is unrealistic that you can handle anything other than firefighting ... (P5) • We shield them, and then it becomes: "well, there is a sitter", so sometimes there's a patient that we hardly see at all…. We forget them…. We don't follow up (P22)	• Competing clinical priorities • Lack of continuity • Right competencies for the right patient • Workload • Patient invisibility	The patient with delirium is deprioritized	Delirium care practices in an acute neurological setting
• I experience that nothing happens if we have a patient CAM-screened positive for delirium. We do not initiate nursing actions. Our nursing care is lagging (P23) • The idea of calm, proper physical surroundings and staff who have time to take care of the patient is almost a utopia to imagine in an acute department (P7) • It requires commitment. It is challenging to talk to a delirious patient and determine who the person is. Relatives need to be involved…. It is just a bigger task. (P15)	• Fragmented care • Limited nursing actions • Lack of follow-up • Inadequate care environment • Time pressure	Person-centered care has tough conditions in an acute environment	
• We could work more interdisciplinarily from the start if we had a daily meeting or a discussion about the patient, where we then agree on who does what (P5) • Sometimes we create barriers ourselves. When a patient is referred, and the patient is delirious, we wait. But maybe we can do something here and now during the hospitalization (P15) • It really calls for us to talk across professions….I see one thing, the occupational therapist sees another… we need to put it together (P12)	• Lack of early collaboration • Clinical passivity • Potential for early actions • Silo care plans & efforts • Unstructured interdisciplinary communication	Mono-professionalism hinders multidisciplinary collaboration	Multi-disciplinary collaboration in delirium care
• …we also have stroke patients, who have many of the same symptoms as delirium, so it can be difficult to sort out (P8) • I sometimes miss that we truly share the same understanding of what good delirium management is…we are not always on the same wavelength (P13) • It is rare that a junior doctor says, "I think the patient is delirious." Instead, it is the nurses who say that the patient is delirious (P1)	• Symptoms overlap • Fragmented team understanding • Misalignment within the team • Inconsistent recognition • Variation in perspectives	Joint clarification of delirium as a concept	
• There is a lack of staff… many new staff and many temps… no one really has a sense of the patient who has been here for a while… or any sense of attachment to the department (P4) • We could be better at involving the physicians. They have responsibility too (P19) • Also, aspects such as the physical environment play a role. When a patient is admitted, the only available option may be to place them in a four-bed room (P9) • Our system is very simply difficult, and we are not able to manage situations like this (P11)	• Lack of staff continuity • High proportion of temporary staff • Patient overview is missing • Organizational system constrains	Organization impact perceptions of responsibility	Responsibility for delirium care
• To avoid the patient developing delirium in the hospital, we need to get the patient home quickly (P2) • They're just so fragile... They don't get a chance to sleep peacefully, and cooperation is difficult. Those patients don't really belong in a hospital ward. We often see that those patients get severe delirium, which prolongs their hospitalization unnecessarily (P1) • It prolongs hospitalization, and they (patients) can even die from it. It is not harmless (P21)	• Increase delirium risk • Fast-track pathway • Worse outcomes • Patient vulnerability • Poor fit between patient and hospital setting	The relevance of hospitalizing patients with delirium	

Figure 1. The analytical process. This illustrates the development from data extracts (quotations) to initial codes, subthemes, and themes.

3.1.1. Delirium Care Practices in an Acute Neurological Setting

3.1.1.1. The Patient with Delirium Is Deprioritized

Interviews revealed that delirium care was often assigned low priority in the acute neurological ward. Participants described how delirium care was often overlooked, and at times framed as disruptive rather than as involving vulnerable patients. Care was frequently delegated to temporary agency sitters or different caregivers, who were perceived as insufficiently prepared to manage the complexity of delirium care. As a result, delirium care could "disappear" from the workflow, particularly when a sitter was present. Because delirium does not always present as agitation or obvious hallucinations, but may instead be presented as confusion or quiet withdrawal, several participants expressed moral discomfort when these patients were overlooked:

"I know that we deprioritize them because they do not draw attention to themselves." (P11).

Nurses described how this care organization led to gaps in fundamental care. Essential elements such as mobilization, nutrition, medication administration, and observation were inadequately performed. These experiences highlighted how practical organization of care, rather than lack of knowledge alone, shaped delirium management:

> *"It should be the permanent staff who takes care of the patients (instead of a temporary staff), so that assessment was done, food and drink were provided, medication, toilet visits, and mobilization... all the basic things that can get the patient out of delirium again" (Nurse, P18)*

Physicians reported that their involvement typically occurred only when delirium had escalated:

> *"When we as physicians get involved, it is because it has already gone far… If we do not hear about it, then it has probably been handled well by the nursing staff" (P1)*

Limited continuity in patient observations contributed to delayed recognition of symptom changes. This could lead to late interventions of delirium care:

> *"Nurses discover it… but we do not see the fluctuation. It is the nurses who are with the patients the most." (P3)*

Therapists emphasized that engagement in delirium care required time, attentiveness, and involvement of relatives. However, this work was described as resource-intensive, undervalued, and insufficiently prioritized within the acute setting. Therapists reported that delirium care, including family involvement, was often viewed as burdensome rather than as a clinical priority.

Collectively, these findings indicate that delirium care was often deprioritized in daily practice due to time constraints and competing clinical demands. Screening was frequently omitted, as attention was directed towards more acute tasks, while short hospitals admissions further limited opportunities for assessment. As a result, patients with delirium, particularly those with less overt symptoms, were less likely to attract clinical attention and could become less visible within routine workflows. Collectively, these conditions led to inconsistent delivery of fundamental care, discontinuity, limited interdisciplinary coordination, and insufficient integration of relatives' perspectives. Participants highlighted systematic screening, followed by early, preventive, multicomponent interventions, as well as earlier collaboration across healthcare professionals, as key areas for improvement.

3.1.1.2. Person-Centered Care Has Tough Conditions in an Acute Environment

Across professions, participants described person-centered care as an important ideal, but rarely achievable in the acute neurological ward. Overcrowding, high patient turnover, and limited delirium-specific competencies constrained the ability to individualize care. Patients with delirium were often labeled as 'troublesome' and received little meaningful interaction from qualified staff. This dilemma between ideals and clinical reality was reflected in participants' emphasis on both fundamental care and the development of delirium-specific competencies as central to improving practice:

> *"I think that a patient with delirium represents the fundamental nursing care that we must provide. That is the core of our nursing care: finding the triggering factors and uncovering what needs these patients have. If we become competent in delirium patients, then we will also become competent in all other patients" (P23)*

Therapists and neuropsychologists, whose assessments required longer interactions, described a more dialogical approach, underlining that meaningful assessment depended on sustained interaction with both patients and relatives. They noted that this type of knowledge often remained invisible in a fast-paced acute culture:

> *"We sit down and try to communicate with the patient, but at the same time, we also get information from the relatives about the patient, which the nursing staff and the physicians who are rushing in and out do not get. So, we have some knowledge that the other professional groups need" (P12)*

A tension emerged between efficiency-driven workflow and relational care needs:

> *"The patient becomes 'the difficult patient'… staff need to move quickly, but this patient really needs you to enter the room slowly and be able to contain them." (P9)*

Physicians described how these constraints affected their professional role, with the inability to provide relational care experienced as a loss of professional meaning. Therapists and nurses highlighted repeated disruptions that prevented continuity of care plans, including sleep–wake routines, environmental adjustments, and reorientation strategies:

> *"Reality is unpredictable… especially on an acute ward. The plans can be very difficult to follow through." (P15)*

These findings showed a persistent tension between the ideal of person-centered care and the realities of acute neurological practice. Organizational constraints, limited competencies, and workflow pressures hindered individualized and relational care, disrupted continuity, and contributed to a perceived loss of professional meaning.

This theme indicates that person-centered care is fragile within acute neurology, affecting both patient care and staff well-being. Despite shared knowledge of and commitment to person-centered care, structural pressures such as overcrowding and time constraints, alongside a culture focused on efficiency and crisis management, undermined relational care. Participants highlighted approaches to support delirium care, including continuity of staff, involvement of relatives as an active resource, and preventive interventions aimed at reducing both the development and consequences of delirium.

These approaches emphasized prioritizing relational care, calmness, circadian rhythm, and attentiveness before medication.

3.2.1. Multidisciplinary Collaboration in Delirium Care

3.2.1.1. Mono-Professionalism Hinders Multidisciplinary Collaboration

Across interviews, participants emphasized the importance of supporting patients with delirium, but collaboration was often described as fragmented and predominantly mono-professional. Each profession tended to focus on its own tasks, and genuine joint efforts, shared goals, and coordinated interventions were rare. While all professional groups recognized delirium as a common complication associated with hospitalization, collaboration was hindered by siloed practices and unclear expectations. Physicians reported being involved late in the process and primarily for specific tasks:

> *"When we are asked to act, it involves medication."* (P4)

Despite established plans, implementation frequently faltered due to workload, communication gaps, and inconsistent follow-up:

> *"It can be hard to implement the good plans… everyone has so many other tasks."* (P15)

Nurses described reluctance among colleagues to intervene or screen when delirium was suspected, noting that insufficient or missing nursing data often left physicians without the necessary basis for decision-making. Engaging colleagues in delirium screening was described as difficult, and the lack of systematic documentation weakened collaboration:

> *"I have a really hard time persuading my colleagues to go into the delirium problem and screen the patient. They always expect a prescription from the physicians.... It is always me who is left with the delirium patient… We need physicians, but I do not always experience that we provide the data that the physicians demand "* (P20)

> *"There is a lack of reflection… some feel you step on their toes when suggesting screening."* (P21)

Therapists also noted that assessments were often postponed or incomplete when delirium was present:

> *"When the patient is delirious, we cannot assess them… we do not see them continuously, and our assessments become delayed."* (P13)

Findings showed that mono-professional approaches limited coordinated delirium care. Stronger interdisciplinary structures, covering systematic meetings, joint reflection, role clarity, and dedicated expertise, were viewed as essential to improve coherence and accountability, and to support person-centered care. Participants highlighted the importance of shared care plans and their consistent maintenance, as well as early interdisciplinary collaboration. Timely cross-professional discussions were described as essential for creating stability and preventing late escalation.

3.2.2.2. Joint Clarification of Delirium as a Concept

Interviews revealed considerable uncertainty across professional groups in distinguishing delirium from symptoms of underlying neurological conditions. There was inconsistency across professions in how delirium was understood, identified, and managed. Nurses reported reliance on subjective impressions rather than validated tools:

> *"I miss that we use the screening tools… it quickly becomes a subjective judgement: 'Well, it is probably just the neurological condition.'"* (P19)

This uncertainty was described as leading to misdiagnosis and delayed treatment. Nurse managers described situations where behavior initially interpreted as delirium was later recognized as part of a chronic condition:

> *"Last week, we had a patient who was acting violently and threatened us with death and destruction. We were sure that he was delirious! But it turned out that he was always like that, and that he had alcoholic dementia. ... it can sometimes be a muddy picture!"* (P9)

Therapists and neuropsychologists also reflected on this challenge, emphasizing that even in interdisciplinary discussions, there was confusion about basic terminology:

> *"When we attend the morning conferences, I experience that there is uncertainty about the concepts of confusion and delirium. When is what, what? I don't know what the right definition is, but at least we must speak the same language!"* (P12)

Physicians noted that their assessments were largely shaped by nursing reports, underscoring the need for shared definitions:

> *"Physicians are primed by what the nurses say… If nurses do not alert delirium, we don't recognize it."* (P2)

Participants emphasized the need for shared terminology and a more structured, shared approach to delirium care. Conceptual ambiguity was described as undermining both confidence and consistency in delirium care. Participants highlighted the importance of closer interdisciplinary dialogue, joint clarification of terminology, early collaborative prevention, and consistent follow-up on care plans.

Collectively, this theme suggested that multidisciplinary collaboration in delirium care was constrained by mono-professional practices, unclear expectations, inconsistent communication, and conceptual ambiguity. Although delirium was recognized as a shared challenge, collaboration remained fragmented, with delayed involvement, difficulties in implementing care plans, and inconsistent documentation and follow-up. These challenges highlight the need for shared definitions, structured communication, and earlier cross-professional collaboration.

3.2.3. Responsibility for Delirium Care

3.2.3.1. Organization Impact Perceptions of Responsibility

Across professional groups, participants described clear understandings of their own roles, yet uncertainty about overall responsibility for delirium care. Participants described uncertainty about who holds overall responsibility, particularly when sitters, new staff, or inexperienced colleagues were involved. Senior physicians, however, clearly recognized the nurses' central role in delirium care:

> *"It is most often the nursing staff that discovers delirium in the patient. We physicians have more supportive functions."* (P1)

Participants emphasized the importance of organizational structures that support interdisciplinary continuity in delirium care. A stable team around the patient was described as essential for ensuring consistent follow-up, ongoing revision of care plans, and shared responsibility across professions. This perspective highlights how continuity is not only a clinical issue but also an organizational one, requiring structured collaboration and sustained coordination over time:

> *"I think that a permanent interdisciplinary team around the patient, ensuring continuity, revision, and ongoing follow-up on the plan, is the way forward."* (P14)

At the same time, responsibility was shaped not only by professional boundaries but also by organizational and economic constraints. Nurse managers described financial and staffing pressures as a constant challenge, particularly when aligning staffing with patient needs:

> *"From a management perspective, it is a burden that there must always be someone with the patient, and temporary staff are expensive. They (temporary staff) have no authority or ability to care"* (P8)

Participants described a strong sense of responsibility for ensuring appropriate delirium care. However, care was often delegated to temporary agency staff, who were perceived as lacking the necessary knowledge, competencies, and engagement. This mismatch undermined continuity of care and limited the team's ability to provide timely and appropriate care. Participants highlighted the need for greater structure and systematization, including checklists, standardized workflows, and clinical guidelines to reduce person-dependence. They also emphasized the importance of increased access to knowledge and key personnel, such as visible resource persons and ongoing training.

3.2.3.2. The Relevance of Hospitalizing Patients with Delirium

Participants described a paradox in distinguishing symptoms of neurological disease from delirium. While participants spoke of the responsibility to detect delirium, they also experienced that a diagnosis could prolong hospitalization. Transfer often required symptom resolution, which was difficult to achieve in patients with delirium. Thereby prolonging hospital stays and delaying rehabilitation.

A recurring dilemma concerned whether hospitalization was always beneficial for frail older adults at high risk of delirium. Physicians questioned the appropriateness of admitting patients who might deteriorate due to environmental changes rather than medical illness, and instead advocated for community-based alternatives:

> *"Some patients… I really think they would have been better off never coming here. We do not help them very much… One could wish for alternatives. Some should be seen by outreach teams instead of being admitted." (P1)*

Nurses, physicians, and managers similarly reflected that, for some patients, admission exacerbated confusion and distress:

> *"Some patients might have been better off staying at home… the admission makes them more confused." (P8)*

Participants described a paradox in which detecting delirium could prolong hospitalization and delay rehabilitation. Participants highlighted alternatives such as avoiding unnecessary transfers and expanding nursing home–based or outreach services as more appropriate options for high-risk, frail patients.

Overall, this theme illustrated how responsibility for delirium care was shaped by the interaction between professional roles and organizational and economic conditions. Although individual responsibilities were clear, overall responsibility remained diffuse, particularly in the context of staffing instability and resource constraints that undermined continuity and coordination of care. Participants also highlighted dilemmas related to hospitalization, where admission could both support and worsen patient outcomes, emphasizing that responsibility extends beyond individual professionals and is embedded in organizational structures and care pathways.

4. Discussion

This study explored how multidisciplinary healthcare professionals in an acute neurological department perceive and manage delirium. Although delirium was widely recognized as a serious and complex condition, the findings reveal a persistent gap between this recognition and the care provided in everyday clinical practice. Collectively, delirium care was shaped by tensions between clinical ideals and organizational realities across three interrelated themes: care practices, multidisciplinary collaboration, and responsibility.

In relation to care practices, organizational pressures and environmental constraints limited the consistent implementation of preventive and person-centered approaches. Patients with delirium, particularly those with less overt symptoms, were at risk of becoming less visible within routine workflows, contributing to discontinuity and inconsistent delivery of care [33,34]. Similar challenges have been described in literature, in which less overt presentations of delirium are more likely to be overlooked [34–36]. The diagnostic complexity of delirium in neurological populations further contributed to these challenges. Overlapping and fluctuating symptoms, often difficult to distinguish from underlying neurological conditions, introduced uncertainty in both recognition and clinical decision-making [9,10]. This complexity is further intensified using overlapping and imprecise

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terminology, such as “acute confusion” or “altered mental status”, which may obscure the clinical significance of delirium and contribute to unrecognition and inconsistent management [37–39]. In contrast, delirium is a well-defined clinical syndrome characterized by disturbances in attention, awareness, and cognition with an acute and fluctuating course [1,3,14]. The use of non-specific terms may therefore reinforce diagnostic ambiguity, particularly in neurological settings where symptom overlaps are common, further complicating clinical decision-making and interdisciplinary communication. This aligns with the results from the current study, where the participants were missing a common delirium language. According to the participants’ perspectives, addressing these barriers requires structured approaches, including systematic screening linked to clear clinical actions, continuity of staff and care plans, and early, preventive, multicomponent interventions. These strategies align with evidence demonstrating that multicomponent, non-pharmacological interventions reduce delirium incidence when implemented within structured care processes [35,40,41]. The findings highlighted a gap between the ideal of person-centered care and the realities of acute neurological practice. Person-centered care was described as a shared professional value, yet difficult to realize in an environment characterized by time pressure, high patient turnover, and competing clinical priorities. Within the Fundamentals of Care framework, delirium management requires integration of physical, psychosocial, and relational dimensions of care; however, these dimensions were often undermined by structural constraints [42]. Similar barriers to person-centered and preventive delirium care have been identified in previous research, including limited time, competing demands, and lack of continuity [19,34,35,43]. Participants emphasized that relational and preventive approaches, such as maintaining circadian rhythm, creating calm environments, and involving relatives, are essential components of effective delirium care, yet remain difficult to prioritize without organizational support.

Multidisciplinary collaboration was recognized as essential but was often characterized by mono-professional practices and limited coordination. Physicians were typically involved later and primarily in pharmacological decision-making, while nurses and therapists managed fluctuating symptoms with limited interdisciplinary support. Even when care plans were developed, implementation was inconsistent due to communication gaps, workload pressures, and a lack of systematic follow-up. This aligns with research demonstrating that delirium care often lacks coordinated, interdisciplinary approaches despite clear recommendations [3,11,15,36]. A key barrier to collaboration was the absence of a shared conceptual understanding of delirium. Uncertainty in distinguishing delirium from neurological symptoms, combined with inconsistent screening practices, delayed recognition, and intervention. Nurses often depend on subjective assessments, while physicians rely on nursing reports, reflecting interdependence without a shared framework. Similar challenges have been reported, where variability in terminology and assessment practices contributes to inconsistent management [3,15,36]. In this context, delirium care appeared to fall between professional domains, limiting coordinated action and reinforcing fragmented care processes. Strengthening collaboration, therefore, requires shared terminology, structured communication, and regular cross-professional dialogue, supported by shared care plans and consistent follow-up. These approaches are consistent with implementation research showing that structured interdisciplinary processes improve coherence and continuity in delirium care [19,34,41,43].

Responsibility for delirium care was depicted as both shared and ambiguous. While healthcare professionals described clear individual roles, overall responsibility was often unclear and negotiated in practice, particularly in contexts characterized by staffing instability and resource constraints. This contributed to situations where responsibility was implicitly transferred rather than consistently maintained, reducing patients’ visibility within the system. Organizational and economic constraints further shaped how responsibility was enacted. Time pressure, staffing shortages, and competing priorities limit the ability to provide continuous, relational care, contributing to task-oriented rather than person-centered approaches [19,20]. Participants also described ethical tensions related to hospitalization, particularly for frail patients at high risk of delirium, where admission could both support and exacerbate symptoms. Similar concerns have been raised in the literature, suggesting that care pathways and environments influence both responsibility and patient outcomes [44,45]. To support clearer ownership, participants emphasized the need for defined roles, visible resource persons, and ongoing education, alongside organizational structures such as standardized workflows and checklists to reduce person-dependence and support continuity of care [15,19,34,43].

Overall, these findings suggest that delirium care is constrained by interconnected challenges related to clinical complexity, organizational conditions, and professional practices. Across the three domains, participants consistently pointed towards solutions that emphasize structure, collaboration, and continuity. These findings align with previous research demonstrating that delirium care is often fragmented, inconsistently implemented, and shaped by organizational and systemic constraints in acute settings [3,11,15,36]. In summary, this suggests that improving delirium care requires system-level approaches that integrate structured practices, interdisciplinary collaboration, and clearly anchored responsibility, thereby enabling more consistent and person-centered care in acute neurological settings.

4.1. Methodological Considerations

This study is strengthened by its qualitative design, which enabled an in-depth exploration of healthcare professionals' experiences, perceptions, and practices related to delirium management. Qualitative methods are well-suited to investigate complex clinical phenomena as they occur in real-world contexts, allowing insight into meanings, interactions, and organizational processes that are not easily captured through quantitative approaches [25,46]. The inclusion of multiple professional groups provided a multidisciplinary perspective on delirium care, allowing comparison across roles and contributing to a more comprehensive understanding of clinical practices and organizational challenges. In addition, the relatively large number of participants increased the variation in perspectives and supported the transferability of findings within similar clinical contexts. The focus on an acute neurological setting further strengthens the study, as this represents a complex and underexplored context in delirium research. In line with Lincoln and Guba (2005), credibility was supported through variation and triangulation of perspectives across professional groups [31].

Several limitations should be considered. The study was conducted within a single neurological department, which may limit transferability to other settings with different organizational structures or patient populations. However, qualitative research aims to provide contextually grounded insights rather than statistical generalization, and a detailed description of the setting may support assessment of relevance to other contexts [25]. In addition, the researchers were employed within the same department as participants, which may have influenced data collection and interpretation. Although there was no direct collaboration in daily clinical work, familiarity with the organizational context may have shaped both participants' responses and the researchers' interpretations. At the same time, this contextual knowledge may have supported a deeper understanding of clinical practice. This dual position underscores the importance of reflexivity in qualitative research and relates to considerations of confirmability and dependability, where the researcher's role is recognized as integral to the knowledge production process [25,31].

4.2. Implications for Practice and Research

Improving delirium care in acute neurology requires prioritizing delirium as a high-risk condition and implementing structured, interdisciplinary approaches rather than reactive or individualized practices. In clinical practice, this includes systematic screening linked to clear actions, shared care plans, continuity of care, and regular interdisciplinary communication to strengthen coordination and accountability. At an organizational level, the structuring of care, through primary care teams, minimizing unnecessary transfers, and embedding delirium care within routine workflows, appears central to supporting consistent and person-centered practice [15,19,34,35,41,43]. For future research, the findings highlight the need to move beyond identifying barriers and instead test interventions that explicitly address how care is organized in practice. Future studies should evaluate how structured workflows, shared responsibility, and multidisciplinary collaboration can be operationalized within routine care, and how organizational models influence the implementation and sustainability of delirium care interventions [15,19,34,35,38,41,43,44].

5. Conclusions

This study explored how multidisciplinary healthcare professionals perceive and manage delirium in an acute neurological setting. Although delirium was widely recognized as a complex condition, its management was constrained by organizational pressures, limited interdisciplinary coordination, and unclear responsibility, leading to inconsistent person-centered and preventive care. The findings suggest that delirium care extends beyond a clinical challenge and reflects a system-level issue shaped by the interaction between clinical complexity, professional practices, and organizational structures. Patients with delirium were at risk of reduced clinical visibility and fragmented care, particularly in contexts of high workload and staffing instability.

This study adds to existing research by providing a multidisciplinary perspective on how these challenges intersect in practice. Improving delirium care, therefore, requires structured organizational and interdisciplinary approaches that support early identification, continuity, shared understanding, and clearly defined roles and responsibility.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study. The study was conducted in accordance with the ethical principles of the Nordic Nurses' Federation. Participants received both verbal and written information, participation was voluntary, and all data were anonymized.

Data Availability Statement: The data presented in this study are available on reasonable request from the corresponding author. The data are not publicly available due to ethical and privacy restrictions.

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