

## Delirium, Depression & Dementia (3D's) Quiz (Based on the 3D's Resources)

### PART I – Questions for All Staff

#### True or False:

1. T/F Delirium is often reversible with treatment.
2. T/F Delirium fluctuates over 24 hour period and is worse at night.
3. T/F Delirium is a gradual and progressive decline in mental processing ability that affects short-term memory, communication, language, judgment, reasoning, and abstract thinking.
4. T/F Depression is a medical emergency characterized by an acute and fluctuating onset of confusion, disturbances in attention, disorganized thinking and/or decline in level of consciousness.
5. T/F Depression is usually reversible with treatment and often worse in the morning.
6. T/F Depression is characterized by unexplained changes in mood that persist for over months to years.
7. T/F Dementia has a slow, chronic progression and is irreversible.
8. T/F A person with dementia has reduced memory, concentration and thinking, and low self- esteem.
9. T/F Prevalence of depression may increase in dementia.
10. T/F Sleep pattern in delirium is disturbed with early morning awakening or hypersomnia.
11. T/F A person with a hypoactive delirium is agitated.
12. T/F Apathy is a common symptom in dementia.
13. T/F A person with delirium has diminished interest or pleasure.
14. T/F There is fluctuation in mood or emotions in delirium such as outbursts, anger, crying and fear.
15. T/F Agitation, restlessness and hallucinations are examples of hyperactive delirium.

**PART I – SCORE: \_\_\_\_/15**

<input type="checkbox"/> I have completed this quiz and the DOC/ADOC/Manager has reviewed the correct information with me.	
Signature of DOC/ADOC/Manager	
Home/Department	
Name of Employee	<input type="checkbox"/> Full time <input type="checkbox"/> Part time

## PART II – Questions for Registered Nursing Staff and Other Healthcare Professionals

### Fill in the blanks:

1. In dementia, there is cognitive decline with problems in memory plus one or more of the following:  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.
2. \_\_\_\_\_ is a sensory experience without any real world stimulus, may be visual, auditory, tactile, gustatory or olfactory.
3. The acronym I WATCH DEATH stands for \_\_\_\_\_.
4. The screening tool to use to assess for behavioural issues is \_\_\_\_\_.
5. \_\_\_\_\_ is a false belief not shared by one's culture.
6. A person with hypoactive depression is \_\_\_\_\_.

### Select the best answer:

1. The onset for delirium is:
  - a) slow, chronic progression
  - b) sudden, hours to days
  - c) slow and persists for at least 2 weeks
  - d) gradual deterioration over months to years
2. Depression workup includes the following tests:
  - a) Albumin, Hgb, ESR, Ferritin
  - b) TSH, B12, K, Iron
  - c) Folate, Calcium, FBS
  - d) All of the above
3. I WATCH DEATH is used to assess causes for:
  - a) Delirium
  - b) Depression
  - c) Dementia
  - d) All of the above
4. Delirium is a medical emergency and requires the involvement of:
  - a) attending physician
  - b) internal team members including Psychogeriatric Resource Person
  - c) family members
  - d) All of the above
5. Dementia workup includes the following tests:
  - a) CBC, TSH, Blood glucose
  - b) Electrolytes and Calcium
  - c) a & b
  - d) TSH, B12, folate
6. The following screening tools may be used to assess for dementia except:
  - a) Clock Drawing Test
  - b) Mini-Mental Status Examination
  - c) SIG E CAPS
  - d) Mini-Cog Dementia Screen

**PART II – SCORE: \_\_\_/15**

**PARTS I & II TOTAL SCORE: \_\_\_/30**

*(total score applies only to Registered Nursing staff & other Healthcare Professionals)*