

ANSWER SHEET – see answers in bold font.

**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

ANSWER SHEET – see answers in bold font.

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: **aphasia, apraxia, agnosia, executive functioning.**
2. **Hallucination** 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 **Infections, Withdrawal, Acute metabolic, Toxins, drugs, CNS pathology, Hypoxia, Deficiencies, Endocrine, Acute vascular, Trauma, Heavy metals.**
4. The screening tool to use to assess for behavioural issues is the **Cohen-Mansfield Agitation Inventory (CMAI).**
5. **Delusion** is a false belief not shared by one's culture.
6. A person with hypoactive depression is **withdrawn.**

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)