



**HARTFORD INSTITUTE FOR GERIATRIC NURSING**  
**NEW YORK UNIVERSITY COLLEGE OF NURSING**

*ConsultGeriRN.org*



**TOPIC: DELIRIUM**  
**TEST YOUR KNOWLEDGE !**

**Please note: There are currently no contact hours associated to these post-tests.**  
This post-test is to be used for review.

When you feel that you have fully completed reviewing the materials on ConsultGeriRN.org regarding this topic, please do the following:

1. Print out the Post-Test.
2. Complete the Post-Test in pencil or pen.
3. Please be sure that your NAME, ADDRESS, TELEPHONE #, and RN LICENSE # are on your TEST.
4. Mail your post-test to:

Ms. Yamilee Bazile  
The Hartford Institute of Geriatric Nursing  
New York University College of Nursing  
726 Broadway, 10<sup>th</sup> Floor  
New York, NY 10003  
[yjb200@nyu.edu](mailto:yjb200@nyu.edu)/ Fax 212.995.4561

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### **Delirium: Learning Objectives**

1. Describe the prevalence of delirium in older adults.
2. Describe risk factors for and symptoms of delirium.
3. Describe the common causes of delirium.
4. Screen for delirium using the Confusion Assessment Method.
5. Identify medications that most likely cause delirium in older adults.
6. Implement assessment and treatment strategies for delirium.
7. Differentiate between dementia, delirium, and depression in older adults.

### **Delirium Post-Test Questions**

1. Which of the following statistics about delirium is most accurate?
  - a. Incidence in acute care may be up to 40 percent.
  - b. Onset is about the 5<sup>th</sup> day of hospitalization.
  - c. Prevalence at hospital admission is about 50 percent.
  - d. Symptoms can last up to one year after discharge.
2. Which of the following is the most appropriate screening tool for delirium?
  - a. Confusion Assessment Method
  - b. Folstein Mini-Mental Status Examination
  - c. Katz Activities of Daily Living Scale
  - d. Lawton Scale of Instrumental Activities of Daily Living
3. Delirium is primarily characterized by:
  - a. Lack of appetite
  - b. New onset of fluctuation in mental status
  - c. Progressive memory loss
  - d. Sleep deprivation
4. When conducting the Mini Mental Status Exam a delirious patient would have more problems with which of the following compared to a solely demented patient?
  - a. Attention span
  - b. Identifying a pencil and watch
  - c. Orientation
  - d. Registration

Name: \_\_\_\_\_

5. Which category of medications is most likely to cause delirium due to anticholinergic side effects?
  - a. Analgesics
  - b. Antihypertensive medications
  - c. Benzodiazepines
  - d. Tricyclic antidepressants
  
6. One nursing intervention to prevent exacerbation of delirium includes:
  - a. Discharge patient early
  - b. Have companions present
  - c. Keep asking the patient his/her name
  - d. Reduce over or under-stimulation
  
7. Persons with delirium have impaired recent memory, but have an intact remote memory.
  - a. True
  - b. False
  
8. Which of the following is a common risk factor for delirium in older adults?
  - a. Diabetes
  - b. Hypertension
  - c. Neglect
  - d. Newly prescribed medication
  
9. Delirium
  - a. Is self-limiting and requires no intervention
  - b. Requires acute assessment and work-up
  - c. Should be treated symptomatically
  - d. Usually has no identifiable cause

Use the following case for questions 10-12:

Mr. T. is a 70-year-old male admitted to the orthopedic unit. Mr. T. fractured his right ankle and had an open reduction with internal fixation in the morning. Pre-op medications included HCTZ 25 mg daily, Percocet 1 tablet every 6 hours as needed for pain, and Lipitor 10 mg daily. Medication orders are the same postoperatively with the addition of Demerol as needed for pain. In the afternoon, Mr. T. insists on going home and keeps getting out of bed. Multiple attempts to explain that he is unable to walk safely in the cast have not convinced him and he is now yelling, disturbing other patients on the floor.

Name: \_\_\_\_\_

10. Given the above information, you suspect that Mr. T.'s condition is caused by:
- Delirium
  - Depression
  - New onset dementia
  - Personality disorder
11. A medication that could cause delirium in this case is:
- Demerol
  - HCTZ
  - Lipitor
  - Tylenol
12. An important strategy to assist in caring for Mr. T. would include:
- Assessing Mr. T.s' level of pain and either change medication or increase dosage or frequency
  - Calling family to visit the patient
  - Reality orientation offered in a calm, nonjudgmental manner
  - Telling the patient to relax and his ankle will heal

Use the following case for questions 13-15:

Mrs. D. is a 75 year old female who lives at home. She was recently hospitalized for COPD exacerbation following a recent upper respiratory infection (URI) and urinary tract infection (UTI). She now has a new diagnosis of Diabetes Type 2 with new medications. She also has a history of hypertension and coronary artery disease. She returned home after two weeks of rehabilitation able to walk 100 feet back and forth well without assistance, but has been having episodes of confusion and weakness. She would like to remain in her home.

13. Mrs. D. developed a change in mental status upon returning home from the hospital and sub-acute nursing facility. Which of the following statements best describes cognitive changes in older adults?
- Changes in cognition are a normal part of aging
  - Changes in cognition are often a sign of a medical problem
  - Cognition refers to the ability to perform cognitive tasks
  - Sensory changes represent the most frequent cognitive changes
14. Mrs. D. experiences weakness and confusion. These symptoms are most likely due to:
- A fracture after a fall
  - Alzheimer's disease
  - Change in environment

- d. Underlying infection or exacerbation of another medical problem
15. If Mrs. D. had new onset urinary incontinence associated with weakness and confusion, which of the following etiologies would be most likely?
- Inability to get to the bathroom
  - Overflow incontinence
  - Recurrent urinary tract infection
  - Stress incontinence
16. Mrs. R., an 88 year old female with a 5 year history of vascular dementia, has been living alone with her only daughter. She has a past medical history of hypertension, Diabetes, CVA with minimal left lower extremity weakness, and recurrent UTI. After a 1 week hospitalization for hyperglycemia, Mrs. R.'s mental status and functional status have declined. Her daughter can no longer care for Mrs. R. at home because she works full-time and Mrs. R. is often awake at night calling out, and recently sustained a fall. Mrs. R. is transferred to a nursing home. What is the most important assessment a gerontological nurse should make if Mrs. R.'s confusion is an acute change? The gerontological nurse should:
- ascertain Mrs. R.'s educational level before performing the Mini-Mental Status Exam
  - determine if Mrs. R. has a reversible medical problem
  - find out if Mrs. R. has a history of dementia
  - look for signs and symptoms of depression
17. Ms. N., a 90 year old female with Alzheimer's Dementia, is newly diagnosed with Congestive Heart Failure and started on Furosemide (Lasix) 20 mg daily. One week later, Ms. N. paces all day and night and appears more confused than usual. Vital signs are normal and the patient is not orthostatic. The most likely cause of delirium in this case is:
- Depression
  - Electrolyte imbalance
  - Progressing dementia
  - Urinary incontinence from the medication
18. Mr. B. is an 80 year old male admitted with COPD exacerbation and placed on IV Solumedrol. He is now well hydrated with PO fluids and his COPD is stabilizing. Hence, he now only needs a heplock for the Solumedrol. Chronic conditions of HTN and Hypercholesterolemia are well-managed with HCTZ 12.5 mg daily and Lipitor 20 mg daily. Lab tests are all normal. One week into the hospitalization, the medications are the same and Mr. B. starts trying to remove the heplock. Wrists restraints are ordered. As the gerontological nurse, you suggest:
- Ask the doctor to remove the restraint order and replace the heplock if Mr.

Name: \_\_\_\_\_

- B. pulls it out.
  - b. Immediately stopping the IV Solumedrol.
  - c. Request a companion in the room.
  - d. Tapering the IV Solumedrol, starting PO Prednisone, and discontinuing the heplock.
19. Mrs. K. is a 90 year old female admitted to the hospital with right lower extremity cellulitis secondary to poor peripheral vascular disease. She is treated with IV antibiotics and placed on bed rest upon admission. On the third day of hospitalization, Mrs. K. starts yelling, pulling out her IV, and trying to climb over the side rails. Vest and wrist restraints are ordered. On the fourth day of hospitalization, Mrs. K. becomes combative during bathing and tries to hit the nursing staff. Upon thorough nursing assessment, you realize Mrs. K. has not moved her bowels since admission. The nurse should:
- a. Assess for fecal impaction.
  - b. Remove the restraints.
  - c. Request a high fiber diet.
  - d. Transfer the patient from bed to chair.
20. Delirium is a reversible confusional state, while dementia is an irreversible confusional state.
- a. True
  - b. False

**Please Print:**

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