Delirium Quiz

Teams of 3 please.
Give your team a name.
If you think you know the answer "buzz in" by using your team name.
First team to "buzz-in" with the correct answer gets one point.
The team with the most points at the end of the quiz gets the prize and the glory.

1. What is delirium?

An acute disturbance of the mind/cognition.
It is a symptom of an underlying problem.

2. Name three umbrella medical issues that can cause delirium.

Infection
Metabolic disorders
Dehydration/Constipation
Liver or kidney disease
Thiamine deficiency
Postoperative states
Postictal states
Sequelae of head trauma

"And I would have also accepted…"

3. Name three prescribed medication categories that can cause delirium.

Analgesics
Steroids
Anticonvulsants
Antiparkinsonians
Antidepressants*
Antihistamines*
Antipsychotics*
* anticholinergic delirium

"And I would have also accepted…"

4. When would it be a good idea to use benzodiazepines in delirium?

Alcohol withdrawal.

5. What else is different about delirium in alcohol withdrawal?

More readily predictable.
Medication-preventable.
Follows are pretty well-known set course, ie: symptoms will nearly always emerge within the first 3 or 4 days of abrupt alcohol cessation (can be sooner).
Alcohol withdrawal is over-and-done with within a week.

6. There are two basic categories of delirium that are related to the person's behaviour. What are these two categories called?

Hyperactive delirium
Hypoactive delirium

PRN Hint: The name of these two categories is related to how active, or inactive, the person is.

7. Which of these two categories of delirium is most likely to be missed?

Hypoactive delirium.

Bonus point: Why is hypoactive delirium more likely to be missed?
- compared to hyperactive delirium, the hypoactive delirium patient is quiet and not causing staff problems
- hypoactive delirium may be mistaken for depression

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8. A 75yo man is admitted to your ward. Which of these statements by his adult daughter is a 'red flag' for delirium?

A. Dad's memory has been pretty dodgy for the last couple of years.
B. I don't know what's going on with Dad's thinking since he's come into hospital. He was fine last week.
C. When Dad says, "I'd rather have a bottle in front of me instead of a frontal lobotomy" he's trying to be funny. Laugh along or ignore him. That's just Dad.

B. Seek elaboration re acute changes and fluctuations.

9. Going back to the same 75yo man.
The night shift nursing team handover that he's been confused and agitated all night and they think he has delirium. When the medical team round in the morning he's lucid, calm, and knows why he's in hospital; the medical team say he does not have delirium.
Who's right?

The nurses.
Fluctuation in mental state is a hallmark of delirium. Symptoms are most likely to be worse in the evening (sundowning) or overnight.

10. What sort of hallucinations are most likely in delirium?

Visual and/or tactile more likely than auditory.

Bonus point: What sort of hallucinations are most likely in schizophrenia?

Auditory are more common than visual/tactile.

11. What tools are readily available for you to measure delirium?

- 4AT
- CAM (Confusion Assessment Method)
- RASS (Richmond Agitation Sedation Scale) in ICU

There are other valid tools, the 4AT & RASS are the ones most likely to be used here.

Bonus Point for obtaining collateral/history from family.

12. True or False. Pre-existing dementia increases risk of delirium.

True.

Bonus point: Why?

- Decreased cognitive reserve = more prone to acute cognitive changes as a side-effect of underlying medical probs.

13. True or false. Delirium is an indicator of increased risk of dementia.

True.

Bonus point: Why?

- Delirium is a serious cognitive insult, that can cause lasting cognitive changes – a more stepwise deterioration than 'typical' Alzheimer's dementia.

14. What age groups are most of risk of delirium?

Age ≥ 65 years

≥ 45 years for Aboriginal and Torres Strait Islander people

15. Age is a predisposing factor for delirium. What other things can predispose an older person to develop delirium?

- Sensory impairment (eg: difficulty in hearing or seeing because of missing hearing aids or glasses)
- Infection
- The use of certain medicines or multiple medicines
- Abnormal serum sodium levels
- Urinary catheterisation
- Depression
- Surgery

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16. What non-pharmacological strategies decrease the likelihood or duration of delirium?

- Communication – hearing aids, glasses etc
- Involve and educate the family (a family member staying overnight will be more helpful than an AIN)
- Encourage mobility – eg: walking, sit out of bed for meals
- Encourage and monitor hydration and nutrition - eg: favourite meals/snacks from home?
- Encourage and monitor bladder and bowels – constipation and diarrhoea are your enemies
- Aim for nocte sleep/normal sleep-wake cycle – make sure lighting reflects this
- Reorientate regularly (verbally & with clock, calendar)
- Reassure regularly
- Avoid room moves as much as possible
- Aim for a calm, quiet environment
- Pain management

One point for each correct answer. "I would have also accepted…"

17. One point for each de-escalation technique you can name:

– being respectful
– introducing yourself by name & role
- try using their title rather than their given name if the patient does not know you
– talking slowly and calmly
– not disagreeing with the patient
– asking questions and listening to the answers
– expressing empathy and concern to show that you have understood
– inclining your head slightly, to show you are listening and to give you a non-threatening posture
– acknowledging their feelings and that the situation they find themselves in is frightening or distressing
– providing a distraction

18. Why aren't antipsychotic medications usually recommended to treat delirium?

- Antipsychotic meds don't treat the underlying cause of delirium. Masking symptoms ≠ cure.

- Antipsychotic medications have side-effects which can include causing/contributing to anticholinergic delirium.

19. If antipsychotics meds are used in delirium, what are some principals to keep in mind?

- this is a second-line strategy for when non-pharmacology strategies fail and the patient is distressed
- who is going to provide consent?
- one dose may be enough
- lowest effective dose for the shortest possible duration
- monitor for efficacy – often they don't help, so should be stopped
- expert advice from D&D/psycho-geris is a good idea

20. When the person recovers from delirium, will they have any memory of it?

Yes.

Elaborate that it may not be a clear, sequential memory, but for many it will be like remembering a nightmare, but without the reassurance that it was just a dream.
People who experience delirium are more prone to developing PTSD-like symptoms.

Further reading (source for most of the quiz questions)

Australian Commission on Safety and Quality in Health Care. (2021), Delirium Clinical Care Standard. Sydney: ACSQHC www.safetyandquality.gov.au

Cody, S et al (2021), Improving the quality of delirium practices in a large Australian tertiary hospital: an evidence implementation initiative. *Australian Journal of Advanced Nursing*, 38(2). www.ajan.com.au/index.php/AJAN/article/view/330

Weir, E. & O'Brien, A.J. (2019), Don't go there – It's not a nice place: Older adults' experiences of delirium. *International Journal of Mental Health Nursing*, 28(2). doi.org/10.1111/inm.12563

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