Delirium and Acute Encephalopathy
CARE PATHWAY LEARNING ASSESSMENT

This learning assessment is designed to be used with the Alliant Health Solutions bite-size learning videos (https://quality.allianthealth.org/topic/delirium/) to document understanding of the Care Pathways following review of the videos . The learning assessment and videos can be used as one element of a delirium education program for new hire orientation, ongoing staff education and competency assessment. Trend incorrect responses to the post learning assessment to target additional education.

Name of Individual taking the Pre-Learning Assessment: _____

Date: _____ ID Number (if required): _____

Pre-Learning Assessment

1. The first element of a Confusion Assessment Method©(CAM) assessment is identification of *both* an acute onset of mental status change from baseline AND fluctuating mental status.	☐ True ☐ False
2. Research demonstrates that delirium is nearly impossible to avoid and there are no interventions that can be done proactively to reduce the possibility of delirium development.	☐ True ☐ False
3. The CAM© requires all four elements to be present for a diagnosis of Delirium to be conclusively determined.	☐ True ☐ False
4. Medications are frequently the root cause for a change in mental status, therefore it is important to know what medications to avoid.	☐ True ☐ False
5. The root cause of delirium is generally due to infection or medications, there is rarely ever any other cause.	☐ True ☐ False
6. If the determination of Delirium cannot be made by using the CAM©, the Modified Richmond Agitation Sedation Scale (mRASS) should be used.	☐ True ☐ False
7. The word DELIRIUM can be used as an acronym to help individuals identify the possible underlying causes of mental status change.	☐ True ☐ False

Pre-Learning Assessment Score: _____

Post-Learning Assessment

1. If a medication has been determined to contribute to the change in mental status it is important to stop that medication immediately.	☐ True ☐ False
2. When Delirium has been identified there are many interventions and care practices that can be implemented to reduce the impact and support the individual.	☐ True ☐ False
3. The incidence of Delirium can be reduced with the appropriate patient/resident centered care and focused interventions.	☐ True ☐ False
4. If an individual is difficult to awaken or has difficulty staying awake, they should automatically be considered positive for delirium.	☐ True ☐ False
5. Detection and diagnosis of Delirium early will likely reduce the severity as well as the possibility of secondary problems developing.	☐ True ☐ False
6. When a patient/resident has been identified as having Delirium it is not necessary for ongoing dialogue between healthcare providers, family and the patient/resident because the diagnosis is made.	☐ True ☐ False
7. The word DELIRIUM can help remember root causes for Delirium and stands for Drugs, Emotions, Living Environment, Infection, Respiratory, Infection, Unhappiness and Mental change.	☐ True ☐ False

Post-Learning Assessment Score: _____

Pre-Learning Assessment Answer Guide

1. The first element of a Confusion Assessment Method©(CAM) assessment is identification of *both* an acute onset of mental status change from baseline AND fluctuating mental status.	☐ True ☒ False
2. Research demonstrates that delirium is nearly impossible to avoid and there are no interventions that can be done proactively to reduce the possibility of delirium development.	☐ True ☒ False
3. The CAM© requires all four elements to be present for a diagnosis of Delirium to be conclusively determined.	☐ True ☒ False
4. Medications are frequently the root cause for a change in mental status, therefore it is important to know what medications to avoid.	☒ True ☐ False
5. The root cause of delirium is generally due to infection or medications, there is rarely ever any other cause.	☐ True ☒ False
6. If the determination of Delirium cannot be made by using the CAM©, the Modified Richmond Agitation Sedation Scale (mRASS) should be used.	☒ True ☐ False
7. The word DELIRIUM can be used as an acronym to help individuals identify the possible underlying causes of mental status change.	☒ True ☐ False

Post-Learning Assessment Answer Guide

1. If a medication has been determined to contribute to the change in mental status it is important to stop that medication immediately.	☐ True ☒ False
2. When Delirium has been identified there are many interventions and care practices that can be implemented to reduce the impact and support the individual.	☒ True ☐ False
3. The incidence of Delirium can be reduced with the appropriate patient/resident centered care and focused interventions.	☒ True ☐ False
4. If an individual is difficult to awaken or has difficulty staying awake, they should automatically be considered positive for delirium.	☐ True ☒ False
5. Detection and diagnosis of Delirium early will likely reduce the severity as well as the possibility of secondary problems developing.	☒ True ☐ False
6. When a patient/resident has been identified as having Delirium it is not necessary for ongoing dialogue between healthcare providers, family and the patient/resident because the diagnosis is made.	☐ True ☒ False
7. The word DELIRIUM can help remember root causes for Delirium and stands for Drugs, Emotions, Living Environment, Infection, Respiratory, Infection, Unhappiness and Mental change.	☐ True ☒ False

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