NCLEX 2026 · PSYCHIATRIC / NEUROLOGICAL

Delirium vs Dementia vs Delusion

The "3 D's" of altered mentation — how to tell them apart, what to prioritize, and how to avoid the test traps that trip up new grads on the Next Gen NCLEX.

💡 At-A-Glance: The 3 D's

Quick snapshot before we dive deep. Memorize these anchors first.

ACUTE · REVERSIBLE

Delirium

A **sudden**, temporary state of confusion caused by an **underlying medical problem** (infection, meds, electrolytes, hypoxia). Think: "Something is wrong, fix it, and the mind comes back."

Onset	**Hours → days**
Course	**Fluctuates**
Reversible?	**YES ✅**
LOC	**Altered**

CHRONIC · PROGRESSIVE

Dementia

A **gradual, permanent** decline in memory and thinking from **neurodegeneration** (Alzheimer's, vascular, Lewy body, frontotemporal). Think: "The brain is slowly losing ground."

Onset	**Months → years**
Course	**Progressive**
Reversible?	**NO ❌**
LOC	**Usually intact**

THOUGHT · BELIEF

Delusion

A **fixed, false belief** that is **not based in reality** and cannot be corrected by logic or evidence. It is a *symptom*, most often of schizophrenia, bipolar mania, or psychotic depression.

Onset	**Variable**
Course	**Persistent**
Reversible?	**Treatable ⚕**
LOC	**Intact**

Side-By-Side Comparison

This table alone is worth 2–3 NCLEX points. Know it cold.

Feature	Delirium	Dementia	Delusion
Onset	Sudden (hours–days)	Slow (months–years)	Variable; often with psychiatric episode
Duration	Days to weeks	Years; lifelong	Persists until treated
Reversibility	✅ Reversible — treat the cause	❌ Irreversible	Responds to antipsychotics
Level of consciousness	Altered, fluctuating	Clear / alert	Clear / alert
Attention	Severely impaired	Intact early, declines late	Normal (focused on delusion)
Memory	Impaired (recent)	Recent memory lost first	Intact
Orientation	Disoriented to time, place	Declines over time	Oriented
Hallucinations	Common (often visual)	Possible late stage (Lewy body)	May coexist, but delusion ≠ hallucination
Thought content	Disorganized, confused	Impoverished, vague	Fixed false belief
Speech	Rambling, incoherent	Word-finding difficulty	Normal in structure
Sleep–wake cycle	Disrupted; sundowning common	Often disturbed	Usually intact
Most common cause	UTI / infection in elderly	Alzheimer's disease (60–80%)	Schizophrenia / mania

Pathophysiology Simplified

Follow the arrows — know *why* the signs appear.

Delirium

- → Acute insult (infection, drug, ↓O_2, electrolyte shift, withdrawal)
- → Disrupts neurotransmitters (↓ acetylcholine, ↑ dopamine)
- → Widespread cortical dysfunction
- → Acute confusion, inattention, fluctuating LOC
- → Resolves once underlying cause is treated

Dementia

- → Chronic neurodegeneration begins
- → Alzheimer's: β-amyloid plaques + tau tangles
- → Vascular: repeated small infarcts
- → Progressive neuronal / synaptic loss
- → Permanent cognitive and functional decline

Delusion

- → Dopamine dysregulation (mesolimbic pathway)
- → Seen in schizophrenia, mania, psychotic depression, substance-induced
- → Altered reality-testing in frontal/temporal circuits
- → Fixed false belief forms, resistant to reason
- → Responds to antipsychotic therapy

Signs & Symptoms

Red-flag cues are the ones the NCJMM will test you on.

Delirium

- **Early:** restlessness, mild confusion, anxiety
- Inattention — cannot focus or track a question
- Disorganized, rambling speech
- Fluctuating LOC — lucid one hour, confused the next
- Visual hallucinations common
- Disrupted sleep–wake cycle
- **Late:** agitation, combativeness, or lethargy / stupor

Dementia

- Gradual short-term memory loss (recent events first)
- Word-finding difficulty, repeating questions
- Getting lost in familiar places
- Difficulty with ADLs, finances, cooking
- Personality / mood changes
- **Sundowning** — ↑ confusion late afternoon/evening
- Late: incontinence, immobility, aphasia

Delusion

- **Persecutory:** "They are out to harm me"
- **Grandiose:** "I am God / a famous person"
- **Somatic:** "Bugs are inside my body"
- **Referential:** "The TV is sending me messages"
- **Religious:** Special divine connection
- **Erotomanic:** A stranger/celebrity loves them
- Belief is *fixed* — cannot be reasoned away

Red Flag: Sudden confusion in an elderly client — always assess for **UTI, pneumonia, hypoxia, or new medication** first.

Red Flag: A dementia client with **sudden worsening** is NOT "just dementia" — suspect **superimposed delirium** (very common!).

Red Flag: Command hallucinations or persecutory delusions with a plan to harm self/others = immediate safety priority.

Priority Nursing Interventions

Action verbs + NCLEX prioritization. Always ABCs → Safety → Psychosocial.

Delirium

1. **ASSESS** airway, VS, O_2 sat, glucose, mental status
2. **IDENTIFY + TREAT** the underlying cause (UA, CBC, electrolytes, med review)
3. **PROVIDE** a calm, well-lit, familiar environment with clocks & calendars
4. **REORIENT** frequently; place familiar objects at bedside
5. **PREVENT** falls — bed low, call bell, non-skid footwear
6. **MINIMIZE** restraints & sedatives (worsen delirium!)
7. **INVOLVE** family for reorientation and comfort

Dementia

1. **MAINTAIN** a consistent, structured daily routine
2. **USE** simple, short sentences & one-step directions
3. **REDUCE** stimulation during sundowning (dim noise, close blinds)
4. **LABEL** rooms, drawers, and personal items
5. **SAFETY:** remove rugs, lock meds, monitor wandering, bed alarms
6. **REDIRECT** (don't argue) if client is confused or agitated
7. **SUPPORT** caregivers — respite, education, support groups

Delusion

1. **ASSESS** for safety — risk to self or others?
2. **DO NOT ARGUE** with the delusion; do not reinforce or agree
3. **ACKNOWLEDGE** the feeling: "I understand this feels very real to you"
4. **PRESENT REALITY** calmly, then redirect to reality-based activity
5. **ADMINISTER** prescribed antipsychotics; monitor for EPS, NMS
6. **BUILD TRUST** with consistent one-on-one interactions
7. **AVOID** whispering or laughing in the client's presence (↑ paranoia)

Pharmacology

Know the class, mechanism, and the big side effects.

Dementia — Alzheimer's Agents

Donepezil (Aricept) · Rivastigmine (Exelon) · Galantamine

Class: Cholinesterase inhibitors · **Action:** ↑ acetylcholine in the brain → slows cognitive decline · **Side effects:** N/V, diarrhea, bradycardia, syncope · **Nursing:** Give at bedtime; monitor HR; not a cure — slows progression only.

Memantine (Namenda)

Class: NMDA receptor antagonist · **Action:** Blocks excess glutamate → slows neuronal damage · **Side effects:** Dizziness, headache, confusion · **Nursing:** Used in moderate-to-severe Alzheimer's; often combined with a cholinesterase inhibitor.

Delirium & Delusion — Antipsychotics

Haloperidol (Haldol) — Typical / 1st-gen

Use: Acute agitation in delirium (low-dose, short-term); psychosis · **Side effects:** EPS (dystonia, akathisia, pseudo-parkinsonism, tardive dyskinesia), **NMS** (fever, rigidity, ↑CK), QT prolongation · **Nursing:** Monitor for EPS & NMS; avoid in Lewy body dementia.

Risperidone · Olanzapine · Quetiapine · Aripiprazole — Atypical / 2nd-gen

Use: Schizophrenia, bipolar mania with delusions · **Side effects:** Metabolic syndrome (weight gain, ↑ glucose, ↑ lipids), sedation, orthostasis · **Black box:** ↑ mortality in elderly dementia clients with psychosis · **Nursing:** Monitor glucose, lipids, weight, fall risk.

NCLEX Test Traps

Where students lose points. Read every stem carefully.

Trap 1: "Sudden confusion in the elderly = dementia"

Sudden = DELIRIUM until proven otherwise. Always check for UTI, dehydration, new meds, hypoxia.

Trap 2: Arguing with a delusion

Never argue, agree, or try to prove the belief wrong. Acknowledge the feeling and redirect — do NOT reinforce reality vs. delusion as a debate.

Trap 3: Hallucination vs. Delusion

Hallucination = *false sensory perception* (hears/sees things). Delusion = *false belief*. Different answers, different interventions.

Trap 4: Sundowning is not delirium

Sundowning = predictable late-day confusion in **dementia**. Intervention = decrease stimulation, not treat an acute illness.

Trap 5: Restraints for delirium

Restraints and benzodiazepines often WORSEN delirium. Priority = reorientation, family at bedside, treat the cause.

Trap 6: Memantine vs. Donepezil confusion

Donepezil ↑ acetylcholine (mild–moderate Alzheimer's). Memantine blocks glutamate (moderate–severe). Know both mechanisms.

Trap 7: Elderly + antipsychotics = black box

Atypical antipsychotics carry a black-box warning for ↑ mortality in elderly dementia clients with psychosis — NEVER the first choice.

Trap 8: "Client with delusions refuses food claiming it is poisoned"

First action is **not** correcting the belief — offer food in original sealed containers the client can open themselves.

NCJMM Clinical Judgment Framework

The 2026 Next Gen NCLEX thinks in these 6 steps. Apply them to every scenario.

1. Recognize Cues

Sudden vs. gradual change? LOC altered? Fixed belief? Recent med changes? Infection signs? Visual or auditory content?

2. Analyze Cues

Match onset + LOC + reversibility to delirium, dementia, or delusion. Is this new delirium on top of baseline dementia?

3. Prioritize Hypotheses

Rule out life-threatening (hypoxia, sepsis, hypoglycemia, self-harm from delusion) before psychiatric causes.

4. Generate Solutions

Delirium → treat cause. Dementia → structure & safety. Delusion → safety, don't argue, antipsychotics if ordered.

5. Take Action

ABC → safety → reorientation/redirection → administer meds → document → communicate with team & family.

6. Evaluate Outcomes

Is LOC improving (delirium)? Is the client safe (dementia / delusion)? Are interventions working or do we escalate?

Patient & Family Education

What to teach caregivers — common Next Gen NCLEX prompt type.

Delirium

- ✓ Delirium is **temporary** if the cause is treated
- ✓ Keep glasses, hearing aids, and dentures in place
- ✓ Maintain day/night cues (open blinds, clocks, calendars)
- ✓ Limit visitors to familiar faces; keep environment calm
- ✓ Report any new confusion in a hospitalized loved one immediately

Dementia

- ✓ Establish a **predictable daily routine**
- ✓ Simplify choices: "Do you want the blue or red shirt?"
- ✓ Use labels, photos, and signs around the home
- ✓ Home safety: remove rugs, lock meds, install alarms on doors
- ✓ Plan for **legal matters early** (advance directives, POA)
- ✓ Caregivers need rest — respite care prevents burnout

Delusion

- ✓ Medication **adherence is essential** — do not stop abruptly
- ✓ Expect symptom relief in 2–6 weeks (not immediate)
- ✓ Report EPS, high fever + rigidity (NMS), or suicidal thoughts
- ✓ Avoid alcohol and recreational drugs (worsen symptoms)
- ✓ Keep follow-up appointments; family should learn de-escalation

🧠 Memory Boosters & Mnemonics

The quick pattern-recognition tools that survive test anxiety.

The 3 D's

Delirium → "Days" (acute, temporary) · **Dementia → "Decline"** (slow, permanent) · **Delusion → "Distorted belief"** (fixed, false).

DELIRIUM Causes

Drugs · **E**lectrolytes · **L**ack of drugs (withdrawal) · **I**nfection · **R**educed sensory input · **I**ntracranial (stroke, bleed) · **U**rinary / fecal retention · **M**yocardial / metabolic

"FAST" for Dementia Red Flags

Forgetfulness · **A**DLs declining · **S**peech problems (aphasia) · **T**ime/place disorientation. Plus: **Sundowning** = classic late-day worsening.

Delusion Rule of 3

1. Don't argue · **2.** Don't agree · **3.** Do acknowledge the feeling, then redirect. "That must feel frightening — let's walk to the dayroom together."

Delirium vs Dementia Quick Test

Hallucination ≠ Delusion

Ask: **"When did it start?"** — Family says "yesterday" → **Delirium**. Family says "over the past year" → **Dementia**.

Hallucination = **H**earing/seeing (sensory) · **D**elusion = **D**eeply-held belief (thought). Different symptom, different intervention.