Questions #1-10 refer to the article about patient bedside handoff by Givens, Skully, and Bromley on pages 33-37.

1. The patient bedside handoff quality improvement project was initiated because nurses:
   A. recognized an opportunity to influence shift communications.
   B. responded to patients’ complaints surrounding care.
   C. collected information of medication non-compliance.
   D. reacted to the probability that staff ratios were changing.

2. Use of patient bedside handoff enhances communication and reduces errors related to:
   A. medication administration.
   B. physical assessment.
   C. information from the interdisciplinary team.
   D. uniform sharing of information.

3. During handoff, nurses should consider discussing abuse-sensitive patient concerns:
   A. by notation in the patient’s chart.
   B. outside the patient’s room prior to bedside handoff.
   C. in a conference room.
   D. in the patient’s room because open communication is therapeutic.

4. Having patients involved in bedside handoffs promotes:
   A. increased staff accountability to patients.
   B. greater awareness of the patients’ progress.
   C. improved documentation.
   D. effective use of nurses’ time.

5. Implementing a quality improvement patient bedside handoff has the potential for:
   A. greater patient engagement and changed unit activities.
   B. medication compliance and physical assessment.
   C. a quiet interval providing a transition time.
   D. more efficient patient-centered communication.

6. Implementing patient bedside handoffs was controversial because nurses:
   A. did not understand the advantages.
   B. believed assessment/planning was best discussed during team meetings.
   C. believed traditional reporting was a better use of their time.
   D. thought that this would be anxiety-inducing for patients and interfere with passing medications.
7. The patient bedside handoff practice model:
   A. blends an overview of the therapeutic milieu with the patient’s individual care.
   B. follows the principle of meeting patients in their room and reviewing their medications.
   C. incorporates unit safety checks and discussion of plans for the shift.
   D. ensures transparency regarding patients’ progress and plans for discharge.

8. This quality improvement project was implemented to:
   A. determine if patients want to be more involved in their plans of care.
   B. more fully involve patients in their care planning.
   C. explore the comfort level patients had discussing their goals of care.
   D. minimize medication errors.

9. Nurses benefit from the patient bedside handoff because patients have a way to:
   A. inform nurses of their wants and needs.
   B. contribute to changes involving their goals of care.
   C. feel more involved with continuity of care.
   D. get to know the various roles of staff on the unit.

10. Nurses involved in shared governance and quality improvement projects have an opportunity to:
   A. obtain feedback with the goal of enhancing communication.
   B. support evidence-based initiatives for their specialty practice.
   C. promote new care delivery models that can save time.
   D. attain new insights surrounding patient care.

Questions #11-20 refer to the article about advocating for the use of pharmacogenomics by Pestka and Shea on pages 38-42.

11. To implement pharmacogenomics into clinical practice, Blix (2014) suggests that nurses serve as:
   A. observant guardians and navigators.
   B. patient advocates and educators.
   C. problem solvers and caring healers.
   D. researcher clinicians and key communicators.

12. Following more frequent use of pharmacogenomics testing, it is important for nurses to recognize that:
   A. not all physicians understand its importance.
   B. costs for medications are decreasing.
   C. research supports improved patient outcomes.
   D. medication treatments usually work for all patients.

13. The response to pharmacogenomics testing for enzyme and drug metabolism may vary from poor to:
   A. ultra-rapid.
   B. extensive.
   C. immediate.
   D. slow.

Questions 14-20 refer to the following scenario:

M.S. took advantage of the CYP450 enzyme nurse manager’s mentoring and Nursing Genomics Support Group to learn strategies and clinical considerations when pharmacogenomics testing is warranted.

14. M.S. had a “clinical hunch” that pharmacogenomics were relevant to her practice because she observed patients:
   A. displaying inappropriate responses during group therapy.
   B. responding appropriately to prescribed medications.
   C. experiencing shorter and less frequent hospitalizations.
   D. reacting to medications in unexpected ways.

15. M.S. remembered Missy, described as a typical psychiatric patient, taking fluoxetine for depression and consistently experiencing adverse symptoms of:
   A. agitation and thoughts of suicide.
   B. increase in appetite and hopelessness.
   C. loss of interest and restlessness.
   D. decreased concentration and feelings of guilt.

16. M.S.’s clinical observation of Missy prompted her to think about her brother’s dizziness and confusion in response to pain medications. She urged him to have CYP450 testing performed using the approach of:
   A. legal support and persistence.
   B. health care costs and tenacity.
   C. technical data and toughness.
   D. clinical evidence and courage.

17. M.S.’s sister was prescribed 30 mg of mirtazapine per day, and its adverse medication effects included:
   A. postural hypotension.
   B. atrial fibrillation.
   C. serious hypertension.
   D. unexplained bradycardia.
18. M.S. recognized a family pattern of inability to metabolize medications when her mother experienced side effects from prescriptions following a myocardial infarction. Aware of the difficulty in obtaining pharmacogenomics testing and selecting appropriate medications, M.S. sought professional guidance from a:
A. cardiologist.
B. pharmacist.
C. psychiatrist.
D. scientist.

19. M.S. soon recognized a family pattern of inability to metabolize certain medications and her adverse reaction to pain medication related to surgery and a facet injection. Unable to work for several weeks, she reported her symptoms to the physician, who suggested she:
A. see a psychiatrist for panic attacks.
B. stop reading about pharmacogenomics testing.
C. learn to network with others outside of the health care industry.
D. join a health club to begin an exercise program.

20. M.S. has advocated that her CYP450 enzyme deficiencies be identified prominently in her:
A. medication list.
B. medical diagnoses list.
C. emergency contact information.
D. history in the electronic medical record.

Questions #21-30 refer to the article about the effect of a cognitive-behavioral prevention program by Bingol and Buzlu on pages 43-51.

21. A risk factor for depression among working adolescents is:
A. limited employment opportunities.
B. friction in peer relationships.
C. high school performance.
D. living in constant stress.

22. Booij, Bouma, de Jonge, Ormel, and Oldehinkel (2013) reported adolescents exposed to chronic stress are:
A. adversely affected in brain development.
B. restricted in employment options.
C. susceptible to developing psychosomatic disorders.
D. unwilling to seek mental health support services.

23. Banaag (2010) suggested a significant source of stress for working adolescents is:
A. absence of close relationships.
B. lack of coping skills.
C. poor nutrition.
D. inadequate sleep.

24. Most employment opportunities for working adolescents are:
A. regulated for safety reasons.
B. not financially rewarding.
C. limited career options.
D. reserved for more educated workers.

25. Participants stated they left school because of:
A. completion of course work.
B. economic difficulties.
C. family conflicts.
D. problems with friends.

26. A tool used to measure depression risk and level of severity in high-risk adolescents is:
A. cognitive-behavioral therapy.
B. Rosenbaum’s Learned Resourcefulness Schedule.
C. the Beck Depression Inventory.
D. the Automatic Thoughts Questionnaire.

27. An objective of the Cognitive-Behavioral Prevention Program (CCBP) was to study working adolescents in relation to their:
A. social interactions.
B. physical development.
C. health habits.
D. patterns of thought.

28. Adolescents selected for the study were ages 15 to 17, working a regular job, and:
A. enrolled in apprentice education.
B. their parents were still married.
C. scored 0 to 9 on the depression tool.
D. scored >30 on the depression tool.

29. According to the CCBP study flow chart, the intervention comprised:
A. 1 week of evaluation before formal group work.
B. a program of eight weekly group sessions.
C. a 6-month follow-up booster session.
D. a series of individual sessions over 12 months.

30. The authors suggest a role for psychiatric nurses in detecting youths at risk for depression includes:
A. monitoring family conflicts.
B. considering psychological testing.
C. reviewing academic records.
D. assessing school progress.