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SAJAA CPD ANSWER FORM – March/April 2024

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Please answer the following questions:

Implementation of the prospective PURE (Point of Care Ultrasound Registry)

1. What is the main focus of the prospective PURE (Point of Care Ultrasound) Registry?
a. To assess the financial impact of POCUS on healthcare systems.
b. To accumulate essential ultrasound data through a dedicated collection tool.
c. To evaluate the efficiency of POCUS training programmes.

2. What aspect of the PURE Registry implementation had the lowest scores, indicating areas for improvement?
a. User satisfaction.
b. Efficiency and feasibility.
c. Accessibility.

3. What was the primary goal of the PURE Registry?
a. To enhance the understanding and impact of perioperative ultrasound in South Africa.
b. To replace existing diagnostic tools with POCUS.
c. To decrease the use of ultrasound in clinical settings.

4. What does the article suggest as a method to improve the PURE Registry's utility?
a. Limiting the registry to cardiovascular ultrasounds only.
b. Reducing the number of participating clinicians.
c. Optimising the data collection tool and bolstering training programmes.

5. How were data for the PURE Registry collected?
a. Through patient self-reports.
b. At various sites of anaesthesia and intensive care under supervision.
c. Via automated electronic health records.

Towards improved theatre efficiency: a study of procedural times for common elective surgical procedures at Tygerberg Hospital

6. Theatre inefficiency:
a. Has no negative effects on staff moral.
b. Has negative implications for the hospital, patients, and staff.
c. Is not linked to day-of-surgery cancellations.

7. Minor surgical procedures can be defined as:
a. Expected blood loss < 500 ml with significant fluid shifts.
b. Expected blood loss > 500 ml and with minimal fluid shifts.
c. Expected blood loss < 500 ml, minimal fluid shifts, and typically done on an ambulatory basis.

8. Turnover time:
a. Is the time from when one patient leaves the theatre until the next patient enters the theatre.
b. Has a benchmark of 30 minutes.
c. Does not have to be considered when scheduling a theatre slate in South Africa.

9. Total procedure time:
a. Only includes surgical cutting time.
b. Is the sum of surgical cutting time and non-surgical time.
c. Is always accurately predicted by a subjective estimate made by the surgeon.

10. Day-of-surgery cancellations:
a. Have minimal financial implications for the hospital.
b. Have negative financial and emotional implications for the patients.
c. Do not affect registrar training.

Informed consent for peripheral nerve blocks at a tertiary level hospital in South Africa: a quality improvement project

11. What is the reasonable patient standard in the context of informed consent?
a. A patient must be informed of all material risks that would influence a reasonable person in determining whether or not to consent to the treatment.
b. A patient must be informed of all the consequences of refusing the procedure that would influence a reasonable person in determining whether or not to consent to the treatment.
c. A patient must be informed of all the alternatives that would influence a reasonable person in determining whether or not to consent to the treatment.

12. What is the primary benefit of using a standardised consent form for the performance of regional nerve blocks?
a. It ensures patients' autonomy and basic human rights.
b. It reduces the time required to obtain informed consent.
c. It eliminates the need for verbal consent.

13. What is the purpose of integrating informed consent documentation into the standardised anaesthetic chart?
a. To assist practitioners in documenting and improving the quality of informed consent.
b. To make the consent valid.
c. To provide the practitioner with information for the informed consent process.

Postoperative pulmonary complications in adult surgical patients in low- to middle-income countries: a systematic review and meta-analysis

14. This meta-analysis found that the pooled incidence of postoperative pulmonary complications (PPCs) in studies from low- to middle-income countries (LMICs) was:
a. 22.4%
b. 35.1%
c. 12.5% after major abdominal surgery

15. It is difficult to compare the results of different studies due to:
a. Lack of published studies in LMICs.
b. The use of different definitions to define PPCs in studies.
c. Postoperative pulmonary complications are often missed.

16. The StEP-COMPAC group excluded pulmonary embolism, pleural effusions, cardiogenic pulmonary oedema, pneumothorax, and bronchospasm as PPCs because:
a. These complications do not alter patient outcomes.
b. These complications lack common biological pathophysiological mechanisms.
c. These complications cannot be detected clinically.

17. The following risk model to predict postoperative pulmonary complications was proven to be the superior model for discrimination by the STARSurg and TASMAN collaborative:
a. Surgical Lung Injury Prediction (SLIP) model.
b. The LAS VEGAS risk score.
c. The Assess Respiratory Risk in Surgical Patients in Catalonia (ARISCAT) risk score.

18. In this meta-analysis one of the following was associated with an increased risk for the development of PPCs:
a. Advanced age.
b. Emergency surgery.
c. Female sex.

19. In this meta-analysis the second most common postoperative pulmonary complication was:
a. Pulmonary oedema.
b. Bronchospasm.
c. Pneumonia.

20. As proven in previous studies, the sensitivity analysis done in this review found a high incidence of postoperative pulmonary complications in patients undergoing:
a. Vascular surgery.
b. Abdominal surgery.
c. Cardiac surgery.

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