Dear Member

Attached you will find the questions for the 7 accredited journal articles. The articles are still in a process to be accredited but we have applied for 3 CPD point per article (21 points in total).

As discussed previously, we are making use of CPD Solutions to manage our CPD administration. Please refer to the short CPD guide in order to ensure that you are registered on the system and are familiar with the procedure. Please ensure that you are registered as a SANDTA member in order to qualify for CPD points. You also need to pay your CPD Solutions subscription as indicated.

You have time until the end of December 2011 to complete your multiple choice questionnaires. You need to get a score of 80% to pass the test. Should you fail, you will get a second chance to complete the test. The system will immediately score your response and you can expect immediate feedback. Please see to it that you have constructed your SMS accurately to avoid unnecessary errors.

In order to refresh your mind you would find the capturing of the multiple tests in the summary block below.

**CPD SOLUTIONS:**

Answers for each question are either True(a) or False(b).

Compose an SMS with your test number followed by all 12 answers to 31029

For example, send a13456babbabaababb to 31029

You will get immediate feedback regarding your test results ☺☺ ☺☺

The following articles are available:

1. a72223 Stroke: Medical and neurological complications during in-patient stroke rehabilitation. (Dromerrick & Redding)
2. a51860 The Effect of Intervention on the Free –Play Experience for Mothers and their Infants with Developmental Delay and Cerebral Palsy. (Hazlik)
3. a36012 A systematic review of the effects of early intervention on motor development. (Hospers)
4. a22527 Guidelines of good practice in the healthcare professions: Guidelines for the withholding and withdrawing of treatment. (Booklet 12)
5. a74665 Guidelines of good practice in the healthcare professions: Ethical guidelines for good practice with regard to HIV. (Booklet 11)
6. a14812 Guidelines of good practice in the healthcare professions: Guidelines on the keeping of patient records: (Booklet 14)
7. a49366 Guidelines of good practice in the healthcare professions: Seeking patients' informed consent: The ethical considerations (Booklet 9)
QUESTIONS

1. **Stroke: Medical and Neurological Complications during in-patient stroke rehabilitation (Dromerick & Redding)**

   Questions: (True a and False b)

   1. The background and expertise of medical and nursing staff in in-patient stroke rehabilitation units dictate the extent of medical instability considered appropriate for admission to a specific unit.
   2. The location of the unit may affect patient selection and medical management decisions.
   3. In this study there was no significant correlation between patient’s age and interval from stroke to rehabilitation hospital admission and number of complications.
   4. Depression, vertigo and seizures were not observed as neurological complications, in this study.
   5. According to this study, it is safe to assume that commonly encountered problems such as urinary tract infections, diabetes, and hypertension have already been detected at the acute care hospital.
   6. Depression was the most common neurological complication observed.
   7. Most of the patients in this study responded poorly to antidepressants and the milieu of expectant optimism in the stroke rehabilitation unit.
   8. A previous study done by Dobkin indicated that up to 94% of patient admitted from other institutions had neuromedical complications either on admission or during their rehabilitation stay.
   9. This study found that the extent of stroke-related neurological impairment cannot be used as a predictor of the number of complications observed.
   10. Patients whose deficits included motor, somatic sensory and hemianopic visual impairments had a greater number of complications than those with a pure motor hemiparesis.
   11. It is important that protocols for prevention detection and treatment of commonly encountered problems should be established in each rehabilitation unit.
   12. There is no significant need for further investigation into the prevention and treatment of common complications in stroke patients.

2. **The Effect of Intervention on the Free – Play Experience for Mothers and their Infants with Developmental Delay and Cerebral Palsy (Hazlik)**

   Questions: (True a and False b)

   1. Researchers have noticed that, during interaction with their mothers, infants with developmental delays are more responsive than their non-delayed counterparts.
   2. Research has shown that when mothers of infants with developmental delay receive special training, positive interactive changes occur for both mother and infant.
   3. There appears to be a need for interaction intervention programs that include a non-verbal component for mothers with infants who have Cerebral Palsy.
   4. Studies have shown that mothers of infants with C.P. physically direct and hold their infants more frequently and engage in less face to face interaction.
   5. Research results have indicated that interactive characteristics of mothers and their infants with C.P. appear to be facilitative of normal development.
   6. Studies have shown that maternal control imposed on infants and children with no delays inhibits responsiveness.
   7. Findings from this study have indicated that with interaction intervention, infants were more responsive to their mothers than infants who did not receive interaction intervention.
   8. In this study, the hypothesis that an increase in independent play would occur in infants receiving intervention, was confirmed.
   9. In this study, mothers in the intervention group engaged in less directive physical contact with more positive responses than mothers in the control group.
   10. An additional finding regarding the non verbal intervention strategy of this study is that its success is not reliant on the effect of positioning through the use of adaptive seating.
   11. According to this study, the use of adaptive seating should prove to be a therapeutic step in beginning the separation process within a relatively painless format.
   12. There seems to be no need for further research to determine the effects of a direct services infant program than includes a traditional infant intervention curriculum and verbal and non-verbal interaction components.
3. **A systematic review of the effects of early intervention on motor development. (Hospers)**

Questions: (True a and False b)

1. Earlier studies on Early Intervention focused primarily on motor skills.
2. The brain is considered to be plastic in the phase occurring after the completion of neuronal migration during which the processes of dendritic outgrowth and synapse information are highly active.
3. There are no potential disadvantages that are associated with intervention early in life.
4. According to this article intervention in children with a developmental disorder usually starts during infancy or preschool age when the condition is expressed in dysfunction.
5. In this study, it was attempted to investigate the elements that might contribute to a beneficial effect on motor development.
6. One of the dilemmas of research studies is that assigning participants to a control group that does not receive treatment is considered unethical.
7. Many studies focused on the effect of intervention on outcome beyond pre-school age.
8. According to this study, Kangaroo Care had no effect on developmental outcome as measured by Griffiths Developmental Scale of 6 and 12 months corrected age.
9. One of the NICU studies showed that developmental intervention had a positive effect on motor development where intervention was continued for 2 years in the home situation.
10. The current review indicates that intervention programs in the first post natal years according to the principles of NDT or Vojta do not have a beneficial effect on motor development in children at high risk for developmental disorders or C.P. or Down Syndrome.
11. This study indicates that intervention in children at risk for developmental disabilities should be adapted to the infant’s age.
12. At preterm age, infants do not seem to benefit from intervention such as NIDCAP intervention.

4. **Guidelines of good practice in the healthcare professions: Guidelines for the withholding and withdrawing of treatment (Booklet 12)**

Questions: (True a and False b)

1. Patients should be encouraged to appoint in writing a person to make decisions on their behalf when they are no longer capable to do so.
2. Health care practitioners should seek a second opinion when they are not sufficiently experienced or knowledgeable.
3. Health care practitioners must respect the decisions made by competent adult patients to refuse a particular medical intervention even if it may result in serious harm or death.
4. When a patient has difficulty retaining information or to communicate their views, the health care practitioner does not have to provide assistance to enable him/her to reach and communicate a decision.
5. The HPCSA consider it as acceptable that patients are transferred to state institutions after all their funding has been exhausted as a result of prolonging futile treatments.
6. When treatment is to be withheld or withdrawn it is no longer necessary for the health care practitioner to inform the patient and his family regarding appropriate palliative or terminal care.
7. When health care practitioners record information on decision-making it is not advised to use abbreviations and other terminology that may confuse those that provide care.
8. Health care practitioners should seek a second opinion where the patient’s condition is not progressing as expected.
9. Health care practitioners should respect the decisions of children who have the legal capacity to make decisions about refusing health care except where it is believed that it is not in the child’s best interest.
10. The World Medical Association condemns as unethical both euthanasia and physician assisted suicide.
11. The patient’s right to autonomy in decision making must be respected with regard to decisions in the terminal phase of life.
12. It is not expected of physicians to try to ensure that psychological and spiritual resources are available to patients and their families to help them deal with the anxiety, fear and grief associated with terminal illness.
5. **Guidelines of good practice in the healthcare professions: Ethical guidelines for good practice with regard to HIV (Booklet 11)**

**Questions: (True a and False b)**

1. The majority of people infected with the virus only become aware of their status by choosing to have an HIV test.
2. Health care practitioners should obtain informed consent prior to testing patients for HIV.
3. Health care professionals do not have to support all measures aimed at preventing HIV infection.
4. The decision to divulge information relating to a patient's HIV status must always be done in consultation with the patient.
5. It is the responsibility of health care practitioners to ensure that patients that test positive for HIV will go for post test counseling by providing them with contact details of appropriate facilities.
6. All patients have a right to refuse testing for HIV.
7. It is permissible for health care practitioners to tell patients that HIV testing is mandatory.
8. If the patient is unable to give informed consent, every reasonable attempt should be made to obtain 'proxy consent' (consent by a person legally able to give such consent in terms of the National Health Act).
9. Health care practitioners should attempt to encourage their HIV positive patients to disclose their status to their sexual partners.
10. There is a slight risk of transmission of HIV infection in the health care environment through the exchange of infected blood or other body fluids.
11. It is expected from health care practitioners to make their employees aware of the importance of HIV.
12. Health care practitioners could be obliged to disclose their HIV status to an employer.


**Questions: (True a and False b)**

1. A health record contains information about the health of an individual recorded by a health care practitioner either personally or at his/her direction.
2. Forms completed during the health interaction such as insurance forms or documentation of injury on duty cannot be regarded as essential components of a health record.
3. Documents should be retained in order to, amongst other, make case reviews possible and serve as basis for accreditation.
4. Erasure fluid may be used in documents or records.
5. Signing documents include writing initials and surname in block letters as well as a signature next to it.
6. It is expected from a health care practitioner to issue a brief factual report to a patient when such a patient requires information concerning himself or herself.
7. No information or entry may be removed from a health record.
8. Health records should be stored for a period of no less than three years as from the date they become dormant.
9. It is required that records of mentally incompetent patients should be kept for the duration of the patient’s lifetime.
10. Health care practitioners in private practices who decide to close their practice has to inform patients of the closure and request that records are transferred to other health care practitioners of their (the patient’s) choice.
11. A health care practitioner may make available a patient’s record to a third party without authorization of the patient where a court orders the records to be handed to the third party.
12. Health care practitioners should use a standardized format when writing patients’ records.
7. Guidelines of good practice in the healthcare professions: Seeking patients’ informed consent: The ethical considerations (Booklet 9)

Questions: (True a and False b)

1. Health care practitioners have to remind patients that they (the patients) can change their minds about a decision concerning treatment at any time.
2. It is of vital importance that health care practitioners provide a patient with a very short simple statement about the treatment that is to follow, in order not to confuse or overwhelm that patient.
3. Health care practitioners should respond to a patient’s questions about the treatment only as far as the health care practitioner sees appropriate.
4. Health care practitioners should not withhold information necessary for decision making.
5. Obtaining informed consent is a once off and isolated event.
6. For a patient to provide informed consent he or she must have, amongst other, knowledge of the nature or extent of the harm or risk and appreciate and understand the nature of the harm / risk.
7. Health care practitioners must inform patients that they have the right to refuse treatment.
8. Generally speaking, it is for the patient, not the health care practitioner, to determine what is in the patient’s own best interest.
9. It is the responsibility of health care practitioners to take appropriate action if they believe patients are being offered inappropriate or unlawful financial or other rewards.
10. Health care practitioners have to assume that every adult has the capacity to decide whether to consent to, or refuse treatment, unless it is shown that they cannot understand information presented in a clear way.
11. Persons who consent on behalf of mentally incompetent patients include a person authorized by the court or a family member such as a spouse, partner, parent etc.
12. Health care practitioners must assess a child’s capacity to decide whether to consent to, or refuse treatment, before they provide treatment.