

GAME: Guess the form...

Treatment - noun

Treat – verb

Treated – adjective

Treating – adj.

Restrict – verb

Restriction - noun

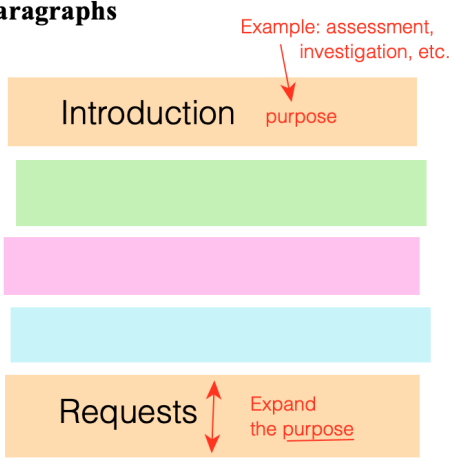
Restricted / restricting – adj. – limited / no access / you cannot do

Restrictive – adj. – the effect of being limited

TODAY:

- 1 How to write a letter
- 2 Group plan
- 3 (Try) agree on details

How to write a letter...

<p>Types</p> <ul style="list-style-type: none"> • Discharge: someone going home / usually writing to a GP • Transfer: someone is moving place (ward, hospital, city, etc.) • Referral (to a Specialist): You are sending them to someone who has more knowledge 	<p>Paragraphs</p> 
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How do I select case notes for my letter?

Choose what is relevant for the reader

Needed to do the job: very important – must be there

CUP, WATER / COFFEE

Appropriate for the reader: suitable / useful / helpful to know

SUGAR / CRÈME / MILK / ETC.

Band	Purpose	Band	Content	Conciseness & Clarity	Genre & Style	Organisation & Layout	Language
3	Purpose of document is immediately apparent and sufficiently expanded as required	7	Content is appropriate to intended reader and addresses what is needed to continue care (key information is included; no important details missing); content from case notes is accurately represented	Length of document is appropriate to case and reader (no irrelevant information included); information is summarised effectively and presented clearly	Writing is clinical/factual and appropriate to genre and reader (discipline and knowledge); technical language, abbreviations and polite language are used appropriately for document and recipient	Organisation and paragraphing are appropriate, logical and clear; key information is highlighted and sub-sections are well organised; document is well laid out	Language features (spelling/punctuation/vocabulary/grammar/sentence structure) are accurate and do not interfere with meaning
		6	Performance shares features of bands 5 and 7				
2	Purpose of document is apparent but not sufficiently highlighted or expanded	5	Content is appropriate to intended reader and mostly addresses what is needed to continue care; content from case notes is generally accurately represented	Length of document is mostly appropriate to case and reader; information is mostly summarised effectively and presented clearly	Writing is clinical/factual and appropriate to genre and reader with occasional, minor inappropriacies; technical language, abbreviations and polite language are used appropriately with minor inconsistencies	Organisation and paragraphing are generally appropriate, logical and clear; occasional lapses of organisation in sub-sections and/or highlighting of key information; layout is generally good	Minor slips in language generally do not interfere with meaning
		4	Performance shares features of bands 3 and 5				
1	Purpose of document is not immediately apparent and may show very limited expansion	3	Content is mostly appropriate to intended reader; some key information (about case or to continue care) may be missing; there may be some inaccuracies in content	Inclusion of some irrelevant information distracts from overall clarity of document; attempt to summarise only partially successful	Writing is at times inappropriate to the document or target reader; over-reliance on technical language and abbreviations may distract reader	Organisation and paragraphing are not always logical, creating strain for the reader; key information may not be highlighted; layout is mostly appropriate with some lapses	Inaccuracies in language, in particular in complex structures, cause minor strain for the reader but do not interfere with meaning
		2	Performance shares features of bands 1 and 3				
0	Purpose of document is partially obscured/unclear and/or misunderstood	1	Content does not provide intended reader sufficient information about the case and what is needed to continue care; key information is missing or inaccurate	Clarity of document is obscured by the inclusion of many unnecessary details; attempt to summarise not successful	The writing shows inadequate understanding of the genre and target reader; mis- or over-use of technical language and abbreviations cause strain for the reader	Organisation not logical, putting strain on the reader; or heavy reliance on case note structure; key information is not well highlighted and the layout may not be appropriate	Inaccuracies in language cause considerable strain for the reader and may interfere with meaning
		0	Performance below Band 1				

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

TIME ALLOWED: **READING TIME: 5 MINUTES**
WRITING TIME: 40 MINUTES

Read the case notes below and complete the writing task which follows.

Notes:

Your patient, an 81-year-old woman, recently had a right total knee replacement (R.TKR) on 25/02/2015. She is being discharged today.

Patient: Ms Betty Johnson

Address: 12 Merry Street, Stillwater

Marital Status: Widowed

Past Medical History: Aortic valve replacement & pacemaker 2010
 Osteoarthritis since 2011 — pain & immobility ↑ past 3yrs
 For R.TKR Feb 2015: full blood work, typing & cross matching, X-rays, ECG etc.

Regular Medication (25/2/15):

Paracetamol 665mg 2 tabs tds
 Warfarin 3mg mane — ceased 5 days preoperatively, started Clexane (enoxaparin sodium — anticoagulant)

Social Background: Widowed 1986. Lives alone. 4 children

Post Op:

25/02/15 11:30am Returned to ward following R. TKR.
 Vital signs — BP 115/70, P 82, R 16, T 36.9°C.
 Circulation observation good, knee ↑ on pillow.
 Hb 80g/l → IVT Transfusion.
 IV cephalothin 1g qid for 24 hours.
 Increase regular oral paracetamol (1g qds).
 Patient Controlled Analgesia (PCA) — morphine ✓ effective.
 Wound — nil ooze.

26/02/15 Wound — good, sponged.
 Restart warfarin 5mg today.
 s/c Clexane 80mg given for anticoagulation.
 Cease PCA. Start oxycodone 5 — 10mg prn.
 Pathology: FBE, U&Es, Liver Function Tests (LFTs), Hb.
 Path results ✓, Hb 100g/l → commence Feratab (iron sulphate) 300mg mane.

27/02/15 s/c Clexane 80mg.
 Start warfarin 5mg nocte.
 Removal of (R/O) dressing, wound good, R/O ait. clips on 03/03/15.

28/02/15 Crutches, short walks. Wound good, afebrile.
 s/c Clexane 80mg given.

01/03/15 s/c Clexane 80mg given.

02/03/15 X-rays, bloods ✓, INR — 3.0, Hb 111g/l, ECG — no abnormalities.
 Managing w/ min assistance.
 Cease Clexane.

03/03/15–05/03/15 Wound clean, R/O ait clips tomorrow. Mobility good. Obs ✓.

06/03/15 R/O remaining clips. Pathology ✓. Transfer to rehab today.

Rehab:

07/03/15 Admission complete — stable. Circ ✓. Mobility, crutches good.

08/03/15–19/03/15 Mobility, frame use, trial stick, pool, gentle exercises = good. Showering w/ min assistance.
 Path & X-ray.

14/03/15 Path ✓, INR — 3.8.
 ↓ warfarin 4mg nocte, Hb — 112g/l, ↓ Feratab 150mg mane.

15/03/15–19/03/15 Uneventful — gradually ↑ independence.
 Wound good. Obs ✓. Physio exercises good. Home list provided.

21/03/15 No cardiac issues.
 Discharged w/ home nursing assistance (personal hygiene, home care). Wound exposed, shower w/ min assist. Stick / frame prn.
 Discharge medication: warfarin 4mg nocte, Feratab 150mg mane, paracetamol 1g qds, oxycodone 5–10mg prn.
 Rehab appt in 2 weeks.
 Advised to see local doctor in 1 week, referral for local doctor — suggest repeat FBE, INR.

Writing Task:

Using the information given in the case notes, write a letter of referral to Ms Johnson's local doctor, Dr Tony Jones, to update him on her condition following her recent surgery and discharge from rehab. Address the letter to Dr Tony Jones, Private Practice, 12 New Street, Stillwater.

In your answer:

- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180–200 words.

PLAN:

Introduction	<ul style="list-style-type: none"> • update
Timeline	<ul style="list-style-type: none"> • 25th – day of surgery • Good progress • INR – 14/03 (last one)
Current Condition	<ul style="list-style-type: none"> • No cardiac issues • Home nurse & detail about care: <ol style="list-style-type: none"> a. Mobility b. Showering c. Etc. • Medications: <u>dose</u> & name • Please note: rehab appointment
Requests	<ul style="list-style-type: none"> • possible visit 1 WK to YOU • FBE / INR

Sentence 1: WHO / WHERE / WHY

*I am writing to update you on your **patient, Mrs Johnson**, who was admitted to our hospital for knee replacement surgery.*

Sentence 2: LETTER TYPE / **PURPOSE**

She is due to be discharge, and has been advised to visit you.....

Past event with consequences in present/future