

TODAY:

- 1 Planning in general / Review OET Writing test
- 2 Groups: you will plan a real letter together
- 3 Make a detailed plan



OET Writing

• Time: 45 minutes



5 minutes with writing (plan here)

35 minutes

5 minutes checking

• How do I plan?

Reader (he/she will DO something)

Think about Purpose of the letter

Care & support / management / assessment, etc.

Tell reader what to do

Decide on organisation: paragraphs

Give situation

Choose the <u>relevant</u> information



Think about what the reader will DO





OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: NURSING

TIME ALLOWED: READING TIME: 5 MINUTES

WRITING TIME: 40 MINUTES

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

Notes

Age:

Assume that today's date is 24 June 2018

You are a ward nurse working in the osteopathy unit at Newton General Hospital. A patient, Miss Hilary

Di Santo, has been admitted to your unit for a planned hallux valgus operation on her right foot.

Patient: Ms Hilary Di Santo

0, 1,

Marital status: Single

Next of kin: Sister, Linda, also single, 72 yo, shares room with pt

70 years old

at Rosewood Care Home. Very supportive.

Admission date: 23 Jun 2018

Discharge date: 24 Jun 2018

Diagnosis: R hallux valgus

Ongoing high BP

Social background: very active, walks, swims, enjoys social life and sheltered

atmosphere provided by Rosewood.

Many interests, travelling, reading, cinema, theatre.

No longer drives

Retired at 60 from nursing career.

Adequate pension, non-smoker, alcohol nil.

Treatment: R Osteotomy (23 Jun 2018)

Staples, surgical boot.

Writing task:

Using the information given in the case notes, write a discharge letter to Denise Pizzica, Rosewood Care Home, 44, High Street, Newton, where Ms Di Santo is a resident.

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.

Past medical history: Pneumonia (2000)

Hypertension - since age 50 (Verapamil 80mg TID)

Hysterectomy (2001)
Osteotomy L foot (2010)
Allergies: latex, dust mites, nickel
Mother, sister → bunion

Medical background Pt presents with severe pain in R first metatarsophalangeal (MTP) joint,

slight swelling, difficult ambulation, requiring osteotomy.

Nursing management: Vital signs (normal limits)

ECG normal range

Oral analgesia (Panadeine Forte, codeine/paracetomol 30/500mg x 2, 6

rly p.r.n.).

Antibiotic therapy (Augmentin Duo Forte 875/125mg orally b.d.).

Assessment: Overall good progress

Discharge plan: Monitor medication compliance (Panadeine Forte, Augmentin Duo Forte,

for review at completion of current course).

Verapamil to continue Elevation of right foot Bed rest, avoid weight-bearing

Ice if needed

Review in Osteopathy Outpatients on 07 Jul 2018 (removal surgical

boot and staples, application brace for support).

Preserve skin integrity after removal of boot

Equipment required: crutches (provided by hospital).

Follow-up physiotherapy Outpatients (appointments to be fixed at

osteopathy review).

Anticipated needs of patient:

Help with ADLs, showering, toilet use etc.



Write and send to me alain@set-english.com

PLAN

Introduction	Ongoing care and assistance [main idea]
Timeline	 23rd July – successful osteotomy Recovering well
Requests	Medication
	2 Reviews (follow ups)
	Care
	• Elevate foot
	 Crutches (provided) Avoid weight
	Avoid weightIce (if needed)
	Bed rest