SET English

OET Nursing Writing Week

Charlotte Price

The task is: *Write a letter to a healthcare professional requesting* ***continuation of care*** *for a patient.*

Planning

10 - 15 minutes:

- Find the **purpose**
- Identify the **case notes** you will use
- Organise the case notes into **logical paragraphs**

What is the situation after the above steps?

I can **focus on writing** *= Perfect circumstances in which to write a letter*

General Paragraph Purposes

Introduction	• Name • General medical context • General request • (urgency)
Timeline 1	• Beginning of this medical context up to the present. (Sometimes includes the present)
Timeline 2	• Current condition / Today's presentation
Background – Medical	• Related medical information that is not part of this medical context/timeline
Background - Social	• lifestyle / smoking / family / work / exercise
Request	• Expands the purpose/request – tasks, updates

Identifying Purpose & Choosing Case Notes:

Ask yourself these questions about Charlotte Price case notes:

1. Who is the reader?	Leyla Ward – Community Nurse
2. What is the reader's task?	Home visits twice a week – ongoing care
3. Does the reader know the patient?	No
4. Does the writer have any tasks?	Write a referral including patient's current condition and needs for ongoing care
5. Why am I writing <u>today</u>?	ready for discharge
6. Is it urgent?	No

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You are a registered nurse in the hospital where Mrs Charlotte Price has been staying. She is now ready to be discharged with home visits from a community nurse.

Patient: Mrs Charlotte Price

Date of birth: 04/08/1932

Age: 86

Admission date: 2 December 2018

Discharge date: 4 December 2018

Diagnosis: Mild concussion (following fall at home)

Infected right toe (discovered during hospital stay)

Social background:

Lives alone – reluctant to receive visitors
Retired 19 years (postal worker)
2 children, both medical doctors, one lives overseas
Husband deceased – lung cancer 14 years ago
Owns dog – neighbour walks it occasionally
Lives in 3-bedroom house (owned by daughter)
Wants to live independently / refuses meal delivery service
Reluctant to visit GP
At risk of falls (walking stick, scoliosis, infected toe)

Medical history:

Severely infected right toe since approximately 9/18 (result of untreated ingrown toenail)
Conjunctivitis (02/02/18, 18/03/18 & 08/08/18) & Gastroenteritis (13/05/18) – both possibly associated with poor hygiene
Skin cancerous moles (x3) removed 2000
Knee replacement 1998
Whiplash injury in 1987

Medical background:

Hypertension (25 years)
Occasional drinker (whisky)
Heavy smoker (cigarettes x 40 /day)
Urinary incontinence
Mild scoliosis
Walks with stick

Medication:

Ramipril 10 mg (hypertension)
Ibuprofen (as required for scoliosis)
Amoxicillin 500 mg x 3 daily x 2 weeks (for toe infection)
(concerns re. compliance)

Nursing management and progress:

Concussion tests: Initial questioning (satisfactory), Finger-Nose-Finger test (satisfactory), CT scan (satisfactory)
48 hours precautionary admission, monitoring and rest – now ready to be discharged home
Right toe cleaned and dressed, antibiotics prescribed

Discharge plan:

- Home visits by community nurse twice a week
- Provide assistance with showering, dressing
- Provide advice re. hand and food hygiene
- Oversee treatment of right toe – (clean, change dressings twice a week, encourage adequate rest)
- Monitor medication compliance (Amoxycillin and Ramipril)

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Writing task

Using the information in the case notes, write a referral letter to Ms Leyla Ward, Community Nurse, Ashton Health Centre, Somerville, outlining the patient's current condition and needs for ongoing care.

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.

Letter Plan

Introduction	**Name:** Charlotte Price **Context:** recovering from a fall / ready for discharge **Request:** home visits / ongoing care
Timeline / Current	• Admission : Why / When • Toe infection discovered • Management - Summarise: Concussion tests: Initial questioning (satisfactory), Finger-Nose-Finger test (satisfactory), CT scan (satisfactory) 48 hours precautionary admission, monitoring and rest – now ready to be discharged home Right toe cleaned and dressed, antibiotics prescribed
Background	**Social:** Lives alone – reluctant to receive visitors ~~Retired 19 years (postal worker)~~ ~~2 children, both medical doctors, one lives overseas~~ ~~Husband deceased – lung cancer 14 years ago~~ ~~Owns dog – neighbour walks it occasionally~~ ~~Lives in 3-bedroom house (owned by daughter)~~ Wants to live independently / refuses meal delivery service ~~Reluctant to visit GP~~ At risk of falls (walking stick, scoliosis, infected toe) **Medical:** Hypertension (25 years) ~~Occasional drinker (whisky)~~ Heavy smoker (cigarettes x 40 /day) Urinary incontinence Mild scoliosis Walks with stick Ramipril 10 mg (hypertension) Ibuprofen (as required for scoliosis)
Request	• Home visits by community nurse twice a week • Provide assistance with showering, dressing • Provide advice re. hand and food hygiene • Oversee treatment of right toe – (clean, change dressings twice a week, encourage adequate rest) • Monitor medication compliance (Amoxycillin and Ramipril) Amoxicillin 500 mg x 3 daily x 2 weeks (for toe infection) (concerns re. compliance)

Write introduction: send to paul@set-english.com