

OET Nursing Writing Week

Lisa Simmonds

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

180 – 200 Guideline word count

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** <u>= Perfect circumstances in which to write a letter</u>



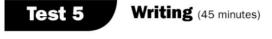
Identifying Purpose & Choosing Case Notes:

Ask yourself these questions about Lisa Simmonds case notes:

1. Who is the reader?	Charge nurse – gastroenterology
What is the reader's task?	prepare patient for urgent cholecystectomy
Does the reader know the patient?	no
Does the writer have any tasks?	no
5. Why am I writing <u>today</u> ?	diagnosis – yesterday and treatment decided
6. Is it urgent?	yes

https://www.dropbox.com/scl/fi/ryop6if1srapugri9py8n/Lisa-Simmonds.pdf?rlkey=k9xt62tsj2eroplrq7xci5tk0&dl=0





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

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

Notes:

Assume that today's date is 22 May 2017.

You are a nurse in a hospital emergency department where you have been looking after a female patient.

PATIENT DETAILS:

Name:	Lisa Simmonds (Ms)
DOB:	2 January 1987 (30 y.o.)
Address:	23 Brighton Avenue, Cookstown
Social background:	Fashion designer
eeelar baokgrounar	Lives alone in 2-bedroom flat
	Parents – overseas, no siblings
	Generally sedentary – 'hates' exercise
	Diet: processed, ready-to-eat meals
	Interests: watching movies, baking
Past medical history:	Atopic dermatitis (3–6 y.o.)
	R arm fracture (12 y.o.)
	No smoking or alcohol consumption
	No hypertension/allergies
	BMI 29 (borderline obese) – unsuccessful 'fad' diets 2016
Emergency Dept (ED)	Admission: 21 May 2017
Presenting factors:	
Subjective	Acute abdominal pain in RUQ (7/10)
	Regular acid reflux, nausea & vomiting 1 wk
	Fever
	Diaphoresis
Objective	BP: 145/90 mmHg (elevated), P: 97 beats/min (elevated), T: 37.8°C (elevated), RR: 18 breaths/min (normal), oxygen saturation (SaO2): 96% (normal)
	Pt. worried, pain intense \rightarrow protective behaviour (guarding)
Tests:	Murphy's sign (positive)
	Ultrasound = clinical ascending cholangitis, dilated CBD 6 mm, pericholecystic fluid

(GGT) & serum bilirubin (6 mg/dL)

LFTs (liver function tests): elevated alkaline phosphatase (ALP), gamma-glutamyl transferase



Urinalysis: normal <u>CRP</u> (C-reactive protein): elevated (infection present) Full blood count: elevated WBCs (13,000 µL)

Diagnosis: Acute cholecystitis (→ laparoscopic cholecystectomy)

Nursing treatment record:

21 May 2017:	Analgesia: diclofenac 75 mg IM (2x/day) Anti-emetic: stemetil 12.5 mg IM (2x/day) IV: fluids for hydration, cefuroxime 750 mg 3x/day, metronidazole 500 mg 3x/day (antibiotics) NBM (nil by mouth) Catheter inserted – monitor urine output: 15 ml/hr (low) Pt. stabilised – ↓pain (3/10)
22 May 2017:	Continued analgesia, anti-emetic Continued IV: fluids, cefuroxime 750 mg 3x/day metronidazole 500mg 3x/day BP: 119/80 mmHg (normal), P: 92 beats/min (normal), T: 37.4°C (low-grade fever), RR: 14 breaths/min (normal), oxygen saturation (SaO2): 96% (normal) WBC: 12,500 µL (elevated) Pt. stable, comfortable, slight nausea, no vomiting Urine output: 50 ml/hr (satisfactory) Pain controlled (1/10)
Action:	 Transfer to gastroenterology department: prepare for urgent laparoscopic cholecystectomy (scheduled 24 May) continue IV: fluids, cefuroxime, metronidazole review analgesia (following 2-day diclofenac dose) continue NBM → surgery

Plan:

Write to gastroenterology nurse

Writing Task:

Using the information in the case notes, write a letter to Ms Brown, the charge nurse of the gastroenterology department, summarising the patient's case and the treatment already provided, and outlining the pre-operative treatment required. Address your letter to Ms Zara Brown, Charge Nurse, Gastroenterology Department, Cookstown Hospital, Cookstown.

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	 Patient name: Lisa Simmonds General medical context/status: Acute cholecystitis General request: Pre-op preparation – cholecystectomy Urgent request
Timeline	Admission Acute abdominal pain in RUQ (7/10) Regular acid reflux, nausea & vomiting 1 wk Fever- Diaphoresis- BP: 145/90 mmHg (elevated), P: 97 beats/min (elevated), T: 37.8°C (elevated), RR: 18 breaths/min (normal), oxygen saturation (SaO2): 96% (normal) Future Pt. worried, pain intense → protective behaviour (guarding) Murphy's sign (positive) Ultrasound = clinical ascending cholangitis, dilated CBD 6 mm, pericholecystic fluid LFTs (liver function tests): elevated alkaline phosphatase (ALP), gamma-glutamyl transferase (GGT) & serum bilirubin (6 mg/dL) Sum Urinalysis: normal CRP (C-reactive protein): elevated (infection present) Full blood count: elevated WBCs (13,000 µL) Treatment
	Homework!
Background	



Request	Transfer to gastroenterology department:
	 prepare for urgent laparoscopic cholecystectomy (scheduled 24 May)
	 continue IV: fluids, cefuroxime, metronidazole
	 review analgesia (following 2-day diclofenac dose)
	• continue NBM \rightarrow surgery

Homework: Write introduction (& consider the level of detail necessary for Nursing Management) : send to paul@set-english.com