

OET Nursing Writing Week

Margaret Helen Martin

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

This entails including all of the **content** necessary to do **this task**

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** = Perfect circumstances in which to write a letter



Identifying Purpose & Choosing Case Notes:

Ask yourself these questions about Margaret Helen Martin case notes:

1.	Who is the reader?	Nurse in charge, district nursing service
2.	What is the reader's task?	monitoring / follow up care
3.	Does the reader know the patient?	no
4.	Does the writer have any tasks?	no
5.	Why am I writing <u>today</u> ?	patient is probably going to be discharged
6.	Is it urgent?	no



Notes:

You are a ward nurse in the cardiac unit of Greenville Public Hospital. Your patient, Ms Martin, is due to be discharged tomorrow.

Patient: Ms Margaret Helen Martin

Address: 23 Third Avenue, Greenville

Age: 81 years old (DOB: 25 July 1935)

Admission date: 15 July 2017

Social/family background:

Never married, no children Lives in own house in Greenville Financially independent

Three siblings (all unwell) and five nieces/nephews living in greater Greenville area

Contact with family intermittent

No longer drives

Has 'meals on wheels' (meal delivery service for elderly) - Mon-Fri (lunch and dinner), orders frozen

meals for weekends

Diagnosis: Coronary artery disease (CAD), angina

Treatment: Angioplasty (repeat – first 2008)

Discharge date: 16 July 2017, pending cardiologist's report

Medical information:

Coeliac disease Angioplasty 2008

Anxious about health – tends to focus on health problems

Coronary artery disease → aspirin, clopidogrel (Plavix)

Hypertension → metoprolol (Betaloc), ramipril (Tritace)

Hypercholesterolemia (8.3) → atorvastatin (Lipitor)

Overweight (BMI 29.5)

Sedentary (orders groceries over phone to be delivered, neighbour walks dog)

Family history of coronary heart disease (mother, 2 of 3 brothers)

Hearing loss - wears hearing aid

Nursing management and progress during hospital stay:

Routine post-operative recovery Tolerating light diet and fluids

Bruising at catheter insertion site, no signs of infection/bleeding noted post-procedure

Pt anxious about return home, not sure whether she will cope



Discharge plan: Dietary

Low-calorie, high-protein, low-cholesterol, gluten-free diet (supervised by dietitian, referred by Dr)

Frequent small meals or snacks

Drink plenty of fluids

Physiotherapy

Daily light exercise (e.g., 15-minute walk, exercise plan monitored by physiotherapist)

No heavy lifting for 12 weeks

Other

Monitor wound site for bruising or infection Monitor adherence to medication regime Arrange regular family visits to monitor progress

Anticipated needs of Pt:

Need home visits from community health/district nurse – monitor adherence to post-operative medication, exercise, dietary regime

Regular monitoring by Dr, dietitian, physiotherapist

? Danger of social isolation (infrequent family support)

Writing Task:

Using the information in the case notes, write a letter to the Nurse-in-Charge of the District Nursing Service outlining Ms Martin's situation and anticipated needs following her return home tomorrow. Address the letter to Nurse-in-Charge, District Nursing Service, Greenville Community Health Care Centre, 88 Highton Road, Greenville.

https://www.dropbox.com/scl/fi/9tjfopbrvciyi7w4b1oyo/Margaret-Helen-Martin.png?rlkey=ryx94c03f71yjalg9bknyn4r9&st=fbdatxyr&dl=0



Letter Plan

 General Medical Context: Recovering from angioplasty General Request: Follow up care at home 			
Background Never married, no children	Never married, no children		
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Medical information: Coeliac disease 7			
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7 Hearing loss – wears hearing aid			
Admission date: 15 July 2017			
Admission / Diagnosis: Coronary artery disease (CAD), angina			
Treatment: Angioplasty (repeat – first 2008)			
Nursing management and progress during hospital stay:			
Routine post-operative recovery Tolerating light diet and fluids Bruising at catheter insertion site, no signs of infection/bleeding noted post-pro	ocedure.		
✓ Pt anxious about return home, not sure whether she will cope	,ccaarc		
Request — physio / dietitian Discharge plan: Dietary Low-calorie, high-protein, low-cholesterol, gluten-free diet (supervised by dietitian, reference) Frequent small meals or snacks Drink plenty of fluids	rred by Dr)		
Physiotherapy			
✓ Daily light exercise (e.g., 15 minute walk, exercise plan monitored by physiotherapist) ✓ No heavy lifting for 12 weeks			
Regular monitoring by Dr, dietitian, physiotherapist			
Request - me Other			
Monitor wound site for bruising or infection			
Monitor adherence to medication regime			
Arrange regular family visits to monitor progress —? Danger of social isolation (infrequent family	support)		



Homework: Review your plan for Request & Write introduction and send to paul@setenglish.com