

TODAY:

- 1 **Review**
- 2 Grading your work
- 3 Next assignment

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

Notes:

Assume that today's date is 18 August 2019

You are a ward nurse working in the vascular unit of Ellesmere General Hospital. A patient, Mrs Rachel Brown, has been admitted with an infected venous leg ulcer.

PATIENT DETAILS:

Name: Rachel Brown
DOB: 12 Dec 1943
Marital status: Widow
Next of kin: Daughter, Jane (48 y.o.)

Social background:

Occupation: retired florist
Has lived in self-contained unit in retirement village for 7 years
Not supported by any care workers
Daughter lives nearby with husband and 3 children. Very supportive - visits regularly
Active - does Pilates
Interests: theatre, reading, watching football

Past medical history:

Hypercholesterolemia (8.9) → Atorvastatin (Lipitor)
Hypertension (Verapamil 80mg 3 x daily)

Admission date: 16 Aug 2019

Presenting factors:

Swollen L leg, bleeding from venous ulcer, fever, pain, warmth; brown staining around wound, foul smell.
Pt. confused
Pt. noticed ulcer (01 Aug 19) - reluctant to have treatment at that time

Assessment:

BP (140/90), height 158cm, weight 83kg.
Urinalysis (5.1) - normal
Doppler ultrasound to establish ABI (ankle brachial index): (1.2) - normal
No necrotic tissue, presence of epidermis reconstruction.

Diagnosis: Infected venous leg ulcer, L leg

Medical treatment:

Leg washed (normal saline, body temperature)
Cadomexer iodine dressings
Monitor vital signs
Monitor cadomexer iodine dressing
4-layer compression bandaging
Leg elevation
Antibiotic therapy (Oxacillin)
Paracetamol

Assessment:

18 Aug 2019 Good progress - vital signs within normal range
Pt alert & aware

Discharge plan:

Discharge to self-contained unit with compression stockings
Weight loss advised, review of diet (dietitian?) – reduce ulcer reoccurrence
Pt. to take paracetamol p.r.n. (no more than 8/day, discontinue after 1 week), continue Oxacillin IM, 300 mg, every 4-6 hrs.
Pt. informed of importance of compression stockings, and bed rest, with leg elevation.
Dressings (daily): cadomexer iodine, triamcinolone ointment (topical steroid) – reduce irritation, bandaging.
Community nurse to change dressings daily, monitor for infection/healing rate, help with ADLs (activities of daily living) & refer to OT if needed. Also monitor medication compliance.
Progress review: 25.08.2019 at Community Clinic


Writing Task:

Using the information given in the case notes, write a referral letter to Ms Fiona McKie, Community Health Nurse, 101 Collins St, Ellesmere, outlining wound management for the patient.

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.

| | |
|---|---|
| Introduction | Purpose: <u>wound management</u> I am writing regarding ____, who was admitted to our hospital |
| Timeline (context) <div style="background-color: #90EE90; padding: 2px; display: inline-block;">PAST + NOW</div> | 16 th August: <ul style="list-style-type: none"> • Symptoms: give <u>some</u> details (a little bit) • Treatment: “she was treated <u>accordingly</u>” (according to the protocol) + management • Mention <i>weight</i> 18 th August: <div style="background-color: #FFFF00; padding: 2px; display: inline-block;">Good progress - <u>vital signs within normal range</u></div> <div style="background-color: #FFFF00; padding: 2px; display: inline-block;"><u>Pt alert & aware</u></div> Write Timeline: alain@set-english.com PAST PAST PAST PAST PAST PAST PRESENT: present perfect  This is narrative |
| Background | Social background: <ul style="list-style-type: none"> Has lived in self-contained unit in retirement village for 7 years Not supported by any care workers <u>Daughter lives nearby with husband and 3 children</u> Very supportive - visits regularly <u>Active</u> - does Pilates Past medical history: <ul style="list-style-type: none"> Hypercholesterolemia (8.9) Hypertension |
| Requests | Purpose: <u>wound management</u> (general) |



| | |
|--|--|
| <p style="background-color: #90EE90; display: inline-block; padding: 2px 5px; margin: 0;">FUTURE</p> | <p>Details:</p> <p>Discharge plan: Discharge to self-contained unit with compression stockings Weight loss advised, review of diet (dietitian?) – reduce ulcer reoccurrence Pt. to take paracetamol p.r.n.(no more than 8/day, discontinue after 1 week), continue Oxacillin IM, 300 mg, every 4-6 hrs. Pt. informed of importance of compression stockings, and bed rest, with leg elevation. Dressings (daily): cadomexer iodine, triamcinolone ointment (topical steroid) – reduce irritation, bandaging. Community nurse to change dressings daily, monitor for infection/healing rate, help with ADLs (activities of daily living) & refer to OT if needed. Also monitor medication compliance. Progress review: 25.08.2019 at Community Clinic</p> <p>Most of this</p> |
|--|--|

| Original | Corrections |
|---|---|
| <p>Timeline paragraph:</p> <p>Reluctant patient, Mrs Brown noticed the ulcer two weeks previous to her admission. Her nursing management consisted of washing her leg, applying four – layer compression bandaging and monitoring cadomexer iodine dressing. She must complete her course of antibiotic, oxacillin intramuscular 300 mg, every six hours and paracetamol if required, no more 8 per day. Her hypertension and hypercholesterolaemia medication must also continue.</p> <p>This means they have to fill out a form and wait for some days</p> | <p>Usually in OET we do say ‘patient’, we use the name only</p> <p>Timeline paragraph:</p> <p>Reluctant patient, Mrs Brown noticed the ulcer two weeks previous to her admission on 16th August. Her nursing management consisted of washing her leg, applying four – layer compression bandaging and monitoring cadomexer iodine dressing. She must complete her course of antibiotic, oxacillin intramuscular 300 mg, every six hours and paracetamol if required, no more than 8 per day. Her hypertension and hypercholesterolaemia medication must also continue.</p> <p>Language is actually quite good but too much detail on things that do not really matter. And you forget the current condition...</p> <p>This will be discussed in Requests</p> <p>When you mix it, it can be confusing</p> <p>In speaking we say:</p> <p>On <u>the</u> 16th</p> <p>In writing we say:</p> <p>On 16th</p> |

On the 16th August 2019, Mrs Brown applied to our hospital with complaints of swollen left leg, fever and pain as well as bleeding from a venous ulcer. She was diagnosed with an infected venous ulcer as a result of the assessments. During hospitalization, she was treated and made good progress.

On 16th August 2019, Mrs Brown was admitted to our hospital with his left leg swollen and bleeding from venous ulcer as well as presenting fever, pain and warmth. She was diagnosed with aforementioned diagnosis and treated accordingly. Now his vital signs are within normal range, and she has made good progress.

Is an ulcer

On 16th August 2019, Mrs Brown **was admitted** to our hospital with complaints of a swollen left leg, fever and pain as well as bleeding. She was diagnosed with an infected venous ulcer as a result of the assessments. During hospitalization, she was treated and made good progress. Currently, she is aware and alert.

You can always use 'was admitted' ☺

'has been admitted' is used when the patient is still in the hospital at the time writing. You cannot use it with a DATE

Note:

If you are writing to a *nurse* usually normal things we don't need to mention... (vitals)

If you are writing to a specialist usually normal things we don't need to mention...

I am writing regarding Mrs Brown, who was admitted to our hospital due an infected left leg ulcer.

On 16th August, Mrs Brown was admitted to our hospital with a swollen left leg and bleeding from a venous ulcer as well as ~~presenting~~ fever, pain and warmth. She was diagnosed and treated accordingly. **Currently**, ~~her~~ vital signs are now within normal range, and she has made good progress.

For this, this is enough for a CV+₋

On 16th August, Mrs Brown was admitted with the aforementioned condition. She was bleeding from left leg, had fever, pain and had warmth on her leg. She has been treated accordingly, wound, pain and infection treatment has been given and she responded well. Today she is aware, alert and her vital signs are in normal range.

On 16th August, Mrs Brown was admitted with the aforementioned condition. She was bleeding from left leg, had fever, pain and had warmth on her leg. She has been treated accordingly. Wound, pain and infection treatment has been given and she **has** responded well. Today, she is aware, alert and her vital signs are in normal range.

Okay some corrections but good overall

| | |
|--------------------|---|
| Introduction | arding Mrs Brown, who was admitted to our hospital due to an infected venous ulcer on her left leg. She is scheduled to be discharge today and now requires ongoing care and monitoring. |
| Timeline (context) | Having developed a discoloured and swollen wound on her left leg, Mrs Brown was admitted to our hospital on 16th August, resulting in her being diagnosed with the aforementioned condition. After being treated accordingly with effective wound, pain and infection management, she has responded well to the treatment. Although she was confused on admission, she is alert and aware at present and has made good progress. |
| Background | <p>Social background:</p> <ul style="list-style-type: none"> Has lived in self-contained unit in retirement village for 7 years Not supported by any care workers Daughter lives nearby with husband and 3 children. Very supportive - visits regularly Active - does Pilates <p>Past medical history:</p> <ul style="list-style-type: none"> Hypercholesterolemia (8.9) Hypertension <p>You will write your own:</p> <p>alain@set-english.com</p> |
| Requests | <p>Purpose: <u>wound management</u> (general)</p> <p>Details:</p> <p>Discharge plan: Discharge to self-contained unit with compression stockings Weight loss advised, review of diet (dietitian?) – reduce ulcer reoccurrence Pt. to take paracetamol p.r.n.(no more than 8/day, discontinue after 1 week), continue Oxacillin IM, 300 mg, every 4-6 hrs. Pt. informed of importance of compression stockings, and bed rest, with leg elevation. Dressings (daily): cadomexer iodine, triamcinolone ointment (topical steroid) – reduce irritation, bandaging. Community nurse to change dressings daily, monitor for infection/healing rate, help with ADLs (activities of daily living) & refer to OT if needed. Also monitor medication compliance. Progress review: 25.08.2019 at Community Clinic</p> <p>Most of this</p> |