1 Planning
2 Read some case notes
3 Make a plan

OET Writing

Reading time: 5 mins at the start (no pens) Writing time: 40 mins	Better way: **10 mins reading and planning** 30 mins to write the letter 5 mins checking your work

10 Mins: Read Case Notes....

Steps in Planning

1. UNDERSTAND	2. CHOOSE	2. ORGANISE
Understand the situation... 1 Reader? Task? 2 Known? 3 Writer? Tasks? 4 Urgent? 5 Where is everyone? 6 Why am I writing today?	How do I choose **relevant** case notes? 1. **Needed:** must put in everything (Directly connected) 2. **Appropriate:** helpful, useful, might be a good thing.... (Not directly connected) You do not have to put everything...	Paragraphs: Introduction Requests: talk about the TASKS

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 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 (Oxacilin)
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

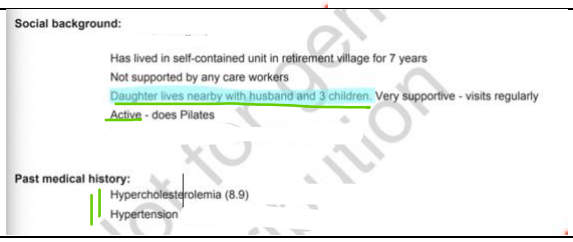
Writing Task:

Using the information given in the case notes, write a referral letter to Ms Fiona McKie, Community Health Nurse, 101 Collins St, Elmesmere, 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: wound management Write Introduction: alain@set-english.com
Timeline	16th August: • Symptoms: give some details • Treatment: "she was treated accordingly" • Mention *weight* 18th August: Good progress - vital signs within normal range Pt alert & aware
Background	 **Social background:** 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 **Past medical history:** Hypercholesterolemia (8.9) Hypertension
Requests	Purpose: wound management (general) **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 Most of this