OET Nursing Writing Week

Martha Brown

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*

Paragraph Functions

Introduction	• patient name • general medical context • general request/purpose
Timeline	• Say what happened from the beginning of this medical context • Go towards the present
Timeline - Current	• How the patient is now
Background - medical	• Unrelated but possibly useful information regarding health/medication
Background – social	• General lifestyle: Drinking/smoking, living situation, work etc
Request	• Specific detail about what we want - actions to continue care

Any other type: You choose – do you want another paragraph for a specific issue?

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Identifying Purpose & Choosing Case Notes:

Ask yourself these questions about Martha Brown case notes:

1. **Who am I writing to?**	Community nurse
2. **What is the reader's task?**	provide follow up care:
3. **Do they know the patient?**	No
4. **Does the writer have any tasks?**	appointment booked – 30th November
5. **Why am I writing today?**	Patient is ready for discharge
6. **Is it urgent?**	No

https://drive.google.com/file/d/1_-nN-B9VCyajUAGnYVKRJHVq7dblrY_-/view?usp=sharing

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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 20 October 2019.

You are a nurse in a hospital emergency department where you have been treating an elderly patient.

PATIENT DETAILS:

Name:	Mrs Martha Brown
DOB:	23 September 1941 (78 y.o.)
Address:	98 Huntingdon Close, Lamington
Social background:	Retired social worker Lives alone Husband died 10 yrs ago Primary caregiver = 40 y.o. daughter Stephanie (away on 6-wk vacation since 15 October 2019) Interests: knitting, playing cards w friend, TV
Past medical history:	2004: Rheumatoid arthritis (RA) 2016: R lateral malleolus fracture after fall 2018: Diag. diabetes mellitus – HbA1c 6.5% (Metformin 500mg 2x/day) 2018: Smith's fracture (L hand) after fall June 2019: ↑HbA1c (>7.5%), Metformin ↑ to 500mg 3x/day

<u>Admission to Emergency Dept. (ED)</u>:
20 October 2019

Presenting factors:	4 puncture wounds on R hand, inc. deep wound near thenar muscles (2mm depth approx.) after dog bite (brought to ED by neighbour) Unable to move hand – pain 6/10 Low-grade fever (37.3°C) – pt reported 3-day duration
Tests:	• FBCs, U&Es, X-ray (R hand) – NAD (no abnormalities detected) • Urinalysis – positive to protein, leucocytes & nitrites; some pain on micturition, UTI evident • Blood sugar (post-prandial) = 9.7mmols

Nursing management:

- Wound cleaned w saline & iodine dressing applied, covered w padding & bandaging
- Tetanus prophylaxis
- Analgesia – paracetamol 1g 4x/day (to continue prn)
- Co-amoxiclav commenced 500mgs 3x/day for 7 days (UTI & wounds)

Assessment:

Pt. stablilised, ready for discharge

Pain ↓slightly (4/10)

Limited movement of L thumb, index, middle finger (cause = pain)

BP: 120/79, Pulse: 84 BPM, Temp: 37.2°C (normal)

Discharge plan:

Pt. agreed to ↑fluid intake (usual intake: 2 glasses/day)

Refer to community nurse:

- Provide wound & dressing care (change 2–3x/wk x 14 days w iodine-based dressing, padding & bandaging)
- Monitor UTI symptoms
- Encourage/monitor ↑fluid intake (>8 glasses/day)
- Monitor progress & report any problems to family doctor (daughter away)

Note: Pt's follow-up appt. w family doctor = 30 November

Plan:

Write to community nurse

Writing Task:

Using the information in the case notes, write a discharge letter to Ms Smith, the community nurse, summarising the patient's hospital treatment and outlining her ongoing care needs. Address your letter to Ms Naomi Smith, Community Nurse, Community Nursing Centre, Lamington.

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.

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Paragraph Plan

Make a paragraph plan using the planning and discussions in class, using any of the below paragraph functions:

Letter Plan

<table>
<tr><td>Introduction</td><td>Patient:
General Medical Context:
General Request:</td></tr>
<tr><td>Presentation & management</td><td>Admission to Emergency Dept. (ED):
20 October 2019
Presenting factors: 4 puncture wounds on R hand, inc. deep wound near thenar muscles (2mm depth approx.) after dog bite (brought to ED by neighbour)
Unable to move hand – pain 6/10
Low-grade fever (37.3°C) – ~~pt reported 3-day duration~~
Tests:
• FBCs, U&Es, X-ray (R hand) – NAD (no abnormalities detected)
• Urinalysis – positive to protein, leucocytes & nitrites; some pain on micturition, UTI evident
• ~~Blood sugar (post-prandial) – 9.7mmols~~
Nursing management:
• Wound cleaned w saline & iodine dressing applied, covered w padding & bandaging
• Tetanus prophylaxis
• ~~Analgesia~~ paracetamol ~~1g 4x/day~~ (to continue prn)
• Co-amoxiclav commenced 500mgs 3x/day for 7 days (~~UTI & wounds~~)
summarise</td></tr>
<tr><td></td><td>Assessment:
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Limited movement of L thumb, index, middle finger (cause = pain)
BP: 120/79, Pulse: 84 BPM, Temp: 37.2°C (normal)
summarise</td></tr>
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Lives alone
~~Husband died 10 yrs ago~~
Primary caregiver = ~~40 y.o.~~ daughter Stephanie (away on 6-wk vacation ~~since 15 October 2019~~)
~~Interests: knitting, playing cards w friend, TV~~
~~2004: Rheumatoid arthritis~~ (RA)
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summarise</td></tr>
<tr><td>Request</td><td>Pt. agreed to ↑fluid intake (usual intake: 2 glasses/day)
~~Refer to community nurse:~~
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• Monitor UTI symptoms
• Encourage/monitor ↑fluid intake (>8 glasses/day)
• Monitor progress & report any problems to family doctor (~~daughter away~~)
Note: Pt's follow-up appt. w family doctor = 30 November</td></tr>
</table>

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Homework:

Write introduction and send through to paul@set-english.com