SET English

OET Nursing Writing Week

Lisa Simmonds

The task is: *Write a letter to a healthcare professional requesting **continuation of care** 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** *= Perfect circumstances in which to write a letter*

General Paragraph Purposes

Introduction	• patient name • general medical context • general request • (urgency)
Timeline 1	• beginning of this medical context – up to the present
Timeline 2 / Current	• focusing on the present situation
Background – Medical	• Family history / unrelated yet relevant medical history of patient / BMI
Background - Social	• Lifestyle / living situation/ stress / job
Request	• expand on the request – discharge plan / follow up care

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Identifying Purpose & Choosing Case Notes:

Ask yourself these questions about Lisa Simmonds case notes:

1. Who is the reader?	Charge nurse Gastroenterology Dept
2. What is the reader's task?	Continue the pre-operative treatment
3. Does the reader know the patient?	No
4. Does the writer have any tasks?	No
5. Why am I writing today?	She is ready for her op after acute care
6. Is it urgent?	No

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

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Test 5 Writing (45 minutes)

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 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

<u>Emergency Dept (ED) Admission: 21 May 2017</u>

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 → protective behaviour (guarding)
Tests:	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)

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Urinalysis: normal
CRP (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.

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Letter Plan

Intro	• Patient Name: • General Medical Context: • General Request:
Initial presentation & Diagnosis	**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 → protective behaviour (guarding) **Tests**: 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) Urinalysis: normal CRP (C-reactive protein): elevated (infection present) Full blood count: elevated WBCs (13,000 µL) **Diagnosis:** Acute cholecystitis (→ laparoscopic cholecystectomy)
Treatment	**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)
Request	**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

Homework: Write introductions: send to paul@set-english.com