GURLEEN KHAIRA

OET WRITING STRATEGY GUIDE

EVERYTHING YOU NEED TO KNOW
ABOUT THE REVISED ASSESSMENT CRITERIA

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Dedicated to my beloved parents,
Parmjit Singh Khaira
and
Surinder Khaira.

Contents

Introduction

Revised Assessment Criteria

Lesson 1: Assessment Criteria

Exam Strategy

Lesson 2

The Writing Process

Lesson 3: The Writing Process

Organisation of Ideas

Lesson 4: Organisation of Ideas

Practice Makes Perfect

Lesson 5: Practice Test

Lesson 6: Practice Test

Lesson 7: Practice Test

Lesson 8: Practice Test

Lesson 9: Practice Test

Lesson 10: Practice Test

Mistakes to Avoid

Lesson 11: Common Mistakes

Introduction

At the outset, I' like to congratulate you on deciding to take the OET; this is the first step towards your dream journey. You've also made a positive step by picking up this book.

The Writing test is a daunting aspect for many candidates, but it does not have to be. This book will guide you through the stages of writing and approaching the task confidently. The first chapter sets out all you need to know about maximizing your score on each criterion as well as choosing a correct layout for your letter. The following chapters contain practice tests with a diverse range of tasks, along with guidance on how the writing process can be broken down into different stages that make your job easier. Several high-quality sample letters have been included with each task to help you understand what is expected from you. Although each task is unique and requires a different response, a basic understanding of the tone, style, and, sometimes, organization styles in the samples can help you approach the task confidently, with less effort. Within each unit, I've tried to include short exercises that help not just in the acquisition of good letter-writing skills but make your learning journey more enjoyable.

Developing good writing skills for passing the OET is not a matter of good luck; it takes hard work and consistent practice. Remember to revise the rules of grammar as, without it, your sentences and paragraphs will come crashing down.

I look forward to your suggestions and feedback regarding the book.

Gurleen Khaira

Revised Assessment Criteria

Lesson 1: Assessment Criteria

1. PURPOSE

(3 MARKS)

Be clear about why you are writing the letter and include this in the introduction so it can be read and understood immediately and acted upon without delay. The language should be plain and simple and should clearly indicate the action your letter requests.

TIPS

- Read the writing task and the case notes carefully to understand why you are writing the letter.
- Think about the patient's situation: Is it urgent? Does this need to be highlighted in the introduction?
- Provide a rationale to justify the action you are requesting. For example, if you are requesting assessment of a patient, include a reason for why it is needed.

Exercise 1

Mr. Singh has been patient at the clinic where you work as a head nurse. Below is a snippet of his patient information record.

Patient Name: Mr. Rajbir Singh DOB: 27.05.1989	
22.30	Mr. Singh c/o of feeling

hours	tired, reduced vision. BP 120/80 P 80 • Random Glucose: 230 mg/dl • Fasting Glucose: 135 mg/dl **Preliminary Diagnosis:** Results indicate diabetes mellitus (DM) Type 2
Treatment	Refer to endocrinologist for assessment and treatment plan

Answer the following questions.

1. Who is the patient? _____
2. What is the purpose of writing the letter? _____
3. Why does the patient need this referral? _____

Answers

1. *Mr. Singh*
2. *to request assessment and further management plan*
3. *presenting with signs and symptoms consistent with DM type-2*

Exercise 2

Now, transform these answers to complete sentences to write an introductory paragraph that states the purpose of writing

the letter clearly.

Suggested Answers

I am writing to request assessment and further management of Mr. Singh who is presenting with signs and symptoms indicative of DM type-2.

Or

The purpose of this letter is to request assessment and further treatment of Mr. Singh, who is demonstrating signs and symptoms consistent with diabetes mellitus type 2.

2. CONTENT

(7 MARKS)

Selecting relevant information from the case notes to support the purpose of your letter is the cornerstone of writing an effective letter. The credibility of your response hinges on the accuracy and completeness with regard to the key information.

Answer this **guiding question** when selecting information from the case notes.

What information does the recipient need to complete the action that you are requesting?

TIPS

- Read the case notes carefully and ensure that you include all details necessary for the recipient to act on your request. Remember the golden rule: the data must be selected keeping the recipient and the purpose of the letter in mind.
- Stay on track and proofread the letter to ensure that you have provided the recipient with enough information to encourage the desired action.
- Never add your own interpretation to the case notes. Your letter will never be effective if the accuracy is ignored. Always rely on the information in the case notes and ensure that the accuracy of meaning is not compromised when you paraphrase or summarise the case notes.

3. CONCISENESS AND CLARITY

(7 MARKS)

TIPS

- Exclude any details that are not relevant to the action you are requesting, no matter how interesting they seem as they will only distract the recipient.
- Brevity is the soul of the wit, said William Shakespeare. I'll say modify this slightly and say, Brevity is the soul of your letter. To put it simply, write in a simple and direct way; it does mean that your writing needs to be simplistic but sharing the information with as much clarity, simplicity, and purpose as possible. You must ensure that the information you put across is unambiguous and will not be misinterpreted or misunderstood in any way.

Exercise 3

Match each wordy phrase with its m
concise alternative.

1. as a result	although
2. has the ability to	consequently
3. on a regular basis	regularly
4. for the reason	regarding
5. owing to the fact	therefore
6. at the present time	to
7. in addition to this	presently
8. In order to	additionally
9. in respect to	can
10. in spite of the fact that	because

Answers

1. consequently
2. can
3. regularly
4. therefore
5. because
6. presently
7. additionally
8. to
9. regarding
10. although

- Consider the recipient and read the letter, constantly asking yourself whether all statements are relevant keeping

in mind the intent of the letter. Explain the relevant information in the most efficient way possible so as to initiate the desired action. Think about which details can be mentioned briefly and which points require extensive explanation. Remember, it is your duty to communicate effectively, and the information should be selected, omitted, summarised, or paraphrased in detail, keeping in mind the needs of the reader.

- Consider what the reader already knows, and how much more do they need to know?
- Give the reader clear reasons for why the patient needs their assistance. The paragraphs following the introduction should make a clear statement about what the patient's current needs are and how the recipient can address those needs. Always plan the letter keeping the recipient in mind so that you do not inadvertently include unnecessary information or in the wrong order.

How to Make Your Writing More Interesting for the Reader?

To ensure that the letter is engaging, you should avoid verbosity, which means using excess words to convey the same meaning. By using fewer words, you would be able to express ideas more clearly and make it easy for the recipient to understand them. Another common mistake is redundancy, which occurs when words with the same meaning are placed together.

INCORRECT: She has been a patient of obesity since childhood. (verbosity)

CORRECT: She has been obese since childhood.

INCORRECT: Her past medical history is significant for… (redundancy)

CORRECT: Her medical history is significant for ……

Explanation: History means record of the past

Write as concisely as you can and use linking words to make your letter easier to read. Utilising these tools will have a positive impact on your reader.

Look at the following two excerpts:

She first presented on 07/02/2018. The patient complained of frequent symptoms of productive cough	*During her initial visit on 07/02/2018, she presented with a 3-day history of productive cough,*

that began 3 days ago. The productive cough was also accompanied by fatigue and fever. The physical examination was done in which her vitals were recorded as remarkable. Scattered rhonchi were heard over lung field. All of the symptoms were consistent with a case of acute bronchitis. Amoxicillin 500mg t.d.s. was given and she was asked to come back after two days for review.	*fever, and fatigue. The examination that day revealed scattered rhonchi over lung field based on which an assessment of acute bronchitis was made; therefore, she was prescribed Amoxicillin 500mg t.d.s. and advised to return for a review after two days.*

Excerpt 2 is more interesting – can you work out why?

Here are some possible reasons, but maybe you can come up with some more too!

- Varied use of punctuation and sentence structure
- Use of linking words
- No redundant words
- No verbose

4. ORGANISATION AND LAYOUT

(7 MARKS)

TIPS

Poor organisation stems from lack of planning. Always plan before you begin to write. When you have selected the relevant information, spend a few minutes to organise them in the order best suited for the recipient.

- Prepare a rough outline of the points, in the order you want to present them. When you decide on a sequence, this may be different to the order of information in the case notes. That's okay. The goal of planning an outline is to present your ideas in a logical order and make the transition between them smooth for the reader. In other words, sort out your relevant information into easy-to-handle units or parts which can get your point across in a clearer fashion.
- Divide the relevant information into different categories and regroup ideas to fit into these categories. Each paragraph should focus on a specific aspect related to the purpose of writing; too many different ideas in a single paragraph can confuse the reader; likewise, related ideas put at different places in a letter can confuse the reader.

- State what you want the reader to do, provide all supporting details, and finish this point before moving on to the next one. At the end of each paragraph, ask yourself what you intended to say and whether it conveys the meaning. **TIP:** It helps if you can read your letter out loud; your ears sometimes detect the errors that the eyes miss.
- Do not rely on templates as each set of case notes and the accompanying task presents a unique scenario. There are, however, different organisational schemes like chronological, problem-solution, or hierarchical that can help you plan your letters effectively. Keeping the purpose of the letter in mind, you may rely on any of these organisational styles if it fits the information relevant for the reader. In case the relevant information may fit into more than one kind of structure, the important thing to consider is this: which order of information would be most clear for the reader?

Chronological: presenting the events in the order in which they happened (begins with "when it started" and ends with "today's findings/latest development" followed by the call to action.
Problem-solution: Each paragraph deals with a distinct idea or point. Each paragraph beings with "here's what the patient's needs are" and ends with "this is what needs to be done."
Hierarchical: You present the facts or information in order of decreasing

importance. In other words, the most important information is presented first followed by less important ideas.

Exercise 4

Organise the following sections/paragraphs in an efficient way for writing a letter to a gynaecologist. The patient is presenting with signs and symptoms consistent with ectopic pregnancy and is being referred for assessment of her condition.

- Brief outline of the patient's medical history (previous pregnancies, medications, relationship history)
- Details about patient's current complaints and examination findings from today's visit
- Stating the purpose for writing the letter
- Summary of the patient's recent visits (when the symptoms began and subsequent management and progress)
- Call to action – Requesting the doctor to examine and treat the patient

If you were the recipient, in what order what you want to receive the information?

1. _____
2. _____
3. _____
4. _____
5. _____

Suggested Answer

1. Stating the purpose for writing the letter
2. Summary of the patient's recent visits (when the symptoms began and subsequent management and progress)
3. Details about patient's current complaints and examination findings from today's visit
4. Brief outline of the patient's medical history (previous pregnancies, medications, relationship history)
5. Call to action – Requesting the doctor to examine and treat the patient

- Use an appropriate layout that makes your letter presentable and attractive. Margins should be flush left which means that the first letters of each line are vertically aligned to the left side or margin of the page.
- There is no standard format that is recommended but as a general rule, you may incorporate the following entities when writing a formal letter:

➢ **Date:** This is the date of writing of the letter. Your case notes are designed in a way that the date of referral/transfer/discharge will be the same as the date of discharge.

What is the format of writing the date?

There are different ways the date can be written. One way is DD/MM/YYY. Another way is Date (numerical) Name of the month (spelled out), year (YYYY).

For example, 25/09/2019 and 25 September, 2019 are both acceptable ways of writing date.

If you have to mention a date in the body of the letter, it is advisable to use the DD/MM/YYYY format.

➢ **Name and Address of the Recipient**

Write the recipient's name, job title, and address under the date. Remember to leave a line between the date and the name and address of the recipient. Ensure that you use correct salutation before the recipient's name. Start with the recipient's name followed by the job title in the next line. The address details can be put below the job title.

- **Reference/Subject Line**

Health professionals handle a large volume of correspondence, so stating the patient's name and date of birth in the reference line will help the recipient in quickly identifying whom the letter is about.

Place the reference one-line space apart below the address. It can be written as

Re: Mr./Ms. (Patient's full name); DOB:DD/MM/YYYY

Or

RE: Mr./Ms. (Patient's name); DOB: DD/MM/YYYY

If the DOB is not mentioned, use the Patient's age.

- **Greeting**

The greeting begins with standard "Dear (Mr./Ms./Dr. last name of the recipient). If the recipient's name is not mentioned, you can use "Dear Sir/Madam." Put the greeting under the reference and one-line space apart.

Body of the Letter

Your letter will begin by introducing the reader to the purpose of writing the letter. The remaining paragraphs should deal with the relevant information that the recipient needs to carry out the desired action. As stated earlier, each paragraph should be anchored by its own theme or main idea. The introduction should be separated from the greeting with a one-line gap and the subsequent paragraphs should commence with a one-line gap from

each other.

There is no standard paragraph length nor a minimum or a maximum number of paragraphs. Your paragraphs should have a logical sequence of ideas that are suitable for the recipient. The final words in your letter can be used to reinforce the purpose of your letter and express thanks for their assistance in the matter. You might also conclude by inviting the recipient to get in touch with you in case they need any clarification.

These are good examples that can be used as closing statements.

- *Should you have any further queries, please do not to hesitate to contact me.*
- *Please do not hesitate to contact me if you have any questions.*
- *Thanks for agreeing to assist in this matter.*

➢ **Complimentary close**

Use *"Yours sincerely"* when you know the recipient's name, and use *"Yours faithfully"* when you the recipient's name is not known.

5. GENRE AND STYLE

(7 MARKS)

TIPS

- Write to the recipient's perceived level of understanding. In other words, use language that that the reader will be able to understand. A common misconception is that medical abbreviations or acronyms should be avoided; this generalisation is not true. The tone and content should be compatible with the profession of the reader. For example, it would not be appropriate to use any medical words when writing to a social worker or a family member as they are not health professionals. Similarly, using simplified explanations of medical terms or abbreviations when writing to a specialist in a field would not be wise. The decision of whether to use medical abbreviations or acronyms will be determined by the recipient. When in

doubt, ask yourself**, *"Who is my reader? Would she be familiar with this abbreviation? Is the reader an expert in the subject, or will I have to simplify some medical terms or concepts?"***

- Remember to use only those abbreviations or acronyms that are globally accepted. Abbreviations which are more common than the full form can be used e.g. MRI, ECG. Avoid in-house jargon or local or regional expressions as this can lead to a misunderstanding.
- It is important to note that abbreviations are associated with informal writing, and too many abbreviations will reduce the formal appearance of your letter. It is also not advisable to use abbreviations as a means of controlling word count.
- It is a formal letter, so ensure that your letter is professional and courteous. Respectful and polite words leave a good impression on the reader.
- Learn about the features of formal English and use language to create an appropriate formal tone that has a positive impact on the recipient.

Some do's and don'ts are mentioned below:

Dos	**Don'ts**
Use the formal equivalent of a word rather than its informal version or idiomatic language. Compare the following	Do not use contractions. For example, instead of 'don't' write 'do not.'

two examples and decide which would be more appropriate for a formal letter. Example 1: I thought I'd write to you about… Example 2: I am writing regarding… (Suggested answer: Example 2)	
Use passive instead of active voice to emphasize the action.	Do not use slang words in your letter.

Exercise 5

Transform the informal or semi-formal version of the following sentences to a formal style.

1. Thanks for your reply.
2. Hello there!
3. I'm writing to let you know how you can care for Nancy at home after her discharge.
4. I'd like to ask for some help for Ms. Kumar, who had coronary bypass surgery in our hospital. She is getting better and is getting discharged today.

5. Make sure that the patient is compliant with his physiotherapy.
6. Can you oversee his medications?
7. Please look after this patient from now on.
8. Feel free to contact me for any information.

Suggested Answers

1. Thank you for agreeing to assist in this matter.
2. Dear Mr./Ms./Dr. ……. (last name) …… OR Dear Sir/Madam
3. I am writing regarding Nancy's future care requirements following her discharge.
4. I am writing to request follow-up care for Ms. Kumar, who is recovering from coronary bypass surgery and is being discharged from our facility today.
5. Kindly ensure the patient's adherence to the recommended physiotherapy regime.
6. Please ensure the patient's compliance with the prescribed medications.
7. It would be greatly appreciated if you could take over the management of this patient from this point on.
8. Should you require more information, please do not hesitate to contact me.

6. LANGUAGE

(7 MARKS)

- Albert Einstein said, **"The definition of genius is taking the complex and making it simple."** Even renowned American poet Walt Whitman shares his viewpoint, "**Simplicity is the glory of expression**." Make your writing simple and direct. However, please keep in mind that it does not mean simplistic and short. Choose specific

and concrete words rather than vague or abstract words. Consider which type of sentence or structure would be appropriate to deliver your message simply and effectively. Be precise and efficient: choose fewer words that convey maximum meaning. Write to express, not to impress.

- Many students believe that relying on complexity or wordy phrases is a smart scoring approach; however, doing so is going to obstruct your communication process rather than expedite it. Make your letter less time-consuming for the reader by writing in the fewest possible words that convey maximum meaning.
- Use correct spellings. Do keep in mind that two spelling systems can be followed: American and British. I will not advise you to choose one over the other, but will give this advice: be consistent. Whether you use American or British spellings, choose one form and use the same throughout your letter. For example, if you write, “anaemia” (American) ensure you use the same spellings in your letter when using this word again. Similarly, if you use the UK-spelling variant, “anemia,” use the same spellings throughout the letter. Do not use a mix of UK and US spelling variants in the letter.
- Use correct punctuation to aid the reader’s clarity. Master the usage of different punctuation symbols, like a comma, semi-colon, period, colon, a hyphen, apostrophe, etc., used in formal writing.
- Invest time in improving your grammar proficiency. That said, do not complicate things by trying to use complex grammatical structures which leads to unnatural sentences with little or no meaning! As a result, the reader finds it challenging to understand your message, and that is where the problem begins. Learn about the practical use of grammar, and whenever in doubt, ask yourself this question: what am I trying to convey?

- A minor, carless mistake can distract your reader and also undermine your credibility. Prepare yourself to finish the letter with a few minutes to spare for proofreading your letter. Once you've written the letter, double check for accuracy of spellings, capitalisation, and punctuation rigorously. Do not overlook the importance of this 'final examination' that can help you avoid an embarrassing error.

Language Focus: Adjectives

Adjectives are words that are used to describe nouns, giving them depth and interest. You should use a range of adjectives to add detail and to make your writing more precise and concise.

For example, if the noun is **pain**, a patient may use any of the following adjectives to describe it: burning, dull, throbbing, excruciating, worsening, stabbing, pounding, tingling, sharp.

Let's look at another example.

The patient eats a diet that comprises of mainly fatty foods.

This can be re-written as:

The patient consumes a fat-rich diet.

In the above sentence, two words 'fat' and 'rich' are two words acting as a single unit to describe the noun 'diet.' Here, I'd like to discuss rule number 1: When two or more words act as an adjective before a noun, they are hyphenated. They are also called compound adjectives.

A few more examples that may be useful for your writing are mentioned below.

The patient has been advised a low-fat diet.

I am writing to refer Ms. Jones, a 45-year-old woman, for follow-up care and management.

Let's now look at rule number 2: If you are using two adjectives before a noun, and they are interchangeable, use a comma to separate them.

For example

The patient is a strong, healthy man.

This could also be rewritten as – The patient is a healthy, strong man.

If the order cannot be switched, then the adjectives are not separated by a comma.

Rule number 3 is about the order of adjectives. When you have more than one adjective modifying a noun, there's a certain pattern in which the adjectives will usually occur in the sentence.

Let's take the example of noun 'pain.' Here is the order in which the adjectives modifying the noun 'pain' will be placed.

1. Severity of pain
2. Origin of pain
3. Type of pain

Look at the following dialogue between a patient and a nurse.

Nurse: So, I understand you've been suffering from headaches. Can you tell me Where you feel the pain during your headaches?

Patient: It's mainly in the left side of my head.

Nurse: Okay! And could you also tell me what does the pain feel like?

Patient: It's a throbbing pain.

Nurse: Hmm. On a scale of 1–10, how would you rate your

pain on a scale of 1–10, where 0 is no pain and 10 is the worst pain you've ever experienced.

Patient: Oh, it's quite severe, so I would rate it at 8.

Nurse: Oh, that must be difficult!

Exercise 6

Complete the following sentence with adjectives in the correct order.

The patient presented with a complaint of _____ headaches.

Suggested Answer

The patient presented with a complaint of severe right-sided throbbing headaches.

Exercise 7

Use a hyphen to punctuate compound words that work together as adjective to modify a noun.

1. Mr. Jones neds to be scheduled for a follow up appointment.
2. The patient developed a bluish black bruise around the wound.
3. The doctor gave the child's parents a patient information leaflet.
4. I am referring the above captioned patient to you for further assessment and further treatment.
5. The patient has been commenced on a high intensity exercise program to promote weight loss.

Answers

1. Mr. Jones neds to be scheduled for a follow-up appointment.
2. The patient developed a bluish-black bruise around the wound.
3. The doctor gave the child's parents a patient-information leaflet.
4. I am referring the above-captioned patient to you for further assessment and further treatment.
5. The patient has been commenced on a high-intensity exercise program to promote weight loss.

Exercise 8

Change each phrase into a compound adjective.

1. pain in the left side of the leg

   _____

2. diet low in salt

   _____

Answer

1. left-sided leg pain
2. low-salt diet

Rule 4: If the first word in a compound adjective is an adverb (ending in -ly) or very, do not add a hyphen between the words in that case.

For example,

The patient has had poorly controlled hypertension for 2 years.

Ms. Conrad is an internationally renowned psychiatrist.

Exam Strategy

Lesson 2

WRITING SUB-TEST: NURSING

Time Allowed: Reading Time: **5 Minutes**

Writing Time: **40 Minutes**

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

CASE NOTES:

Mrs. Anita Ramamurthy, a 59-year-old woman, is a patient in the (IPD) In-patient-department of a hospital in which you are charge nurse.

Hospital: Sydney Women's Hospital

Patient Details

Marital Status:	Married
Height:	5′4″
Weight:	87 kg
BMI:	33 –Obese
Address for Correspondence:	#648, Bourke Street, Sydney
Admitted:	18/06/2017

Date of Discharge:	23/06/2017
Diagnosis:	Acute appendicitis with Appendicular lump
Treatment:	Conservative management with IV antibiotics (Planned for interval appendectomy in 6 wks)
Social Background:	Businesswoman (Education Consultant) – Hectic life, travels a lot due to work Lives with her husband, Mr. Krishnan Ramamurthy Two daughters both married. Elder daughter stays in India, works as an Entrepreneur; younger daughter in Canada, works as a dentist Husband is the primary caregiver, elder daughter visits with husband once a year, Scared of hospitalization,

	prone to anxiety related to this Fond of eating out, rarely cooks at home, sedentary lifestyle, complains of no time to exercise due to work, does not drink or smoke
Diet:	Whole Milk, Ice-cream shakes, Fruit drinks, Doughnuts, Pancakes, Waffles, Pizzas, Cheeseburgers, Biscuits, muffins, Cajun Fries, Hash brown
Medical Background:	Known case of Essential Hypertension (2014) and Diabetes Mellitus type-2 (2010) (not compliant with diabetic medication)
Admission Diagnosis:	Complaints of pain in abdomen in right iliac fossa since 17/06/2017 Pain was sudden in onset, acute in nature and was

	non-Radiating, fever (documented up to 101-degree F), aversion to food, evaluated outside where USG Abdomen revealed acute appendicitis admitted for further evaluation and management
Physical Examination:	Conscious, oriented, No pallor, no icterus, No Clubbing, No Lymphadenopathy, no pedal oedema BP: 126/84, Temp-afebrile, Pulse – 72/min, RR – 22/min SP O2 98%, CNS-NAD, Chest – Bilateral entry equal, No added sounds

Nursing Management and Progress:

18/06/2017 – Abdomen CT (plain) 18/06/2017 – acute appendicitis with hypodense area in the region of base of appendix at its attachment with caecum? Phlegmonous collection. Possibility of sealed perforation cannot be ruled out; total leucocyte count – 21,000/cumm

I/V Fluids, broad spectrum antibiotics (Imipenem), PPI,

Analgesics, antipyretics, other supportive treatment (6/6), Regular Blood Sugar Monitoring (6/6)

19/06/2017 – TLC – 18,000/cumm; complaints of considerable pain in abdomen, headache, sips of water, extremely distressed, constipation, unable to pass gas

20/06/2017 – TLC – 14,000/cumm; complaints of insomnia, headache, tenderness in abdomen, weakness, tolerating sips of coconut water and tea

21/06/2017 – TLC – 11,000/cumm; tolerating soft diet, can ambulate with assistance, complained of weakness, Rev. Dietician re diabetic diet

22/06/2017 – TLC – 8,000/cumm, able to ambulate slowly, independent with ADL's

23/06/2017 Pt. stable, accepting orally well, adequate urine output, TLC showing improving trend, Pt. stable, Rev. Endocrinologist – regular chart BSL, INJ Human Mixtard Subcutaneously bd (12 hrly) 8 units (1 wk.) AC Breakfast and 6 units AC dinner

Assessment: Pt. stable with plan for interval appendectomy (6 wks)

Medications: TAB Dolo (Paracetamol) 650 mg, t.i.d. (8 hrly) for 3 days then PRN

TAB Pantocid (Pantoprazole) 40mg mane for 10 days

Tab Tenorid 25 mg (Atenolol) mane

	Tab Supradyn (multivitamin) mane, Tab Farobact 200 b.d.
Discharge Plan:	Avoid strenuous activities/Travel
	Advised to lose weight (exercise program to start after appendectomy)
	Normal Diabetic diet and low-fat diet – Pt. requests more information, esp. simple recipes that can be easily prepared at home Monitoring of fasting and postprandial blood sugars (present chart during Follow-up consultation)
	Follow up in OPD on 30/06/2017 at 3p.m.
	Husband advised to contact us immediately in case of persistent high-grade fever/pain at 03492250
	Pt. concerned re monitoring of blood glucose levels and insulin
	Injections-Husband requests

home visit for demonstration

WRITING TASK 1

STEP 1

During the first five minutes of the writing sub-test, you will not be allowed to write anything. Use this time to read the case notes carefully.

As you read the case notes, mentally answer the following questions:

- Who is the intended recipient?
- What is the purpose writing this letter? In other words, what do you want the intended recipient to do?
- What does the recipient need to know in order to fulfil the purpose of the letter or to perform what you are requesting?
- What information would be considered irrelevant or unnecessary for the recipient?

Now, answer these four questions for the following three tasks

Task 1

Using the information given in the case notes, write a referral letter to Ms. Prabha, Shrishti Nursing Home Care Agency, Sydney, requesting a home visit following Mrs Ramamurthy's discharge.

Who is the intended recipient?

What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

What does the recipient need to know in order to fulfil the purpose of the letter or to perform what you are requesting?

What information would be considered irrelevant or unnecessary for the recipient?

Task 2

The patient has requested advice on simple recipes for low-fat diabetic diet. Using the information given in the case notes, write a letter to Ms. April, Dietician, 258, George Street, Sydney on the patient's behalf.

Who is the intended recipient?

What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

What does the recipient need to know in order to fulfil the purpose of the letter or to perform what you are requesting?

What information would be considered irrelevant or unnecessary for the recipient?

Task 3

Using the information provided in the case notes, write a letter detailing the post-discharge care required for the patient to the patient's husband, Mr. Krishnan Ramamurthy, #648, Bourke Street, Sydney.

Who is the intended recipient?

What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

What does the recipient need to know in order to fulfil the purpose of the letter or to perform what you are requesting?

What information would be considered irrelevant or unnecessary for the recipient?

SUGGESTED ANSWERS

Task 1

- Who is the intended recipient?

  Ms. Prabha, Nurse working at Shrishti Home Care Agency

- What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

  To guide the patient regarding self-monitoring glucose levels and self-administering insulin injections

- What does the recipient need to know in order to fulfil the purpose of the letter or to perform what you are requesting?

  Information about patient's diabetes, poor compliance with its management, current diagnosis and further treatment planned, brief summary of patient's diabetes management in hospital, advice by the hospital endocrinologist to chart her blood glucose levels and present them during her follow-up appointment after a week and controlling her blood sugar levels with Insulin Injections, patient's concerns about doing these herself, husband requested a home visit for demonstration

- What information would be considered irrelevant or unnecessary for the recipient?

  Details about her social background, diet, height, weight or BMI, Information about her hypertension, details of presenting complaints and examination on admission, nursing management in hospital, current medications, all tasks outlined in the discharge plan other than the purpose of writing the letter

Task 2

- Who is the intended recipient?

  Ms. April, dietician

- What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

Request information on simple recipes of low-fat, diabetic diet that can be easily prepared at home. Information to be sent to the patient's home address

- What does the recipient need to know in order to fulfil the purpose of the letter or to perform what you are requesting?

Details about patient's diet and medical history of poorly controlled diabetes and hypertension, some information about patient's social situation like BMI, sedentary lifestyle, occupation due to which she has no time to cook, current diagnosis and further treatment planned, medications, brief summary of management in hospital by dietician and endocrinologist, advice to follow a low-fat, diabetic diet to lose weight and control her diabetes

- What information would be considered irrelevant or unnecessary for the recipient?

Details about her presenting complaints, physical examination on admission, nursing management and progress, details of endocrinologist's advice and patient's concerns regarding this, all tasks in the discharge plan than the purpose of writing the letter, other details in the social background, information about follow-up appointment

Task 3

- Who is the intended recipient?

Mr. Krishnan Ramamurthy, patient's husband

- What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

guide him regarding his wife's future care requirements at home following her discharge

today

- What does the recipient need to know in order to fulfil the purpose of the letter or to perform what you are requesting?

  Information about the patient's current condition and further treatment planned in optimistic language, devoid of medical terminology, Detailed guidelines for what to do at home: contact the hospital in case the patient has high-grade or persistent fever or pain, ensure that she avoids travelling or rigorous activities. Inform him about arrangements made by the hospital: arranged a home visit by a nurse to assuage his wife's concerns regarding self-monitoring of glucose levels and self-administering Insulin Injections, dietician requested to send dietary guidelines for low, fat diabetic duet to the home address, reminder about presenting the glucose chart during the follow-up appointment on 30th of June.

- What information would be considered irrelevant or unnecessary for the recipient?

  Details about her presenting complaints, physical examination on admission, nursing management and progress, medical background, social background, current medications

STEP 2

The way you structure your letter i.e. the order of information is very important in OET writing. The second and the following paragraphs should build on the purpose mentioned in the introduction paragraph i.e. the subsequent paragraphs should give information to support the recipient in carrying out the task that you are requesting. To ensure clarity of information for the recipient, the information should be organised into different paragraphs in a logical way that aids the retrieval of information for the reader.

There's more than one way to structure the content of your letter!

There is no standard framework or template that covers different types of letters, and letters structured differently can be equally good and score a pass mark of 350 and above. Whichever structure you use, keep in mind that body of the letter should start with an introduction to the purpose of the letter and expand on the important points at appropriate places in the letter. As stated above, the information should be broken down into manageable sections or paragraphs that make it easier for the recipient to navigate through the document.

SAMPLES FOR TASK 1

1st Sample Letter for Task 1

23/06/2017

Ms. Prabha

Shrishti Nursing Home Care Agency

Sydney

RE: Ms. Anita Ramamurthy; DOB: 05/03/1954

Dear Ms. Prabha

The purpose of this letter is to request a home visit for Mrs. Ramamurthy, a diabetic patient, who needs education on self-monitoring her blood glucose levels and administering insulin injections. She has been recovering from acute appendicitis in our facility since 18/06/2017 and is being discharged home today with a plan for interval appendectomy after six weeks.

Mrs. Ramamurthy has had diabetes since 2010 but has poor adherence to the prescribed medications and a diabetic diet. She has been educated regarding the importance of both to control her diabetes effectively, and the hospital endocrinologist has advised her to chart blood glucose daily and present this chart on her follow-up appointment on 30/06/2017.

She has also been prescribed insulin injections to control her sugar level. Although she is accepting of both, she lacks the confidence to do these independently.

Owing to Mrs. Ramamurthy's concerns, her husband has requested a home visit for demonstration and guidance regarding these procedures. Therefore, it would be greatly appreciated if you could visit her at her house and guide her accordingly.

Should you have any further inquiries, please do not hesitate to contact me.

Yours sincerely

Charge Nurse

2nd Sample Letter for Task 1

23/06/2017

Ms. Prabha

Shrishti Nursing Home Care Agency

Sydney

RE: Ms. Anita Ramamurthy; DOB:05/03/1954

Dear Ms. Prabha

The purpose of this letter is to request a home visit for Mrs. Ramamurthy, a diabetic patient, who needs education on self-monitoring her blood glucose levels and administering insulin injections. She has had diabetes since 2010 but has had poor adherence to its management.

Mrs. Ramamurthy has been recovering from acute appendicitis in our facility since 18/06/2017 and is being discharged home today with a plan for interval appendectomy after six weeks. She has been educated regarding the importance of both to control her diabetes effectively, and the hospital endocrinologist has advised her to chart blood glucose daily and present this chart on her follow-up appointment on 30/06/2017. She has also been prescribed insulin injections to control her sugar level. Although she is accepting of both, she lacks the confidence to do

these independently.

Owing to Mrs. Ramamurthy's concerns, her husband has requested a home visit for demonstration and guidance regarding these procedures. Therefore, it would be greatly appreciated if you could visit her at her house and guide her accordingly.

Should you have any further inquiries, please do not hesitate to contact me.

Yours sincerely

Charge Nurse

3rd Sample Letter for Task 1

23/06/2017

Ms. Prabha

Shrishti Nursing Home Care Agency

Sydney

RE: Ms. Anita Ramamurthy; DOB:05/03/1954

Dear Ms. Prabha

I am writing to request a home visit for Mrs. Ramamurthy, a diabetic patient, who needs education on self-monitoring her blood glucose levels and administering insulin injections. She has had type-2 diabetes since 2010 and has had poor adherence to its management. She was admitted to hospital on 18th of June because of acute appendicitis and is being discharged today with a plan to undergo interval appendectomy six weeks later.

During hospitalization, she has been educated regarding the role of nutrition in effectively controlling her diabetes by the dietician. Additionally, the hospital endocrinologist has advised her to chart blood glucose daily and control her sugar levels with insulin injections, and she has been asked to present her blood glucose chart during her follow-up

visit scheduled on 30/06/2017. Although she is keen to do these, she does not feel that she is competent to do these independently.

Given the above, her husband has requested a home visit for the demonstration of blood glucose monitoring and taking insulin injections at home. It would be greatly appreciated if you could visit her and provide the requisite instructions so that she can perform these procedures herself.

Should you have any further inquiries, please do not hesitate to contact me.

Yours sincerely

Charge Nurse

Below Is A Sample of A Bad Response. Can You Work Out Why?

23/06/2017

Ms. Prabha

Shrishti Nursing Home Care Agency

Sydney

RE: Ms. Anita Ramamurthy; DOB:05/03/1954

Dear Ms. Prabha

I am writing to request a home visit for Mrs. Ramamurthy who was admitted to our facility on 18th of June because of acute appendicitis and is being discharged today. She has been recovering well and will undergo interval appendectomy six weeks later.

In the context of Mrs. Ramamurthy's medical history, she has had hypertension since 2014 and diabetes since 2010. She is poorly complaint with her diabetic medication. Socially, she lives with her husband and has a sedentary lifestyle.

During hospitalisation, she was commenced on conservative management to which she responded well. She is now accepting fluids and was also reviewed by the hospital endocrinologist who has advised her to chart

blood glucose daily and control her sugar levels with insulin injections.

Following her discharge, she has been advised to avoid strenuous exercise and consume a low-fat, diabetic diet. Her husband has been asked to contact us in case of high-grade persistent fever. The endocrinologist has also asked to present her blood glucose chart during her follow-up visit scheduled on 30/06/2017 but the patient is not confident to do these herself; therefore, her husband has requested a home visit for demonstration of these procedures.

Consequently, it would be greatly appreciated if you could visit her and guide her regarding self-monitoring her glucose levels and administering glucose injections. Please do not hesitate to contact me in case of any questions.

Yours sincerely

Charge Nurse

Here are some possible reasons, but maybe you can come up with some more too!

- The purpose is not immediately identified in the introduction.
- Includes a lot of information unnecessary for the reader.
- The key details are found in the middle and near the end

of the letter.

- The order of information is confusing for the reader.

SAMPLES FOR TASK 2

23/06/2017

Ms. April

Dietician

258 George Street

Sydney

RE: Ms. Anita Ramamurthy; 59-year-old businesswoman
#648, Bermuda Street

Sydney

Dear Ms. April

The purpose of this letter is to request information about low-fat, diabetic diet for Ms. Ramamurthy, who is a patient of poorly controlled diabetes and has a significantly high BMI of 33.

Socially, she is a businesswoman, rarely has time to cook, and is fond of eating out. Up until now, she has led a sedentary lifestyle and has consumed a fat-rich diet that mainly consisted of sugary drinks and fast foods like pancakes, cheeseburgers etc. In regards to her medical history, she suffers from hypertension and has recently been diagnosed

with appendicitis for which she was hospitalised on the 18th of June. She is being discharged today with a plan to undergo interval appendectomy six weeks later. Her medication chart is attached to this letter.

During hospitalisation, she has been reviewed by the hospital dietician who has educated on the importance of proper nutrition in the management of her diabetes. She has also been advised to lose weight. Given her busy lifestyle, she has requested healthy, simple recipes of a low-fat, diabetic diet that can be easily prepared at home.

It would be greatly appreciated if you could send the requested information to her home address.

Please contact with any questions.

Yours sincerely

Charge Nurse

23/06/2017

Ms. April

Dietician

258 George Street

Sydney

RE: Ms. Anita Ramamurthy; 59-year-old businesswoman
#648, Bermuda Street

Sydney

Dear Ms. April

I am writing to request low-fat, diabetic dietary guidelines for Ms. Ramamurthy, who is a patient of poorly controlled diabetes and has a remarkable BMI of 33. She was admitted to our hospital on the 18th of June for treatment of appendicitis and is being discharged today with a plan to undergo interval appendectomy six weeks later.

Socially, she is a businesswoman, rarely has time to cook, and is fond of eating out. Up until now, she has led a sedentary lifestyle and has consumed a fat-rich diet that mainly consisted of sugary drinks and fast foods like pancakes, cheeseburgers etc. Her medical history is also remarkable for hypertension, and her current medication chart is attached to this letter.

During hospitalisation, she has been reviewed by the hospital dietician who has educated on the importance of proper nutrition in the management

of her diabetes. She has also been advised to lose weight. Given her busy lifestyle, she has requested healthy, simple recipes of a low-fat, diabetic diet that can be easily prepared at home.

Given the above, it would be greatly appreciated if you could send the requested information to her home address.

Please contact with any questions.

Yours sincerely

Charge Nurse

23/06/2017

Ms. April

Dietician

258 George Street

Sydney

RE: Ms. Anita Ramamurthy; 59-year-old businesswoman
#648, Bermuda Street

Sydney

Dear Ms. April

The purpose of this letter is to request information about low-fat, diabetic diet for Ms. Ramamurthy, who is a patient of poorly controlled diabetes and has a significantly high BMI of 33.

Socially, she is a businesswoman, rarely has time to cook, and is fond of eating out. Up until now, she has led a sedentary lifestyle and has consumed a fat-rich diet that mainly consisted of sugary drinks and fast foods like pancakes, cheeseburgers etc. Pertinent medical history also includes hypertension, and her current medication chart is attached to this letter.

Mrs. Ramamurthy was recently admitted to our hospital on the 18th of June for treatment of appendicitis and is being discharged today with a plan to undergo interval appendectomy six weeks later. During hospitalisation, she has been reviewed by the hospital dietician who has educated on the importance of proper nutrition in the management of her diabetes. She has also been advised to lose weight.

Given her busy lifestyle, she has requested healthy, simple recipes of a low-fat, diabetic diet that can be easily prepared at home; therefore, it would be greatly appreciated if you could send the requested information to her home address.

Please contact with any questions.

Yours sincerely

Charge Nurse

23/06/2017

Ms. April

Dietician

258 George Street

Sydney

RE: Ms. Anita Ramamurthy; 59-year-old businesswoman
#648, Bermuda Street
Sydney

Dear Ms. April

The purpose of this letter is to request information about low-fat, diabetic diet for Ms. Ramamurthy, who is a patient of poorly controlled diabetes and has a significantly high BMI of 33.

In the context of her medical history, she is hypertensive and was recently diagnosed with appendicitis for which she is scheduled to undergo interval appendectomy after six weeks. Her current medication chart is attached to this letter.

Socially, she is a businesswoman, rarely has time to cook, and is fond of eating out. Up until now, she has led a sedentary lifestyle and has consumed a fat-rich diet that mainly consisted of sugary drinks and fast foods like pancakes, cheeseburgers etc.

Mrs. Ramamurthy was recently admitted to our hospital on the 18th of June for treatment of appendicitis and is being discharged today with a plan to undergo interval appendectomy six weeks later. During hospitalisation, she has been reviewed by the hospital dietician who has educated on the importance of proper nutrition in the management of her diabetes. She has also been advised to lose weight.

Given her busy lifestyle, she has requested healthy, simple recipes of a low-fat, diabetic diet that can be easily prepared at home; therefore, it would be greatly appreciated if you could send the requested information to her home address.

Please contact with any questions.

Yours sincerely

Charge Nurse

TASK 3

23/06/2017

Mr. Krishnan Ramamurthy
648, Bourke Street
Sydney

Dear Mr. Ramamurthy

I am writing regarding your wife's future care requirements at home following her discharge today. Her recovery has been encouraging so far but continued attention will be necessary. Her infection is under control now, and her surgery has been scheduled in six weeks from today.

To ensure a continuing recovery, it is vital that she avoids travelling or rigorous activities until the surgery. Please monitor her at home, and in case she experiences any persistent pain or fever, please contact us immediately at 03492250.

For controlling her diabetes effectively, she needs to chart blood

glucose daily and control her sugar levels with insulin injections. We are aware of your wife's concern regarding this; therefore, a home visit by a nurse has been arranged for instructions on correct technique of these procedures. Worthy to note, the blood glucose chart needs to be presented during the follow-up consultation scheduled next week on 30/06/2017 at 3 p.m.

To promote weight loss, she has been advised to ensure compliance with a low-fat, diabetic diet. Ms. Ramamurthy has requested more information about dietary guidelines and simple recipes which will be directly sent to your house by a dietician.

We hope Ms. Ramamurthy continues to make a speedy recovery.

Yours sincerely
Charge Nurse

The Writing Process

Lesson 3: The Writing Process

Every writing task can be broken down into stages. Once you learn how to plan a task before you actually begin writing the letter, your task will become much more manageable and easier. Let's understand the different stages involved with the following case notes.

WRITING SUB-TEST: NURSING

Time Allowed: Reading Time: **5 Minutes**

Writing Time: **40 Minutes**

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

CASE NOTES:

Mr. Tej Singh is a 41 years old man who has been a patient at a clinic you are working in as a head nurse.

Today's date: 31/01/2017

Name:	Mr. Tej Singh Randhawa
DOB:	09/09/1976
Address:	28, Raymond Street, Romaville
Medical History:	Hypothyroidism – thyroid replacement

	No history of trauma or weight loss
	Hospitalized (2010) due to appendicitis
	No POHx (Previous ocular history)
	No allergies
	Immunizations are current
	Smoker (Cigarettes & Cigars)
	Teetotaller
Social History:	Works as a Systems Analyst
	Arrived in Australia from
	India with wife in 2012
	as a permanent resident
	Lives in own home
	Married – wife Mona
	Randhawa aged 37
	1 daughter
10/01/2017	
Subjective:	Headache, right-sided, no Cough, no dizziness, denied vomiting and nausea

	HA accompanied with significant nasal discharge
Objective:	P 96, BP 130/70, T 101.0 f, neuro Exam normal, neck supple Alert, well-nourished, well-developed man
General Assessment:	Infectious sinusitis
Plan:	Augmentin (Amoxicillin/clavulanic acid)
24/01/2017 Subjective:	Complaints of severe headaches (HA), right-sided throbbing, radiating to right eye, teeth, and jaw lasting 15 mins to < 2 hrs, persistent HA intermittent episodes, pt. described pain as “like someone has put red hot poker in my head” Pain so severe (10/10) that pt. unable to stand still, Sit down or go to bed, no

	effect when light/noise avoided rhinorrhoea, no nausea, no vomiting
Objective:	P 105, BP 150/90, Physical & Neuro exam normal, neck tender-right side
Assessment:	Cluster Headache
Plan:	Given acetaminophen and non-steroidal anti-inflammatory
29/01/2017 **Subjective:**	Pt. accompanied by wife, Mona Previous complaints of severe headaches – occurring in episodic attacks associated with rhinorrhoea and epiphora Right eye “Droopy” and sometimes as “sunken” eyelids, first Noted by Mona 1 day ago, facial flushing before and during HA
Objective:	Right eye upper eyelid drooping, Constriction of

pupil of right eye in dark lighting, decreased sweating on right side of face

P 95 BP 130/85

Assessment: possibility of ? Horner's syndrome

Referral plan: Referral to ophthalmologist for further evaluation and management

WRITING TASK 4

Using the information given in the case notes, write a referral letter to Dr. John Dyer, an ophthalmologist at West Suburban Eye Care Centre, 396 Remington Boulevard, Suite 340, Romaville requesting him to look into this case.

STAGE 1

Stage 1: Considering the Most Important Elements for Selecting Relevant Information

Answer the following questions

- Who Is the Intended recipient?

- What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

- What does the recipient need to know?

- What does the recipient not need to know?

Suggested Answers

- Who Is the Intended recipient?

  Dr. John Dyer, an ophthalmologist

- What is the purpose writing this letter? In other words, what do you want the intended recipient to do?

  Assess and treat the patient as the patient's symptoms are consistent with Horner's syndrome

- What does the recipient need to know?

How the condition started and developed: summary of relevant findings, treatment given, and patient's response during each visit, suspected diagnosis

- What does the recipient not need to know?

Medical history and social history

STAGE 2

Stage 2: Text Planning

The next step is to plan the overall structure of the text by organising the relevant information in a logical order. The necessary information should be sorted into a series of sections and then arranged strategically in a manner that aids purpose of communication.

The information necessary for the reader in this task can be represented by a timeline. Let us use a flow chart to create an outline of the events or visits and arrange them in a logical sequence so that the letter is coherent and compressible for the reader.

(One clearly stated visit per paragraph, from initial visit to today)

Alternatively, you could write down the relevant pieces of information on a rough paper and re-order them until you are satisfied with a sequence.

STAGE 3

Stage 3: Writing the First Draft

3.1 Writing the Introduction

Who is the patient? *Mr. Singh*

What is the purpose of writing the letter? *assessment and further management of his condition*

What is the patient's current status? *Presenting with signs and symptoms indicative of Horner's syndrome*

Now, transform these answers into complete sentences to write an introduction.

_____

_____

_____

3.2 Write the body paragraphs. After each paragraph, evaluate its effectiveness by answering the following question in yes or no.

Are my sentences well connected? In other words, do the ideas flow smoothly?_____

If your answer is no, answer the following question.

What kind of cohesive devices can I use to show how my ideas are connected to each other? _____

STAGE 4

Stage 4: Proofreading, Revising, and Editing

4.1 Do not forget to polish what you have written. First, evaluate the content and organisation of your letter.

Ensure that you can answer the following questions with a 'yes' after reading your draft.

Does the introduction highlight the purpose of the letter?

Is there a clear link between the paragraphs?

Is there a specific purpose to each paragraph?

Is there a logical progression of ideas?

Is the vocabulary appropriate for the recipient?

4.2 Then, proofread your letter to ensure there are no errors of grammar, spelling, or punctuation.

SAMPLE LETTERS

Sample 1

31/01/2017

Dr. John Dyer
West Suburban Eye Care Centre
396 Remington Boulevard
Suite 340
Romaville

Re: Mr. Tej Singh Randhawa; DOB: 09/09/1976

Dear Dr. Dyer

I am writing to request an assessment and further management of Mr. Randhawa who is presenting with signs and symptoms consistent with Horner's syndrome.

Initially, he presented to us on 10/01/2017 complaining of rhinorrhea and headaches. At that time, it was suspected that sinus pressure was causing the headaches; consequently, he was treated for infectious sinusitis.

He returned two weeks later with deteriorating symptoms. At this subsequent visit, he complained of excruciating, right-sided, throbbing

headaches that occurred intermittently and did not subside despite attempts to rest. Additionally, he reported of concurrent aching teeth and previously described rhinorrhea. A diagnosis of a cluster headache was made, and the patient was prescribed acetaminophen and non-steroidal anti-inflammatory medications.

On his last visit two days ago, he presented along with his wife who noted that his right eye (ipsilateral to the headaches) seemed "droopy and sunken" and that his face flushed preceding and during the headaches. Moreover, the pupil of his right eye constricted in darkness, and he had decreased sweating on the right side of his face.

Given the above, it would be greatly appreciated if you could assess, examine, and treat the patient as deemed appropriate.

Please contact me in case you have any questions.

Yours sincerely
(Your name here)

Head Nurse

Sample Letter 2

31/01/2017

Dr. John Dyer
West Suburban Eye Care Centre
396 Remington Boulevard
Suite 340

Romaville

Re: Mr. Tej Singh Randhawa; DOB: 09/09/1976

Dear Dr. Dyer

I am referring the above-captioned patient who is exhibiting signs and symptoms suggestive of Horner's syndrome.

Mr. Randhawa has attended our clinic thrice over the past three weeks, during which time he has had several episodes of severe right-sided headache. He first presented on 10/01/2017 with complaints of a headache and rhinorrhoea. On that day, he was prescribed Augmentin based on a diagnosis of infectious sinusitis.

He returned two weeks later with complaints of dressing right-sided throbbing headaches, which occurred periodicallly and were not relieved by rest. Additionally, rhinorrhoea had persisted, and headaches were

accompanied by aching teeth. The symptoms were suggestive of a cluster headache; consequently, he was commenced on acetaminophen and non-steroidal anti-inflammatory medications.

Two days ago, accompanied by his wife, he presented again as his right eye seemed 'droopy and sunken.' Moreover, his wife reported that his face flushed before and during headaches. An examination that day revealed decreased sweating on the right side of his face and that his right pupil constricted in darkness.

Given the above, it would be greatly appreciated if you could assess, examine, and treat the patient as deemed appropriate.

Please contact me with any questions.

Yours sincerely
(Your name here)

Head Nurse

Language Focus: Time Order Words

Look again at the two sample letters. Note the kind of words or phrases that have been used in the above samples to show a time order. For e.g. Initially

Exercise 9

Complete the below table with time order words or phrases that you can find in the sample letters.

Words	Phrases

Suggested Answer

Words	Phrases
Initially	*Two days ago*
First	*At that time*
	Two weeks later
	At this subsequent visit
	Over the past three weeks

	Two weeks later
	On that day

Organisation of Ideas

Lesson 4: Organisation of Ideas

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

Your name is Diana Jones. You are the charge nurse on the medical ward where Mrs. Davies was admitted as a patient.

Hospital: Prince Wales Hospital

PATIENT DETAILS

Name:	Nina Davies
Sex:	Female
Date of Birth:	25/12/1943
Address:	95, Eagle Vale Sydney
Occupation:	Retired Librarian
Race:	Caucasian
Marital Status:	Married
Next of Kin:	Thomas Davies, John Davies
Family Hx:	Mother died at 40 – Cancer,

	Father died at 57 – coronary Heart disease, has 2 siblings, brother aged 79 with CAD, twin sister with osteoporosis and depression
Social History:	Lives with husband in own house. Home has 2 stories, 2 steps to entrance
	Supports full bath on second floor only, 2 grown children living nearby Pt. is very active; walks 1–2 miles/day, stopped smoking 30 years ago
Diet:	Occasional drink, drinks a cup of coffee a day, reports diarrhoea and gas with dairy products
Allergies:	NKDA
Past Medical History:	Diagnosed with osteoporosis – first signs noted in 2015
	Mild hyperlipidaemia, Mild hypertension, Coronary artery disease, Tendonitis of R. Shoulder-2009, PTCA-2009 without recurrence

Medications:	Simvastatin (Zocor) 20 mg. daily Aspiring daily – pain in ribs and back Furosemide (Lasix) 10 mg. daily Alendronate (Fosamax) 10 mg. daily Calcium + Vit. D 600 mg. daily Vit. E, Vit. C, Mg
Date of Admission:	28/6/2017
Date of Discharge:	02/07/2017
Chief Complaint:	Injury on the left hip – had a fall after slipping
Diagnosis:	Fractured L NOF

Nursing Management And Progress

28/06/2017	Admitted through ER, medical evaluation found her a good candidate for Left Hemiarthroplasty
Post-opt:	IV Fluids at 100 cc/hr, morphine 10 mg IM q. 4 hours

as needed for pain, IV famotidine (Pepcid) 20 mg. every 12 hours due to GI distress postop, cefazolin (Ancef) 1 g. IV q. 8 h. X 3 doses

29/06/2017 Complaints of hip and back pain,

Pt. restless and confused with hallucinations-possibly due to morphine
Doctor discontinued IM morphine, replaced with hydrocodone/acetaminophen 5 mg./325 mg. (Lortab) 1 or 2 q. 4 to 6 hours as needed for pain IV famotidine (Pepcid) switched to oral route Aspirin and furosemide restarted

30/06/2017 PT (physiotherapy) started, complaints of dizziness and light-headedness almost resulting in a fall Found to be hypotensive – diuretic (furosemide discontinued)

01/07/2017 PT continued Complaining of

constipation – not had a bowel movement since surgery
Docusate 100 mg. daily
Can ambulate short distances with a walker
Assistance with ADL's

02/07/2017 Original dressing changed;

Ready for discharge

Discharge Plan: LLE (Left lower extremity) wt. bearing limited to 30% for next 6 weeks

Elderly husband not able to care for her; home not set up for a walker
Neither of children can take her in their homes – lack of space, too many stairs, and working spouses
Decision is made to transfer her to Helping Hand rehabilitation centre near her house
Continue Physio program and medication
Assistance with ADL
Staples to be removed on day 14

– at hospital
Dressings to remain dry & intact

Discharge Medications:

Hydrocodone/acetaminophen 5 mg./325 mg.
(Lortab) 1 to 2 q. 4 to 6 hrs prn pain

Acetaminophen 325 mg. 1 to 2 q. 4 to 6 hours prn
headache or minor pain
Famotidine (Pepcid) 20 mg. b.i.d.
Docusate 100 mg. daily
Alendronate 10 mg. daily

WRITING TASK 5

Using the information in the case notes, write a referral letter to the Ms. Susan Parry, Charge Nurse at Helping Hand Rehabilitation centre, Eagle Vale, Sydney, NSW where Mrs. Davies will be discharged to from your ward.
In your answer

- Expand the relevant case notes into answers
- Do not use note form
- Use letter format

SAMPLE ANSWERS

Sample Answer 1

02/07/2017

Ms. Susan Parry
Charge Nurse
Helping Hand Rehabilitation Centre
Eagle Vale
Sydney NSW

Re: Mrs. Nina Davies; DOB: 25/12/1943

Dear Ms. Parry

I am writing to request rehabilitative care for Mrs. Davies, a patient of osteoporosis, who is recovering from a left hemiarthroplasty necessitated by a fractured left NOF. She was admitted on 28/06/2017 and is being transferred to your facility today.

Postoperatively, she responded well postoperatively and was commenced on physiotherapy to promote strength and recovery. She suffered from constipation during hospitalisation for Dulcosate has been prescribed. Currently, Mrs. Davies can ambulate short distances with a walker, and her LLE weight bearing is limited to 30% for the next six weeks.

Her home is not set up for a walker, and her elderly husband will not be able to care for her at home; therefore, she is being referred to you for further management.

Following her discharge, please ensure her compliance with the recommended exercise program. Kindly also monitor her adherence to the medication regime, which includes her previous medications for her hypertension, mild hyperlipidaemia, coronary heart disease along with those prescribed in the hospital. Additionally, please assist her in ADLs and ensure that her dressing remains intact and dry until her staples are removed on day 14 at our hospital.

Please contact with any questions. Her medication chart is attached to this letter.

Yours sincerely
Diana Jones
Charge Nurse
Prince Wales Hospital

Sample 2

02/07/2017

Ms. Susan Parry
Charge Nurse
Helping Hand Rehabilitation Centre
Eagle Vale
Sydney NSW

Re: Mrs. Nina Davies; DOB: 25/12/1943

Dear Ms. Parry

I am writing to request rehabilitative care for Mrs. Davies, who was admitted to our hospital on 28/06/2017 with a fractured left NOF, underwent left hip hemiarthroplasty, and is scheduled to be transferred to your facility today.

Although Mrs. Davies has been progressing well, she is currently dependent on a walker for mobilisation, and her LLE weight bearing is limited to 30% for the next six weeks. Her home is not set up for a walker, and her elderly husband will not be able to care for her at home; therefore, she will need your assistance with ADLs until she recuperates.

To ensure a continuing recovery, you are requested to ensure her

adherence to the exercise program that was initiated by the hospital physiotherapist to promote strength and recovery. Her staples are due to be removed on Day 14 at out hospital and until then, please ensure that the dressing remains intact and dry.

In the context of her medical history, she suffers from osteoporosis, hypertension, mild hyperlipidaemia, and coronary heart disease. She also suffered from constipation during hospitalisation. Kindly oversee her compliance with the all the medications in her medication chart, attached to the letter.

Please do not hesitate to contact me with any questions.

Yours sincerely
Diana Jones
Charge Nurse
Prince Wales Hospital

	Sample 1	Sample 2
Organisation	**Chronological**	**Problem-Solution**

Body paragraph 1	Outline of treatment offered during hospitalisation, her progress, description of her current condition and rationale for transferring her to the rehabilitation centre	Description of her current condition, rationale for transferring her to the rehabilitation centre, request assistance with ADLs
Body paragraph 2	Details of all requests to be acted on following her discharge 1. Assistance with ADLs 2. Ensure compliance with medication regime, including	Requests for keeping the dressing dry and intact until Day 14 and adherence to physiotherapy program

	current and previously prescribed 3. Dressing to remain intact and dry until staples are removed 4. Adherence to recommended physiotherapy program	
Body paragraph 3	-	Overview of her medical history prior to this hospitalisation and constipation during hospitalisation. Request to ensure compliance with all

		medications

LANGUAGE FOCUS; COMPLEX AND COMPOUND SENTENCES

What Is a Complex Sentence?

To put it simply, a complex sentence is used to combine two related ideas (clauses). These ideas are joined together with a "subordinating conjunction." Some examples of commonly used **subordinating conjunctions** are after, although, since, because, while, when, until, before, if, unless, because.

A complex sentence contains an independent clause and a dependent clause. The clause that begins with a subordinating conjunction becomes a dependent clause or subordinate clause, and the other is referred to as the independent clause.

For example, see the complex sentence written below:

Since Mary has poor compliance with diabetic diet, she has been commenced on medications to manage her diabetes.

In this above sentence, "since" is the subordinating conjunction. I would like to point out that since can have different meanings: in the above sentence, it means "because," but it can also be used to indicate time span or period Take time to understand the different definitions of words like since, while, as, etc. so you can use them well when creating complex sentences.

This is the dependent clause: **Since Mary has poor compliance with a diabetic diet**

This is the independent clause: **she has been commenced on medications to manage her diabetes.**

The purpose of subordinate conjunction is to subordinate. In other words, subordinating conjunction in a complex sentence assigns a lower grammatical status to the subordinate clause. That is why a subordinate clause can also be called a dependent clause as it depends on the independent clause to complete the sentence.

Let us see the example mentioned above.

There are two actions in this sentence: Mary's poor compliance with a diabetic diet and initiating a new treatment plan to control her diabetes. "Since" relegates a less important status to the first action. The recipient would instinctively know that the second action is the main point of the sentence.

How do you know which clause to subordinate and which to elevate?

The recipient's needs will dictate this. When is doubt, answer these guiding questions"?

What Does Your Recipient Most Want to Know?

Which Idea Do You Want to Emphasize?

Which Information Would Be Most Interesting to Your Recipient?

It is okay if you find this slightly daunting! As with any new concept, it takes time for you to become adept, and that happens with consistent practice. Do not worry if it takes longer than you expect; remember, it is time well spent.

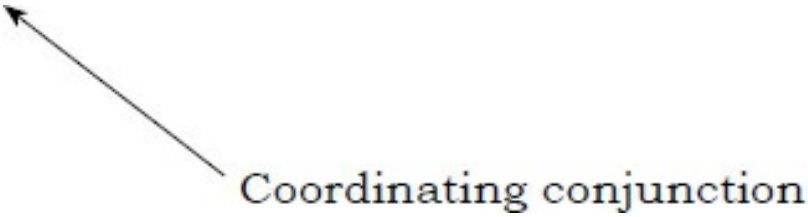
What Is a Compound Sentence?

A compound sentence is used to combine two related ideas (clauses) or sentences. These ideas are joined together with a comma and "coordinating conjunction." Some examples are so, and, but, so, or etc.

A compound sentence is formed with at least two independent sentences or clauses; in other words, a compound sentence has at least two subject-verb combinations.

For example,

Her staples are due to be removed on Day 14, and until then, please ensure that the dressing remains intact and dry.



A compound sentence can also be formed by joining the two sentences with a semicolon and conjunctive adverb.
For example,

Her home is not set up for a walker, and her elderly husband will not be able to care for her at home; therefore, she is being referred to you for further management.

A compound sentence should be used when you want to assign equal importance to each idea in the sentence.

Where to Use Complex or Compound Sentences?

Compound sentences allow you to fit more information into a sentence instead of choppy sentences. Complex sentences allow you to highlight the hierarchy and emphasize one idea over the other.

Comma Rules

Rule	Example
1. Put a comma after a discourse marker or time order word or phrase that precedes the subject at the beginning of a sentence.	*Currently, Mrs. Davies can ambulate short distances with a walker.*

2. Put a comma to separate the dependent clause and the independent clause in a complex sentence if the dependent clause comes before the independent clause. Do not put a comma between the dependent and independent clause if the independent clause comes before the dependent clause.	*Although Mrs. Davies has been progressing well, she is currently dependent on a walker for mobilisation.*
3. Put a comma before the coordinating conjunction in a compound sentence. Do not put a comma when the coordinating conjunction joins two predicates in a simple sentence.	*Her home is not set up for a walker, and her elderly husband will not be able to care for her at home. She was admitted on 28/06/2017 and is being transferred to your facility today.*

	(No comma needed here as it is a simple sentence with two predicates).
4. Put a comma to separate three or more items in a series. These items may be words, phrases, or predicates. The last item is separated from the list with a 'comma' and 'and.'	*She suffers from osteoporosis, hypertension, mild hyperlipidaemia, and coronary heart disease.*
5. Put a comma before and after the appositive or appositive phrase. If the sentence ends with the appositive, then the comma following the appositive is substituted with a full-stop or period. An appositive or an appositive phrase allows us to add more information without adding a whole	*I am writing to request rehabilitative care for Mrs. Davies, a patient of osteoporosis, who is recovering from a left hemiarthroplasty necessitated by*

new sentence. It lends clarity to your noun and offers a quick way for you to squeeze more information in your sentence	*a fractured left NOF. Kindly oversee her compliance with the prescribed medication regime, attached to this letter.*
6. Put a comma before and after a non-restrictive relative clause. If the sentence ends with the non-restrictive relative, then the comma following the clause is substituted with a period or full-stop.	*I am writing to request rehabilitative care for Mrs. Davies, who is recovering from a left hemiarthroplasty necessitated by a fractured left NOF.*

Exercise 10

Add commas wherever necessary and put the applicable rule number underneath the sentence.

1. Although the patient was given appropriate care his

condition did not improve. _____

2. The patient was very worried about the surgery and the doctor reassured him that he would be administered anaesthesia before the procedure. _____
3. Ms. Dawson has been advised to ensure her compliance with the prescribed medication regime exercise program and low-fat diet. _____
4. I am writing request rehabilitative care for Ms. Waldorf a 60-year-old patient who is recovering from a hip replacement surgery. _____
5. Currently the patient can ambulate with a wheelie-walker. _____

Answers

1. Although the patient was given appropriate care, his condition did not improve. Rule number 2
2. The patient was very worried about the surgery, and the doctor reassured him that he would be administered anaesthesia before the procedure. Rule number 3
3. Ms. Dawson has been advised to ensure her compliance with the prescribed medication, regime exercise program, and low-fat diet. Rule number 4
4. I am writing request rehabilitative care for Ms. Waldorf, a 60-year-old patient, who is recovering from a hip replacement surgery. 5
5. Currently, the patient can ambulate with a wheelie-walker. 1

Practice Makes Perfect

Lesson 5: Practice Test

WRITING SUB-TEST: NURSING

Time Allowed:Reading Time: **5 Minutes**

Writing Time: **40 Minutes**

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

CASE NOTES:

You are the registered nurse in the Cardiology Unit at St Luke's hospital, Adelaide. Ms. Kylie Weiss is a patient in your care.

Today's Date:	09/07/2017
Name:	Ms. Kylie Weiss
D.O.B.:	21/05/1952
Address:	8758, Pulteney Street, Adelaide, SA, 5000
Date of Admission:	07/07/2017
Presenting Complaint:	BIBA (Brought in by ambulance) – 2 hour history intermittent discomfort

	jaw/heaviness in both forearms, constant discomfort IV access in ambulance, 10 mg IV Morphine on route, Aspirin 300 mg chewed, Glytrin spray × 3 ECG showing ST elevation
Diagnosis:	Myocardial Infarction
Medical History:	Weight: 85 kilograms, Height: 170 cm –
	Overweight (BMI-29) Ex-smoker – 1994 Mild osteoarthritis Mild asthma – no exacerbations within last 5 years Dyslipidemia – (Raised cholesterol) – not treated
Medications:	NIL
Occupation:	Works as a taxi driver, mixed shifts
Dietary Habits:	Eats fast food – fries, hamburgers, doughnuts, ice cream, non-drinker

Family History:	Brother – Coronary artery bypass grafting (CABG) at 70 years
	Sister MI (Myocardial Infarction) at 60 years, Mother-angina
Social History:	Marital status: Married with one daughter
	Husband-Peter Weiss, 67 years, retired, aged pensioner
Medical Treatment:	Emergency Angioplasty performed
	ST Segment elevation on ECG – Direct stenting to proximal LAD Echocardiogram – Ejection fraction 35% Pain/Discomfort – managed Fasting Bloods (Lipids, Diabetes, TnI (proteins troponin), CBC (complete blood count), Biochem) – High Cholesterol levels Nil further pain/discomfort,

	Cardiac status stable Pt. seemed confused re diagnosis, reality of near experience – Educated re event, MI diagnosis and modifications to risk factors (Cholesterol, wt. loss) R/v (review) by Physiotherapist – cardiac exercise program provided R/v by dietician – diet for weight loss & reduced cholesterol levels Concerned about being unable to manage home on her husband's pension – S/W (Social Worker) input required
09/07/2017	Preparing for discharge
Discharge Medications:	Atorvastatin 40 mg OD, Metoprolol 23.75 mg OD Cilazipril 0.5 mg OD, Aspirin 100 mg OD, Ticegralor 90 mg BD, Glytrin spray prn for chest pain
Discharge	No driving for 6 weeks.

Plan:

Refer to Cardiac Rehabilitation Nurse Specialist – compliance with risk factor management (wt. loss, low cholesterol diet), medications, education re about MI and its management

Refer to Occupational Therapist – to provide guidelines for returning to work, driving and normal daily activities

Refer to Social Worker – due to inability to work for 6 weeks

6-week recovery from MI, assess eligibility for sickness allowance/benefits from the Australian Government Department of Human Services

WRITING TASK 6

Using the information given in the case notes, write a referral letter to Ms. Nina Gill, Cardiac Rehabilitation Nurse Specialist, Cardiac Rehabilitation Clinic, 41, Jones St, Adelaide outlining important information.

WRITING TASK 7

Using the information in the case notes, write a referral letter to Mr. Barney Dyer, Occupational Therapist, Home Occupational Therapy Services, 85 Flinders Street, Adelaide requesting him to visit Ms. Weiss at home and provide guidelines for returning to work, driving and normal daily activities.

WRITING TASK 8

Using the information given in the case notes, write a letter to Ms. Linda Gold, Social Worker, Gold Social Services, 478, Collins Street, Adelaide requesting her to visit Ms. Weiss at her home and assess her eligibility for receiving a sickness allowance or other benefits from the Australian Government Department of Human Services.

WRITING TASK 6

Using the information given in the case notes, write a referral letter to Ms. Nina Gill, Cardiac rehabilitation Nurse Specialist, Cardiac Rehabilitation Clinic, 41, Jones St, Adelaide outlining important information.

SAMPLES FOR TASK 1

Sample 1

Organizational Style: Chronological

09/07/2017

Ms. Nina Gill
Cardiac Rehabilitation Nurse Specialist
Cardiac Rehabilitation Clinic
41 Jones Street
Adelaide

Re: Ms. Kylie Weiss; D.O.B: 21/05/1952

Dear Ms. Gill

I am writing to request cardiac rehabilitative care for Ms. Weiss who was admitted to the hospital on 07/07/2017 for treatment of myocardial infarction. She underwent an emergency angioplasty under our care and is being discharged today.

Her medical history is remarkable for previously untreated dyslipidemia. Moreover, she has a family history of heart problems in both of her siblings and her mother. She consumes a diet that consists almost exclusively of fast foods and is overweight with a BMI of 29.

Postoperatively, she responded well to the treatment and attained a good recovery. She has been commenced on a cardiac exercise program and advised on a low-fat diet to reduce her weight and cholesterol levels. She has been educated on MI and has a reasonable understanding of the event and subsequent diagnosis.

It would be greatly appreciated if you could ensure adherence to the recommended medication regimen diet plan and exercise program. Further please re-enforce Ms. Weiss's understanding about MI and management of its risk factors for an improved quality of life.

Enclosed you will find a copy of her current medications. Should you have any further inquiries, please do not hesitate to contact me.

Yours sincerely
(Your name here)
Registered Nurse

Sample 2: Problem-Solution

09/07/2017

Ms. Nina Gill
Cardiac Rehabilitation Nurse Specialist
Cardiac Rehabilitation Clinic
41 Jones Street

Adelaide

Re: Ms. Kylie Weiss; D.O.B: 21/05/1952

Dear Ms. Gill

I am writing to request cardiac rehabilitative care for Ms. Weiss who was admitted to the hospital on 07/07/2017 for treatment of myocardial infarction. She underwent an emergency angioplasty under our care and is being discharged today.

Her risk factors include being overweight with a BMI of 29, consumption of fat-rich, high-sugar diet, and previously untreated dyslipidemia. For management of these factors, she has been advised to follow a low-cholesterol diet, low-fat diet and a cardiac exercise program that was initiated by the hospital physiotherapist. Please ensure her adherence to these guidelines to ensure a continuing

recovery.

It would also be greatly appreciated if you could ensure her compliance with the prescribed medication regime, attached to this letter. Moreover, Ms. Weiss seemed confused regarding the diagnosis during hospitalization for which she was educated about MI. Although she a reasonable understanding of the event, please reinforce her understanding about MI and its management. Worthy to note, she has a family history of heart problems in both of her siblings and her mother.

Should you have any questions, please do not hesitate to contact me.

Yours sincerely
(Your name here)
Registered Nurse

	Sample 1	**Sample 2**
Organization	**Chronological**	**Problem-Solution**
First body paragraph	Relevant background of	focuses on risk factor

	patient's risk factors (prior to hospitalization)	management
Second body paragraph	Brief description of management and patient's progress during hospitalization	focuses on adherence to medication regime and strengthening patient education about MI
Third body paragraph	Post-discharge requests for the recipient	—

WRITING TASK 7

Using the information in the case notes, write a referral letter to Mr. Barney Dyer, Occupational Therapist, Home Occupational Therapy Services, 85 Flinders Street, Adelaide requesting him to visit Ms. Weiss at home and provide guidelines for returning to work, driving and normal daily activities.

SAMPLE ANSWER

09/07/2017

Mr. Barney Dyer
Occupational Therapist
Home Occupational Therapy Services
85 Flinders Street

Adelaide
Re: Ms. Kylie Weiss; D.O.B: 21/05/1952

Dear Mr. Dyer

This letter will introduce Ms. Weiss who is presently recovering from a myocardial infarction. She was admitted to hospital on 07/07/2017, underwent emergency angioplasty, and is scheduled to be discharged today. She requires home visits from you to instruct her on how she can resume independence of her daily routines.

Ms. Weiss lives with her husband in their own house and works as a taxi driver but has been advised not to return to work for the next six weeks as she recuperates. Her risk factors include being overweight and elevated cholesterol levels, and she has been commenced on a diet plan to promote weight-loss and decrease her cholesterol levels.

A cardiac exercise program has been initiated by the hospital physiotherapist, and she has been educated on lifestyle changes required for ongoing management of her condition. She has also been referred to Cardiac Rehabilitation Nurse for guidance regarding effective management of her risk factors and to reinforce her understanding of her condition.

It would be greatly appreciated if you could provide instructions on returning to her routine activities, work, and driving to ensure a smooth transition back to normal life.

Should you have any further inquiries, please do not hesitate to contact me.

Yours sincerely
(Your name here)
Registered Nurse

WRITING TASK 8

Using the information given in the case notes, write a letter to Ms. Linda Gold, Social Worker, Gold Social Services, 478, Collins Street, Adelaide requesting her to visit Ms. Weiss at her home and assess her eligibility for receiving a sickness allowance or other benefits from the Australian Government Department of Human Services.

SAMPLE ANSWER

09/07/2017

Ms. Linda Gold
Social Worker
Gold Social Services
478 Collins Street
Adelaide

Re: Ms. Kylie Weiss; DOB: 21/05/1952

Dear Ms. Gold

I am writing to request a home visit by you to Ms. Weiss's home to assess her eligibility for receiving a sickness allowance or other benefits that the Department of Human Services provides. She was admitted to our hospital on 07/07/2017 following a heart attack and is scheduled to be discharged today.

Mrs. Weiss works mixed shifts as a taxi driver and lives with her husband, who is an aged pensioner. Her recovery has been encouraging so far, but her recuperation is expected to take at least six weeks, and she has been she has been advised to refrain from driving during this time; consequently, she is concerned about being unable to manage their home solely on her husband's pension.

Given the above, it would be greatly appreciated if you can visit her at home to discuss her eligibility for receiving financial assistance from the government until she is allowed to resume work.

I have attached all the pertinent details for your perusal. Please do not hesitate to contact me in the case of any queries.

Yours sincerely
(Your name here)
Registered Nurse

Lesson 6: Practice Test

You are a Registered Nurse at the Royal Brisbane Hospital were Anthony Nutt is a patient in your care.
Read the case notes below and complete the case notes that follow.

Today's Date:	29/05/2017
Patient Name:	Anthony Nutt
Address:	Unit 8, 37 Albert Street Brisbane 4000
Age:	86 years
DOB:	19/07/1931
Next of Kin:	Son, Joseph Nutt

Medical History

- Breast Cancer 20 years ago – right total mastectomy – did not receive adjuvant radiation, chemotherapy, or hormone therapy or medical follow-up post-operatively.
-

Dementia
- Non-smoker
- No known allergies
- Non-drinker

Family History

- Mother died of colon cancer

Social History

- Retired 20 years ago
- Married – wife suffering from newly onset dementia
- One son – Joseph Nutt, 52 years old, unmarried – lives 30 minutes away

Diagnosis: recurrent infiltrating ductal carcinoma of the breast.

23/05/2017

- Presented to ER with ulcerated, haemorrhaging right anterior chest mass
- Per the patient – developed a mass on his anterior chest wall – 2 years ago
- Mass increased in size, began to ulcerate – bled this morning – did not seek medical treatment until this morning

Objective

- Temperature – 97.4°F
- Pulse – 80
-

RR – 14

- pulse oximetry of 100% on room air
- BP – 162/88.
- a right-sided pedunculated 8 cm × 7 cm mass with a cauliflower-like appearance on chest – ulcerated, erythematous, malodorous, and with scant bleeding
- white blood cell count 6,500
- haemoglobin 12.4
- Haematocrit 36.2
- Platelet count 178,000.
- Creatinine of 1.72
- glucose 106
- A CT chest – a soft tissue mass in right chest wall measuring 5.2 × 2.75 × 5 cm with post-operative changes of the right axilla.
- Incisional biopsy of right breast mass performed

28/05/2017

- Pathology returned consistent with Recurrent moderately differentiated duct carcinoma of the breast with ulceration of overlying epithelium. – Stage 3
- Pt. not found to be suitable for chemotherapy or curative treatment – Oncology evaluation and geriatric evaluations by doctor
- Pt. commenced on hormone therapy with tamoxifen 20 mg daily with one course of palliative radiation.
- Family meeting called – son verbalized concerns over mother's state of health; son unable to take time off work to

care for father-says he won't be able to cope; hospice care recommended for pt. –consensus decision

- Pt. to be transferred to Queensland Aged Care Centre for hospice care – Bed available from 29/05/2017 for patient
- Pt.'s wife to be admitted to the same facility due to general deconditioning when bed is available; mother to live with son interim

Discharge Plan

- Transfer to Aged Care home
- Son will visit weekly
- Contact community social worker to notify son when bed available for wife at Queensland Aged Care Centre

WRITING TASK 9

Using the information in the case notes, write a referral letter to the Ms. Carrie Andrews, Director of Nursing, Queensland Aged Care Centre, 52 Albert Street, Brisbane 4101, introducing the patient. Using relevant case notes, give his background, medical history, and treatment required.

SAMPLE ANSWERS

Sample Answer 1

29/05/2017

Ms. Carrie Andrews
Director of Nursing
Queensland Aged Care Centre
52 Albert Street
Brisbane 4101

Re: Mr. Anthony Nutt; 86-year-old man

Dear Ms. Andrews

I am writing to refer Mr. Nutt who has been diagnosed with stage 3 recurrent right-sided breast cancer. An oncology evaluation has deemed him unsuitable for curative treatment, and he is being transferred to your facility today for hospice care.

Pertinent surgical history includes a right total mastectomy 20 years ago due to right-sided breast cancer. Postoperatively, he did not receive any adjuvant radiation, chemotherapy, or hormone therapy and did not pursue any further medical follow-up. He lives with his wife, and both of them suffer from dementia. They have a son, Joseph, who lives 30 minutes away.

While hospitalization, he was commenced on hormone therapy with tamoxifen 20 mg daily with one course of palliative radiation. A family conference was held on 28/052017 to elicit the goals of care, and hospice care was found ideal for the patient given his illness, cognitive state, his wife's debilitating health status, and Joseph's hectic lifestyle.

It would be greatly appreciated if you could take over the management of this patient and provide care to maintain his dignity and improve his quality of life. Worthy to note, Mrs. Nutt will be transferred to your facility the once a bed comes available for her.

Please contact with any questions.
Yours sincerely
Your name here

Sample Answer 2

29/05/2017

Ms. Carrie Andrews

Director of Nursing
Queensland Aged Care Centre
52 Albert Street
Brisbane 4101

Re: Mr. Anthony Nutt; 86-year-old man

Dear Ms. Andrews

This letter will introduce Mr. Nutt who is suffering from stage 3 recurrent right-sided breast cancer and requires hospice care to improve his quality of life. The doctor believes curative treatment is no longer an option for him.

His medical history is remarkable for right-sided breast cancer 20 years ago which was treated with right total mastectomy; however, he did not pursue any medical follow-up subsequently. He lives with his

wife, and both suffer from dementia. Their son, Joseph, lives 30 minutes away but is unable to care for his father owing to a hectic lifestyle.

While hospitalization, the diagnosis was confirmed with a biopsy, and he was subsequently commenced on hormone therapy with tamoxifen 20 mg daily with one course of palliative radiation. The doctor conferred with the patient's wife and son and advised them to proceed with hospice enrolment given the wife's debilitating mental state.

It would be greatly appreciated if you could take over the management of this patient and provide care to maintain his dignity. His wife will live with Joseph until a bed becomes available for her in your facility.

Please contact with any questions.

Yours sincerely

(Your name here)

Lesson 7: Practice Test

Read the case notes below and complete the writing task that follows

You are a senior nurse working with Helpline Hospital.

Patient Name:	Tom Clarke
DOB:	21/09/1954
Address:	92 Lygon Street Carlton Melbourne
Phone:	0422-894-896
Social Background:	Married, Wife – Miranda Clarke, aged 58 years. Lives together Retired – Police officer Two daughters – elder daughter works in Sydney, younger daughter – Adelaide Quite active
Medical History:	Hypertension – 1985 Did not seek treatment till 2000;

	now managed with Ramipril GERD – 1999
Surgical History:	R. Ankle dislocation surgery following a car accident – 1982, hospitalized for 3 weeks Septoplasty – 1985 Surgery for Anal Fistula – 1992 Eye replacement lens surgery – 2007
Hobbies:	Cycling, watching movies, sports, reading, travelling, Playing golf and Tennis

26/08/2016

- Accident with a motorbike while cycling, claimed he was going at a moderate speed, a motorbike hit him while overtaking, he landed on the left side of his body
- FOOSH (Fall on outstretched hand) injury to L elbow, presented to ER, limited range of motion and extreme pain
- X-RAY– Nondisplaced fracture of the coronoid process of the ulna, marrow oedema head and neck of radius involving articular surface, moderate joint effusion
- Treatment – Sling to keep the elbow immobilized – 6 weeks, Capsule CM Plus, Panadol, Ibuprofen, hot compress for pain and inflammation
- Next Appointment in 6 weeks' time

06/10/2016

- X-ray – injury healing well

- Tab D gain qw
- Tab CM Plus – qd
- Sling taken off
- Exercise program – at home

01/11/2016

- Pt. complains of stiffness and limited range of motion in the elbow
- Arrange home visits by physiotherapist for rehab program
- Tab D gain – qw
- Tab CM plus – qd
- Follow-up appointment – 15/12/2016

WRITING TASK 10

Write a referral letter to Amit Kumar, Physiotherapist, Suite 5, 379 Swanston Street, Melbourne requesting home visits from the physiotherapist.

In your answer

- Do not use note form
- Expand the relevant case notes to explain his background and medical history and the assistance requested.

Activity 1

The following sentences are not in the correct time order. Arrange them in the right order.

- He presented to us on 26/08/2016 following an accident.
- The patient was seen in a follow-up with complaints of stiffness and limited range of motion of the left elbow
- During the first visit, he was advised to restrict the activity of the impacted elbow with a sling for optimal healing and commenced on appropriate treatment plan to manage his pain and Inflammation.
- His X-ray was reviewed which showed progress in healing during his second visit.
- He was advised to use warm compresses to alleviate pain and inflammation.
- He has been recommended a rehabilitation program, supervised by a physiotherapist, to restore movement and strength to the elbow.
- The sling was removed, and an exercise program was initiated to promote healing.
- He will be reviewed in a follow-up appointment on 15th of December.

Activity 2

Now, rewrite the sentences from the previous activity as paragraphs. Remember to use time – order words and conjunctions or conjunctive adverbs to ensure coherence and cohesion in your response.

SAMPLE ANSWER

Sample Answer

01/11/2016

Mr. Amit Kumar

Physiotherapist
Suite 5
379 Swanston Street
Melbourne

Re: Mr. Tom Clarke; DOB: 21/09/1954

Dear Mr. Kumar

I am writing to request daily home visits to refer Mr. Clarke who is recovering from a fracture of the coronoid process of the ulna and a radial head fracture of the left elbow. Although he has been progressing well, he needs rehabilitative care from you to restore range of motion in his left elbow.

Initially, he presented to us on 26/08/2016 following an accident. On that day, he was advised to restrict the activity of the impacted elbow with a sling for optimal healing and was prescribed pain-relief, anti-inflammatory medications.

On his subsequent visit six weeks later, his X-ray was reviewed which showed progress in healing; therefore, the sling was removed, and an exercise program was initiated to promote healing.

Today, the patient was seen in a follow-up with complaints of stiffness and limited range of motion of the left elbow; consequently, he is being

referred to you for a rehabilitation program before his follow-up on 15th of December.

Given the above, it would be greatly appreciated if you could visit him at home and assist him to regain a full function of his elbow. Worthy to note, he is a hypertensive patient.

Should you have any further queries, please do not hesitate to contact me.

Yours sincerely
Ramona Decosta
Senior Nurse
Helpline Hospital

Introduction	Your introduction should convey in clear language why you are writing the letter and why the reader should read the document. The introduction in the above sample letter alerts the reader to

	the patient's current condition (stiffness and limited range of motion in the left elbow caused by a fracture sustained on 26th of August) and links this to the purpose of writing (rehabilitative care required to restore range of motion to the elbow).
Body paragraphs 1,2,3	Description of patient's injuries, treatment given, and progress in a chronological order
Body paragraph 4	The request ties up everything together and recommends future course of action (rehabilitation program before his next follow-up). When writing a letter, the most important information for the reader comes first (information related to the recent injury, patient's current condition, and future care required), and the least important information (history of hypertension) comes last. The history of hypertension is significant for the

	physiotherapist as exercise can cause the blood pressure to rise, and the physiotherapist should be made aware of this condition.

Lesson 8: Practice Test

You are a Registered Nurse at Pullman Medical Centre. Ms. Paula Anderson is a patient in your care who is being transferred to Holy Heart Hospital today for a colostomy scheduled on 05/02/2018.

Patient Name:	Ms. Paula Anderson
Today's Date:	02/02/2018
DOB:	19/05/1954
Marital Status:	Married
Social Background:	Lives with husband – very supportive 1 daughter-lives interstate Two sisters – live nearby Retired school teacher (English) Hobbies: playing badminton, watching movies Likes socialising, playing chess

	Sedentary lifestyle – Overweight since 30's
Medical Background:	appendectomy – 2003 #(fracture) left leg – 2007 pneumonia – 2015 arthritis in hands – uses Voltaren
Diet:	Red meat, processed meat Fast food Alcohol (Vodka, wine) – 4–5 days/wk. Ex-smoker – quit 15 years ago

Nursing Notes

28/12/2017	Visit to GP, 2–3 bleeding from rectum rectal exam – definitely palpable mass Fast track referral for suspected colorectal cancer
11/01/2018	8 cm mass on left lateral wall of rectum likely to be carcinoma – referred for colonoscopy
14/01/2018	colonoscopy – biopsies large bowel mucosa taken

18/01/2018	CT & Local staging of primary tumour with MRI
23/01/2018	Review of histology – colonoscopy report
	Diagnosis – Colon cancer R/v by colorectal and general surgery consultant CT – no evidence of metastatic cancer Recommended colostomy Pt. advised of diagnosis and surgery
02/02/2018	
Identified Needs/Problems	Prepare for colostomyEating and drinking: Potential
	problems of dehydration due to above
	Anxious about probs of stoma on home and social life. Involve family members in care
Objectives:	minimise risk of post-op., wound infection from bowel

contents

Allow surgeons clear access to operation site i.e. free from faeces

Complete pre-op. Care schedule

Encourage patient to voice concerns

Plan:

Rectal wash-out before bedtime for three days (daily)

Purgatives as desired

Low-residue light diet 02/02

Fluids only including soup and ice cream

03/02

Clear fluid 04/02

Charge Nurse to see the pt. to discuss practical problems at home

Nil by mouth from 00.00 hours 05/02

Standard pre-op procedure

Ensure variety of acceptable drinks

WRITING TASK 11

Using the information given in the case notes, write a letter to Ms. Meredith Stevens, Charge Nurse, Holy Heart Hospital, 119 Red Sparrow Road, Docklands, Melbourne outlining relevant findings and patient care plan to prepare Ms. Anderson for the surgery.

Activity 1: Answer the following questions for the case history of Paula Anderson.

Who are you writing to?

Why are you writing to them?

What do they need to know?

What do they not need to know?

Activity 2: Now, decide the most logical order for the information i.e. (Introduction/Paragraph 2/Paragraph 3 etc.) and provide the reason why that order of information is the most is important for the reader.

Introduction

Paragraph 1

Paragraph 2

Closing

SUGGESTED ANSWER

Example Order of Information:

Introduction: Patient name, outline purpose of writing

Paragraph 2: Instructions for the recipient to prepare the patient for the surgery

Paragraph 3: Recommendations to assuage the patient's concerns and education on managing at home following the surgery

Closing

Why Is This Information Important for the Reader?

Introduction: For correct identification of patient.

Provides reason for patient's referral

Paragraph 2: Provides instructions about the timeline and action required

before the surgery

Paragraph 3: Provides an insight into the patient's state of mind at the moment and instructions on how she can be reassured

Why Is This Order Important for the Reader?

Introduction: So, the reader knows who the letter is about.

Provides strong background to the case.

Paragraph 2: Gives instructions that need to be carried out from the day of writing the letter – any associated risks are mentioned at beginning so charge nurse can be mindful of these

Paragraph 3: Recommendations for assuaging the patient's anxiety before the surgery and how the patient can be assisted after the surgery

SAMPLE ANSWER

Sample letter

02/02/2018

Ms. Meredith Stevens

Charge Nurse
Holy Heart Hospital
119 Red Sparrow Road
Docklands
Melbourne

Re: Ms. Paula Anderson; DOB: 19/05/1954

Dear Ms. Stevens

I am writing to refer Ms. Anderson, who has been diagnosed with colon cancer and is being transferred to your facility today for colostomy on 05/02/2018.

To prepare Ms. Anderson for the surgery, she can be given a low-residue diet today, followed by fluids only over the next two days. Please note that she should not eat or drink anything from midnight on the day of the operation. Since her liquid and diet intake will be reduced, there is a possibility of the patient becoming dehydrated, and you are requested to monitor her for the same. Additionally, rectal wash-outs should be given each evening to clear her bowel of all fecal

matter so that the surgeon has unobstructed access to the operation site.

Ms. Anderson is worried about the consequences of colostomy; hence, you are requested to meet her on 04/02/2018 to discuss anticipated problems at home following the surgery and educate her on managing at home. It is also advisable to guide her family on how they can be involved in her care at home.

The patient's medical reports are attached to this letter. Please contact me with any questions.

Yours sincerely
(Your name here)

Lesson 9: Practice Test

Today's Date: 27/12/2017

Notes

You are a registered nurse in the Coronary Care Unit, St Vincent's Hospital Melbourne. Derek Shepherd is a patient in your care.

Patient Details

Name:	Derek Shepherd
DOB:	13 September 1970
Address:	108 Queen Street Melbourne
Admitted:	20 December 2017
Date of Discharge:	27/12/2017
Diagnosis:	Obstructive coronary artery disease
Operation:	Coronary artery bypass grafts (x4)

Social History

-

Never married

- Lives alone in own home
- Works as a Business Development Manager at a bank

Medical History

- Constipation occasionally – takes isabgol for relief
- Smokes 5–6 cigarettes/day
- Alcohol: 2 x 300 ml bottles beer/day
- Ht 185 cm Wt 102 kg (BMI – 29 Overweight)

Dietary Habits: sausages, deep fried chips, pizzas, pastas, Allergic reaction to nuts

20/12/2017

- History of presenting complaint: severe chest pain, extreme tightness in chest – felt like someone is standing on his chest, heaviness in both forearms, shortness of breath
- Chest pain started 3–5 months ago, has been increasing in intensity since, got worse on exertion
- Diagnosed with Obstructive Coronary artery disease

Nursing Management and Progress

21/12/2017

- Operation coronary artery bypass grafts (x4)
- Routine postoperative recovery
- Pain/Discomfort managed

23/12/2017

- Constipation related to decrease response to urge to defecate secondary to surgical procedure – no stool for 2 days
- Pt. given isabgol for constipation
- Pain – 5/10
- PT commenced – Rev. by Physio
- Position change every 4qh

24/12/2017

- Knowledge deficit re diagnosis, surgical procedure, seemed confused – educated regarding event
- PT – continued
- Low fat diet
- No complaints of constipation

26/12/2017

- Pain 2/10
- Pt. walking well – routine visits by PT
- Pt. explained post discharge instructions (resume work after 4 wks., avoid travelling/strenuous exercises till 6 wk., follow-up after 6 wks, medications)
- Pt. counselled on changes to lifestyle (cease smoking – referred to Quit line, decrease alcohol, reduce weight, low-fat diet, exercise regime)
- Pt. has knowledge and understanding of diagnosis, procedure, long term rehabilitation – worried about future as evidenced by patient verbalization “I don’t know how I will cope with my job and finances; I might be fired if I don’t go to work for a month” – refer to Cardiac Rehab. S/W for

support

- Wound healing well – daily dressing change
- Pt. educated re smoking cessation – referred to Quit line
- Pt. educated re decreasing alcohol
- Low fat diet

Medications: Aspirin ½ daily, Vicodin q4

Discharge Plan

- Returning Home – avoid strenuous activities, travelling till 6 wks., resume work after 4 wks.
- Follow-up visit after 6 weeks
- Refer to District Nurse – wound management, monitor medications, diet, temp.
- Call Hospital if wound swollen, temp rises above 101-degree F
- Local physiotherapist to continue rehabilitation exercise program – increase physical strength, gradually increase physical activity
- Low-fat diet after discharge – pt. Requested more information on simple low-fat recipes that can be prepared at home
- Refer to local Social Worker at Cardiac Rehab. for support to pt. for applying leave from work, financial assistance

WRITING TASK 12

Using the information given in the case notes, write a letter to Dr. Addison Burke, Dietician, Suite 1, 348, 5th floor, Church Street, Melbourne requesting information on dietary guidelines for Mr. Shepherd. The information should be sent to his home address.

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words

SUGGESTED ANSWER

27/12/2017

Dr. Addison Burke
Dietician
Suite 1, 348, 5th floor
Church Street
Melbourne

Re: Mr. Derek Shepherd; DOB: 13/09/1970
108, Queen Street, Melbourne

Dear Dr. Burke

The purpose of this letter is to solicit low-fat dietary guidelines for Mr. Shepherd who is recovering from a coronary artery bypass graft under our care. He has been progressing well and is being discharged today.

His risk factors include being overweight, due to a diet primarily consisting of fat-rich foods like sausages, pasta, pizzas, and deep-fried chips. His height is 185 cm, and he currently weighs 102 kg. Moreover, he is a smoker and smokes about 5-6 cigarettes a day. Further, he drinks two 300ml bottles of beer regularly. His medical history is significant for intermittent bouts of constipation that is relieved with isabgol, and allergy to nuts.

Mr. Shepherd has been educated regarding smoking cessation and

reducing his alcohol intake. Moreover, he has been advised to lose weight through exercise and diet; therefore, he has requested detailed advice on simple low-fat recipes that can be easily prepared at home.

In view of the above, it would be greatly appreciated if you could send this information to his address, attached to this letter.

Should you have any questions, please do not hesitate to contact me.

Yours sincerely
(Your name here)

WRITING TASK 13

Using the information given in the case notes, write a letter to Ms. Christina Yang, Senior Social Worker, Cardiac Rehabilitation Program, Elizabeth Hospital, 43–47 King Street, Melbourne to provide support service to the patient to help him re-adjust to normal life.

SUGGESTED ANSWER

27/12/2017

Ms. Christina Yang,
Senior Social Worker
Cardiac Rehabilitation Program
Elizabeth Hospital

43-47 King Street
Melbourne

Re: Mr. Derek Shepherd; DOB:13/09/1970
108, Queen Street, Melbourne

Dear Ms. Yang

I am writing to refer Mr. Shepherd who is recovering from a heart bypass surgery and requires your assistance to apply for financial aid and 4-week leave from work.

Mr. Shepherd was admitted on 20/12/2017 and is being discharged today. Although he has made an encouraging recovery, he has been advised to get sufficient rest and recommence work after four weeks.

Mr. Shepherd works as a Business Development Manager at a bank and is worried about maintaining his employment and taking time off work for a month. Additionally, he is concerned about experiencing financial strains owing to a potential reduction in income until he resumes work.

Given the above, it would be highly appreciated if you could inform his employer of his situation and arrange a 4-week employment leave for him. Moreover, please assist him in applying for financial aid to minimize his stress during the recovery period.

Enclosed herewith is the supportive documentation regarding patient's medical condition. Should you have any further queries, please do not hesitate to contact me.

Yours sincerely
(Your name here)

WRITING TASK 14

Using information given in the case notes, write a referral letter to Ms. Patricia Welsh, Physiotherapist, 305, Third Floor, Central Park, Melbourne requesting her to supervise the patient's home-based exercise program.

SUGGESTED ANSWER

27/12/2017

Ms. Patricia Welsh
Physiotherapist
305, Third Floor
Central Park
Melbourne

Re: Mr. Derek Shepherd; DOB:13/09/1970
108, Queen Street, Melbourne

Dear Ms. Welsh

This letter will introduce Mr. Shepherd, who is recovering from a coronary artery bypass graft surgery and requires ongoing support from you to continue his cardiac rehabilitation exercise program at home. He lives alone and is being discharged today.

He presented to us on 20/12/2017 and underwent an uneventful surgery. Postoperatively, he was reviewed by a physiotherapist who commenced him on an exercise program to promote strength and healing; consequently, his ambulatory status has improved, and he can mobilize

independently. He has attained significant recovery and has been recommended to lose weight to ensure good general health. His height is 185 cm, and he currently weighs 102 kg.

Given the above, it would be greatly appreciated if you could visit him daily to ensure his compliance with the recommended exercise regime and assist him in regaining his physical strength. Of note, he has been advised to refrain from strenuous activities for six weeks; therefore, please ensure that he increases his physical activities gradually.

Should you have any further queries, please do not hesitate to contact me.

Yours sincerely
(Your name here)

WRITING TASK 15

Using the information given in the case notes, write a letter to the Ms. Anna Thompson, District Nurse, requesting follow-up care for this patient.

SUGGESTED ANSWER 1

27/12/2017

Ms. Anna Thompson
District Nurse

Re: Mr. Derek Shepherd; DOB:13/09/1970
108, Queen Street, Melbourne

Dear Ms. Thompson

This letter will introduce Mr. Shepherd who is recovering from a coronary artery bypass surgery. He was admitted to hospital on 20/12/2017. He lives alone and requires follow-up care from you following his discharge today.

During hospitalization, the patient responded well to the adopted treatment plan which focused on adequate pain-relief, postoperative physiotherapy, patient education regarding the risk-factor management, and regular wound dressing.

It would be greatly appreciated if you could monitor his progress to ascertain if any risks are present. Kindly call us immediately if his body temperature rises above 101 degrees or the wound site is swollen

or infected. Additionally, please continue the wound management and ensure compliance with the discharge medications and low-fat diet plan. His medication chart is attached to this letter, and the diet plan will be sent directly to his house by the dietician.

Worthy to note, he needs to abstain from traveling and participation in strenuous activities until his follow-up appointment scheduled in 6 weeks time and should not resume work before four weeks' time

Should you have any further queries, please do not hesitate to contact me.

Yours sincerely
(Your name here)

SUGGESTED ANSWER 2

27/12/2017

Ms. Anna Thompson
District Nurse

Re: Mr. Derek Shepherd; DOB:13/09/1970
108, Queen Street, Melbourne

Dear Ms. Thompson

The purpose of this letter is to request regular home visits for the above – captioned patient who presented to us on 20/12/2017 and underwent a coronary artery bypass surgery under our care. He is being discharged today and lives on his own.

Postoperatively, his wound has been healing well, and you are requested to change the dressing on the wound site daily. Additionally, please monitor him closely, and notify us immediately in case his wound site is swollen or his body temperature exceeds 101 degrees. Kindly also ensure his adherence to the discharge medications, which include 1/2 Aspirin daily and Vicodin every 4 hours.

To promote weight loss, please ensure that the patient is compliant with the low-fat diet plan, which will be directly sent to his by the dietician. Worthy to note, he has been advised to refrain from traveling and rigorous activities until his follow-up appointment six weeks later, but he will be able to resume work after four weeks. He has been counseled on risk-factor management after discharge, and appropriate referrals have made to support his recovery.

Should you have any further queries, please do not hesitate to contact me.

Yours sincerely

(Your name here)

Lesson 10: Practice Test

Case Notes:

You are a Registered Nurse at Brockville Hospital, Melbourne.

Today's Date:	15/02/2017
Patient Name:	Ms. Elizabeth Carmel
Prefers to be Addressed as:	Izzie
Address:	456, Francis Street, Brockville, Melbourne
Next of Kin:	George Thompson (husband)
BMI:	33
DOB:	02/04/1975

13/02/2017

Source of assessment: Husband

- Attended a party last night – complained of abdominal pain and vomiting after the party
- Today – became unconscious after feeling unwell and increasingly drowsy at home
- BIBA with husband to hospital

- Unconscious on admission – Husband thinks she fainted due to diabetes
- Diagnosed with diabetes 2 years ago – poor management with diet and medication (misses insulin doses)
- Diet: pancakes, 3–4 cups coffee, cheese omelette, muffins, biscuits, Fish and chips, fried chicken, sweetened juices, drinks wine daily (1–2 glasses), whiskey occasionally
- Irregular eating pattern, fasting for long periods of time/bingeing
- Underwent cataract surgery 10 years ago
- Takes multivitamins at home daily
- Not very active – goes for a slow walk 1–2 times/week
- No hx of any allergies/no medications
- Nil relevant medical history

Objective

Breathing rate – 32/min

Cough – Nil

Colour – pale dry skin, lips pink

BP – 90/45 mmHG

P – 128/min

Teeth – own

Mouth – clean and dry

Acetone breath

Blood gas analysis – severe metabolic acidosis (pH – 6.74, bicarbonate 5 mmol/L, blood ketones – > 8.0 mmol/L, serum glucose – 400mg/dL, anion gap – 24)

Other lab tests – abnormal

Admission Dx (diagnosis) – diabetic ketoacidosis

Nursing Management:

- Aggressive IV Fluids, norepinephrine, bicarbonate, insulin, IV bolus
- No evidence of infection
- Regained consciousness
- K replacement administrated
- Intake/output accurately
- Oxygen sat.

14/02/2017

- Blood glucose, Fluid, electrolyte, hydration status constantly monitored
- Mental status – normal
- Vital signs – normal
- Pt. urinating – renal function restored
- ECG reading – no sign of hyperkalaemia
- K+ values approaching normal
- Pt. tired – reports feeling "crampy and achey"
- Pt. educated re importance of taking insulin on time, importance of timely balanced meals to avoid emergency situations in future

15/02/2017

-

Pt. ready to be discharged home with husband

Discharge plan

- Initiate referrals to dietician, outpatient diabetes education, physiotherapist, District Nurse,
- Physiotherapist – initiate exercises for weight-loss, increase physical activity
- Dietician – correct imbalanced nutrition related to food, low-fat diabetic diet schedule – pt. requests info on options when out – send to home address
- Diabetes education from Diabetes Specialist Nurse re diabetes (maintain metabolic control in future, bingeing, wrong foods & T less physical activity S hyperglycaemia, monitor urine –ketones) – to T risk of future episodes – request home visit
- District nurse to monitor pt. – compliance with diabetes management, reinforce education re not missing insulin dose and mealtimes, educate re timing of insulin inj. & mealtime (30 minutes), monitor compliance with diet regimen and weight-loss program – Contact hospital immediately if unable to retain oral fluids
- Review after 15 days

WRITING TASK 16

Using the information given in the case notes, write a letter to Ms. Samantha Golden, Diabetes Specialist Nurse, Victoria Health Education Centre, Suite 548, 4th floor, 34 Collins Street, Melbourne requesting her to visit your patient at home to provide instructions on continued self-care after discharge.

SAMPLE ANSWER

15/02/2017

Ms. Samantha Golden
Diabetes Specialist Nurse
Victoria Health Education Centre
Suite 548 4th floor
34 Collins Street
Melbourne

Re: Ms. Elizabeth Carmel; DOB: 02/04/1975
456, Francis Street, Brockville, Melbourne.

Dear Ms. Golden

I am writing to refer Ms. Carmel, a diabetic patient, who was admitted in an unconscious state on 13/02/2017, was diagnosed with diabetic ketoacidosis, and is being discharged today. She requires a home visit for education on diabetes management to reduce the risk of a future diabetic emergency.

Ms. Carmel was diagnosed with diabetes two years ago but has been poorly compliant with timely administration of insulin. She consumes fat-rich diet, a moderate quantity of alcohol, and has an irregular eating pattern. Her BMI is above the ideal range (33), and she engages in little physical activity.

During hospitalization, she responded well to the treatment and on was educated on the role of timely doses of insulin and diet to control her diabetes. Her condition has stabilized, and she will be reviewed after 15 days.

Given Ms. Carmel's history and recent emergency, please guide her on how to maintain metabolic control in the future as well as the dangers of hyperglycaemia resulting from excessive food intake, eating the wrong

kinds of food, and decreased activity levels. Finally, she will also need to know the methods of testing urine for ketones. Please note, she prefers to be addressed as Izzie.

Should you have any further queries, please do not hesitate to contact me.

Yours sincerely
(Your name here)

WRITING TASK 17

Using the information given in the case notes, write a letter to Ms. Angelina Hobbs, Dietician, Salona Health Clinic, Suite 404, 11th Floor, Bourke Street, Melbourne.

SAMPLE ANSWER

15/02/2017

Ms. Angelina Hobbs
Dietician
Salona Health Clinic
Suite 404, 11th Floor
Bourke Street
Melbourne.

Re: Ms. Elizabeth Carmel; DOB: 02/04/1975
456, Francis Street, Brockville, Melbourne.

Dear Ms. Hobbs

The purpose of this letter is to request low-fat, diabetic guidelines for Ms. Carmel, a diabetic patient, who was admitted to hospital on 13 February in an unconscious state owing to diabetic ketoacidosis. Her condition has stabilized, and she is being discharged today.

Ms. Carmel has had poorly-controlled diabetes for two years, and her risk factors include non-compliance with timely administration of insulin and consumption of a fat-rich diet including pancakes, 3-4 cups of coffee, cheese omelette, muffins, biscuits, fish and chips, fried chicken, and sweetened juices. She also consumes 1-2 glasses of wine daily and

whiskey occasionally. Furthermore, little physical activity compounded with the wrong choice of foods and erratic eating patterns have led her to become obese (BMI 33).

During hospitalisation, she has been educated on the importance of nutrition in effective management of diabetes, and adequate referrals have been made to increase her knowledge of precipitating factors to avoid recurrences in the future.

Given the above, it would be greatly appreciated if you could advise a low-fat, diabetic dietary timetable for Ms. Carmel to correct her nutrition imbalance. She has also requested information on meal choices outside the home. This information needs to be sent directly to her home address.

Please contact me with any questions.

Yours sincerely
(Your name here)

THE IMPORTANCE OF CLEAR PARAGRAPHING

Think of paragraphs as a type of punctuation. As a sentence has a group of words that work together to function as a sensible whole, a good paragraph achieves the same.

It's not enough to just sort your information into different paragraphs; it is important that each paragraph develops a

main point.

Let us look closely at the structure of the letter to the dietician, on the previous page.

Paragraph 1

The letter begins with an introduction to the purpose of the letter. It clearly establishes the purpose and engages the reader. Specific details about the recent episode of diabetic ketoacidosis and her admission in an unconscious state provide an important perspective on the necessity of controlling her diabetes.

Paragraph 2

The second paragraph supplies all precise and necessary details about Ms. Carmel's dietary habits and her BMI, which would be important considerations by the dietician.

Paragraph 3

The third paragraph provides a relevant summary of Ms. Carmel's hospitalisation and emphasises the need for dietary modification to control her diabetes.

Paragraph 4

The fourth paragraph neatly rounds off the letter by reiterating the purpose of the letter and includes specific instructions for the reader to act on the request.

WRITING TASK 18

Using the information given in the case notes, write a referral letter to Ms. Pamela Wilkins, District Nurse, requesting her to visit Ms. Carmel at home for monitoring her condition.

SAMPLE LETTER

15/02/2017

Ms. Pamela Wilkins
District Nurse

Re: Ms. Elizabeth Carmel; DOB: 02/04/1975
456, Francis Street, Brockville, Melbourne.

Dear Ms. Wilkins

I am writing to request home visits to monitor Ms. Carmel's condition following her discharge today. She was admitted on 13 February in an unconscious state owing to diabetic ketoacidosis.

Ms. Carmel has had diabetes for the past two years with poor adherence to timely insulin administration. Her risk factors also include consumption of a fat-rich diet with moderate alcohol consumption and irregular eating habits. Although she has been educated on the importance of diabetes management, you are requested to reinforce the guidance already provided in the hospital regarding the necessity of not missing insulin doses, eating meals at regular intervals, and maintaining a gap of 30 minutes between insulin injections and mealtimes.

Ms. Carmel engages in little physical activity and is obese (BMI 33). To promote weight loss, a physiotherapist has been requested to commence the patient on a weight-loss program, and it would be appreciated if can oversee his adherence to the same. In case she is unable to retain any fluids, please contact us immediately. Her follow-up appointment is scheduled after 15 days. Please note, she prefers to be addressed as Izzie.

Should you have any further queries, please do not hesitate to contact me.

Yours sincerely

(Your name here)

WRITING TASK 19

Using the information given in the case notes, write a referral letter to Ms. Alka, Physiotherapist, GNB Medical Centre, 45–50 Sacramento Road, Coburg requesting her to visit Ms. Carmel at home for initiating a weight-loss program.

SAMPLE ANSWER

15/02/2017

Ms. Alka
Physiotherapist
GNB Medical Centre
45-50 Sacramento Road
Coburg

Re: Ms. Elizabeth Carmel; DOB: 02/04/1975
456, Francis Street, Brockville, Melbourne.

Dear Ms. Alka

I am writing to refer Ms. Carmel, an obese woman, who was admitted on 13 February in an unconscious state owing to a diabetes-related complication. She is being discharged today, and she requires home visits from you for a weight-loss program.

Up until now, her lifestyle has comprised of little physical activity in her routine. She goes for a slow walk one to two times in a week. Moreover, she consumes a fat-rich diet; consequently, she is obese, and her current BMI is 33. Owing to these lifestyle habits, she has had

poorly managed diabetes for the past two years.

With treatment, her condition has improved; however, she needs to lose weight and increase physical activity for better management of diabetes and to reduce the risk of diabetes-related emergencies in the future. A dietician has been requested to send low-fat, diabetic guidelines to her house directly, and she is due for a review in 15 days' time.

It would be greatly appreciated if you could visit Ms. Carmel at her house and initiate an exercise program to promote her weight-loss. Kindly assist her in gradually increasing physical activity to achieve better diabetes control. Please note that she prefers to be addressed as Izzie.

Please contact me with any questions.

Yours sincerely
(Your name here)

Mistakes to Avoid

Lesson 11: Common Mistakes

Fused Sentence When two complete sentences are joined together without adequate punctuation.	**INCORRECT**: *Mr. Nutt is being transferred to hospice today his wife is going to stay with her sister until a bed becomes available for her.*
Comma Splice When two complete sentences are joined with a comma but without a conjunction.	**INCORRECT**: *Mr. Nutt is being transferred to hospice today, his wife is going to stay with her sister until a bed becomes available for her.*

To correct the error, you must first identify the two complete sentences.

In the above table, *'Mr. Nutt is being transferred to hospice today'* is one sentence and *'his wife is going to stay with her sister until a bed becomes available for her'* is another sentence.

Then you can choose one of following two ways to write them correctly.

1) Add a period/full-stop between the two complete sentences and capitalize the first letter of the second sentence to let them stand on their own.	*Mr. Nutt is being transferred to hospice today. His wife is going to stay with her sister until a bed becomes available for her.*
2) Add a semicolon between the two complete sentences to create a link between them. (You do not need to capitalize the first letter in the second sentence when joining them with a semi-colon).	*Mr. Nutt is being transferred to hospice today; his wife is going to stay with her sister until a bed becomes available for her.*

If there is a gap in meaning between the two sentences, you can choose between a coordinating conjunction, subordinating conjunction or a conjunctive adverb to guide your reader from one idea to the next and indicate their relationship to each other.

A coordinating conjunction can be	*The patient lost a lot of*

used to strengthen the link between the independent ideas. This sentence is known as a **compound sentence**. The two independent sentences are combined together with a conjunction and a comma between them.	*blood during the surgery, so he was transfused three units of packed blood cells postoperatively.*
Use a semi-colon followed by conjunctive adverb to combine the two sentences when you want to emphasize the relationship between them.	*The patient lost a lot of blood during the surgery; therefore, he was transfused three units of packed blood cells postoperatively.*
Use a subordinating conjunction to combine the two	*Since the patient lost a*

sentences when you want to relegate one clause to a lower status.	*lot of blood during the surgery, he was transfused three units of packed blood cells.*

COMMON MISTAKES

Exercise 1: Editing Errors with Capitalisation

Find the missing capital letter in the following sentences.

1. since the patient lost a lot of blood, he needed blood transfusion.

2. the patient has been referred to dr kapoor, a gastroenterologist.

3. mr. dawson has been treated for hypertension.

4. rose' mother has been diagnosed with alzheimer's disease.

5. the doctor prescribed xanax to the patient.

Answers

1. Since the patient lost a lot of blood, he needed blood transfusion.

(The first letter of a sentence is capitalised).

2. The patient has been referred to Dr Kapoor, a gastroenterologist.

(Capitalise the first letter of a person's name and the first letter of the title that comes before a person's name).

3. Mr. Dawson has been treated for hypertension.

(Capitalise the first letter of a person's name and the first letter

of the title that comes before a person's name).

4. Rose' mother has been diagnosed with Alzheimer's disease.

(Capitalise the first letter of a person's name. If a medical condition is based on a person's name, capitalise the first letter).

5. The doctor prescribed Xanax to the patient.

(The first letter of a sentence is capitalised. The first letter of a brand name is capitalised).

Exercise 2: Correct the Errors in the Following Sentences

1. During initial visit on 01/06/2010, Mr Walter was thermodynamically stable and hence 6 units of blood was transfused.

_____

_____

2. The examination revealed thin-walled gall bladder with severe echogenic foci and acoustic shadows. Thus, recommended for surgical opinion.

_____

_____

Answers

1. During initial visit on 01/06/2010, Mr Walter was thermodynamically stable; hence, 6 units of blood was transfused.

(Two independent sentences can be joined with a semi-colon and a conjunctive adverb followed by a comma).

OR

During initial visit on 01/06/2010, Mr Walter was thermodynamically stable, and hence, 6 units of blood was transfused.

(Two independent sentences can be joined with a comma and a conjunction, and the adverb preceding the subject will be separated from it with a comma).

OR

During initial visit on 01/06/2010, Mr Walter was thermodynamically stable. Hence, 6 units of blood was transfused.

(Two independent sentences can be separated with a period. The adverb preceding the subject will be separated from it with a comma).

2. Mr Singh's examination revealed thin-walled gall bladder with severe echogenic foci and acoustic shadows. Thus, he was recommended for surgical opinion.

(Subject and auxiliary verb were omitted after the adverb in the incorrect sentence)

Coherence

Ensure that your paragraph is coherent i.e., it is easy to read and understand because

- Your supporting sentences are in a logical sequence
- The ideas are connected with the use of appropriate transition words, where necessary.
- It has unity. In other words, it deals with a single idea, and all sentences develop that idea. For example, if your paragraph is about the medical situation of a patient,

mention all relevant details from the social history of the patient in this paragraph. However, information related to medical conditions, current medications, allergies, current complaints, and treatment offered for these complaints should be mentioned in other paragraphs.

Exercise 3

Read the two paragraphs that follow. All of them discuss the patient's first visit to a clinic.

In your opinion,

1. Which paragraph discusses more than one topic?
2. Which paragraph is more coherent?

Rosa initially presented on 11/10/2019 with a 1-day history of productive cough, fever, weakness, and lethargy. The examination findings that day were consistent with bronchitis; therefore, she was prescribed antibiotics and was advised to return for a review after five days.

During her visit on 11/10/2019, Rosa presented with complaints of productive cough, fever, weakness, and lethargy that began one day before. Rosa reported that her current mediations include Ramipril for hypertension and insulin injections for diabetes. Rosa was prescribed antibiotics based on an assessment of bronchitis and was advised to return for a review after a month.

Answers

1. The second paragraph. It discusses the patient's visit on

11/10/2019: her complaints, assessment, and treatment given. It also provides information about her medical history and ongoing medications. The main idea of this paragraph is about the patient's visit on 11/10/2019, so the details about medical conditions and medications do not support the theme of this paragraph.

2. The first paragraph. There are several reasons for this. For a paragraph to be coherent, there must be a logical progression of ideas. In the first paragraph, each sentence flows smoothly into the next one, while in the second paragraph, there are sudden jumps in the first three sentences. Notice how the second paragraph repeatedly uses the patient's name in each sentence, whereas the first paragraph uses a pronoun 'she' to refer back to the patient's name, making it easier and clearer for the reader. The use of transition words like 'initially' and 'therefore' in the first paragraph also make it more coherent than the first one. 'Initially' tells the reader that this was the patient's first visit. 'Therefore' indicates the following sentence is a result of the preceding sentence.

About the Author

Gurleen Khaira is a nationally acclaimed OET trainer and award-winning author of three OET-preparation books. She has a post-graduate qualification in TESOL (Teaching English to Speakers of Other Languages), and her company, Khaira Education, is a Premium Preparation Provider for OET training. She has received four national awards in India for her work in the education sector.