OET 2.0 PRACTICE TESTS
NURSING - WRITING
Information

This test has one part.

What is the Writing sub-test?

The writing sub-test takes 45 minutes. It is profession specific. You take this part of OET using materials specifically for your professional – a nurse does the task for nursing, a dentist does the task for dentistry and so on. In each test, there is one task set for each profession based on a typical workplace situation and the demands of the profession.

The task is to write a letter, usually a referral letter. Sometimes, and particularly for some professions, a different type of letter is required: e.g. a letter of transfer, or a letter to advise or inform a patient, carer or group.

With the task instructions, you receive stimulus material (case notes and/or other related documents), which includes information o use in your response.

The first five minutes of the test is reading time. During this time, you may study the task and notes but may not write, underline or make any notes.

For the remaining 40 minutes you may write your response to the task. You will receive a printed answer booklet in which you must write your response. This also has space for rough work. You may write in pen or pencil.
Practice Test 1.
You are a registered nurse working at Freemont Community Hospital. Your patient, Ms Sheila Cartwright, is being discharged today.

Patient: Sheila Cartwright (Ms)
Age: 69 Years
Martial status: Single
Family: Nil
First admitted: 14 April 2017, Freemont Community Hospital
Discharge: 30 April 2017
Diagnosis: Unstable diabetes mellitus.
Small infected (left) foot ulcer.
Medical history: Non-insulin-dependent diabetes mellitus – 9 years.
Medications: Glibenclamide (Glimel) 5mg daily.
Metformin (Diabex) 800mg t.d.s.
Amoxycillin/clavulanate (Augmentin Duo Forte, 125mg orally, b.d.)
Family background: Retired at 67 from administrative position.
Lives alone in own three-bedroom home.
Income: small pension – much lower than pre-retirement income.
Reports no relatives or close friends.
Reports no outside interests.
Since retirement – alcohol intake ↑, and dietary quality ↓
Periodic problems with self-administration of hypoglycaemic medication.
Nursing management and progress:
Medical hypoglycaemic agent (glibenclamide) to continue.
Antibiotic therapy (Augmentin Duo Forte) for review at completion of current course.
Ulcer daily saline dressing, monitor wound margins, observe for signs of complications, review healing progress etc.

Discharge plan:
Monitor medication compliance, blood sugar levels, alcohol intake, diet.
Encourage moderate exercise programme.
Suggest establishment of income-producing activity.
Encourage establishment of social activities.
Prepare a letter to the community nurse, emphasising the needs for an overall life-style plan, and suggesting involvement of community social service worker.

Writing Task
Using the information given in the case notes, write a letter of discharge to Mrs Edith Penny, the community nurse at Freemont Community Health Centre, informing her about the patient’s conditions and her medical and social needs. Address your letter to Mrs Edith Penny, Community Nurse, Freemont Community Health Centre, Freemont.

In your answer:
- Expand the relevant notes into complete sentences.
- Do not use note form.
- Use letter format.

The body of the letter should be approximately 180-200 words.
Mrs Edith Penny  
Community Nurse  
Freemont Community Health Centre  
Freemont  

30 April 2017  

Dear Mrs Penny,  

Re: Ms Sheila Cartwright, 69 years old.  

I am writing to you regarding Ms Cartwright, who has been an inpatient at Freemont Community Hospital since 14 June 2017 due to unstable diabetes mellitus and a foot ulcer. She is now ready for discharge.

Ms Cartwright was admitted for stabilisation of her non-insulin dependent diabetes mellitus, for which she has been treated with oral anti-hyperglycaemic agents (glibenclamide 5mg daily; metformin 850mg t.d.s.) for the past 15 years. In relation to the small ulcer on her left foot, this has responded to antibiotic therapy (Augmentin Duo Forte) and daily saline dressings. The Augmentin Duo Forte will need to be reviewed at the completion of the current course. Furthermore, Ms Cartwright will require ongoing management and monitoring of the wound for complications.

Ms Cartwright retired in 2015, and her lifestyle has deteriorated since this time. She would benefit from your help in monitoring her medication, blood sugars, alcohol intake and diet. It might also help to introduce her to some ways of expanding her social activities and engaging in moderate exercise. As her income has decreased since her retirement, Ms Cartwright might be encouraged to undertake some income-producing activity. A referral to the community social worker may be of benefit.

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

Yours sincerely,  

Registered Nurse
Practice Test 2.
You are the Midwife at the Saint Daphne Maternity Hospital overseeing Baby Nesbitt.

**Patient Details**

**Name:** Alicia Nesbitt  
**Age:** 6 days  
**Next of Kin:** Gemma Poole (Mother)  
**Date of birth:** 22 April 2016  
**Discharge date:** 28 April 2016  
**Diagnosis:** Low birth weight & opioid dependence  
**Family:** Will live with mother at maternal grandfather’s house  
**Social background:** Mother (20 yrs) heroin dependent 2 yrs  
Mother, single and recently worked as a sex worker.  
Estranged from father of Alice as alleged domestic violence towards her during pregnancy.  
Gemma’s mother supportive.  
First child.  
Social Services involve but approve of discharge living situation as long as with grandmother

**Medical history & Medications:** See Dr’s notes (to be forwarded)

**Management and Progress during Admission:** Both mother and baby completed heroin withdrawal without complications
Baby 2.0kg at birth; 2.3kg 28/4/11
Bottle feeding erratically ↓ appetite
Poor bonding between mother and baby.
Gemma often needs prompting to care for baby.
Drug and alcohol team involved in managing Gemma’s ongoing
Addiction issue.

Discharge plan:
Daily visits until pt stable weight and feeding stable
Ensure safe environment for baby and update social worker if risks present
Monitor mother’s coping and psychosocial state
Educate mother and grandmother on infant care
Liaise with drug and alcohol team to provide integrated support for mother to ↓ risk of heroin use.

WRITING TASK
You are the Midwife on the maternity ward where Alicia Nesbitt was born and need to write a letter to the local community midwifery team outlining relevant information and requesting discharge follow-up. Address the letter to Saltown Maternal and Child Health Centre, Saltown.

In your answer:

- Expand the relevant notes into complete sentences.
- Do not use note form.
- Use letter format.

The body of the letter should be approximately 180-200 words.
Senior Midwife  
Community Midwifery Team  
Saltown Maternal and Child Health Centre  
Saltown  

28 April 2016  

Dear Senior Midwife,  

Re: Alicia Nesbitt, DOB: 22/04/2016  

I am writing to you regarding Alicia Nesbitt, who has remained at St Daphne’s Maternity Hospital since birth due to being born opioid dependent and with a low birth weight. She is now ready for discharge.  

Alicia’s mother, Gemma, has been heroin dependent for two years and recently worked as a sex worker. Both baby and mother completed heroin withdrawal following Alicia’s birth without complications. The drug team remain involved in managing Gemma’s substance misuse. At birth, Alicia weighed 2.0kg; today, Alicia weighs 2.3kg. However, she has been bottle feeding erratically and her appetite seems to be decreasing. Moreover, Gemma often needs prompting to care for Alicia and the bond between mother and baby appears to be poor.  

Gemma is not in a relationship with Alicia’s father due to domestic abuse. Social Services are involved and have approved of Alicia being discharged with Gemma to maternal grandmother’s home. I am writing to ask you to support this arrangement by undertaking daily visits until Alicia’s weight and feeding routine have stabilised. Please ensure that grandmother’s home is a safe environment for Alicia and educate Gemma and grandmother on infant care. It will be important to monitor Gemma’s psychosocial state and liaise with the social worker and drug and alcohol team to lessen the risk of heroin use.  

The doctor’s notes will be forwarded to you. In the meantime, if you have any queries, please do not hesitate to contact me.  

Yours sincerely,  

Midwife
Practice Test 3.
OCCUPATIONAL ENGLISH 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.

NOTES

You are Joanna Andrews, a senior nurse working with ‘We Care Home Nursing Agency’. Stephen Kerry is the patient. Read the case notes below and complete the writing task which follows.

**Patient Details:**
Stephen Kerry  
8 Shaw Street, Perth, WA 6000  
DOB: 16/06/1963

**Social background:**
Lives with wife, Jennifer Kerry, aged 46.  
Works as an accountant in a company in Perth.

**Medical history:**
Faced cerebrovascular accident (CVA) some 2 years ago.  
Alert, mentally active, speech slightly slurred  
Complains of ill health  
Walks with limp, impaired balance

**12/07/2011** – felt extreme headache in the morning, fell down the stairs. Badly injured right knee, GP requested ‘We Care Home Nursing Agency’ for support with dressing and assisting in taking shower daily. GP advised painkillers as needed to manage pain.

**Management:**

**13/07/2011** – first visit from nursing agency. Stephen was bed bound and did not want to shower. Complained of pain in right knee so 400mg paracetamol dispensed. Warm compress applied to knee and dressing changed.

**15/07/2011** – right leg knee – redressed, no infection noted. Stephen was able to walk little distances with help from his wife. Complained of usual pain while walking, apart from this nothing and he is doing well.

**19/07/2011** – knee healing well. Patient beginning to walk using walking sticks for support. Wife, Jennifer, requested more home visits in order to accelerate progress in his mobility and so that he can get out of the house.
Discussion with Jennifer regarding need for physio to do assessment to determine how regularly pt will need visiting and what type of exercises will be best for him.

**WRITING TASK**

Using the information given in the case notes, write a letter to the Hayman Physiotherapy Centre, 23 West End, Perth, on behalf of Jennifer, requesting a home visit to help her husband in regaining mobility following his recent knee injury.

**In your answer:**

- Expand the relevant notes into complete sentences.
- Do not use note form.
- Use letter format.

The body of the letter should be approximately 180-200 words.
Senior Physiotherapist  
Hayman Physiotherapy Centre  
23 West End  
Perth  

19 July 2011  

Dear Senior Physiotherapist,  

Re: Stephen Kerry, DOB 16/06/1963  

I am writing to refer Mr Kerry to your physiotherapy services to support him in attaining greater mobility following a serious injury to his right knee on 12/07/2011.

Mr Kerry suffered from a cerebrovascular accident in 2009 which has resulted in him walking with a limp and experiencing impaired balance. On 12/07/2011, Mr Kerry had a headache in the morning and then fell down the stairs, injuring his right knee in the process. I have been attending to Mr Kerry daily since 13/07/2011 at the request of his GP to support with dressing the wound, offering pain relief and undertaking personal care. Mr Kerry’s knee is healing well and no infection has been noted. Mr Kerry has been managing the pain with 400mg paracetamol as required.

Mr Kerry is beginning to walk using walking sticks for support. He has spoken of experiencing ‘the usual’ pain when walking, but is doing well. It is important that Mr Kerry regains as much mobility as possible; he works as an accountant and is alert and mentally active. Therefore, being house-bound could have a negative impact on his mental health. Please could you arrange to undertake an assessment at home of Mr Kerry’s mobility and devise an appropriate programme of strengthening exercises for him.

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

Yours sincerely,

Joanna Andrews  
Senior Nurse  
We Care Home Nursing Agency
Practice Test 4.
OCCUPATIONAL ENGLISH 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.

NOTES

You are a Registered Nurse who has been caring for an elderly patient named Phillip Satchell. Mr Satchell now requires further management and care at another facility.

Patient: Phillip Satchell

Marital status: Wife deceased (2014)

Age: 73

Family: Two sons in their 40’s in Darwin.

First attended community centre: March 2015

Last visit to community centre: Feb 2018

Diagnosis: Multiple sclerosis, Type 2 diabetes, chronic L & R leg ulcers

Social/Medical Background:
Current: lives alone in public housing in Orange
Previous: lived with dec. spouse

Patient details: Will move to equivalent housing in Maroubra to access for MS treatment.
Income: small pension
Poor compliance with oral diabetic agents and diabetic diet
MS currently stable but frequent relapses
2-3/12 Staphylococcus Aureus infections in leg ulcers; pus ++
Lonely and isolated, but nil mental illness; good relations with sons but rarely see them. They run a pet shop business.
Nursing management and progress:
Medications: IV antibiotics twice daily and metformin for diabetes three times per day.
Twice daily dressings to L & R legs
Monitored blood sugar levels, medication compliance and provided education for diabetes.
Constantly monitored for signs of MS relapse.

Transfer plan
Switch to oral antibiotics but continue same diabetic medications and dressings.
Please refer to Prince of Wales Diabetic Clinic (medication review + education).
Via your doctors, facilitate referral to neurologist for MS follow up. Support to link with community services to ↑ coping and social network.

WRITING TASK
Using the information in the case notes, write a transfer letter to the Community Nurse, Community Health Centre, Maroubra, outlining relevant information and requesting continued community care.

In your answer:

- Expand the relevant notes into complete sentences.
- Do not use note form.
- Use letter format.

The body of the letter should be approximately 180-200 words.
Community Nurse  
Community Health Centre  
Maroubra  

28 April 2016  

Dear Community Nurse,  

Re: Phillip Satchell, aged 73.  

I am writing to transfer Phillip Satchell into your care. Mr Satchell is moving to Maroubra for improved access to treatment for MS. In addition to MS, Mr Satchell is diagnosed with Type 2 diabetes and experiences chronic right and left leg ulcers.  

Mr Satchell’s MS is currently stable but this frequently deteriorates; he is therefore closely monitored for signs of relapse. For his diabetes, Mr Satchell takes metformin three times daily and is supported with monitoring his blood sugar levels. Despite education, the patient’s compliance with oral diabetic agents and a diabetic diet is poor. Mr Satchell experiences regular staphylococcus aureus infections and the ulcers in his legs are often filled with pus. Therefore, he receives IV antibiotics twice daily and twice daily dressings to both his left and right legs.  

Upon transfer to your locality, Mr Satchell should switch to oral antibiotics but continue with the same diabetic medications and twice daily ulcer dressings. A referral to the Prince of Wales Diabetic Clinic is necessary for a medication review and to reiterate diabetes education. Via the GP, please facilitate a referral to the neurologist in relation to Mr Satchell’s MS diagnosis. Finally, it would be appreciated if you could connect Mr Satchell to community support services to enhance his social network.  

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

Yours sincerely,  

Registered Nurse
Practice Test 5.
Mr Gerald Baker is a 79-year-old patient on the ward of a hospital in which you are Charge Nurse.

**Patient Details**

- **Marital Status:** Widower (8 years)
- **Admission Date:** 3 September 2010 (City Hospital)
- **Discharge Date:** 7 September 2010
- **Diagnosis:** Left Total Hip Replacement (THR)  
  Ongoing high blood pressure
- **Social Background:** Lives at Greywalls Nursing Home (GHN) (4 years)  
  No children  
  Employed as a radio engineer until retirement aged 65  
  Now aged-pensioner  
  Hobbies: chess, ham radio operator  
  Sister, Dawn Mason (66), visits regularly; v supportive  
  - plays chess with Mr Baker on her visits  
  No signs of dementia observed

**Medical Background:**

- 2008 – Osteoarthritis requiring total hip replacement surgery
- 1989 – Hypertension (ongoing management)
- 1985 – Colles fracture, ORIF

**Medications:**

- Aspirin 100mg mane (recommenced post-operatively)
- Ramipril 5mg mane
- Panadeine Forte (co-codamol) 2 qid prn

**Nursing Management and Progress:**

- Daily dressings surgery incision site
- Range of motion, stretching and strengthening exercises
- Occupational therapy
- Staples to be removed in two wks (21/9)
- Also, follow-up FBE and UEC tests at City Hospital Clinic
**Assessment:**

Good mobility post-operation
Weight-bearing with use of wheelie-walker; walks length of ward without difficulty
Post-operative disorientation re time and place during recovery, possible relating to anaesthetic – continued observation recommended
Dropped Hb post-operatively (to 72) requiring transfusion of 3 units packed red blood cells; Hb stable (112) on discharge – ongoing monitoring required for anaemia

**Discharge Plan:**

Monitor medications (Panadeine Forte)
Preserve skin integrity
Continue exercise program
Equipment required: wheelie-walker, wedge pillow, toilet raiser.
Hospital to provide walker and pillow. Hospital social worker organised 2-wk hire of raiser from local medical supplier.

**WRITING TASK**

Using the information given in the case notes, write a letter to Ms Samantha Bruin, Senior Nurse at Greywalls Nursing Home, 27 Station Road, Greywalls, who will be responsible for Mr Baker’s continued care at the Nursing Home.

In your answer:

- Expand the relevant notes into complete sentences.
- Do not use note form.
- Use letter format.

The body of the letter should be approximately 180-200 words.
Ms Samantha Bruin  
Senior Nurse  
Greywalls Nursing Home  
27 Station Road  
Greywalls  

7 September 2010  

Dear Ms Bruin,  

Re: Mr Gerald Baker, aged 79  

Mr Baker is being discharged from City Hospital back into your care today. He underwent a left total hip replacement. He has good mobility and can walk along the ward using a wheelie-walker without difficulty.

Mr Baker was recommenced on 100mg Aspirin daily post-operatively. In addition to his usual treatment for hypertension, he requires pain relief (Panadeine Forte, max 8 tablets/day) and daily dressing changes. He is to undergo a series of range-of-motion, stretching and strengthening exercises, and occupational therapy, to ensure a full recovery. We are sending a walker and wedge pillow with the patient. Our social worker has organised hire of a toilet raiser for two weeks.

During post-operative recovery Mr Baker appeared disoriented. As there is no record of dementia, this may relate to the anaesthetic; continued observation is nevertheless recommended. His sister may be able to comment. Mr Baker’s haemoglobin dropped post-operatively. He was transfused three units of packed red blood cells, without complication, and his Hb on discharge is stable (112). Please monitor for signs of anaemia.

Mr Baker will have his staples removed at City Hospital Clinic on 21 September. Follow-up blood tests (UEC, FBE) will also be conducted.

Please do not hesitate to contact me if you have any further questions.

Yours sincerely,  

Charge Nurse
Practice Test 6.
NOTES

You are a Registered Nurse preparing Mrs Jasmine Thompson’s discharge. Mrs Thompson has had a right total shoulder replacement. She is to be discharged home today with assistance from ‘In-Home Nursing Service.’

Patient: Mrs Jasmine Thompson
Address: 73 White Road, Bayview
DOB: 01.07.1942
Age: 75

Social/family background:
- Lives in single-storey house with large garden
- Utilises cleaning services once a month
- Widow. 1 daughter – lives in Bayview. 1 son – married w/ 2 children, lives in Stillwater.
- Daughter will stay with mother 1 month post-op.

Medical History:
- R humerus fracture – 1997
- Osteoarthritis – r shoulder which has not responded to conservative treatment
- Chronic R shoulder pain - ↓ movement and ability to carry out activities of daily living (ADL)

Medication:
- Voltaren 50mg daily (ceased 14 days pre-operatively)
- Panadeine Forte (codeine/paracetamol) 30/500mg x 2, 6hrly 6.r.n.

Admission diagnosis: R shoulder osteoarthritis

Medical treatments record:
- 11.07.17 – total shoulder replacement (TSR)
Medical progress:  
Post-op R shoulders x-rays – confirm position of TSR  
Post-op exercise regime – compliant with physiotherapy  
Post-op bloods – within normal limit  
Post-op pain mgmt. – analgesia, cold compress r-shoulder  
R shoulder wound – clean & dry, drain site – clean & dry  
Plan for discharge home today, nurse to assist at home

Nursing management:  
Observations – T, P, R, BP (all within normal range)  
Neurovascular observations – colour, warmth, movement  
Oral analgesia  
Wound care and observations  
Cold compress/shoulder-brace 4 hours per day  
ADL assistance as req’d

Physiotherapy management:  
Exercises as per TSR protocol – neck range of movement  
exercises & elbow and hand and pendular  
Cryo cuff (cold compress) 4 hours per day  
Discharge education  
Follow-up physiotherapy outpatients appt  
Referral to community hydrotherapy

Discharge plan:  
Patient discharge education – Post TSR:  
- R arm sling 4 wk & No lifting 4 wk  
- Physio outpatients x 2 per wk, plus hydrotherapy x 1 per wk  
- 10 days post-op staples removal, follow-up appointment in  
Orthopaedic Joint Replacement Outpatient Dept  
- Orthopaedic Joint Replacement Nurse Specialist contactable by  
calling hospital, Mon-Fri, for any concerns  
- Referral to ‘In-Home Nursing Service’ – assist with showering,  
administration of LMWH (Clexane) subcutaneous for 4 days as DVT  
(deep vein thrombosis prophylaxis)

**WRITING TASK**

Using the information given in the case notes, write a letter of referral to Ms, Roberts, a home nurse, informing her of the patient’s situation and requesting appropriate care. Address the letter to Ms Nita Roberts, In-Home Nursing Service, 79 Beachside St, Bayview.

In your answer:

- Expand the relevant notes into complete sentences.  
- Do not use note form.  
- Use letter format.

The body of the letter should be approximately 180-200 words.
Ms Nita Roberts  
In-Home Nursing Service  
79 Beachside Street  
Bayview  

15 July 2017  

Dear Ms Roberts,  

Re: Ms Jasmine Thompson  
73 White Road, Bayview  
DOB: 01/07/1942  

I would be most grateful if you could manage home care for Mrs Thompson, who is being discharged today after a total right shoulder replacement, following admission to the hospital for right shoulder osteoarthritis. Her daughter will stay with her for one month in her single-storey house once she has been discharged.  

Mrs Thompson’s post-operative phase was largely uneventful. She has been compliant with her physiotherapy exercise regime and her post-operative bloods remain in normal limits. Post-operative pain was managed with analgesia and a cold compress for four hours each day.  

On discharge, the patient was educated in post-operative care: she will wear a right arm sling for four weeks, and will require physiotherapy in the outpatient’s clinic twice a week, and hydrotherapy once a week. She is not to do any lifting for four weeks.  

Mrs Thompson will require assistance with showering and administration of her prescription Clexane injection, which is to be administered for four days as DVT prophylaxis.  

In ten days, her staples are scheduled to be removed with a follow-up appointment in the Orthopaedic Joint Replacement Outpatient Department. In case any issues arise, the specialist nurse can be contacted by calling the hospital during the week.  

Do not hesitate to contact me if you require additional assistance.  

Yours sincerely,  

Nurse
Practice Test 7.
OCCUPATIONAL ENGLISH 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.

NOTES

You are a ward nurse in the cardiac unit of Greenville Public Hospital. Your patient, Ms Martin, due to be discharged tomorrow.

Patient: Ms Margaret Helen Martin
Age: 81, DOB: 25 July 1935
Address: 23 Third Avenue, Greenville
Admission date: 15 July 2017
Social/family background:
Never married, no children
Lives in own house in Greenville
Financially independent
3 siblings (all unwell) and five nieces/nephews living in greater Greenville area
Contact with family intermittent
No longer drives
Has ‘meals on wheels’ (meal delivery service for elderly) – Mon-Fri (lunch and dinner), orders frozen meals for weekend
Diagnosis: Coronary artery disease (CAD), angina
Treatment: Angioplasty (repeat – first 2008)
Discharge date: 16 July 2017, pending cardiologist’s report
Medical information: Coeliac disease
Angioplasty 2008
Anxious about health – tends to focus on health problems
Coronary artery disease > aspirin, clopidogrel
Hypertension > metropolol (Betaloc), Ramipril (Tritace)
Hypercholesteolemia (8.3) > atorvastatin (Lipitor)
Overweight (BMI 29.5)
Sedentary (orders groceries over phone to be delivered, neighbour walks dog)
Family history of coronary heart disease (mother, 2 of 3 brothers)
Hearing loss – wears hearing aid

Nursing management and progress during stay:
Routine post-operative recovery
Tolerating light diet and fluids
Bruising at catheter insertion site, no sights of infection/bleedings noted post procedure
Pt anxious about return home

Discharge plan:
DIETARY
Low-calorie, high-protein, low-cholesterol, gluten-free diet (supervised by dietician, referred by Dr)
Frequent small meals, snacks, fluid

PHYSIOTHERAPY
Daily light exercise, 15 min walk, exercise monitored by physio
No heavy lifting, 12 wks

OTHER
Monitor wound site for bruising or infection
Monitor adherence to medication regime
Arrange regular family visits to monitor prog.

Anticipated needs of Pt:
Need home visit from community health/district nurse – monitor adherence to post-op meds, exercise, diet regime
Regular monitoring by Dr, dietician, physio
? Danger of family isolation, infreq. Family support

WRITING TASK
Using the information given in the case notes, write a letter to the Nurse-in-Charge of the District Nursing Service outlining Ms Martin’s situation and anticipated needs following her return home tomorrow. Address the letter to Nurse-in-Charge, District Nursing Service, Greenville Community Health Care Centre, 88 Highton Road, Greenville.

In your answer:
- Expand the relevant notes into complete sentences.
- Do not use note form.
- Use letter format.

The body of the letter should be approximately 180-200 words.
Nurse-in-Charge  
District Nursing Service  
Greenville Community Healthcare Centre  
88 Highton Road  
Greenville  

15 July 2017  

Re: Ms Margaret Helen Martin  
DOB: 25 July 1935  
23 Third Avenue, Greenville  

Dear Nurse,  

Ms Margaret Martin is due for discharge from our hospital tomorrow, after a successful angioplasty today.  

Ms Martin is 81 years old and has an established personal and family history of heart disease. She suffers from coeliac disease, and has reduced hearing, for which she wears a hearing aid.  

Ms Martin is overweight (BMI 29.5) and sedentary. She is anxious about her return home and in general. She does not independent book for herself and currently has meals delivered. Ms Martin will need support for the implementation of a routine to maintain her function and independence. Moreover, dietary and physiotherapy programmes have been devised and will be supported by her dietician and physiotherapy.  

Ms Martin has never married, is financially independent, and lives in her own home. Although she has a number of family members living nearby, their support is irregular, and Ms Martin may be at risk of social isolation. Your support in this regard would be appreciated.  

Please arrange regular home nursing support for Ms Martin. She has some bruising at the catheter insertion site that will need monitoring for infection or bleeding. It is important to ensure that Ms Martin adheres to her medication programme.  

Yours faithfully,  

Ward Nurse