OET 2.0 PRACTICE TESTS

NURSING - WRITING

HP

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 to 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 you 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.

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 working at Freemont Community Hospital. Your patient, Ms Sheila Cartwright, is being discharged today.

Patient: Sheila Cartwright (Ms)

Age: 69 years

Marital 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.
Suggest involvement of social services 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.). The patient has been diabetic for 9 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.

FAST TRACK IELTS

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 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 are involved 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 the 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 the 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 faithfully,

Midwife

Practice Test 3.

FAST TRACK IELTS

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 some pain while walking, apart from this,
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 a walking stick 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.

FAST TRACK IELTS

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 re 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 has been 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 and dressings twice daily 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.

FAST TRACK IELTS

WRITING SUB-TEST: MEDICINE

TIME ALLOWED: **READING TIME: 5 MINUTES**
WRITING TIME: 40 MINUTES

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

NOTES

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 (GNH) (4 years).
No children.
Employed as a radio engineer until retirement aged 65.
Hobbies: chess, 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).
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.

Post-operatively, Mr Baker was recommenced on 100mg aspirin daily. 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.

FAST TRACK IELTS

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 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 shoulder x-ray – 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
Cryon 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, 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.

FAST TRACK IELTS

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, is 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).
Hypercholesterolemia (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:

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, fluids.

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

Dear Nurse-in-Charge,

Ms Margaret Martin is due for discharge from our hospital tomorrow, pending on the cardiologist's report, after a successful angioplasty today.

Ms Martin's post-operative recovery was uneventful, and she is tolerating a light diet and fluids. Whilst there is bruising at the catheter insertion site, there are no signs of infection. Please note that she is anxious about her return home.

Ms Martin is overweight (BMI 29.5) and sedentary. She relies on 'meals on wheels' and wears a hearing aid for reduced hearing. Please note that she suffers from coeliac disease. 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.

Upon discharge, the patient 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 physiotherapist. Please monitor Ms Martin's wound site for bruising or infection and ensure that Ms Martin adheres to her medication programme.

Yours faithfully,

Ward Nurse

Practice Test 8.

FAST TRACK IELTS

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 nurse at Stillwater NHS Walk-In Centre, dealing with minor injuries and common illnesses.

Patient Name:	Ms Sally Brown
Occupation:	High school student
Date of Birth:	10 July 1995
Social History:	Lives at home with parents and younger brother. Loves animals. Wants to be a vet. Spends time with friends at weekends.
Medical History:	No major illnesses; nil allergies; had chicken pox when 5 years old.
Medication History:	Nil
Family History:	Father, mother, both well. Younger brother gets hay fever seasonally.
08/02/2010:	Came to Walk-In Centre with a badly scratched R arm. Was playing with family cat seven days ago – was not too worried about the scratch, however the scratch is now very red and looks to be infected (pus +++). Sally reports it was stinging at time but now stopped. Now ache and dull pain right arm → R armpit.
Prelim Diagnosis:	Cat Scratch Disease (CSD) from cat with *bartonella henselae* bacteria.
Subjective:	Patient reported headache, stomach cramping. Patient reported chills at night.
Objective:	Temp 39°C, pulse 78, BP 155/100 Swollen lymph nodes at R armpit region. Anxious demeanour.

Treatment:

- Heat pad applied to scratched area for pain relief.
- Scratched area cleaned with Savlon.

- Advised to keep scratched area clean – purchase antibacterial soap from pharmacy.
- Nurse Practitioner prescribed ciprofloxacin 500mg t.d.s for 10 days.

WRITING TASK

Using the information given in the case notes, write a letter to the patient, Miss Sally Brown, 10 Wood Street, Stillwater – which she herself could take to her GP if her symptoms do not improve over the coming weeks. Use this letter to outline her diagnosis, the examination and treatment.

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.

Miss Sally Brown
10 Wood Street
Stillwater

8th February 2010

Dear Miss Brown,

I am writing to you regarding your visit today to Stillwater NHS Walk-In Centre. This letter will provide you with information regarding your condition. You may wish to show this letter to your GP should you need further medical treatment for your recent injury.

You visited the Walk-In Centre due to a bad scratch on your right arm. You informed us that you sustained this injury while playing with your cat one week ago. At the time, the scratch stung but you were not too worried about it. However, the scratch then became red, and you thought it may be infected, as there was a lot of pus surrounding the wound. You also reported that your right arm is painful and aching all the way up to your armpit.

At the Walk-In Centre we diagnosed you with Cat Scratch Disease. This diagnosis was based on how the scratch looked, and the fact that you reported that you have been experiencing a headache and stomach cramps, as well as chills at night. Your temperature was high at 39°C, and we also noticed that you had swelling in your right armpit region. Your blood pressure was 155/100, which was a little bit high for your age, but your pulse was 78, which is normal.

As you will recall, we applied a heat pad to the scratch for pain relief and cleaned the scratched area with Savlon, which is an antiseptic. You should continue to keep the scratch clean and dry at home by using antibacterial soap, which you can purchase from the pharmacy. Finally, you must ensure that you take your prescribed medication, which is called ciprofloxacin 500mg. You should take this medication three times daily with meals for 10 days in order to ensure that the infection is properly treated.

If you notice any new symptoms or start to feel unwell, please return to the Walk-In Centre or contact your GP.

Yours sincerely,

Registered Nurse

Practice Test 9.

FAST TRACK IELTS

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 the charge nurse on the neurological ward where Amir Akbari has been treated.

Patient Name: Amir Akbari
Age: 41
Marital Status: Married
Religion and Ethnicity: Muslim and Iranian

Admission Date: 6 March 2011, Prince Charles Hospital Randwick
Discharge Date: 22 April 2011

Diagnosis: Guillain-Barre Syndrome
Family/Psychosocial: Lives in rented house with wife and two children (3&4).
Pt and wife both PhD students; speak good English.
↓ support network in Australia.
Children in university daycare 2/7; nil extra days available at centre.
Pt works at service station 3/7
Pt has PTSD due to war trauma in mid 80s. Prone to depression and anxiety.

Medical History and Medications:
Otherwise physically healthy prior to onset of GBS.
Medication info to be forwarded by doctor.

Management and Progress during Hospitalisation:

- Rapid deterioration and recovery.
- Required ventilation in ICU 3/7 March 20-22nd.
- At peak of GBS could not move limbs independently.
- Now ↓ muscle tone/strength and needs light assistance with ADLs but can walk slowly with frame.
- Went for regular plasmapheresis and had a total of 5/7 worth of IV gamma globulin.
- Daily physio program including self exercises.
- Now feeling depressed about his prospects.
- Wife not coping with financial, study and childcare pressure.

Discharge Plan:

- Continue physio program and encourage pt to do his own limb exercises too.
- Discuss with your team re ? need for psych assessment re? depression.
- Ensure social worker is aware of family and wife's stress and follows up.
- Requires halal meat
- Pt oxygenation very stable on R/A now but observe for any ↓ in respiratory status or ↑ in neurological signs.

WRITING TASK

Using the information given in the case notes, write a letter of transfer to the charge nurse at the Prince Henry Rehabilitation Centre, Malabar Bay, where he will be transferred to for rehabilitation after discharge from your ward.

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.

Charge Nurse
Prince Henry Rehabilitation Centre
Malabar Bay

22nd April 2011

Dear Charge Nurse,

RE: Amir Akbari, 41 years old

I am writing to transfer Mr Akbari into your care for rehabilitation following treatment on the neurological ward at Prince Charles Hospital Randwick for Guillain-Barre Syndrome. Mr Akbari was first admitted on 06/03/11 and is due for discharge today.

During hospitalisation, Mr Akbari deteriorated rapidly and required ventilation in the ICU for three days between 20/03/11 and 22/03/11. At the peak of the GBS, Mr Akbari could not move his limbs independently. As a result of this, his muscle tone and strength has decreased, and the patient therefore needs light assistance with ADLs. He can walk slowly with a frame. Mr Akbari had regular plasmapheresis and had IV gamma globulin for five days.

It should be noted that Mr Akbari is prone to depression and anxiety and has a diagnosis of PTSD due to experiencing war trauma in the mid-1980s. He is feeling depressed about his prospects following his illness. Mr Akbari and his family are socially isolated, and his wife is not coping with pressures associated with finances, study, and childcare.

Upon transfer to your facility, please ensure Mr Akbari continues with his physiotherapy programme and encourage him to do his own limb exercises too. The patient's oxygenation is currently stable, but please observe for any decrease in respiratory status or increase in neurological signs. Mr Akbari may need a psychiatric assessment, so please discuss this with your team. In addition to this, ensure that the social worker is aware of the pressures on the family and liaises with Mrs Akbari. Finally, please note Mr Akbari requires a halal diet.

Please feel free to contact me if you have any questions.

Yours sincerely,

Charge Nurse

Practice Test 10.

FAST TRACK IELTS

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 nurse in the Nurse-Led Outpatient Clinic at Newtown Hospital. You are taking care of Mr Pitman.

Patient Name: Mr Walter Pitman
Age: 69 years
Family: Married, 2 adult children
Job: Retired accountant

Habits: No smoking or alcoholism
Sedentary lifestyle, no exercise

Medical History: Hypertension since 2008
BMI 30

Admission Date: 01.07.2018
Discharge Date: 03.07.2018

History of Recent Admission:

- Accidental cut injury when using hand saw for cutting wood, referred by family physician for further care.
- Brought to Newtown Hospital with deep lacerations on lower left arm.
- On admission, wound cleaned, sutured, and dressed. Prophylactic IV antibiotic started, course completed.

02.07.18

- Stopped IV antibiotics.
- Oral antibiotics started, regular dressings.
- BP: 140/90mmHg (sitting)
  180/90mmHg (supine)

03.07.18

- Discharged, advised visits to Nurse-Led Outpatient Clinic.

04.07.18

- Now in care of Nurse-Led Outpatient Clinic
- He had severe pain with mild hematoma: recorded 8/10 on pain scale.
- BP: 186/89mmHg (sitting)
  190/86mmHg (supine)

06.07.18

- Wound condition is better, healing, dressing done
- BP: 190/86mmHg (sitting)
  196/88mmHg (supine)

08.07.18

- Wound is healing
- BP: 182/80mmHg (sitting)
  194/86mmHg (supine)

11.07.2018

- Wound dressing done, healing well without infection
- Blood pressure still elevated

14.07.18

- Wound healed well.
- BP: 190/84mmHg (sitting)
  196/86mmHg (supine)

Assessment: BP elevated, hypertension
Plan: Cardiac assessment for hypertension
Family physician referral

WRITING TASK

Using the information given in the case notes, write a referral letter to the family GP, Dr Laricell, Sneinton Surgery, Newtown, 2143, asking him to do a full cardiac assessment and management of Mr Pitman's hypertension.

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.

Dr Laricell, GP
Sneinton Surgery
Newtown
2143

14th July 2018

Dear Dr Laricell,

RE: Walter Pitman, 69 years old.

I am writing to refer Mr Pitman to you for a full cardiac assessment due to hypertension. Mr Pitman was initially admitted to Newtown Hospital on 01.07.2018 due to deep lacerations on his lower left arm following a handsaw injury. The wound was sutured, and he was treated with antibiotics and discharged on 03.07.2018. He has since visited the Nurse-Led Outpatient Clinic on five occasions for follow-up treatment.

Mr Pitman has had hypertension since 2008. While he is a non-smoker, he does lead a sedentary lifestyle and has a BMI of 30. During his visits to the Outpatient Clinic, Mr Pitman's wound has been regular dressed and has healed well without infection. However, his blood pressure has been taken on each of these visits and is a cause for concern. Mr Pitman's blood pressure has been consistently high. For example, on 04.07.18, his BP when sitting was 186/89mmHg, and 190/86mmHg when supine. On 06.07.18, the readings were 190/86mmHg (sitting) and 196/88mmHg (supine). On 08.07.18, his sitting BP was 182/80mmHg, while his supine BP was 194/86mmHg. Finally, today the readings were 190/84mmHg (sitting) and 196/86mmHg (supine).

On the basis of these consistently high blood pressure readings, I believe that Mr Pitman would benefit from further assessment and management of his hypertension from you.

Please feel free to contact me if you have any questions.

Yours sincerely,

Registered Nurse

Practice Test 11.

FAST TRACK IELTS

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 nurse with West County Home Care Agency, and you are caring for a patient named Harry Dawson.

Pt name: Harry Dawson

Address: 12 Beaconsfield St
Newshire
Durham

DOB: 04/03/1943

Social bg: Married – wife dec. 2016 (aged 80).
Retired military.
Mild stroke in 2014, no further attacks.
2 adult children (45 , 49).

MHx: Cerebrovascular accident (CVA) 6 years ago.
Gen. obs. All OK. Slight speech slur. Limp r/ leg.
Balance impairment.

18/02/19: Pt fell descending stairs, injured r/ knee.
GP request daily visits from West Country HCA.

19/02/19: No signs of infection, nil pus, slight mobilisation.

21/02/19: Pt exhausted from movement: “can’t feel my legs.”
Disturbed sleep.

23/02/19: Pt energy levels ↑, 8 hr sleep undisturbed.
Mobilised with use of wheelie-walker for 4 steps, unable to proceed.

29/02/19: Funding cut for West County Home Care Agency, unable to further assist pt.
Request referral to local nurses/GP surgery to further improve and assess pt mobility.
Pt requires further assistance with wheelie walker.

WRITING TASK

Using the information given in the case notes, write a referral letter to the local GP and nurses surgery. Address your letter to Senior Nurse, West County Surgery, Newtown, 2100 requesting further assistance for Mr Dawson.

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 Nurse
West County Surgery
Newtown
2100

29th February 2019

Dear Senior Nurse,

Re: Mr Harry Dawson, DOB: 04/03/1943

I am writing to refer our patient, Mr Harry Dawson, to you for continued assessment and assistance in improving his mobility after an injury to his right knee. Due to funding cuts, we can no longer provide this level of service to Mr Dawson, and we would appreciate your support in this.

On 18/02/19, the patient fell whilst descending stairs and injured his right knee. Following the GP's request for daily visits, we returned the following day to Mr Dawson's house. He showed no signs of infection, but his mobility was poor. On 21/02/19, he complained of exhaustion, numbness in his legs and disturbed sleep, however, over subsequent days his sleep and energy levels have improved. On 23/02/19, the patient began to mobilise with a wheelie-walker for short distances but with limited success.

Please note that Mr Dawson suffered from a CVA six years ago which resulted in a limp in his right leg and impaired balance. He also had a mild stroke in 2014 but there have been no further attacks since that point.

Due to the circumstances, we would greatly appreciate it if you could continue to support Mr Dawson in his recovery by assessing his mobility and assisting him with his wheelie-walker to further improve his mobility.

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

Yours faithfully,

Registered Nurse

Practice Test 12.

FAST TRACK IELTS

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 nurse who has just begun treating Ms. Catherine Royal. The patient is to be transferred to another facility today after worsening of her condition.

Name: Ms Catherine Royal

DOB: 19.09.72

Height: 163cm
Weight: 84kg (BMI 35.4 - morbid obesity risk)

Social history: Teacher (secondary – History, English)
Divorced, 4 children at home, born 1999 – 2007
Non-smoker (since children born)
Social drinker (mainly spirits)

Substance intake: Nil

Allergies: Codeine, dust mites, sulphur dioxide

Family history: Mother – hypertension, Father – peptic ulcer
Mat. Grandmother: died heart atk. Aged 80
Mat. Grandfather – died asthma atk
Pat. Grandmother – unknown
Pat. Grandfather – died "old age", 94 yrs

Pt details:

- Reports breathlessness, exhaustion, gas + air administered on ward.
- Mental health concerns, depression since 2016, low mood, socially isolated.
- Lower back pain, 2 yrs.
- Increased use of toilet (8-10x daily), urine analysis: nil irregularities.
- Gained 60lbs in 1 yr.

Nursing management and progress:

- Refer to outpatient clinic for support to lose weight.
- Low available beds at Newtown Infirmary Hospital, pt requires transfer to local community nurse.
- Advise 2x daily exercise.
- Social worker involvement for ADLs.
- Suggested psychological support to aid pt. recovery.

WRITING TASK

Using the information given in the case notes, write a transfer letter to Ms Sherry Winters, Community Nurse, Newtown Clinic, Newtown, 2143, asking for her to further evaluate and care for the patient in her community day ward.

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.

Sherry Winters
Community Nurse
Newtown Clinic
Newtown
2143

10th November 2018

Dear Ms. Winters,

Re: Ms Catherine Royal, DOB: 19/09/72

I am writing regarding Ms Catherine Royal, who has been receiving care at Newtown Infirmary Hospital. Ms Royal is at risk of morbid obesity and is suffering from symptoms potentially linked to this. Due to low bed availability, we request that this patient is transferred to you for further evaluation and care.

Ms Royal has a BMI of 35.4 which puts her at risk of morbid obesity. She reported feelings of breathlessness and exhaustion; therefore, she was given gas and air on the ward. The patient's toilet use has also increased to 8 – 10 times per day, however, a urine analysis confirmed no irregularities.

Please note that we have mental health concerns for Ms Royal, who has been suffering from depression since 2016. She complains of having a low mood and whilst she has four children at home, she reports feelings of isolation. The patient gained 60lbs in a year and has been suffering from lower back pain for the last two years. Ms Royal has a family history of heart attack, asthma and hypertension. She is a non-smoker, socially drinks and has an allergy to codeine.

Please refer this patient to the outpatient clinic for weight loss support and encourage her to exercise twice daily. I would also suggest the involvement of a social worker for support with ADLs. Finally, I would recommend that Ms Royal makes an appointment with a psychologist to support her recovery.

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

Yours sincerely,
Registered Nurse

Practice Test 13.

FAST TRACK IELTS

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 the nurse in a Community Health Centre. A patient you have been monitoring is moving to another city to live with his daughter.

Patient Details:

Name: Mr Peter Dunbar
DOB: 18.03.1932

Current medication:

Metformin (500mg t.d.s.) (oral hypoglycaemic)
Rampiril 5mg daily (anti-hypertensive, ACE inhibitor) for hypertension
Warfarin variable 3-5mg (anti-coagulant)
Solatol 40mg daily (beta blocker)

Treatment record:

September 2017

- Diagnosed with type diabetes Aug '16. Fasting blood sugar levels (BSL) = 9
- GP recommend dietary mngmt: low-fat, low-sugar, calorie restriction, limit alcohol. ↑ exercise
- Pt lives at home with wife. Wife cooks + managing dietary requirements. Pt likes 2-3 glasses wine with meals.

December 2017

- Wife deceased. PT depressed/grieving. Referred back to GP for monitoring/medicating. Fasting BSL = 9.
- Pt non-compliant with diet. Excessive fat, salt, sugar, alcohol (wine/beer)

March 2018

- GP prescribed metformin (oral hypoglycaemic agent).
- Now pt cooking for self, non-compliant with diet.

- Non-compliant medication. Blames poor memory → pt appears unmotivated. Resents taking medication: “always been healthy”.
- Takes medication intermittently, encourages to ↑ compliance
- Educated regarding need for regular medication

June 2018

- Pt hospitalised (City Hopital, Newtown) with myocardial infarction (MI) following retrosternal pain, nausea/vomiting, dizziness, swearing. Confirmed by ECG.
- Treatment: aspirin, streptokinase infusion. Prescribed rampiril 5mg daily. Diagnosed with atrial fibrillation post MI – commence sotalol and warfarin.

October 2018

- Pt now walking with stick. Sign of diabetic neuropathy. Poor exercise tolerance. Restricted mobility.
- Non-compliance with diet – still self-catering.
- Pt discontinued all other medication as felt unwell. Resumed medications but still only taking intermittently.
- Provided education re importance of adherence to medication.

22 January 2019

- Pt attended with daughter. Pt moving to Centreville to live with daughter & husband. Daughter will cook – requires education re: pt needs & monitoring.
- Pt resistant to dietary alterations and medication regimen.
- Still misses or double dose – all medication.
- Pt continues to require monitoring & encouragement
- Letter to transfer the pt to the care of the community health nurse in Centreville, where the pt is moving to live with his daughter.

NOTES

Using the information given in the case notes, write a letter to the Community Health Nurse in Centreville, outlining the patient’s history and requesting ongoing monitoring. Address the letter to the Community Health Nurse, Eastern Community Health Centre, 456 East Street, Centreville.

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 Health Nurse
Eastern Community Health Centre
456 East Street
Centreville

22 January 2019

Dear Nurse,

Re: Mr Peter Dunbar, DOB: 18.03.1932

Thank you for accepting Mr Dunbar into your care for the regular monitoring of his diabetes and encouragement to comply with his medication and dietary regimens. Mr Dunbar is moving to Centreville to live with his daughter.

Since October 2018, Mr Dunbar has shown signs of diabetic neuropathy and consequently mobilises with a walking stick. His type 2 diabetes is controlled by metformin and through his diet, however, he remains resistant to any form of treatment, and has not been compliant with his medication regimen, reporting poor memory as the primary cause of his neglect. On occasion he also doubles doses.

Contrary to advice, Mr Dunbar has continued to consume excessive amounts of alcohol, fatty foods, salt and sugar since the death of his wife last year, contributing to his current condition. While his daughter will now be cooking for him, she will require some guidance related to his needs.

In June 2018, he suffered a myocardial infarction for which he was hospitalised at City Hospital in Newtown. He was diagnosed with atrial fibrillation on the same admission and was subsequently prescribed warfarin and sotalol. His hypertension is controlled by Ramipril. As with his other medication, Mr Dunbar is intermittent in his compliance.

Thank you for your continued management of this patient.

Yours faithfully,

Nurse

Practice Test 14.

FAST TRACK IELTS

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 working at Kings Hospital. Your patient, Ms June Fortune is being discharged today.

Patient Details:

Name:	June Fortune (Ms)
Age:	46 years
Marital Status:	Divorce
Family:	Nil
Admission:	14 June 2015
Discharge:	19 June 2015
Diagnosis:	Thyrotoxicosis Atrial Fibrillation (new)
Medical History:	Hyperthyroidism – 9 years
Allergies:	Nil
Medication:	Carbimazole – as directed Propranolol Diazepam 2mg PRN
Family History:	CAD (Coronary Artery Disease) – father died at 89 years Eczema (sister)
Family Background:	Works as financial advisor. Lives alone in studio apartment. Income £38,000 per annum. Very stressful job. No outside interests, too tired after work.

Non-compliance of medications due to divorce.
Recent ↑ alcohol use.

Medical Background: Admission – dizziness, SOB, HR: 120

Nursing Management: Antithyroid medications to continue.
Referral to cognitive behaviour therapy (CBT) in the community.

Discharge Plan: Monitor medication compliance.
Monitor alcohol intake - ? refer to Drug and Alcohol Liaison.
Encourage establishment of social activities.
Write letter to CBT team in community for further management of condition.

WRITING TASK

Using the information given in the case notes, write a letter to Ms Fortune's GP, Dr Gerald Smith, informing him about the patient's condition and healthcare and social needs. Address the letter to Dr Gerald Smith, Freemont Surgery, 150 Buxton Avenue, London W1.

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.

Dr Gerald Smith
Freemont Surgery
150 Buxton Avenue
London W1

19th June 2015

Dear Dr Smith,

RE: Ms June Fortune, age: 46 years old.

I am writing regarding Ms June Fortune, who was admitted to Kings Hospital on 14/06/15. She was diagnosed and treated for thyrotoxicosis and atrial fibrillation. She is now ready to be discharged today into your care.

Upon admission on 14/06/15, Ms Fortune presented with dizziness, shortness of breath and a heart rate of 120. Considering these symptoms and her medical history, she was diagnosed with thyrotoxicosis along with atrial fibrillation. She was prescribed Carbimazole which is to be taken as directed.

You may be aware that the patient finds her job as a financial advisor very stressful and she is currently non-compliant with her medications to control her hyperthyroidism. In addition to this, Ms Fortune is also taking Propranolol and Diazepam 2mg prn. The patient is quite isolated being divorced, living along and with no close family. Her alcohol intake has also reportedly increased recently.

Following her discharge, please support Ms Fortune by monitoring her medication compliance and encouraging the establishment of social activities. I would also recommend that you perhaps refer the patient to a Drug and Alcohol liaison to monitor her alcohol intake. Finally, please write a letter to the local cognitive behaviour therapy team to further manage the patient's condition.

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

Yours sincerely,
Nurse

Practice Test 15.

FAST TRACK IELTS

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 the charge nurse at the Northwest Rehabilitation Hospital overseeing Mr O'Connor.

Patient Details

Name: Mr Andrew O'Connor

Age: 74 years

Date: 19 March 2010

Marital Status: Married

Religion: Catholic

Admission Date: 2 December 2009

Discharge Date: 22 March 2010

Diagnosis: L CVA (stroke) → right side hemiplegia (paralysis)

Social/Family History: Retired baker
Wife, 71 years, angina.
2 married children, not close proximity.
Lives in 3-bedroom family home.
Enjoyed fishing and golf prior to stroke.

Medical History and Medications:
See Dr's notes (to be forwarded).

Management and Progress:
Slow progress despite intensive physiotherapy and OT.
Requires assistance with ADLs.
Mobilises slowly with pick-up frame, able to self-feed.
Mood swings (angry, tearful, happy).
09/03/10 - Advised nursing home placement to family → refused.
11/03/10 - OT home assessment. Added handrails in bathroom and bedroom for ↑ mobility.

Discharge Plan: Review appointments 3x per week.
District nurse to visit 2x daily to:

- Assist with transferring in and out of bed.
- Grooming and hygiene needs.
- Monitor medication compliance.
- Monitor how pt coping at home, note also wife's health.
- Re-refer to hospital if necessary.

WRITING TASK

Using the information given in the case notes, write a letter of referral to the 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 Health Care Centre
88 Highton Road
Greenville

22nd March 2010

Dear Nurse,

Re: Mr Andrew O'Connor, aged 74 years old

I am writing regarding Mr O'Connor, who was admitted to the Northwest Rehabilitation Hospital on 02/12/09 following a left-side CVA which led to paralysis on the right side of his body. He is now ready for discharge today.

Following the patient's treatment, he has been making slow progress despite intensive physiotherapy and occupational therapy. He experiences mood swings, and he requires assistance with ADLs, however, he can still mobilise slowly with a pick-up frame, and he is still able to self-feed. On 09/03/2010, Mr O'Connor's family were advised to admit him to a care home, but they refused. Consequently, an OT assessment was carried out on 11/03/2010 on Mr O'Connor's home and improvements were made such as handrails in the bathroom and bedroom to support his mobility.

Regarding Mr O'Connor's discharge, he must attend three review appointments each week. We would kindly request a district nurse to visit him twice per day to assist him with transferring in and out of bed, personal hygiene, monitoring medication compliance and emotional support whilst living at home. His wife has angina so please enquire about her health also. If Mr O'Connor's condition declines, please re-refer him back to hospital. The doctor's notes will be forwarded to you shortly.

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

Your faithfully,

Nurse

Practice Test 16.

FAST TRACK IELTS

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

Mrs Mary Sands, a 75-year-old, is a patient in the medical ward on which you are Charge Nurse.

Hospital:	Francombe Public Hospital, 14 Lake Road, Francombe
Admission Date:	12 May 2016
Discharge Date:	22 May 2016
Diagnosis:	Fracture – left femoral neck
	Ongoing osteoporosis

Patient Details:

DOB:	15/12/42
Marital Status:	Married, husband 82 years old – cannot provide care at home
Residence:	28 Mercer Street, Francombe
Next of Kin:	Son, Andrew (42, married, not living in close proximity)

Social Background:

Retired travel agent
Active in local community
Hobbies: gardening, reading, walking, playing piano

Medical History:

12/05/16	Admission (following fall at home): x-ray revealed fracture of L femoral neck Pt complaining of acute severe pain in area of L hip and lower back – no numbness or burning On admission: BP 124/68 mmHg Temp: 36.6 C HR 100
13/05/2016	ORIF surgery (Open Reduction Internal Fixation) (L femoral neck)

Past Medical History:

2011, diagnosed with osteoporosis – Alendronate 10mg daily
Moderate drinker (3-4 glasses of winde per week)
Family history of lung cancer (father, uncle, grandfather)
No allergies

Medications:

- Post-op morphine 10mg IV 3 times a day prn → night-time confusion and hallucinations – morphine discontinued
- Risperidone 2mg daily (for confusion/hallucinations)
- Movicol (1 sachet b.d.) (ongoing)
- Alendronate 10 mg and Calcium and Vitamin D 600mg (once daily)
- Co-codamol (30mg/500mg) prn 2-4 times a day.

Nursing Management:

Monitor nutritional intake (pt complains of loss of appetite)
3 weeks of physio: can independently perform isometric & flexion/extension exercises in both lower extremities

Assessment: Good physical progress & good mobility overall.
Weight-bearing with use of wheelie-walker.
Able to dress, shower herself, use toilet with seat-raiser
To continue with Alendronate, Vit D, & Calcium, Movicol prn

Discharge Plan: Monitor medications (Co-codamol & Alendronate)
Monitor constipation
Continue physio programme
Dietician advice: high-protein & calcium- rich nutrition
Equipment required: toilet seat raiser; wheelie-walker, elevated chair cushion.

WRITING TASK

Using the information given in the case notes, write a letter to Mrs Sarah Lane, Manager of Francombe Nursing Home, 14 Lake Road, Francombe, who will be responsible for Mrs Sands' 1-month recuperative 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.

Mrs Sarah Lane
Manager of Francombe Nursing Home
14 Lake Road
Francombe

22nd May 2016

Dear Mrs Lane,

Re: Mrs Mary Sands, 75 years old

I am writing regarding Mrs Mary Sands who was admitted to Francombe Public Hospital on 12/05/16 with a fracture in her left femoral neck and ongoing osteoporosis. She will be discharged into your care today for one month of recuperative care.

Following a fall at home, Mrs Sands was admitted with complaints of severe pain in her left hip and lower back. An x-ray revealed that she fractured her left femoral neck. On 13/05/16, the patient received ORIF surgery for this injury and she is now making good progress overall. Mrs Sands can mobilise with a wheelie-walker and is able to carry out ADLs independently with the aid of a seat-raiser.

Mrs Sands has been taking risperidone 2mg daily to treat her confusion and hallucinations following the surgery. She is also receiving Movicol, 1 sachet twice per day, alendronate 10mg, calcium and vitamin D 60mg once per day. She can take Co-codamol 30mg as required.

Upon discharge, please monitor Mrs Sands' medications and constipation. She will need to continue her physio programme and she will require equipment such as a toilet seat-raiser, a wheelie-walker, and an elevated chair cushion. Finally, please encourage her to follow a nutritious diet which is rich in protein and calcium.

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

Yours sincerely,
Nurse

Practice Test 17.

FAST TRACK IELTS

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 nurse conducting a Nurse Home Visit as part of routine follow-up care after this patient's recent hospital discharge.

PATIENT DETAILS:

Name: Ms Patricia Styles
DOB: 27 Apr 1957 (Age 62)
Address: 57 Market Drive, Newtown
Social background:
Retired primary school teacher
Lives on her own
Husband died 3 yrs ago (lung cancer); no children

Medical history:

Hypertension (HT)
- Diagnosed 2011 – mild 145/95
- 2013 – moderate 168/105, commenced quinapril
- Regular monitoring, currently well managed at around 140/90

Diabetes mellitus (DM) Type 2
- Diagnosed 2013 – Pt counselled re diet/lifestyle, incl. weight loss
- 2014 – commenced oral hypoglycaemics (metformin + gliclazide)
- Well managed generally

Depression
- Diagnosed June 2016, triggered by death of husband
- Regular counselling since July 2016 to control mood swings and support DM management

Lifestyle: Smoking/Alcohol: Non-smoker; 1-2 glasses wine/wk
Exercise: Walks dog 20mins/day Diet: Ongoing counselling re DM management to maintain balanced diet

Medications: Quinapril (Accupril) oral 40mg/2xday
Metformin (Diabex) oral 500mg/2xday
Gliclazide (APO-Gliclazide MR) oral 30mg daily

Green Valley Hospital Treatment Record:

23 Aug 2019 Pt visiting sister for weekend, sister lives 3hrs away from Newtown in Green Valley
Pt admitted to Green Valley Hospital late evening with fever, sharp & pleuritic chest pain (worse on breathing), general weakness & malaise, tachycardia (rapid heartbeat)

24 Aug 2019

Assessment: Vital signs RR 29; BP 170/106; HR 98; T 39.3ºC
Full blood examination (FBE): Ó ESR (erythrocyte sedimentation rate), Ó CRP (C-reactive protein), Ó WCC (white cell count) i.e. inflammation/stress
Throat swab: viral influenza type B
Chest X-ray (CXR) – normal
Echocardiogram – pericarditis

Management: IV saline Ibuprofen 600mg every 8hrs
Evaluation: Viral influenza type B plus pericarditis

25 Aug 2019 Pt discharged and advised on self-care at home
Niece drove Pt home & agreed to stay overnight for 3 nights
Follow-up Nurse Home Visit arranged for 30 Aug 2019

Nurse Home Visit – 30 Aug 2019:

Observations: Pt frustrated. Reports feeling chest pain (relieved by sitting up), shortness of breath
Medication adherence – reports compliance & regular blood glucose monitoring
Vital signs: low-grade fever: T 38.1°C. Elevated RR 28 & HR 115
BP: 125/78 (usual BP 140/90)
Niece no longer staying overnight – work commitments in Green Valley

Assessment: Pt unwell. Nil improvement
? relapse/complications of pericarditis

Plan: Organise urgent hospital transfer to Newtown Hospital (nearest hospital)
Write referral to Emergency Department, include relevant:
• Medications, patient history, test results/observations

WRITING TASK

Using the information in the case notes, write a letter of referral to the Emergency Department Consultant on Duty, outlining the case and requesting urgent assessment and management for pericarditis. Address the letter to Emergency Department Consultant on Duty, Newtown Hospital, 100 Main Street, Newtown

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.

Emergency Department
Consultant on Duty
Newtown Hospital
100 Main Street
Newtown

30 August 2019

Dear Doctor,

Re: Ms Patricia Styles DOB 27.04.1957

Thank you for seeing Ms Styles, a 62-year-old widow and retired school teacher, who requires your investigation of a possible relapse of pericarditis.

Today, Ms Styles reports chest pain, relieved by sitting up, shortness of breath and fatigue. She has a low-grade fever (38.1°C), tachypnoea (28bpm) and tachycardia (115bpm). Her blood pressure is 125/78, lower than her usual 140/90.

Ms Styles became unwell on 23 August while visiting her sister in Green Valley. She was admitted to Green Valley Hospital with fever, pleuritic chest pain, tachycardia, and general malaise. Throat swab investigations confirmed viral influenza type B and an echocardiogram indicated pericarditis. Her chest X-ray was normal, and Ms Styles was managed with IV saline and ibuprofen. She was discharged home on 25 August. A Nurse Home Visit was arranged for today.

Ms Styles has hypertension, diabetes type 2 and depression, managed with quinapril (Accupril) 40mg twice daily, metformin (Diabex) 500mg twice a day, and gliclazide (APO-Gliclazide MR) 30mg daily.

I suspect a relapse of pericarditis, perhaps with complications. I refer her to you for urgent assessment and management.

Yours faithfully,

Nurse

Practice Test 18.

FAST TRACK IELTS

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

Assume that today's date is 15 May 2021. You are a nurse in Oldtown Hospital, responsible for the care of an elderly patient who was admitted after a fall. He is now ready to be discharged.

PATIENT DETAILS:

Name:	George Gale (Mr)
DOB:	24 Apr 1936, 85 y.o.
Address:	14 Long Street, Oldtown
Social background:	Retired retail manager Widower (wife died 2019) Son, 47 y.o., works abroad No family close by Living alone in own flat, level 2, no lift Socialises w. neighbours Independent, cooks, daily walks to shops Social drinker, smoker – 10 cigs/day
Medical history:	2003: Osteoarthritis diag. 2009: Hypertension diag. 2013: GORD (gastro-oesophageal reflux disease) – self treated with antacid tablets 2019: Non-specific colitis – ongoing monitoring, no treatment required
Medications:	Paracetamol 500mg 2 tablets 4x/day (osteoarthritis) Felodipine 5mg 1x/day (hypertension)
Presenting complaint:	Disorientation & fever (following fall)

Hospital admission:
10 May 2021:

Subjective:	Pt reports fall 09 May – while brushing teeth, felt weak, 'legs gave way', fell backwards w. headstrike, approx. 5hrs lying on floor Neighbours heard call for help around 0300 10 May, called ambulance 2 wks before fall: single episode of vomiting, palpitations, dysuria

Objective:	Confusion, disorientation Temp: 38.1°C (high), BP: 155/80 (elevated), Pulse: 86 bpm (normal), RR: 26/min (elevated) Urinalysis: ≥ 100,000 cfu/ml (high), 2 wbc/hpf
Diagnosis:	Urinary tract infection (UTI) –? cause of fall

Treatment Record:

10 - 14 May 2021:	IV antibiotics: amoxicillin 1 x 750mg/8 hrs & Pt's regular meds continued Observations: nil dizziness, nil palpitations Temp: 37.2°C (normal), BP: 130/80 (normal), Pulse: 86 bpm (normal), RR: 20/min (normal)
15 May 2021:	Ready for discharge to nursing home for temporary care Concerns: • Pt lives alone, no home help • Keen to return to own home ASAP • Significantly lowered mobility ®30 min/day of physical activity to be encouraged • Still episodes of confusion ®assessment for independent living recommended
Plan:	Write to head nurse at nursing home re further care required

WRITING TASK

Using the information given in the case notes, write a letter of discharge to Ms Gold, the Head Nurse at Primrose Nursing Home. In your letter briefly outline Mr Gale's history as well as your concerns and recommendations. Address the letter to Ms Jane Gold, Head Nurse, Primrose Nursing Home, 3 Blackwood Street, Oldtown.

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 Jane Gold
Head Nurse
Primrose Nursing Home
3 Blackwood Street
Oldtown

15 May 2021

Dear Ms Gold,

Re: Mr George Gale, DOB: 24 Apr 1936

Thank you for taking over Mr George Gale's post-fall care. I am writing to provide a brief summary of his background and plan for temporary residential care upon discharge.

Mr Gale, an 85-year-old widower, lives alone in his own flat. On 9 May, he had a fall at home and hit his head. It was not till several hours later that his neighbours heard his cry for help and called the ambulance. Mr Gale later said that he had suddenly felt very weak before he collapsed. He reported a single episode of vomiting, palpitations, and dysuria two weeks prior to this incident. Mr Gale was admitted to Oldtown Hospital with a fever and disorientation: symptoms later attributed to a febrile urinary tract infection.

Mr Gale has hypertension and osteoarthritis, for which he takes felodipine and paracetamol. He also requires regular monitoring for his non-specific colitis.

Mr Gale now has reduced mobility; therefore, he needs to be encouraged to do 30 minutes of daily physical activity to regain his strength. Despite his UTI being successfully treated with IV antibiotics, he still has episodes of confusion. Although he is keen to return to his own home, an assessment for independent living is strongly recommended prior to discharge from your facility.

Your assistance would be greatly appreciated.

Yours sincerely,

Nurse

Practice Test 19.

FAST TRACK IELTS

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

Mrs Osburn is an elderly patient at the Newport Community Health Centre. You are the attending nurse.

Patient details

Name:	Monica Osburn
Age:	69 years
Marital status:	Divorced
Family:	One daughter (married)

First attended centre: September 2003

Last attended centre: January 2010

Diagnosis: Hypertension, depression

Social background: Present: Lives alone; rented house in Newport
Moving to rented one-bedroom unit in Woodville close to daughter (daughter's request)
Income: aged pension
Long history excessive alcohol intake, ↑ when anxious

Medical history: Hypertension (10 years)
Depression (2 years)
Periodic problems with self-administration of medication

Medications: Anti-hypertensives and anti-depressants

Nursing management and progress:
Regular monitoring by community nurse in Woodville to ascertain medication compliance and alcohol intake

Discharge plan: Establish contact with medical practitioner after moving
Monitor medication compliance, alcohol intake and diet
Encourage expansion of family and social activities — elderly citizens' clubs, voluntary groups, etc.

WRITING TASK

Using the information in the case notes, write a referral letter to the Community Nurse, Community Health Centre, Woodville, outlining relevant information and requesting continued 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
Woodville

21 March 2010

Dear Community Nurse,

Re: Mrs Monica Osburn, aged 69 years

This letter is to introduce Mrs Osburn, who has been a client of the Newport Community Health Centre for the past six years. I am referring her to your services for continued care.

For the last ten years, Mrs Osburn has been treated for hypertension and for the past two years, she has been treated for depression, for which she currently takes anti-hypertensives and anti-depressants. She currently lives alone in a rental house. She has agreed with her daughter's suggestion that she move to Woodville, where they may have more regular contact.

Periodically, Mrs Osburn has experienced problems with self-administration of medications and may require assistance with this aspect of her treatment. Mrs Osburn has experienced periods where her alcohol consumption has been too high, and her anxiety sometimes causes her to drink even more. It is vitally important that this is carefully monitored in addition to her medication intake and dietary habits. More contact with her daughter and family may reduce the incidence of these depressive episodes and I believe that she will appreciate your suggestions for possible expansion of her social contacts: elderly citizens' club, voluntary organisations etc. I would also recommend getting in touch with a GP who is aware of Mrs Osburn's circumstances.

If you require further information, please do not hesitate to contact me.

Yours sincerely,

Nurse