CASE NOTES 01 ALFRED BILLY

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.

- Hospital Royal Perth Hospital

Patient Details

- Alfred Billy
- 52 Years old

Marital Status: Married (Maria Jennifer, lives separately but not divorced.

Address to contact wife: Sun City Arcade 207 Murray Street, Perth; (to be contacted if there is any serious emergency)

Wife has dementia and difficulty travelling..

Admission

- Admission Date 21/03/2010
- Discharge Date 5/05/2010

Diagnosis

- Skin Cancer – BCC (Basal Cell Carcinoma, neck)
- Nodular basal-cell carcinoma

Past Medical History

- No prior hospitalization, no history of medications

Social

- Truck Driver
- Lives with wife
- Habit of consuming liquor for the past 30 years
- Cigarette Smoker
- Skin dark
- Religion: Protestant
- Address: Breeze Villa, opp Davon House Complex, Silver Line, Birmingham - 35224

Medical Progress

- Skin biopsy is taken for pathological study
- CCB Removal done
- Mild Wound infection, breakdown, Suture reactions.
- ? Incomplete excision.
- Healing normal, no persistent swelling.
- Pain reliever: Panadein forte 500mg

Nursing Management

- No complications noted
- Perfectly well at the time of discharge
- No complaint of any pain

Discharge Plan

- Daily obs
- Medicine to be taken for one more week

Writing Task

You are the charge nurse on the hospital ward where Mr. Alfred Billy has recently had his operation. Using the information provided in the case notes, write a referral letter to the Community Nurse Head at Care Well Hospital, Birmingham, who will be attending to Mr. Alfred Billy, following his discharge.

In your answer:

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

The body of the letter should be approximately 200 words.

CASE NOTES 02 HELEN MARSHAL

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

- 15/07/2019
- Helen Marshal is a resident at the Wellness Retirement Village. She needs urgent admission to hospital. You are the registered nurse looking after her.

Patient Details

- Address: Wellness Retirement Village, Waterford St., Berkeley, 4101. Phone: (07) 3441 3257
- Date of Birth: 29/01/1968
- Marital Status: Widowed
- Country of birth: Australia

Social History:

- Moved to Retirement Village following the death of husband due to a heart attack in December 2017. Next of kin: Son, Benjamin Marshal (crippled for life after a right side-paralysis a

month ago, Mrs Marshal not aware of this) 53 Gladison Street, Warwick 4370, Ph (07) 4693 6552.

- Normally alert and orientated. Reading, watching television.

Medical History

- Hypertension - Last 10 years
- 1 pack cigarettes/day; "almost" stopped 5 years ago.
- Alcohol - 2 glass of wine at bedtime daily
- Glaucoma (since 2010)
- Allergic to codeine

Medications

- Under Prescription
- Captopril 25 mg b.i.d
- Timoptol Eye Drops 0.5% 1 drop each eye am & pm
- Normison 20 mg prn
- Non-Prescription Medication (Over the counter - when suggested by neighbors)
- Golden Glow Glucosamine Tablet – 1 with breakfast for joint pain
- Vitamin C Complex Sustained Release – 1 with lunch

Mobility / Aids

- Independent with walking frame. Arthritis (hands). Wears contact

lenses. Continence: Requires continence pad.

Recent Nursing Notes

28/06/2019

- Flu vaccination
- Influenza type B prophylaxis
- 12/07/2019 20:45
- Complaining of epigastric pain and indigestion following evening meal.
- Pain settled with Buscopan tablets p.o

13/07/2019 21:20

- Unable to sleep
- Aches in shoulder.
- Settled following 2 Panadol and Diclofenac 75mg intramuscular.
- Sound sleep for 7 hours.

15/07/2019 19:45

- Tired and feeling generally weak.
- BP 180/95.
- Confined to bed.
- GP called and will visit tomorrow am (was busy)
- Requested buscopan for indigestion, Panadol for shoulder pain

15/07/2019 20:00

- Buscopan tab, Panadol 2 tab p.o at 20:10.

- Didn’t touch the evening meal.
- Says not feeling hungry,
- Trouble sleeping,
- BP 175/95.
- Anxious - Strong, persistent wish to see son.
- "Something is amiss. Why is he not paying a visit."

Rechecked 20:25

- Distressed, pale and sweaty, complaining of tightness and pain in the chest, pain rated 8/10 on pain scale.
- Complaining of radiating shoulder and neck pain.
- Pain not relieved with buscopan and panadol.
- BP 190/100.
- Acute Myocardial infarction??
- Oxygen administered via nasal prongs 2 L/minute
- Nitroderm transdermal patch applied - still complaints of pain.
- Ambulance called and patient transferred.

Writing Task

Write a letter to the emergency consultant of the Holy Spirit Hospital Emergency Department. Give the recent history of events and also the patient’s past medical history and reason for urgent referral.

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.

CASE NOTES 03 BETTY OLSEN

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:

- Today's Date: 10/07/09
- Betty Olsen is a resident at the Golden Pond Retirement Village. She needs urgent admission to hospital. You are the night nurse looking after her:

Patient Details

- Address: Golden Pond Retirement Village, 83 Waterford Rd, Annerley, 4101
- Phone: (07) 3441 3257
- Date of Birth: 29/01/1926
- Marital Status: Widowed
- Country of birth: Australia

Social History:

- Moved to Retirement Village following the death of husband in December 2007.
- Next of kin: Son, Nicholas Olsen, 53 Palmer Street,

Warwick 4370, Ph (07) 4693 6552.
- Normally alert and orientated. Enjoys bridge, bingo and reading.

Medical History

- Hypothyroidism since 1997
- Hypertension since 2003
- Glaucoma since 2004
- Allergic to penicillin

Prescription Medication

- Karvea 150mg 1 daily; Oroxine 0.1mg 1 daily am; Timoptol Eye Drops 0.5% 1 drop each eye am & pm; Normison 10 mg as required

Non-prescription Medication

- Golden Glow Glucosamine Tablet - 1 with breakfast for arthritis
- Vitamin C Complex Sustained Release – 1 with breakfast.

Mobility / Aids

- Independent with walking stick.
- Arthritis in hands.
- Wears glasses
- Continence: Requires continence pad

Recent Nursing Notes

- 16/05/09 - Flu vaccination

- 29/06/09 - Complaining of indigestion following evening meal. Settled with Mylanta
- 07/07/09 - Unable to sleep – aches in shoulder. Settled following 2 Panadol and 1 Normison
- 09/07/09 - Requested Mylanta for indigestion, Panadol for shoulder pain – slept poorly
- 10/07/09 am - Tired and feeling generally weak. BP 180/95. Confined to bed. GP called and will visit 11/7/08 after surgery.
- 10/07/09 pm - Didn't eat evening meal. Says felt slightly nauseous. Trouble sleeping, complaining of shoulder and neck pain. BP 175/95 Given 1 Normison 2 Panadol at 10pm
- Rechecked 10.45pm – Distressed, pale and sweaty, complaining of persistent chest pain, BP 190/100. Ambulance called and patient transferred.

WRITING TASK

Write a letter for the admitting doctor of the Spirit Hospital Emergency Department. Give the recent history of events and also the patient's past medical history and condition.

In your answer:

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

The body of the letter should not be more than 200 words.

CASE NOTES 04 BETSIE ANDERSON

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

- READING TIME: 5 MINUTES | WRITING TIME: 40 MINUTES
- Read the case notes below and complete the writing task which follows.

NOTES

Patient Details

- Betsie Anderson, 89
- Allergy to iodine (flushing, rash)
- Lives in Woodside House nursing home facility; Widowed

Medical Background:

- Hypothyroid
- Dementia
- GERD
- Constipation
- ORIF R Hip 2017

Recent History:

- Pt confused, oriented to person only
- Increased somnolence
- New onset urinary incontinence
- Loss of 6 pounds in one week
- Low grade fever

Admission & Discharge

- 16/02/2020
- 19/02/2020

Diagnosis:

- Urinary Tract Infection
- Hospital Information:
- Norfolk and Norwich University Hospital
- ED record
- Vitals- Temp 38.3C, HR 119, RR 23, O2 Sat 91 on RA
- Labs- WBC 15.2 mg/dl UA + bacteria. Urine & Bld Cx pending
- Pt given acetaminophen 650mg po x1 in ED
- Started on IV ciprofloxacin

Nursing Care:

- Daily assessments including LOC, BP
- Assist w/ ADLs
- Frequent toileting with proper hygiene
- Assist with increasing activity, starting PT
- Orthostatic BP
- Transition during position changes slowly
- Oriented now, no longer confused
- Pt ready for discharge

Discharge Medications:

- levothyroxine 200mcg morning
- Protonix 75mg daily

- Colace 100mg morning
- Ciprofloxacin 250mg PO Q12H x14D
- Multivitamin with calcium night
- Aricept 10mg QHS

Discharge Plan:

- FU with GP Dr. Alex Rose in 2 weeks
- Repeat UA and labs in 2 weeks
- Continue daily vitals and assessment
- Observe for signs of dehydration & orthostatic BP

Equipment required:

- walker, cane, bedside commode

Writing Task

Using the information in the case notes, write a letter to Ms. Stella Howard, head nurse for Woodside Nursing House in Norwich 142 Woodside Rd, Norwich where patient will return after discharge.

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.

CASE NOTES 05 NICHOLAS BRIHMAN

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: Nursing

- READING TIME: 5 MINUTES | WRITING TIME: 40 MINUTES
- Read the case notes below and complete the writing task which follows.

NOTES

- Nicholas Brihman, 61-year-old man, presents to his primary care provider Dr Maria Jones, complaining of recent, recurrent episodes of angioedema. You are a charge nurse at this facility.

Patient Details

- Mr Nicholas Brihman, 61
- Traveller and blogger, not married, next of kin - brother
- Lifestyle: Sedentary, sleeps less, active
- The patient lives in the Southeast and when questioned about tick exposure, he confirms having removed a tick about a year previously, after a long day spent outdoors.

Diet

- Meat-heavy meals (including steak and barbecued pork).

- Eats heavy meals at night.
- Occasionally alcoholic, cigar smoking
- Up to date on all immunizations.

Medical History

- High blood pressure (since 2001)
- On medication - Lisinopril, perindopril and ramipril, ibuprofen
- Negative for rashes, changes in skin color, sores or new lesions, and headaches.
- A history of persistent mild childhood asthma and intermittent adult asthma.

16/08/2019

- Emergency department for facial swelling.
- Diagnosed as angioedema (related to stress and eating spicy foods).
- Advised to eliminate spicy foods and other triggers.
- Prescribed epinephrine auto-injector, diphenhydramine 50 mg.

20/06/2020

- Revisits with complaints of 4 episodes of severe angioedema over an 8-month period.
- Reported irritation of the left eye, sinus pressure, numbness

and tingling in the mouth, and swelling of the lips, throat, and tongue (3 to 4 hours after he eats a large meal)

- Expresses concern that his symptoms will progress to anaphylaxis.
- Important! Has not needed the epinephrine auto-injector.
- Complains of constricted airway during his reactions.
- Denies shortness of breath, coughing, and wheezing.

21/06/2020

- Tested positive for seasonal allergies (grasses, trees, and cat dander) but has no history of food or drug allergies.
- Bilateral swelling in the lips, cheeks, and soft tissue under the jaw.
- The left side of face more severely swollen than right.
- Difficulty closing mouth (due to swelling).
- Mild periorbital swelling, and the sclera of both eyes are mildly pink and watery.
- No chemosis present, no noticeable skin change, redness, or urticaria on the face, trunk, or limbs.

- IgE skin prick test (SPT) ordered to rule out new allergies to protein in his diet.

22/06/2020

- SPT is performed for commercial extracts of beef, pork, lamb, chicken, turkey, and milk, as well as cat and dog dander.
- The patient tests positive for hypersensitivity reaction to cat dander, revealing a 3 - to 5 mm wheal with flare.
- All other SPT results negative.
- These results, along with the patient's history of tick bite and angioedema after high-protein meals, confirm a diagnosis of red meat allergy, or α-gal syndrome.
- Blood samples collected for immunoassay to detect IgE to galactose-α-1, 3-galactose (α-gal).
- The patient tests positive for IgE antibodies to α-gal with the serum assay.

Writing Task

As Dr Jones is under house quarantine for Covid19 from today, 22nd June, 2020, Mr Brihman needs to be referred to Dr Mathias Brown, Royal Lake Hospital, Yamba Dr, Garran ACT 2605, Canberra, Australia +61351240000. As

charge nurse, write this letter detailing Mr Brihman's concerns.

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.

CASE NOTES 06 FELIX SEASTINE

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

- Today's Date 09/09/09
- You are Simmy Joseph, a registered nurse in the Coronary Care Unit, St Andrews Hospital Brisbane. Felix Seastine is a patient in your care.

Patient Details

- Name: Felix Seastine
- DOB 12 January 1956
- Address 9476 Old Dam Road, Blessham Q4390
- Next of Kin Brother, Invictus Seastine, 72 Burke St, New Liverpool Q4490
- Admitted 2 September 2009
- Diagnosis: Obstructive coronary artery disease
- Operation: Coronary artery bypass grafts (x 4) on 4th September.

Social History

- Never married
- Lives alone in own home just outside Blessham
- Online business - home delivery - helped by brother and his three daughters
- Currently out of business due to lock-down and red alert in Blessham.
- Likes reading travel journals.

Medical History

- Smokes 20 cigarettes/day
- Alcohol: 2 x 300 ml bottles beer / day
- Ht 170 cm Wt 99 kg
- Usual diet: Sausages, deep fried chips, eggs, burgers, KFC and occasionally rice pudding.
- Allergic reaction to nuts and oily food
- Warty face due to excess acne; depressed about it.
- Excess Testosterone; tried hormone reduction medication
- Uses face-creams and washes face over 20 - 30 or? times a day (he has OCD?)

Nursing Management and Progress

- Routine post-operative recovery

- Advised to cease smoking, reduce alcohol (he says he cannot)
- On low fat diet (resists and demands food high in fat)
- Walks well
- Wounds healing well
- Routine visit from Social Worker

Discharge Plan

- Returning home to Blessham today.
- Appointment made for follow up visit to local GP Dr. Cinderella Austin, 2 pm 15/9/09
- Local physiotherapist to continue rehabilitation exercise program.

Writing Task

Mr Seastine has requested advice on low fat dietary guidelines and healthy simple recipes along with "more practical advice" on managing acne on face. Write a letter to the Community Information Section of the Wells Foundation, Wimbledon Avenue, Brisbane on the patient's behalf. Use the relevant case notes to explain Mr Seastine's situation and the information he needs.

Include Medical History, BMI and lifestyle. Information should be sent to his home address.

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.

CASE NOTES 07 MR CHRISTOPHER FORT

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

READING TIME: 5 MINUTES | WRITING TIME: 40 MINUTES

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

NOTES

- **Name: Mr Christopher Fort**
- Age: 49 years
- Married, lives with wife and 2 children
- Admission date: 20/2/2020 (with chest pain, radiating to shoulder, difficulty breathing - 2 days along with generalized weakness, nausea, dizziness)
- ECG - ST elevation
- Ckmb+
- Dx - Myocardial infarction

Medical History:

- Peptic ulcer
- Twice clipping done
- Hypertension - 8 years, on tab Nicardia 5 mg once daily
- Diabetic - 9 years, Human mixtrad Bd
- Heavy drinker and smoker (10 years)
- Eats oily foods, sugary creams

- Nil exercise

Nursing Management and progress:

- Height:173
- Weight: 59
- Temp: 98.6°F
- Pulse: 72 b/m
- Blood pressure:150/100 mm of hg

Medications

- Pan 40 mg BD for one month
- Aspirin 325 mg one month
- Statix 40 mg of one month
- Paraffin 10 mg of one month

Investigations Report:

- RBS:190 mg/dl
- FBS:118mg/dl
- LDL:120mg/dl
- HDL:40mg/dl
- HB: 12
- 21/2/2020
- Angiogram
- Presence of clots in the left side of the coronary artery.
- Percutaneous transluminal coronary angioplasty done.

Post-operative progress:

- No complications.
- Blood pressure and blood sugar under control.

Recommended by dietitian:

- Avoid oily foods and carbohydrates.
- Increase green leafy veggies, fruits and vegetables, fluid intake.
- He is ready to be discharged after the consultation with consultant.

Discharge plan:

- Schedule follow up with Fbs, FLP, reports on 3/3/2020.
- Medication monitoring
- Quit-line programs
- Blood pressure and blood sugar monitoring
- Dietary management
- Encourage daily Exercise
- Follow up
- Avoid strenuous exercise for two weeks.

Writing Task

Using the given information, write a letter to the district nurse requesting home visits to ensure medication compliance and dietary restrictions.

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.

CASE NOTES 08 SONA MITTAL

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

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 a paediatric ward of St Charles Children's Hospital, Richmond, Sydney.
- Today's date: 26th October, 2019
- Patient Name: Sona Mittal (Female)
- Age: 2 years
- Admitted - 20/10/2019
- Discharged - 25/10/2019
- Address: 23, Monalisa Street, Bridge Town, Sydney
- Mother: Sangeetha Mittal, 20-year-old unemployed school teacher. Moody, keeping aloof but wishes to be around so many friends. Parents in India (not willing to come to Sydney)

History

- Admitted with: Coughs, catarrh, weakness, fever, shortness of breath, unkempt, malnourished, weighed below her age, sunken eye and dry skin.

- Lives with mother in an uncompleted building, father away in Africa (cannot travel due to travel ban) No relatives around. Occasionally helped by colleagues
- Mother was referred to social worker.
- Treated with antibiotics, inhaler and hot water steaming
- Nutritional needs met while on admission
- Child is physically promising now, eating well and running around. Speaks fewer words as compared to the pre-admission. Sleepy during day, hardly asleep at night. Affects mother's sleep.

Discharge plan

- Teach mother how to prepare nutritious meal - child to continue antibiotics and vitamin C for the next seven days - follow-up with Ms Annette, nutritionist, on 1/11/2019 and with Dr Hillary Mag, speech therapist, on the same day.

Writing Task

Write a letter to the Ms Annette de Cruz, Nutrition Department, D Wing, St. Charles Children's Hospital, Bridge Town, Sydney, highlighting the patient's nutritional needs.

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.

CASE NOTES 09 SHANNON WARNE

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:

- Shannon Warne, 23, is a university student who was involved in a car accident three months ago. He has been in the Royal Adelaide Hospital for three months and is ready to be transferred to the Hampstead Rehabilitation Centre.
- Name: Shannon Warne
- Admitted: April 6, 2007
  Discharged: June 14, 2007

Diagnosis:

- Broken neck and fractured pelvis.
- Whiplash (Examination: Range of motion in neck and shoulders)
- Probable permanent neurological damage affecting mobility, speech and memory areas

Social Background:

- Single.

- 3rd year architectural studies student at Adelaide University.
- Lived in flat prior to admission. Now needs long term rehabilitation.
- Parents living and willing to care for him; may eventually return home
- Currently eligible for disability pension.

Nursing management and progress:

- Made good progress. Needs high level care for some time
- Started using a wheelchair (a fortnight ago)
- Needs daily physiotherapy, hydrotherapy 2x a week and speech therapy 3x a week
- Was suffering bed sores; improving with ↑ mobility.
- Frequent headaches (Nurofen 200g max 4x a day)

Discharge plan:

- Depression (needs to be treated with activities and interests; likes reading & writing)
- Contact university for possible continuation of studies externally. He can use a laptop; net connectivity is unstable)
- Needs contact with people his own age – community access?

- No special dietary requirements

Exercise after discharge (daily, under expert supervision)

- Rotate neck in both directions
- Tilt head side to side
- Bend neck toward chest
- Roll shoulders

WRITING TASK

Write a letter to Su Yin Lee, Sister in Charge, Hampstead Rehabilitation Centre, 695 Hampstead Road, Greenacres 5029.

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.

CASE NOTES 10 DYLAN CHARLES

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 Maternal and Child Health Nurse working at the Romeoville Community Child Health Service.

Today's date: 15 January 2012

Patient History:

- Baby boy: Dylan Charles
- DOB: 04/12/11
- Born: Romeoville Maternity Hospital
- First baby of Raymond and Sylvia Charles
- Address: 19 Mayfield St, Romeoville Discharged 8/12/11

Family History:

- Mother: Aged 24
- Father: Aged 25; Soldier Currently away from home on duty

Birth History:

- Normal vaginal birth at term
- Birth weight: 3400gm
- Apgar score at 5 min: 9
- No antenatal or postnatal complications

15/01/12 Subjective

Silvia and baby attended for routine 6-week check-up. Silvia says she is concerned about constipation: once every three days, hard stool. Mother is asking about stool softener or prune juice for baby.

Breast fed for first three weeks after birth. • Baby became unsettled during summer heatwave in December.

Silvia got sick and had a fever for a few days. Mother-in-law (Mary Charles) came to visit and advised changing baby to formula feeds. Mary advised extra powder in formula feeds to improve weight gain.

Silvia worried she does not have enough breast milk and now gives extra formula feeds as well as breast feeding. Dylan difficult to bottle feed.

Silvia wishes to breast feed properly as she believes it would be the best thing for her son.

Mary Charles plans to stay with the family for at least a further month to help with baby. Tensions developing

between mother and mother-in-law over what is best feeding method for Dylan.

Objective:

- Reflexes normal
- Slightly lethargic
- No abdominal tenderness
- Heart Rate: 174
- Respirations: 56
- Temperature: 37.1
- Weight: 4200gms
- 3 wet nappies in last 24 hours, Urine dark

Assessment:

- Mild constipation and dehydration Plan:
- Increase breast feeds
- Refer to breast feeding support service
- Check formula is correctly prepared
- If continuing formula feeds, advise to supplement with water (boiled and cooled)
- Advise on keeping baby cool in hot weather
- Return for review in 48 hours.

WRITING TASK

Please write a referral letter to the Lactation Consultant at the Breast-Feeding Support Centre, 68 Main Street, Romeoville.

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.

CASE NOTES 11 BILL ORIEL

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:

- Today's Date
- 09/09/09

You are Lee Wong a registered nurse in the Coronary Care Unit, St Andrews Hospital, Brisbane. Bill Oriel is a patient in your care.

Patient Details

- Name: Bill Oriel
- DOB 12 January 1956
- Address: 9476 Old Dam Road, Woodwind Q4390
- Next of Kin Brother, Ernie Oriel 72 Burke St, Cunnamulla Q4490
- Admitted 2 September 2009
- Diagnosis: Obstructive coronary artery disease
- Operation Coronary artery bypass grafts (x 4) on 4th September 2008 Social History
- Never married
- Lives alone in own home just outside, Woodwind

- Fencing contractor

Medical History

- Smokes 20 cigarettes/day
- Alcohol: 2 x 300ml bottles beer / day
- Ht 170cm Wt 99kg
- Usual diet: sausages, deep fried chips, eggs, MacDonald's
- Allergic reaction to nuts

Nursing Management and Progress

- Routine post-operative recovery
- Advised to cease smoking, reduce alcohol
- Low fat diet
- Walking well
- Wounds healing well
- Routine visit from Social Worker

Discharge Plan

- Returning Home to Woodwind
- Appointment made for follow up visit to local
- GP Dr. Avril Jensen 2pm 15/9/09
- Local physiotherapist to continue rehabilitation exercise program

WRITING TASK

Mr Oriel has requested advice on low fat dietary guidelines and healthy simple recipes. Write a letter to the Community Information Section of the Heart

Foundation, Gregory Terrace, Brisbane on the patient's behalf. Use the relevant case notes to explain Mr Oriel's situation and the information he needs. Include Medical History, Body Mass Index and lifestyle. Information should be sent to his home address.

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.

CASE NOTES 12 PAMELA VIDUKA

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 Pamela Viduka is a 72 years old patient in your care. She is now ready for discharge. She has just undergone a mitral valve replacement.

- Name: Mrs Pamela Viduka
- Age: 72 years
- Admitted 18/11/2008
- Diagnosis: Valvular heart disease (Mitral valve prolapse)
- Reason for admission: fainting, light-headedness, chest pain

Social History:

- Lives with daughter, no longer drives, Widow, enjoys reading/ doing crosswords, chatty, friendly, smokers for 55 years.

Medical history:

- Chronic bronchitis
- Hypertension (150/100)

- Chest infections since retirement 12 years ago

18/11/08

- admitted
- Valve replacement
- Antibiotics/anticoagulant therapy
- Analgesics
- Prescribed Warfarin BID

19/11/08

- Patient put on low salt diet
- Wear contact lenses
- Showering /dressing with help of nurses
- Slowly recovering from analgesics
- Able to walk/ stand-short periods of time

20/11/08

- Recovered from analgesia
- Showering and dressing with help of nurses
- Pt educated about causes/
- preventions of infections

21/11/08

- Pt advised to quit smoking/ given tips incl using patches
- Pt was seen by dietician re low salt diet
- Able to walk for longer periods of times with walking stick

22/11/08

- Pt recovery well
- Can now shower/ dress independently
- Still using walking stick/ frame
- Pt advised of discharge on 24/11/08
- Vital signs unremarkable

24/11/08

- Pt told of discharge plan? Discharged

Discharge plan:

- Needs to rest
- Requires home help- to be visited by district nurse
- Patient to monitor medication usage
- Regular follow-up examinations
- INR- to be checked on regular basis
- Avoid invasive surgical or diagnostic procedures until prophylactic antibiotics are given
- Auscultatory assessment of heart
  Current medication:
- Warfarin (anti coagulation therapy)
- Salpetrol 3 puff daily ? Mirax 25 mg daily

WRITING TASK

Using the information in the case note, write a letter of referral to Maxine Mullins (district nurse), who will provide follow up care in this case. Ms Maxine Mullins, 45 Finders Lane, Melbourne, 300 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.

CASE NOTES 13 MARGARET HELEN MARTIN

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
- Address: 23 Third Avenue, Greenville
- Age: 81 years old (DOB: 23 July 1935)
- Admission date: 15 July 2017

Social/ family background:

- Never married, no children
- Lives in own house in Greenville
- Financially independent
- Three 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 meals for weekends

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 - saprin, clopidogrel (Plavix)
- HTN metoprolol (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 during hospital stay:

- Routine post-op recovery

- Tolerating light diet and fluids
- Bruising at catheter insertion site, no signs of infection/ bleeding noted post procedure
- Pt anxious about return home, not sure whether she well cope

Discharge Plan: Dietary

- Low-calorie, high-protein, low-cholesterol, gluten-free diet (supervised by dietician, referred by Dr)
- Frequent small meals or snacks o Drink plenty of fluids Physiotherapy
- Daily light exercise (eg., 15 minute walk, exercise plan monitored by physiotherapist) No heavy lifting for 12 weeks
- Other
- Monitor would site for bruising or infection o
- Monitor adherence to medication regime o Arrange regular family visits to monitor progress

Anticipated needs of pt:

- Need home visits from community health/ district nurse- monitor adherence to postoperative medication, exercise, dietary regime
- Regular monitoring by DR., dietician, physiotherapist

- ? Danger of social isolation (infrequent family support)

WRITING TASK

Using the information in the case notes, writing a letter to the Nursing- 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.

CASE NOTES 14 DIANE CARPENTER

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:

Patient Details

- Name: Diane Carpenter
- Age: 58
- Hospital: Intensive Care Unit, Flinders Medical Centre
- Marital Status: Divorced
- Next of kin: 2 married daughters (both live locally)
- Admission Date: 10 May 2009
- Discharge Date: 24 May 2009 Diagnosis:
- (L) Lung resection

Past Medical History:

- Breast cancer 1988
- Full mastectomy September 1988
- Good response to tamoxifen and remission until 2009

- Dyspnoea April 2009 - investigations revealed small patches in left lung
- Has had Generalized Anxiety Disorder since 20's - sometimes on medication for this but not at present

Social History:

- Recently migrated from Canada (2001)
- Supported financially by children
- Court secretary but unable to work due to visa issues
- Lives in small rented unit
- Drives own car
- Small circle of good friends

Medical Progress:

- Pneumonia - day 4
- Treated with antibiotic therapy and ventilation
- Now fully resolved

Nursing Management:

- Fluid management
- Oxygen therapy
- Nutritional support
- Physiotherapy initiated
- Mobility: Very slow-patient is reluctant to walk
- Psycho/social: difficulties coping
- Discharge Plan
- On-going physiotherapy

- Needs encouragement to mobilize
- Initiate psychiatrist visits (coping strategies)
- Organize visits between psychiatrist and daughters - encourage them to be more supportive emotionally
- Chemotherapy appointments at Flinders Medical Centre to begin 6/6/09
- Monitor medications (antibiotics, tamoxifen)
- WRITING TASK
- Using the information given in the case notes, write a letter to the Director of the Repatriation General Hospital, 216 Daws Road, Daw Park 5041, and request that the hospital take over the care of Mrs Carpenter.
- 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.

CASE NOTES 15 TEJ SINGH

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:

Mr. Tej Singh is a 41 years old man who has been a patient at a clinic you are working in as a head nurse. Today's date: 31/01/2017

- Name - Mr. Tej Singh Randhawa
- DOB - 09/09/1976
- Address - 28, Raymond Street, Romaville

Medical History

- Hypothyroidism
  - Thyroid replacement
  - No history of trauma or weight loss
  - Hospitalized (2010) due to appendicitis
- No POHx (Past Ocular History)
- No allergies
- Immunizations are current
- Smoker (Cigarettes & Cigars)
- Teetotaller

Social History

10/01/2017

- Works as a Systems Analyst
- Arrived in Australia from India with wife in 2012 as a permanent resident
- Lives in own home
- Married- wife Mona Randhawa aged 37, 1 daughter

Subjective

- Headache, right-sided, no cough
- No dizziness, denied vomiting and nausea
- HA accompanied with significant nasal discharge

Objective

- P 96, BP 130/70, T 101.0 f, neuro exam normal, neck supple
- Alert, well nourished, well developed man
- General Assessment: Infectious sinusitis

Plan

24/01/2017

- Given Augmentin (Amoxicillin/clavulanic acid)

Subjective

- Complaints of severe headaches (HA), right- sided, throbbing, radiating to right eye, teeth, and jaw lasting 15 mins to < 2 hrs, persistent
- HA intermittent episodes, pt. described pain as “like someone has put red hot poker in my head” Pain so severe (10/10) that pt. unable to stand still, sit down or go to bed, no effect when light/noise avoided rhinorrhoea, no nausea, no vomiting

Objective

- P 105, BP 150/90, Physical & Neuro exam normal, neck tender-right side
- Assessment - Cluster Headache

Plan - 29/01/201 - Given acetaminophen and non-steroidal anti-inflammatory

Subjective

- Pt. accompanied by wife, Mona
- Previous complaints of severe headaches - occurring in episodic attacks associated with rhinorrhoea and epiphora
- Right eye “Droopy” and sometimes as “sunken”

eyelids, first Noted by Mona 1 day ago, facial flushing before and during HA

Objective

- Right eye upper eyelid drooping,
- Constriction of pupil right eye in dark lighting,
- decreased sweating on right side of face
- P 95 BP 130/85
- Assessment - Possibility of? Horner's syndrome
- Referral plan - Referral to ophthalmologist for further evaluation and management

WRITING TASK

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

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.

CASE NOTES 16 NINA DAVIES

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:

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

Hospital - Prince Wales Hospital

Patient details

- Name Nina Davies
- Date of Birth 25/12/1943
- Address 95, Eagle Vale Sydney
- Occupation Retired Librarian
- Race Caucasian
- Marital Status Married
- Next of Kin Thomas Davies, John Davies
- Family Hx
    - Mother died at 40 - Cancer, Father died at 57 - Coronary Heart Disease,
    - has 2 siblings, brother aged 79 with CAD, twin

sister with osteoporosis and depression.

Social History

- Lives with husband in own house. Home has 2 stories, 2 steps to entrance,
- Supports full bath on second floor only, 2 grown children living nearby
- Pt. is very active; walks 1-2 miles/day, stopped smoking 30 years ago

Diet

- Occasional drink, drinks a cup of coffee a day, reports diarrhoea and gas with dairy products
- Allergies - NKDA

Past Medical

- Diagnosed with osteoporosis first signs noted in 2015

Medical History

- Mild hyperlipidaemia, Mild hypertension, Coronary artery disease,
- Tendonitis of R. Shoulder, PTCA, 2009, without recurrence

Medications

- Simvastatin (Zocor) 20 mg. daily
- Aspiring daily – pain in ribs and back
- Furosemide (Lasix) 10 mg. daily
- Alendronate (Fosamax) 10 mg. daily
- Calcium + Vit. D 600 mg. daily Vit. E, Vit. C, Mg

Admission & Discharge

- Date of admission: 28/6/2017
- Date of discharge: 02/07/2017
- Chief Complaint: Injury on the left hip - had a fall after slipping
- Dx: Fractured L NOF

Nursing Management and Progress

28/06/2017

- Admitted Through ER, medical evaluation found her a good candidate for Left Hemiarthroplasty;
- Post-opt: IV Fluids at 100 cc/hr, morphine 10 mg IM q. 4 hours as needed for pain, IV famotidine (Pepcid) 20 mg. every 12 hours due to GI distress postop,

cefazolin (Ancef) 1 g. IV q. 8 h. X 3 doses

29/06/2017

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

30/06/2017

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

01/07/2017

- PT continued complaining of constipation - not had a bowel movement since surgery
- Docusate 100 mg. daily

- Can ambulate short distances with a walker
- Assistance with ADL's

02/07/2017

- Original dressing changed;
- Ready for discharge

Discharge plan

- LLE (Left lower extremity) wt. bearing limited to 30 % for next 6 weeks
- Elderly husband not able to care for her; home not set up for a walker
- Neither of children can take her in their homes- lack of space, too many Stairs, and working spouses.
- Decision is made to transfer her to Helping
- Hand rehabilitation centre near her house
- Continue Physio program and medication
- Assistance with ADL
- Staples to be removed on day 14
- Dressings to remain dry & intact

Discharge medications:

- Hydrocodone/acetaminophen 5 mg./325 mg.

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

WRITING TASK

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

In your answer

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

CASE NOTES 17 AMY VINEYARD

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:

Ms. Amy Vineyard is a patient in your care at the St Kilda Women's Refuge Centre. She is 6 weeks pregnant with her first child. She presented two days ago, requesting help for her substance abuse problems. She reports a desire to reduce or cease her alcohol consumption and a desire to reduce a cease her drug use. No desire has been indicated to decrease or stop cigarette use. She now wishes to be discharged but will require ongoing support throughout her pregnancy.

- Name: Ms. Amy Vineyard
- Age:21
- Admission: 6/1/09
- Diagnosis: Pregnant substance abuse
- Discharge: 8/1/09

Plan:

- Community mental Health Nursing required daily next 2 weeks minimum.
- Pt wishes to continue living with a friend on her sofa.
- Psychiatric support needed for depression.
- Methadone program Alcoholics Anonymous meetings
- 1 Trimester Ultrasound at 2 weeks;
- maternal health clinic appointment needed.

History:

- Suicidal thoughts, self-harm in past.
- Never seen a psychiatrist

Reason for admission:

- Pt. self-admitted due to concern about pregnancy.
- Confirmed pregnancy test the days before (5/1/09)
- Reported pain in lower back
- Weight loss (6kg over 2 months)
- Some memory loss, tingling in feet, difficulty sleeping, excessive worry and hallucinations
- Feeling depressed-history of depression
- No pain in hips or joints no decrease in appetite
- no double vision

Treatment

- Pt. monitored and blood tests for HIV/AIDS and STDs
- Counselled re nutrition and pregnancy
- Counselled re HIV/AIDS and STDs risk
- Discussed possibility of rehabilitation clinic for 'driving out'
- Counselling has been recommended for appropriate nutrition during pregnancy
- The possibility of attending a rehab clinic to address her alcohol and drug issues

Lifestyle:

- Nicotine daily 30-40 cigarettes
- Started smoking at 15 y. o.
- Drugs used cannabis, amphetamines, cocaine, heroin started all above at 16 y. o.
- Injects heroin, occasionally shares infecting equipment
- Alcohol units/day max. units/day-15
- Started drinking at 16 y. o. lives with a friend, Sophie, on her sofa. no contact with parents

WRITING TASK

Using the notes, write a letter about Ms. Vineyard's situation and history to new community health nurse. Address your letter to Ms. Lucy Wan, Registered

Nurse, Community Health Centre, St Kilda.

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.

CASE NOTES 18 RAMONA DECOSTA

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 Ramona Decosta, a senior nurse working with Helpline Hospital.

- Patient name: Tom Clarke
- DOB: 21/09/1954
- Address: 92 Lygon Street Carlton, Melbourne
  Phone: 0422-894-896

Social Background:

- Married, Wife- Miranda Clarke, aged 58 years. Lives together
- Retired – Army officer
- Two daughters - elder daughter works in Sydney, younger daughter – Adelaide
- Quite active

Hobbies:

- Cycling, watching movies, sports, reading, travelling, playing golf and Tennis

Surgical history:

- R Ankle dislocation surgery following a car accident- 1982,
- Hospitalized for 3 weeks
- Septoplasty - 1985
- Surgery for Anal Fistula - 1992
- Eye replacement lens surgery - 2007

Medical History:

- Hypertension – 1985
- Did not seek treatment till 2000; now managed with Ramipril
- GERD - 1999

26/08/2016

- Accident with a motorbike while cycling, claimed he was going at a moderate speed, a motorbike hit him while overtaking, he landed on the left side of his body
- FOOSH (Fall on outstretched hand) injury to L elbow, presented to ER, limited range of motion and extreme pain
- X-RAY– Nondisplaced fracture of the coronoid process of the ulna, marrow oedema head and neck of radius involving articular surface, moderate joint effusion

Treatment

- Sling to keep the elbow immobilized- 6 weeks,

- Capsule CM Plus, Panadol, Ibuprofen, hot compress for pain and inflammation
- Next Appointment in 6 weeks' time

06/10/2016

- X-ray – injury healing well
- Tab D gain qw
- Tab CM Plus – qd
- Sling taken off
- Exercise program – at home

01/11/2016

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

WRITING TASK

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

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.

CASE NOTES 19 INFORMATION LETTER

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:

- Today's Date: 31/03/17

You are a school nurse at Toohey Hill Primary School and recently there has been an outbreak of threadworms at the school. In response to this situation write a general letter of advice to the parents outlining common symptoms, identification, occurrence, treatment and medication and hygiene relating to threadworms.

Signs and Symptoms

- Intense itchy feeling around the anus
- Restless sleep
- Teeth grinding while asleep
- Irritability
- Loss of appetite
- Occasionally slight stomach pains associated with gastrointestinal upsets

- Can cause urinary tract infections

NB. Many people with threadworms show no symptoms

Identification

- Resemble fine pieces of cotton thread up to 1.5cm long.
- Appear on the outside surface of faeces
- Active during the night

Occurrence

- Common in warm weather – despite good sanitation
- Crowded living conditions promote the spread of worms between family members
- Children 5-14 most susceptible - adults can be infected by eggs spread around in home/school environment
- Outbreaks noted at schools / day cares.

Treatment

- Vermox or Combantrin-1 available from pharmacists.
- Consult doctor or pharmacist first
- Not suitable for pregnant women or children under two.
- Only works on adult worms present in the intestine when medicine taken.

- Treat whole family at same time to minimize risk of reinfestation
- Recommend treat everyone again two weeks after initial treatment if reinfestation suspected

Hygiene

- Morning shower or bath to remove eggs laid during night
- Ensure everyone always uses own towel and facecloth.
- During treatment change night clothes/underwear of infected person daily.
- Vacuum carpets often, especially bedrooms, to remove dust.
- Change bed-sheets frequently, especially first 7 to 10 days after start of treatment.
- Keep nails of infected people short to reduce chance of eggs being stored there.
- Wash hands thoroughly after using bathroom and before meals
- Keep toilet and bathroom area clean.

WRITING TASK

Using the information provided, write a letter addressed to “Parents of students at Toohey Hill Primary School” providing information on threadworm and its 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.

CASE NOTES 20 HENRY O'KEEFE

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 the Blue Skies Home Nursing Centre. You visited this patient at home today for the first time following a referral from the Mater Public Hospital. He was discharged from hospital on 17.3.08.

- Name: Henry O'Keefe
- Address: 12 Donaldson Street, Green Slopes, 4121; Phone: (07) 3941 2267
- Date of Birth: 2 February 1925
- Admitted: 14.3.08
- Diagnosis: Malignant Melanoma Left Shoulder

Family History

- Married aged pensioner.
- Lives in housing commission home with wife Dorothy (also an aged pensioner).
- No children

Medical History

- Large lesion successfully removed 14.3.08. Discharged 17.3.08
- Needs assistance with showering and to dress wound prior to removal of sutures at Mater Public Hospital on 24.3.08

18.3.08. 1st Home visit

- Showered patient.
- Wound dressed – healing satisfactory
- No sign of infection
- Balance a little shaky - complaining of increased arthritic pains in hands and legs.
- Taking Glucosamine & Chondroitin Supplement recommended by GP.
- Pain relieved with 2 Panadol 3 times daily.
- Confused about why he had operation.
- Dorothy concerned about future.
- Tells you she will be 83 in August. Says Henry has not been himself since the surgery. Keeps forgetting things. She finds it difficult to manage the house and garden. Neighbours are helping with shopping. Kitchen and bathroom disordered – trouble finding clean towels – dishes piled in sink, bed unmade.

19.3.08

- Henry showered and wound dressed.
- Still a little unbalanced.
- Rests most of the day.
- Does not remember being showered yesterday.
- House still disorganised, washing piled up in bathroom.
- Dorothy says she would be lost without help from neighbours who also appear to be cooking meals for the couple.

Concerns:

- Provided there are not complications with the wound healing, your role in providing nursing care ends when sutures are removed on 24 March.
- You consider that Jim and Dorothy need to be assessed for further on-going assistance in managing the house and garden and with shopping and the preparation of cooking.

Plan:

- Request a home visit by the Aged Care Assessment Team as soon as possible to fully assess their needs and to arrange for appropriate further assistance to be provided.

WRITING TASK

Using the information in the case notes, write a letter to The Director, Aged Care Assessment Team, Brisbane South Region, 78 Masterson St. Acacia Ridge, Brisbane 4110. Explain why you are writing and what types of assistance may be required.

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.

CASE NOTES 21 PAULA ANDERSON

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

- Patient name: Ms. Paula Anderson
- Today's date: 02/02/2018
- DOB: 19/05/1954
- Marital status: Married

Social background:

- Lives with husband - very supportive
- 1 daughter-lives interstate Two sisters- live nearby
- Retired school teacher (English)
- Hobbies: playing badminton, watching movies
- Likes socialising, playing chess

- Sedentary lifestyle – Overweight since 30's

Medical background:

- Appendectomy – 2003
- # left leg – 2007 pneumonia – 2015
- arthritis in hands – uses Voltaren

Diet:

- Red meat, processed meat
- Fast food
- Alcohol (Vodka, wine) – 4-5 days/wk.
- Ex-smoker – quit 15 years ago

Nursing notes

28/12/2017

- Visit to GP, 2- 3 bleeding from rectum rectal exam- definitely palpable mass
- Fast track referral for suspected colorectal cancer

11/01/2018

- 8 cm mass on left lateral wall of rectum
- Likely to be carcinoma – referred for colonoscopy

14/01/2018

- Colonoscopy- biopsies large bowel mucosa taken

18/01/2018

- CT & Local staging of primary tumour with MRI

23/01/2018

- Review of histology – colonoscopy report
- Diagnosis – Colon cancer
- R/v by colorectal and general surgery consultant CT – no evidence of metastatic cancer
- Recommended colostomy
- Pt. advised of diagnosis and surgery

02/02/2018

- Identified needs/problems:
- Prepare for colostomy
- Eating and drinking: Potential problems of dehydration due to above
- Anxious about probs of stoma on home and social life. Involve family members in care
- Objectives: Minimise risk of post-op., wound infection from bowel contents
- Allow surgeons clear access to operation site i.e. free from faeces
- Complete pre-op. Care schedule
- Encourage patient to voice concerns

Plan

- Rectal wash-out before bedtime for three days (daily)
- Purgatives as desired
- Low-residue light diet 02/02
- Fluids only including soup and ice cream 02/03
- Clear fluid 02/04
- Charge Nurse to see the pt. to discuss practical problems at home
- Nil by mouth from 00.00 hours 02/05
- Standard pre-op procedure
- Ensure variety of acceptable drinks

WRITING TASK

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

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.

CASE NOTES 22 BERYL CASEY

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 Beryl Casey is a 72-year-old woman who is being discharged from hospital to a rehabilitation centre.

- Patient: Mrs Beryl Casey (DOB: 21/11/1941)
- Marital status: Widowed (recently)
- Family: 2 children – son lives locally & daughter interstate.
- Lives alone in 2-bedroom house with stairs to entrance.
- Son (married, 2 children – 6 & 8)
- Lives 20 minutes away – visits twice a week. Enjoys gardening.
- Medications: Anti-hypertensive (Ramipril) 10mg
- **Admission date:** 4/02/14 at 1200hrs
- Fainted getting out of bed & fell to the floor.
- Found by son 2 hours later.

- Diagnosis: X-ray – fractured left neck of femur (# L NOF) post fall

Treatment:

- Left hemiarthroplasty (Austin Moore hip replacement);
- General anaesthesia Incision closed with staples & 2x Exudrain

Post operation:

- Intravenous (IV) therapy: 3 units packed cells – with IV Lasix (furosemide) 40mg therapy after each unit (intraoperative & post op) Maintained IV therapy for 36 hrs, then ceased and oral fluids encouraged Intravenous antibiotics
- (IVABs) – Cephazolin 1g t.d.s. for 3/7 – course completed Vital signs:
- BP hypotensive – 95/60, other obs. within normal limits Antihypertensive medication reviewed by Dr
- Dose - now Ramipril 5mg daily

Pain management:

- Patient-controlled analgesia (PCA) with Fentanyl for 36hrs – pain relief – satisfactory.
- Commenced oral analgesia 36hrs
- Post op - Panadeine or Panadol 4/24 prn, Max 4 doses/24hrs

Wound management:

- Dressing √ Total of
- 600ml haemoserous fluid discharge from
- Exudrains over 24hrs Drain tubes removed 48hrs post op (Day 2) Alternate staples removed Day 5 and dressing Changed

Mobility & activities of daily living (ADLs):

- Day 2 Sitting out of bed (SOOB) short periods, full assistance
- Day 3 Mobilising with pick-up frame (PUF) & 2-person assist
- Day 4 Uneventful
- Day 5 Mobilising short distances with PUF & 1person assist Abduction pillow when resting in bed (RIB) Anti-embolic stockings in situ for 14 days ADLs – full assistance
- Day 6 Uneventful day Preparing for discharge Discharge plan:
- Day 7 (1100hrs) Discharge to the Rehabilitation Centre
    - **Discharge medications** Ramipril 5mg daily, paracetamol 1g qid prn Family to be notified of transfer Hospital

transport arranged for 1100hrs

- Day 8
    - Repeat check of hemoglobin (Hb) levels
    - Monitor BP b.d., for 3/7, due to adjustment in anti-hypertensive meds
    - Assess for rehab therapy (inpatient & on return home)
- Day 10 Removal of remaining staples, wound can remain exposed Afterwards

WRITING TASK

Using the information given in the case notes, write a discharge letter to the Nursing Unit Manager, The Rehabilitation Centre, Waterford.

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.

CASE NOTES 23 ZANE KHALIFA

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:

Zane Khalifa was admitted through the Children's Emergency Department for acute meningitis as a result of a complication following chickenpox.

Patient History

- Address: 28 Seaview Street Cleveland QLD
- Phone: (07) 35443574
- Date of Birth: 13 March, 2013
- Admitted: 28th October 2017
- Gender: Male
- Discharged: 8th November 2017
- City of birth: Johannesburg
- Diagnosis: acute meningitis

Social History

- Parents: Zoya & Abayomi Khalifa, refugees, arrived in Australia in 2015.
- Employment: Abayomi: Helsey strawberry factory, planter

- Zoya: housewife + online music instructor (busy from 10 pm to 12 pm
- Accommodation: Recently moved to rental accommodation
- GP: No family doctor
- Sibling: 3-year-old sister, Siri
- Language: Zulu, Arabic

Interpreter needs:

- Abayomi understands spoken English but has limited written skills.
- Zoya has limited understanding of English.
- Abayomi attends English classes.

Medical History

- Parents state that both children had some kind of vaccination at birth but the vaccination record has been lost. Parents unaware of vaccine for chickenpox.

Discharge Plan

- Appears to have fully recovered from chickenpox and acute meningitis.
- Will need advice on recommended vaccines for both children.
- Will need neurological check-up.

WRITING TASK

Using the information in the case notes, write a letter to The Director, Community Child Health Service, 501 Stanley street, Cleveland, requesting follow-up of this family.

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.

CASE NOTES 24 JAMIE MORGAN

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 Janice Rose a registered nurse in the Coronary Care Unit, St. John's Hospital, London.
Jamie Morgan is a patient in your care.

Patient Details

Name: Jamie Morgan DOB 22 February 1956
Address 9476 Old Dam Road, Goondiwindi QLD 4390
Next of Kin Brother, Justin morgan 72 Burke St, Cunnamulla QLD 4490

Admitted: 27 September 2017

Diagnosis: Obstructive coronary artery disease
Operation: Coronary artery bypass grafts (x 4) on 29 September 2017

Social History

Never married
Lives alone in own home just outside Goondiwindi
Fencing contractor

Medical History

Smokes 30 cigarettes/day
Alcohol: 3 x 300ml bottles beer / day
Ht 177cm Wt 96kg
Usual diet: sausages, deep fried chips, burgers,eggs, MacDonalds
Allergic reaction to peanuts

Nursing Management and Progress

Routine postoperative recovery
Advised to cease smoking, reduce alcohol Low fat diet
Walking well
Wounds healing well
Routine visit from Social Worker

Discharge Plan

Returning Home to Goondiwindi
Appointment made for follow up visit to local GP Dr. Stevensen George, 2pm 10/10/17
Local physiotherapist to continue rehabilitation exercise program

WRITING TASK

Mr. Morgan has requested advice on low fat dietary guidelines and healthy simple recipes. Write a letter to the Community Information Section of the Heart Foundation, Gosbey Simon, Brisbane on the patient's behalf. Use the relevant case notes to explain Mr. Morgan's situation and the information he needs.

Include Medical History, Body Mass Index and lifestyle. Information should be sent to his home address.

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.

CASE NOTES 25 NINA SHARMAN

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:

- Today's Date: 21/03/12

Patient Details

- Name: Ms. Nina Sharman
- DOB: 09/02/1951
- New resident of Dementia Specific Unit, Westside Aged Care Facility
- Single
- Under the Australian Guardianship and Administration Council protection

Medical History

- Ischemic heart disease (IHD) since 2005, takes Nitroglycerine patch, daily
- Stroke May 2011, after stroke - unsteady gait
- In 2011 - diagnosed with severe dementia - able to understand

simple instructions only, confused and disorientated

- Diabetes mellitus (type 2) since 2000 – on a diabetic diet
- Osteoarthritis of both knees 20 yrs.
- Voltaren Gel to both knees BD
- Weight gain 10 kg over the last 5 months, current weight 106kg (BMI of 30) Chronic constipation, takes Laxatives PRN
- No allergies to medication or food
- No teeth – has entire upper or lower dentures, sometimes refuses to wear dentures due to confusion and disorientation
- Increased appetite– usually eats full portion of offered meals x 3 times daily and, also, goes into other residents' rooms and eats their food as bananas, biscuits or lollies

Social History

- No friends
- Lack of interests, but likes colouring and watching TV
- ↑emotional dependence on nursing staff
- Non-smoker, no use of alcohol or illegal drugs

Recent Nursing Notes

15/02/12

Chest infection. Keflex 500mg QID x 7 days

26/02/12

Occasional cough & episodes of SOB with

↑RR

27/02/12

Sporadic throat clearing after eating yoghurt

20/03/12

1700 hrs

Episode of choking on a piece of food (? food not chewed properly). She suddenly turned blue, grabbed the throat with both hands and coughed. The piece of solid food was removed. 1710 hrs

Nursing assessment after treatment

Pulse 110 BPM
BP 120/70 mmHg
RR – 22/min
T– 37.1° C
BSL – 6.0 mmol/L

1800 hrs

No complaints
Pulse – 88 BPM
BP – 115/70 mmHg

RR – 16/min
T- 37.0 °C
Skin: normal colour.
Hospital visit not required

WRITING TASK

You are a Registered Nurse at the Dementia Specific Unit. Using the information in the case notes, write a letter to Dietician, at Department of Nutrition and Dietetics, Spirit Hospital, Prayertown, NSW 2175. In your letter explain relevant social and medical histories and request the dietician to visit and assess Ms. Sharman's swallowing function and nutritional status urgently due to a high risk of aspiration. 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.

CASE NOTES 26 ANNA PARO

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 district nurse (nurse caring patient at their home) taking care of Mrs Anna Paro, who needs daily dressing for the leg ulcer.

Name: Anna Paro Age: 75 years

Medical history:

COPD

Osteoarthritis

Appendectomy - 2009

Suffering with leg ulcer

Taking salbutamol pm

Ipratropium 25/250 2 puffs daily

Social history

Lives alone, husband died

Two children one native, other overseas

10.03.2018 Subjective:

SOB increase (especially day activities, not at night

Salbutamol ineffective

Need rest or sit down to hold breath back

Objective

Comfortable at rest, no sob

RR 18bts/m. BP 130/80mmHg

Auscultation. Good air entry both sides, little wheeze on left side

Observed patient's inhaler use – inappropriate **Diagnosis:**

S0B worse due to COPD, inhaler use Treatment:

Ventolin 2 puffs under supervision

Educated about inhaler use with spacer patient claims "this is not the way my pharmacist told"

Plan

Refer/ advice pharmacist inhaler

WRITING TASK

Write a referral letter to Anna paro pharmacist to teach her about inhaler 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.

CASE NOTES 27 LARISSA ZANEETA

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

- Name: Mrs. Larissa Zaneeta
- Age 38-years-old
- Marketing manager, married, one child (boy, 4 years).

Medical history

- Unremarkable, no medications

11/07/05

- Complains of tiredness, difficulty sleeping for 2 months due to work stress
- Plans another child in 12 months, currently on OCP
- O/E: Appears pale, tired and slightly restless
- BP 140/80
- No abnormal findings
- Assessment: Stress-related anxiety
- Plan: advised relaxation techniques, reduce working

hours, prescribe sleeping tablets tds

15/08/06

- Stopped OCP 4 months earlier, still menstruating
- Worried, Sleep still difficult, work stress unchanged,
- Not possible to reduce hours
- O/E: Tired-looking, slightly teary
- Assessment: Work stress, growing anxiety failure to conceive
- Plan: discussed nature of conception – takes time, patience discussed frequency sexual intercourse discussed methods – temperature / cycle

18/01/07

- Expressed anxiety re failure to conceive, says she's "too old" sleep still a problem
- O/E: crying, pale, fidgety
- Vital signs / general exam NAD
- Pelvic exam, pap smear
- Assessment: as per previous consultation Plan: 1-2 Valium b. d.
- Suggested she re-present next week accompanied by husband.

25/01/07

- Mr. Zaneeta very supportive of having another child

- No erectile dysfunction, libido normal
- Mrs. Zaneeta unchanged
- O/E: Mr. Zaneeta normal
- Plan: Check Mr. Zaneeta's sperm count

02/02/07

- Sperm count normal
- Plan: Refer for specialist advice

WRITING TASK

Using the information in the case notes, write a letter of referral to Dr Elvira Sternberg, a gynaecologist at 123 Church St Richmond 3121.

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.

CASE NOTES 28 KYLIE WEISS

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

Today's date: 09/07/2017
Name: Ms. Kylie Weiss
D.O.B.: 21/05/1952

Address: 8758, Pulteney Street, Adelaide, SA, 5000

Admission:

- 07/07/2017 BIBA (Brought in by ambulance)
- Hours' history of intermittent discomfort jaw/heaviness in both forearms,
- Constant discomfort; IV access in ambulance, 10 mg IV Morphine on route, Aspirin 300 mg chewed, Glytrin Spray x 3 ECG showing ST elevation

- Diagnosis: Myocardial Infarction

Medical History:

- Weight: 85 kilograms,
- Height: 170 cm – Overweight (BMI-29)
- Ex-smoker – 1994
- Mild osteoarthritis
- Mild asthma – no exacerbations within last 5 years
- Dyslipidaemia- (Raised cholesterol) – not treated
- Medications: NIL
- Occupation: Works as a taxi driver, mixed shifts
- Dietary Habits: Eats fast food- fries, hamburgers, doughnuts, ice cream, nondrinker

Family History:

- Brother- Coronary artery bypass grafting (CABG) at 70 years
- Sister MI (Myocardial Infarction) at 60 years,
- Mother-angina

Social History:

- Marital status: Married with one daughter Husband-Peter Weiss, 67 years, retired, aged pensioner

Treatment:

- Emergency Angioplasty performed
- ST Segment elevation on ECG – Direct stenting to proximal LAD
- Echocardiogram – Ejection fraction 35%
- Pain/Discomfort – managed
- Fasting Bloods (Lipids, Diabetes, TnI (proteins troponin), CBC (complete blood count), Biochem)- High Cholesterol levels
- Nil further pain/discomfort, Cardiac status stable Pt. seemed confused re diagnosis, reality of near-death experience
- Educated re event, MI diagnosis and modifications to risk factors (Cholesterol, wt. loss)
- R/v(review) by Physiotherapist – cardiac exercise program provided
- R/v by dietician – diet for weight loss & reduced cholesterol levels
- Concerned about being unable to manage home on her husband's pension -S/W (Social Worker) input required

09/07/2017

- Preparing for discharge

Discharge medications:

- Atorvastatin 40 mg OD,
- Metoprolol 23.75 mg OD,
- Cilazipril 0.5 mg OD,
- Aspirin 100 mg OD,
- Ticegralor 90 mg BD,
- Glytrin spray prn for chest pain

Discharge plan:

- No driving for 6 weeks.
- Refer to Cardiac Rehabilitation Nurse Specialist –compliance with risk factor management (wt. loss, low cholesterol diet), medications, education re about MI and its management Refer to Occupational Therapist – to provide guidelines for returning to work, driving and normal daily activities,
- Refer to Social Worker – due to inability to work for 6 weeks
- 6-week recovery from MI, assess eligibility for sickness allowance/ benefits from the Australian Government

Department of Human Services.

WRITING TASK

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

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

CASE NOTES 29 JOHN WILLIAMS

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:

- Hospital: Royal Perth Hospital, Sydney
- Discharge date: 24 April, 2021

Patient Details

- John Williams
- Age: 68
- 180cm; 80kg.

Telephone number: +61 45631 1286

Social History:

- Lives with daughter Elvie, 32 years (Provides 24-hour supervision and is the primary caregiver)
- Smokes
- Doesn't drink
- Address for correspondence: 172 Auckland Street Gladstone, Australia.

General Conditions

- Sensory vision WNL with glasses

- Somewhat hard of hearing
- Speech is clear with mild dysphasia
- Ambulates with a cane or rolling walker independently
- Sometimes needs supervision or contact guard on the stairs
- Transfers independently
- Continent of bowel, incontinent of bladder
- Wears disposable undergarments

Medical History:

24th October, 2016

- Diagnosed to have high BP;

20th November, 2017

- Mild chest pain.

10 April, 2021

- Admitted
- Presenting symptoms: Pain, aches, discomfort and tightness across the front of the chest
- BP noted as 170/110 mm Hg
- Myocardial perfusion scintigraphy confirmed the diagnosis of angina

18th of April 2021

- Coronary Artery Bypass Surgery

WRITING TASK

Using the information in the case notes, write a letter to Dr. Kendrick Johnson, St. Vincent's Hospital, Sydney, who wanted you to provide all the details about the patient's medical history before taking the patient into his 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.

CASE NOTES 29 MS SYDNEY LOTEN

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 Practitioner at the Medical Center Brisbane.

Patient Details

- Name: Sydney Loten
- DOB: August 14, 1946
- Address: 5 Peanut Hedge, Carina Heights QLD
- Phone: 07 86734214
- Next of kin: Eby Simmons (adopted son)

Social History:

- Retired Professor; Widow, one adopted son 24-year-old student; Husband died 2014.
- Lives with her son in a one-storey house, son is often unavailable to care for patient due to school and work.

- Oxygen readily accessible at home via nasal cannula at 2-4L as needed

Medical History:

- Height: 160cm Wt. 65kg
- Occasional alcoholic beverage drinker. 1-2
- bottles of beer/week (till 2019, Jan; 1 bottle of beer/week (now)
- Smoker, 10-15 sticks/day for 35 years (till
- 2018); 5 e-cigarettes (since then)
- No previous or surgical procedures
- Diagnosed with COPD in 2010, maintained on
- Ipratropium bromide inhaler, 1 puff,
- Budesonide
- + Formoterol, 2 puffs BID and Prednisone 40 mg taken as a single daily dose for acute attacks
- Diabetic since 2007, Metformin 500mg BID, Glipizide 5mg OD
- Hypertensive since 2008, Losartan 40mg OD
- Patient underwent routine colonoscopy, multiple polyps found. Admitted at Medical Center Brisbane on April 11, 2020. Colon polypectomy on April 13, 2020

- Post-op complications at the recovery room, experienced respiratory distress, Arterial Blood Gas revealed. Covid19 test negative.
- Metabolic acidosis. Transferred to ICU and moved to regular ward on April 15, 2020
- Hooked to oxygen support at 3-5L NP as needed.
- Patient uncooperative at times and requires encouragement to take medications.
- Difficulty in sitting and cannot walk around the room.
- Pain meds given as prn: Paracetamol 1g IV and Endone 2.5mg PRN for intolerable pain On laxative, Senna, OD at bedtime.
- Was on folly catheter now with adult diaper due to incontinence.
- Stable vital signs at regular ward 02 sat at 9697% at 2-3L.
- Wean if able to tolerate 1L.
- Moderate post op pain, wound with no exudates

Medical Records

- April 17, 2020
- Patient hesitant to ambulate around her room.
- Prefers to walk with assistance.

- Unable to tolerate O2 at 1L. O^2 sat at 98% at 2L.
- Anxious during wound dressing.
- Minimal pain at the incision site. Encouraged sitting, standing and walking inside her room. Poor appetite. Constipation, resolves with laxative.

April 19, 2020

- Patient walks around her room with walker.
- Can walk along the hospital corridors but requires increase to 3L O^2 after walking.
- O^2 sat at 98% at rest.
- Less uneasy during dressing change.
- Improved appetite.

April 22, 2020

- Patient can walk with a cane.
- Can tolerate O^2 at 1L, O^2 sat 98%.
- Minimal pain at incision site.
- Regular bowel movement.
- Still requires adult diapers for incontinence.
- Eager to go home.
- Discharge will be facilitated once O^2 availability at home is confirmed.

April 23, 2020

- Patient is ready for discharge.

- Home medications and instructions given in the presence of her son.
- Need for transition care program explained.
- Continue dressing change at home.
- Advised to monitor O^2 consumption. Follow up check-up scheduled on April 30. 2020.

WRITING TASK

Given the patient's current situation, you need to write a formal letter to the Nursing Director, Jane Hall, Southern Valley Community Transition Care, 64 Gladstone Road, Highgate Hill Qld 4101. Discuss the need of the patient's continuity of care at 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.

CASE NOTES 31 ANITA RAMAMURTHY

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

Hospital: Sydney Women's Hospital

Patient details

- Marital Status: Married
- Height: 5'4"
- Weight: 87 kg | BMI: 33 –Obese
- Address for correspondence: #648, Bourke Street, Sydney
- Admitted: 18/06/2017
- Date of discharge: 23/06/2017
- Diagnosis: Acute appendicitis with Appendicular lump
- Treatment: Conservative management with IV antibiotics (Planned for interval appendectomy in 6 wks)

Social Background:

- Businesswoman (Education Consultant)
- Hectic life, travels a lot due to work
- Lives with husband, Mr. Krishnan Ramamurthy
- Two married daughters
- Elder daughter stays in Sydney – about three hours away, works as an Entrepreneur; younger daughter in Canada, works as a dentist
- Husband is the primary caregiver, elder daughter visits with husband once a year,
- Scared of hospitalization, prone to anxiety related to this
- Fond of eating out, rarely cooks at home, sedentary lifestyle, complains of no time to exercise due to work, does not drink or smoke
- Diet: Whole Milk, Ice-cream shakes, Fruit drinks, Doughnuts, Pancakes, Waffles, Pizzas, Cheeseburgers, Biscuits, muffins, Cajun Fries, Hash brown

Medical Background

- Known case of Essential Hypertension (2014) and Diabetes Mellitus type-2 (2010) (not compliant with diabetic medication)

Admission Diagnosis

- Complaints of pain in abdomen in right iliac fossa since 17/06/2017
- Pain was sudden in onset, acute in nature and was non-radiating fever (documented up to 101-degree F), aversion to food, evaluated outside where USG Abdomen revealed Acute Appendicitis, admitted for further evaluation and management

Physical Examination

- Conscious, oriented, No pallor, no icterus, No Clubbing, No Lymphadenopathy, no pedal oedema
- BP: 126/84, Temp-afebrile, Pulse-72/min, RR- 22/min SP O2 98%, CNS-NAD, Chest- Bilateral entry equal, No added sounds

Nursing Management and Progress

18/06/2017

- Abdomen CT (plain)

18/06/2017

- acute appendicitis with hypodense area in the region of base of appendix at its attachment with caecum?

- Phlegmonous collection. Possibility of sealed perforation cannot be ruled out; total leucocyte count 21,000/cumm
- I/V Fluids, broad spectrum antibiotics (Imipenem), PPI, Analgesics, antipyretics, other supportive treatment (6/6), Regular Blood Sugar Monitoring (6/6)

19/06/2017

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

20/06/2017

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

21/06/2017

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

22/06/2017

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

23/06/2017

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

Assessment:

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

Medications:

- TAB Dolo(Paracetamol) 650 mg, t.i.d. (8 hrly) for 3 days then PRN
- TAB Pantocid(Pantoprazole) 40 mg mane for 10 days
- Tab Tenorid 25 mg (Atenolol) mane
- Tab Supradyn(multivitamin) mane, Tab Farobact 200 b.d.

Discharge Plan

- Avoid strenuous activities/Travel
- Advised to lose weight (exercise program to start after appendectomy)
- Normal Diabetic diet and low-fat diet – Pt. requests more information, esp. simple recipes that can be easily prepared at home

- Monitoring of fasting and postprandial blood sugars (present chart during Follow-up consultation)
- Follow up in OPD on 30/06/2017 at 3PM.
- Husband advised to contact us immediately in case of persistent high-grade Fever/pain (at 03492250);
- Pt. concerned re monitoring of blood glucose levels and insulin injections
- Husband requests home visit for demonstration

WRITING TASK

Using the information given in the case notes, write a referral letter to Ms. Prabha, Srishti Nursing Home Care Agency, Sydney, requesting a home visit to provide instructions on self-monitoring of blood glucose levels and administering insulin injections following Mrs. Ramamurthy's discharge.

In your answer

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