CASE NOTES: 16

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 at North Romand Infant Welfare Centre.
You visited this patient at home today for the first time, after a referral from the maternity hospital.

Name: Guy Hoang Chueng
Date of Birth: 17.05.53
Gender: Female
Occupation: Home duties

Personal History
Recently migrated (1/1991) with husband and 3 children (survivors of 6 pregnancies) from Vietnam to Australia

Family Background
Husband works in factory: setting up small Import business:
English at night school.
Children (boy 13, boy 11, girl 7) all at school; working hard to adjust.
Strong family commitment to school/work/study/business/Increasing financial stability/learning English: may not provide necessary assistance to overcome operation and manage new baby.
No other family in Australia.

Medical History
No operations/illnesses
6 normal pregnancies previously, birth weight approx. 2.8 kg.

10/7/1992
Incoordinate contractions and inadequate outlet- Caesarean section
Birthweight 4 kg (probably result of recently improved diet/antenatal care).
? Circumstances not understood by patient; language barrier / poss. Cultural differences.

20/7/1992
Mother sutures removed: suture lines healed.
Baby: no jaundice; breast feeding satisfactory, normal weight gain.
Mother and child discharged from hospital.

27/7/1992
1st home visit

Most time since operation depressed and in bed (reasons unclear, but suspect due to circumstances of operation).
Physically well. Apparent resistance to medical intervention in hospital (language barrier).

Requirements
? Understanding of reasons for Caesarean section.
? Home help.

Plan
Refer to social worker;
arrange management plan.

WRITING TASK
Using the information in the case notes, write a letter of referral to Hoa Tran,
who is a Cambodian social worker with Romans Council
Introduce Mrs Chueng and explain why you are referring her to the social worker. Discuss reasons for her depression and explain how you think Mrs Tran can help.

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: 17

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:

Health Facility: Glenelg Aged Care Home, Anzac Highway, Glenelg

Patient Details: Alex Maydew, 23, has neurological injuries as a result of a car accident 10 months ago.

Past Medical History: NAD

Social History:
Alex was a third year Physical education student at the University of South Australia before the accident
Keen mountain climber and surfer
Mother and sister very attentive and caring
Mother is a nurse at Modbury Hospital

Nursing Notes:

- 4 months in coma at Royal Adelaide Hospital
- 4 months in coma at Glenelg Aged Care Home
- Woken from coma 2 months ago with normal brain function but loss of speech facility
- Confined to wheelchair. Improving mobility with physiotherapy
- Depressed to be in an aged care setting
- Mother believes that the aged care setting is slowing his recovery
- Able to use a computer - could possibly resume part-time study

Writing Task
Write to the Director of the Julia Farr Rehabilitation Centre, 229 Fullarton Road, 5097, requesting a transfer of your patient to more appropriate care. Mention need for ongoing speech therapy and physiotherapy, and possible continuation of online studies

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

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: North West Hospital Rehabilitation Unit

Patient Details:
Name Mr Ted Watson
Age: 72 y.
Marital status: widowed -10 yrs
Next of kin: daughter Margaret Alwood ph. 9825 3899

Admission Date: 10 May 2007
Discharge Date: 12 August 2007

Diagnosis: ↓ed mobility - surgical repair (dynamic hip screw) of # R Neck of Femur (1 May 2007 at Newtown Hospital

Past Medical History:
NB: Medical Alert
Anaphylactic reaction to amoxicillin/penicillin (antibiotics) 1997

Social History/Supports:
Retired storeman - Ramsay's Ltd
Lives alone- ground floor flat in public housing
Hobbies: quiet reading / listening to 'big band music/TV sports
All home aids installed by O.T
Very supportive daughter, visits frequently ? anxious how father will manage when returns home
Local day centre 2 x wkly
Local council home support visits

Medical Progress
Slow due to

1. Febrile episode - periods of confusion.
   Caused by urinary tract infection.
   Treated w. trimethoprim (antibiotic), Ural (urinary alkalizer) and paracetamol (analgesic)
   Now fully resolved.
2. Onset of large arterial leg ulcer R ankle.
   Regular dressings, now ↓ing in size.

Nursing Management:
Vital observations stable, afebrile.
Mobility- V. slow independent ambulation with pick-up frame

Hygiene: max. assistance with showering/dressing
Continence: self care with permanent indwelling catheter.
Skin integrity: DuoDerm (occlusive) dressing wkly to ulcer.
Psychosocial: alert, reserved.

Discharge Plan:
Continue with all home supports
Community nurse referral-

- for hygiene: assistance with showering/dressing
- wound management
- urinary catheter change 6-wky
- ongoing monitoring and care

WRITING TASK
You are the charge nurse on the hospital ward where Mr Ted Watson has resided during his hospital stay. Using the information given in the case notes, write a letter of referral to the Community Nurse Supervisor at the Community Nursing Centre, Newtown, who will be attending to Mr Watson following his 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: 19

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 Jane Simms is a 46-year-old patient on the ward of a rehabilitation hospital in which you are Charge Nurse

Patient Details
Marital Status: Single
Admission Date: 26 July 2008 (South Eastern Rehabilitation Hospital)
Discharge Date: 16 August 2008

Diagnosis: Progressive Multiple Sclerosis

Social Background:
Lives with unmarried sister in 3-bedroomed house
Employed as graphic artist until September 2007
Now invalid pensioner.

Medical Background:
Multiple sclerosis diagnosed 20 yrs ago/recent exacerbation Obesity
↑depression since stopping work
Pressure area-R buttock

Nursing Management and Progress:

- Medications previous regime of ACTH and corticosteroids and recently prescribed Prothiaden 150mg daily
- antidepressant: dosulepin hydrochloride
- Daily dressings → R buttock. Now healed
- Low calorie diet
- Range of motion, stretching and strengthening exercises
- Occupational therapy

Assessment: Good progress all areas

Discharge Plan

- Monitor medications (NB Prothiaden)
- Preserve skin integrity
- Monitor weight
- Continue exercise program
- Encourage new activities/interests

WRITING TASK

Using the information given in the case notes, write a letter to Ms Mary Wright, the Community Nurse at Lakeside Community Health Centre, 50 Hope Street, Newtown, who cared for Ms Simms at home until her recent admission to hospital. The letter is to accompany Ms Simms home upon her discharge tomorrow.

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

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 History
Maria Ortiz is a seven-day old baby. Her mother has been discharged from the maternity hospital.
Baby: Maria Ortiz, 7 days old

Social History
Mother: Voletta Ortiz
DOB: 07/08/1967
Husband Jose, 36 years, Occupation Security guard (night shift)
Other children- Sam, 5 years (currently not attending school) Teresa, 3 year
Accommodation Two bedroom flat (rented)

Nursing Notes
Normal birth
Breast fed
Mother anxious about coping with 3 children
Baby sleepy, reluctant to feed
Baby's weight- birth-3010 g : Discharge -3020 g
Father unable to assist with children (night work)
Mother very tired
No car: 20-minute walk to shops
Discharged from hospital 10 April, 1997

Writing Task
Using the information in the case notes, write a letter of referral to the maternal and child health nurse. Who will provide follow-up care in this case: Ms Josie Hext, Maternal and Child Health Centre, 133 Elm Grove, Westfield, 2692

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

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:

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

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: 22

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 patients inhaler use – inappropriate

Diagnosis:
S0B worse due to ? COPD, inhaler use

Treatment:
ventolin 2puffs under supervision
Educated about inhaler use with spacer patient claims “this is not the way my pharmacist told”

Plan
Refer/ advice pharmacist inhaler

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: 23

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: Intensive Care Unit, Flinders Medical Centre

Patient Details
Name: Diane Carpenter
Age: 58
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 Generalised 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)
- Organise 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: 24

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 visiting Ms Styles at her home who is taking self-care at home

Patient History
Name: Ms Patricia Styles
Age: 04/08/1955 (63 years)

MEDICAL BACKGROUND

- Hypertension : diagnosed in 2012. on Carpinol medicine, blood pressure ↑2014 (190 /100) Now BP under control (140/90)
- Diabetes Mellitus: diagnosed in 2009 (Type II), taking oral hypoglycemic (Metformin+Glipizide)
- Depression: diagnosed first in 2015. depressed after her husbands death, attends medical counseling for mood swings and diabetes mellitus management

SOCIAL BACKGROUND
Hobbies: walking, reading
Lives alone, no close relatives, her cousin helps her sometimes

Medications

- Carpinol-6.25 x2 times daily
- Metformin-500mg x 2 times daily
- Glipizide-10 mh x I daily

MEDICAL HISTORY
On 07/04/2018 she admitted in Green Valley Hospital with chest pain (pleuritic).shortness of breath(SOB), tiredness.

Management
Glucose monitored regularly, sugar and BP (well controlled)

Blood test
ESR ↑(24), Creat ↑(2.0), Platelets ↓

(Stress/inflammation)
Oral throat swab: Type B influenza
Chest X-ray: Normal
Echocardiogram: Pericarditis

Diagnosis : Type B influenza plus pericarditis

Treatment: IV saline, Antibiotics

Discharged on 09/04/2018 advising further follow up home visits.
She was on self-home care after discharge. She was keeping well and the home nurse left her 2 days ago.

14/04/2018 Home visit
Subjective: Ms Styles feels tired and has chest pain
Examination: Unwell, Chest pain (↓ when sitting), SOB, fatigue
Vital signs: Mild temperature (38), HR-122, RR-28, BP-180/90
Assessment: ?? Relapse Complication pericarditis
Plan: Refer patient to Newtown Hospital Emergency Department (nearest hospital)

Inform emergency doctor about patients

- Medical history
- Medications
- Past history

WRITING TASK
Write a referral letter for MS Styles to the Emergency Doctor on Duty requesting urgent assessment and management of her pericarditis. Address the letter to:
Emergency Doctor on Duty, Newtown Hospital. Corner Street, Newtown 1104

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

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 Brown is a patient in your care. She is now ready for discharge and will be transferred to a rehabilitation hospital

Discharge Summary

Name: Ms Rose Brown
Age: 27 years
Admitted: 27/5/07
Diagnosis: Dislocated knee
Discharge: 18/6/07

Reason for admission: Dislocated knee

Treatment
After X-ray, it was determined that Ms Brown had dislocated her left knee, The knee was rested and strapped. Topical heat and cold were used.

Social Situation
Ms Brown is a young woman with a mild intellectual disability. She is a large woman, and the extra strain her weight has put on her leg has made her progress very slow, She lives alone in a council flat, and as she is still unable to walk confidently with crutches, it has been decided that, at present she will not be able to cope living alone. Her mother is willing to help her, but is not able to help Rose into and out of the shower by herself

Progress
Ms Brown is experiencing less pain but has little strength in her leg. She is using a frame at present. She lacks confidence with crutches and requires at least one other nurse to assist when she is using them

Discharge plan
Transfer to rehabilitation centre. Ms Brown needs to continue to be seen by a physiotherapist and to have water aerobics to build up strength and stamina. She needs to progress from the frame, to crutches, and then to a walking stick Domiciliary care needs to be contacted - a ramp and bathroom aids will need to be placed in Ms Brown's home before she returns

Writing Task
Using the discharge summary, write a nursing letter about Ms Brown to the Director of Nursing at the Repatriation General Hospital, Daw Park.

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

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.

Patient: Susan Sarandon
DOB: 17-7-90
Marital status: Single
Family: Only child. Parents are still married and living together. Pt is student in the 10th grade.

First admitted:
13.9.05
Patient did not present to ER until 13.9.05, at which time she displayed signs of peritonitis and septic shock with a fever of 39°C

Discharge date: 8.9.05

Diagnosis: Ruptured appendix Peritonitis

Medical History:
Pt received adenoidectomy in 1987
Meds: Pt takes methylphenidate 10mg bid for ADHD. May be continued.
Denies EtOH Tab use. Denies sexual activity.

Background:
Pt was on class trip to Perth from her school in Bunbury when she developed
peri-umbilical pain and anorexia, beginning on 10.9.2005.
Initial pain followed by nausea. The pain then migrated to the RLQ with a maximum over McBurney's point

Management and Progress:

- Labs showed leukocytosis with left deviation, Hb of 13.1, Hct 41%. B-HCG was negative.
- The patient was immediately given ampicillin/gentamicin IV.
- A U/S was carried out, which displayed free fluid in the intra-abdominal space.
- A standing CXR was also performed which showed free air in the hepaticophrenic recess.
- An emergent laparotomy was performed. A perforation of the severely inflamed appendix observed, along with intraperitoneal abscess formation
- Appendectomy performed; abscess drained
- Pt transferred to SICU. Fever subsided. Transferred to a normal room Ciprofloxacin IV on Post op Day 1 →3 days

Discharge plan:

- Pt is ready to be discharged to rehab centre.
- She should re-present to this clinic on 1.10.05 for general assessment

- Contact Dr. Brown if fever >38°C, signs of infection or inflammation, SBP < 100 or 160 mmHg.

WRITING TASK:
You are transferring Miss Susan Sarandon to the Bunbury General Rehabilitation Centre. Write a discharge summary to accompany the patient.

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

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:

Tracy Chapman is a 20 year old single woman with 3 children. She was admitted for an appendicectomy and has recovered. She is ready to be discharged home.

Name: Tracy Chapman

Age: 20 years

Admitted: 18 April 1990

Discharged: 23 April 1990

Diagnostics: Acute Appendicitis

Operation: Appendicectomy 18 April 1990

Social background

- Single with 3 children aged 18 months, 3 years and 4 years
- Lives in a rented flat with her children
- The father of the children has no contact
- Only income is the Single Mother's Pension
- Has several friends who all work fulltime
- Tracy's mother is caring for the children but will be returning to her home in the country when Tracy comes home.

Nursing management and progress

- Routine post operative recovery
- Tolerating a light diet and fluids
- Walking normally
- Minimal pain relieved with 2 panadol 3 times a day
- Wound healed, sutures removed

Discharge plan

- Rest
- Moderate exercise
- No heavy lifting or activity for 6 weeks
- High protein diet
- Observe wound for infection
- Council "home help”

WRITING TASK

Tracy will require support and assistance to manage her children when she returns home. Using the information in the discharge summary, write a letter of referral to the community health nurse, Rae Willis, who will assist Tracy 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: 27

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.
Social: 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 & 1-person 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: 29

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 on duty at the Children's Hospital. You have been caring for this patient, Ann, an infant.

Patient Details
Name: Ann Ballard Age: 22 months
Next of Kin: Christine Ballard (mother)

Admission date: 16 March 2010

Discharge date: 22 March 2010

Diagnosis:
2nd degree burns to right trunk & arm following accidental scalding with hot water
Family: Lives with mother and 4yr old brother (Tom)

Background:
Mother (28 yrs) separated from husband 4 mths ago
Financial difficulties following separation
Housing: 3 bedroomed house in new housing development
Family reliant on public transport
Socially isolated (Christine's parents interstate, has few friends)
Christine ?depressed
Children spend alternate weekends with father

Medical history and medications:

- Nil medications
- Nil significant history
- No known allergies

Management and progress during hospital stay:

- 2 x daily Silvazine dressings to affected area
- IV fluids for 24 hrs post admission and then oral fluids
- Mother referred to hospital social worker

Medications: Prophylactic antibiotic cover & analgesia

Discharge plan:

- Daily Silvazine dressings
- No discharge medications

- Monitor mother's mental state
- Introduce to local supports (e.g., mothers' group/activities, local childcare centre, etc.)
- Appointment with local financial counsellor (for financial problems)

Writing task:
Using the information given in the case notes, as the Charge Nurse on duty, write a letter to the family's local maternal and child health nurse, outlining relevant information and requesting follow-up on discharge. Address the letter to Greenville Maternal and Child Health Centre, Main Rd, 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: 30

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:

CASE NOTES

Name: Mrs. Larissa Zaneeta
Age 38-years-old

Family and social history
Marketing manager, married, one child (four-year-old boy).

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 oral contraceptive pill (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 Sterinberg, 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: 31

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
25/07/09

Notes

Vamuya Obeki was admitted through the Children's Emergency Department for acute meningoencephalitis as a result of a complication following mumps.

Patient History
Address: 32 Sexton St,
Ekibin Phone: (07)
38485555
Date of Birth: 23 May 2005
Admitted: 15th July 2009
Gender: Male

Discharged: 25th July 2009
Country of birth: Sudan
Diagnosis: acute meningoencephalitis

Social History
Parents: Miri & Abdullah Obeki, refugees, arrived in Australia in 2008. Employment: Abdullah: Golden Circle pineapple factory, shift worker Miri: housewife
Accommodation: Recently moved to rental accommodation GP: No family doctor
Sibling: 2 year old brother, Saeed
Language: Dinka, Arabic
Interpreter needs: Abdullah understands spoken English but has limited written skills. Miri has limited understanding of English. Abdullah 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 Mumps.

Discharge Plan
Appears to have fully recovered from mumps and acute meningoencephalitis. 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, 41 Jones Street, Ekibin, 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: 32

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 Medications
Karvea 150mg 1 daily
Oroxine 0.1mg 1 daily am
Timoptol Eye Drops 0.5% 1drop 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: 33

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
01/08/09

You are Sarina Chai, a registered nurse at the Royal Brisbane and Women's Hospital (RBWH). Maeve Greerson is a patient in your care.

Patient Details

Name: Maeve Greerson
Address: Unit 6, 45 Walter St, Holland Park 4121
Phone: (07) 3942 1658
Date of Birth: 9 October 1951
Country of birth: Australia

Social History:
Widowed, no children.
Next of kin: Brian Hewson (brother) 67 Bridge Street, Toowoomba Ph (07) 4693 6558.
Family and patient have requested no further treatments be used, other than those necessary to maintain comfort and dignity and to relieve pain.

Medical History:
March 2009: Laparotomy. Found to have cancer of the lower intestine with wide spread metastases. Partial bowel resection and colostomy performed.
April 2009: 6 weeks radiation therapy for relief of symptoms.
Prognosis: Not expected to survive more than 3 – 4 months.

24/07/09
Admitted to RBWH following collapse at home. Dehydration, nausea, severe pain IV fluids commenced - transdermal patch for pain, light low fibre foods only.

25/07/09.
Nausea less severe – tolerating jelly, low fat yoghurt
Occasional break through pain – pain medication increased Severe oedema of ankles and lower legs, bladder incontinence.
Does not feel she will recover sufficiently to leave hospital. Requests visit from Social Worker

28/07/09
Generally pain free, very weak and disorientated at times. Rejecting solids but able to tolerate fluids

- requests apple juice and lemonade.
Social Worker contacted brother. Advises place available at Glen Haven Hospice in Toowoomba from 1 August 2008.

01/08/09
Transferred via ambulance to Glen Haven Hospice

Writing Task
Using the information in the case notes, write a letter to the Director of Nursing, Glen Haven Palliative Care Hospice, 971 Arthur Street, Toowoomba, introducing this patient. Using the relevant case notes, give her background, medical history and treatment 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: 34

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 O'Riley is a patient in your care.

Patient Details
Name: Bill O'Riley
DOB 12 January 1956
Address 9476 Old Dam Road, Goondiwindi Q4390
Next of Kin Brother, Ernie O'Riley 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 Goondiwindi
- 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, MacDonalds
- 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 Goondiwindi

- 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 O'Riley 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 O'Riley'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: 35

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: 12/07/11
You are Sonya Matthews, a registered nurse at the Spirit Hospital. Robyn Harwood is a patient in your care. Read the case notes below and complete the writing task which follows.

Patient Details
Name: Robyn Harwood
Address: 8 Peach St, New
Farm Phone: (07) 3397 2695
Date of Birth: 4 February 1950

Social Background
Marital status: Widow. No children. Lives alone Next of kin: Megan Mack (Niece)
Niece lives with husband in Sydney who works as software engineer for Google Australia. Sister died recently. No other relatives.

Medical History
Diabetes Mellitus Type 2
Metformin 500mg mane

Diagnosis
Right partial rotator cuff tear Presented to Spirit hospital with pain and weakness in the right shoulder, especially when lifting arm overhead.

Descending stairs at home and slipped, falling onto outstretched arm. X-ray and MRI showed a partial rotator cuff tear.
Orthopaedic surgeon discussed surgery. Patient prefers to try non-surgical treatment.
Date of admission: 30-06-2011
Date of discharge: 12-07-2011

Treatment
Ibuprofen orally QID
Cortisone injections
Daily physiotherapy

Nursing Care Needs
Needs blood glucose level monitoring 4 hourly May be elevated because of cortisone
Needs assistance with shower and housework Orthopaedic review on 01/08/11

WRITING TASK

Using the information in the case notes, write a letter to the Nursing Director Ms. Jenny Attard of the Community Home Care Agency, requesting visits from the home care nurse.

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.