OCCUPATIONAL ENGLISH TEST

NURSAMPLE05

WRITING SUB-TEST – TEST BOOKLET

INSTRUCTIONS TO CANDIDATES

You must write your answer for the Writing sub-test in the **Writing Answer Booklet.**

You must **NOT** remove OET material from the test room.

Occupational English Test

WRITING SUB-TEST: NURSING
TIME ALLOWED: READING TIME: 5 MINUTES
WRITING TIME: 40 MINUTES

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

Notes:

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

PATIENT DETAILS:

Name: Ms Patricia Styles

DOB: 27.04.1957 (Age 62)

Address: 57 Market Drive, Newtown

Social background:
Retired primary school teacher
Lives on her own
Husband died 3 yrs ago (lung cancer); no children

Medical history:

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

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

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

Family medical history:
Mother – HT, DM

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

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

Green Valley Hospital Treatment Record:

23/08/2019 Pt visiting sister for weekend, sister lives 3hrs away from Newtown in Green Valley
Pt admitted to Green Valley Hospital late evening with fever, sharp & pleuritic chest pain (worse on breathing), general weakness & malaise, tachycardia (rapid heartbeat)

24/08/2019

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

Management: IV saline
Ibuprofen 600mg every 8hrs

Evaluation: Viral influenza type B plus pericarditis

25/08/2019 Pt discharged and advised on self-care at home
Niece drove Pt home & agreed to stay overnight for 3 nights
Follow-up Nurse Home Visit arranged for 30/08/2019

Nurse Home Visit – 30/08/2019:

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

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

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

Writing Task:

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

In your answer:

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

The body of the letter should be approximately 180–200 words.

Any answers recorded here will not be marked.