OET Nursing starter pack

Free, original practice for nurses preparing for OET. You are welcome to share this file with colleagues.

What is inside

- Three writing samples with model letters
- Listening Part A question paper and answer key
- Reading Part A question paper and answer key
- Role-play cards to practise out loud
- Vocabulary and spelling list

Hear the audio and check your work online

Scan to find the Listening audio, timed tests and explanations. No account is needed for the free tests.

OETAce is an independent practice site and is not affiliated with or endorsed by OET or CBLA. All material is original and fictional. Practise with timed questions, answer keys and explanations.

OET writing samples: nurses, with answers

3 original practice cases with case notes and a model letter. Allow 5 minutes to read and 40 minutes to write, then compare. A model shows one good way to answer. It is not an official OET sample or a marking guide, and all patients are fictional.

Sample 1: Discharge letter

Discharge to the community nursing service: new insulin and diabetic foot ulcer

Assume that today's date is 21 October 2026. Mr Bates is being discharged home this afternoon. You are a registered nurse on the medical ward at Lakeside Hospital. Using the information in the case notes, write a letter to Ms Jane Ellis, Nurse Unit Manager of the Community Nursing Service, requesting continued care for Mr Bates at home. Address the letter to Ms Jane Ellis, Nurse Unit Manager, Northside Community Nursing Service, 17 Station Road, Northside. 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.

Patient details

- Name: Mr Harold Bates
- DOB: 04/02/1952 (74 yrs)
- Address: 9 Wattle Court, Northside
- Admitted: 13/10/26; discharge: 21/10/26

Social background

- Lives with wife (78), who has mild memory problems — unable to assist with insulin or dressings
- Retired postman; enjoys lawn bowls
- Son lives 30 min away, visits weekly
- Single-level home, 2 steps at front door
- Wife told staff that pt 'never listens to doctors and eats whatever he likes'

Medical history

- Type 2 diabetes (15 yrs); HbA1c 10.2% on admission
- Diabetic retinopathy — reduced vision; cannot read insulin pen dose window or small print
- Peripheral neuropathy both feet
- Hypertension — perindopril 5 mg daily
- Hypercholesterolaemia — atorvastatin 40 mg nocte
- L total knee replacement 2018
- Allergies: nil known

Admission

- Infected neuropathic ulcer R foot (under 1st metatarsal head) with cellulitis
- Foot X-ray: no evidence of osteomyelitis; wound swab: Staphylococcus aureus (methicillin-sensitive)
- IV cefazolin 5 days → oral cefalexin 500 mg QID until 28/10/26
- Cellulitis resolved; afebrile since 16/10

Diabetes management

- Insulin glargine commenced 15/10 — current dose 14 units at 08:00 daily
- Gliclazide ceased; metformin 1 g BD continued
- BGLs 6–11 mmol/L over last 48 hrs; target 6–10 mmol/L before meals
- Pt and wife educated about hypoglycaemia; uses meter with large display; hypo treatment at home
- Prefers to have breakfast at 07:30 after reading the newspaper

Wound

- Ulcer 1.5 × 1.0 cm, depth 0.3 cm; granulating; minimal exudate; surrounding skin intact
- Dressing: clean with sodium chloride 0.9%, non-adherent foam dressing — change daily
- Must wear offloading shoe when walking

- Physiotherapy: mobilising independently with offloading shoe
- Complained about noise from patient in next bed

Discharge plan

- Community nursing daily from 22/10: administer/supervise insulin, check BGL, wound care; if BGL < 4 mmol/L treat per hypoglycaemia protocol, recheck in 15 min and notify GP; report BGL > 15 mmol/L or signs of infection to GP
- GP review 28/10 — insulin titration
- High-risk foot clinic (podiatry) 29/10
- Diabetes educator 04/11

Model letter: sample 1

21 October 2026

Ms Jane Ellis
Nurse Unit Manager
Northside Community Nursing Service
17 Station Road
Northside

Dear Ms Ellis,

Re: Mr Harold Bates, DOB 04/02/1952

I am writing to request daily community nursing from 22 October for Mr Bates, a 74-year-old man being discharged today after treatment for an infected right foot ulcer with cellulitis.

Mr Bates has type 2 diabetes with retinopathy and peripheral neuropathy. As he cannot read his insulin pen and his wife is unable to assist, please administer or supervise his insulin glargine, 14 units at 08:00 daily, and check his blood glucose, aiming for 6–10 mmol/L before meals. Readings below 4 mmol/L should be treated according to the hypoglycaemia protocol, rechecked after 15 minutes and reported to his GP. Please also report readings above 15 mmol/L.

The ulcer under his first metatarsal head measures 1.5 × 1.0 × 0.3 cm and is granulating. Please clean it with 0.9% sodium chloride and apply a non-adherent foam dressing daily, reporting any signs of infection to his GP. He continues cefalexin 500 mg four times daily until 28 October and must wear his offloading shoe when walking.

He will see his GP on 28 October, the high-risk foot clinic on 29 October and the diabetes educator on 4 November.

Yours sincerely,
Registered Nurse
Medical Ward, Lakeside Hospital

Why this letter works

Kept: The reader must act from tomorrow, so the request comes first, followed by exactly what the nurse has to do and when to call the GP.

Left out: His bowls, the newspaper, the noisy patient in the next bed, the knee replacement and the wife's comment about doctors change nothing for the community nurse.

Sample 2: Advice letter to a carer

Advice to a carer: managing newly diagnosed heart failure at home

Assume that today's date is 21 October 2026. You are the heart failure nurse at Riverbend Heart Clinic. Mr Russo has agreed that you may write to his daughter, who is his main carer. Using the information in the case notes, write a letter to Ms Teresa Russo advising her on how to help her father manage his condition at home. Address the letter to Ms Teresa Russo, 31 Olive Grove, Riverbend. 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.

Patient details

- Name: Mr Vincent Russo
- DOB: 12/12/1946 (79 yrs)
- Retired builder

Social background

- Lives with daughter (Teresa, 52), who is his main carer; she works part-time (3 days/wk)
- Mr Russo has consented to information being shared with his daughter
- Daughter describes father as 'stubborn and difficult'
- Daughter going through a divorce — 'very stressed'
- Has a dog; enjoys walking it to the local park

Medical history

- Heart failure with reduced ejection fraction — diagnosed 10/26 (echocardiogram: ejection fraction 35%)
- Hypertension (since 2005)
- Gout — takes ibuprofen (bought over the counter) during flare-ups
- Inguinal hernia repair 1998
- Brother died of a heart attack aged 70
- Allergies: nil known

Clinic review 20/10/26

- Presented to GP with breathlessness and swollen ankles; referred to cardiology
- Now breathless climbing one flight of stairs; sleeping on 2 pillows
- Mild ankle swelling; weight today 84.2 kg (was 87.5 kg 2 wks ago)
- BP 112/68; HR 76
- ECG: sinus rhythm

Medications (cardiologist)

- Furosemide (fluid tablet) 40 mg each morning
- Perindopril 2.5 mg daily; bisoprolol 1.25 mg daily (dose to be increased slowly at clinic visits)
- Avoid ibuprofen and other anti-inflammatories — GP to advise alternative gout treatment
- May feel dizzy when standing — stand up slowly
- Cardiologist plans to add spironolactone and dapagliflozin at later visits if kidney function and potassium allow
- Baseline bloods 20/10: creatinine 98 µmol/L, eGFR 64, Na 139 mmol/L, K 4.4 mmol/L
- Repeat blood test in 1 wk at local pathology collection centre (form given)

Self-care advice

- Weigh every morning after using toilet, before breakfast, same scales, similar clothing; record in diary
- Contact clinic if weight increases by > 2 kg in 2 days, or breathlessness/ankle swelling worsens, or needs more pillows to sleep
- Individual fluid allowance prescribed: 1.5 L/day, including drinks and liquid foods (tea, soup, ice cream); review at next clinic
- Reduce salt — no added salt; avoid processed foods
- Take furosemide in the morning to avoid passing urine at night; plan outings accordingly

- Call ambulance for chest pain, severe breathlessness at rest or fainting
- Gentle daily walking encouraged
- Influenza vaccine given 20/10

Plan

- Heart failure clinic review 03/11/26 — bring weight diary
- Clinic phone: 5550 1234 (Mon–Fri 8:30 am–4:30 pm); after hours — GP after-hours service

Model letter: sample 2

21 October 2026

Ms Teresa Russo
31 Olive Grove
Riverbend

Dear Ms Russo,

Re: Mr Vincent Russo, DOB 12/12/1946

I am writing, with your father's consent, to advise you how to help him manage his newly diagnosed heart failure at home.

Each morning, please encourage him to weigh himself after using the toilet and before breakfast, using the same scales and similar clothing, and to record the result in a diary. Please telephone our clinic on 5550 1234 if his weight increases by more than 2 kg in two days, if his breathlessness or ankle swelling worsens, or if he needs more pillows to sleep. Outside clinic hours, contact the GP after-hours service. Call an ambulance if he has chest pain, severe breathlessness at rest or faints.

He should have no more than 1.5 litres of fluid daily, including tea, soup and ice cream, and should avoid added salt and processed foods. His fluid tablet is best taken in the morning. He may feel dizzy, so he should stand up slowly. He must also avoid ibuprofen; his GP will advise on gout treatment. Gentle daily walking is encouraged.

He needs a blood test in one week. Please bring his weight diary to the clinic on 3 November.

Yours sincerely,
Heart Failure Nurse
Riverbend Heart Clinic

Why this letter works

Kept: The reader is a carer, not a clinician, so the letter uses plain words such as fluid tablet and tells her exactly when to call and whom.

Left out: Her divorce, her comment that he is stubborn, kidney results, the ejection fraction and medicines planned for later visits do not help her at home.

Sample 3: Referral letter

Referral to a community mental health nurse after an intentional overdose

Assume that today's date is 22 October 2026. Ms Gledhill is being discharged home this afternoon. You are a registered nurse on the medical ward of the local hospital. Using the information in the case notes, write a letter to Ms Eleanor Holroyd, Community Mental Health Nurse, referring Ms Gledhill for follow-up in the community. Address the letter to Ms Eleanor Holroyd, Community Mental Health Nurse, Community Mental Health Service, 14 Park Street. 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.

Patient details

- Name: Ms Caroline Gledhill
- DOB: 14/03/2004 (22 yrs)
- Address: Flat 4, 61 Mill Street (shared flat)
- Admitted: 19/10/26; discharge: 22/10/26

Social background

- Final-year law student; exams in 5/52; part-time café job, hours recently ↓ → money worries
- Shares flat with 2 flatmates (both students)
- Relationship with boyfriend (2 yrs) ended 3/52 ago
- Mother lives 1 hr away; will stay with pt at flat for 1/52 after discharge
- Close to older sister, who phones daily
- Parents divorced 10 yrs ago; father remarried, minimal contact
- Plays netball weekly; owns a cat
- Mother told staff ex-boyfriend 'was always a waste of space'

Medical history

- Low mood, poor sleep, ↓ appetite approx 4/12; not previously treated; no GP contact
- Self-harm (cutting) age 15–16, saw school counsellor at the time; nil since
- Alcohol: binge drinking most weekends (approx 8–10 standard drinks/night); nil illicit drugs
- Tonsillectomy age 8
- Allergies: nil known

Admission

- Intentional OD: approx 30 × paracetamol 500 mg tabs, taken alone at flat after phone argument with ex-partner; alcohol taken same evening
- Texted friend 2 hrs later → ambulance called; presented approx 4 hrs post-ingestion
- IV acetylcysteine full course completed; LFTs and INR normal on completion; medically fit for discharge
- Complained about hospital food and being woken for overnight obs

Psychiatric assessment (20/10/26)

- Dx: moderate depressive episode; OD described as impulsive; pt regrets OD — 'I just wanted everything to stop'
- Denies current suicidal intent or plan; ongoing intermittent passive thoughts ('better if I wasn't here')
- Protective factors: close to sister and mother, wants to finish degree, responsibility for cat
- Sertraline 50 mg mane commenced 21/10; monitor for ↑ agitation / suicidal thoughts early in treatment (age < 25)

Safety plan

- Written safety plan completed with pt: warning signs (isolating, not sleeping, drinking alone), coping strategies, contacts (sister, mother), crisis line & ED
- Means restriction: no paracetamol/other OTC medicines kept at flat; mother to hold & give sertraline; 1/52 supply only dispensed
- Pt agreed to avoid alcohol; effect of alcohol on mood discussed
- Consent given for referral & for information sharing with mother

Plan

- Community MH nurse: home visit within 48 hrs of discharge (by 24/10); ongoing support, risk review, monitor mood & response to sertraline
- GP review 1/52 (29/10) — sertraline review & repeat prescription
- Referred to university counselling service; pt considering request for exam deferral

Model letter: sample 3

22 October 2026

Ms Eleanor Holroyd
Community Mental Health Nurse
Community Mental Health Service
14 Park Street

Dear Ms Holroyd,

Re: Ms Caroline Gledhill, DOB 14/03/2004

I am referring Ms Gledhill, a 22-year-old law student being discharged today after an intentional paracetamol overdose, for a home visit by 24 October, ongoing support and risk review.

She was admitted on 19 October after taking approximately 30 paracetamol 500 mg tablets with alcohol following an argument with her ex-partner. She completed intravenous acetylcysteine, and her liver function and INR were normal. Psychiatric assessment diagnosed a moderate depressive episode. She regrets the overdose and denies current suicidal intent or plan, although she has intermittent passive thoughts. She self-harmed at 15–16 and binge drinks most weekends.

Sertraline 50 mg each morning was commenced on 21 October. As she is under 25, please monitor for increased agitation or suicidal thoughts, as well as her mood and response to treatment.

A written safety plan has been completed, and she has agreed to avoid alcohol. Her mother will stay for one week and will hold and give her sertraline, and no over-the-counter medicines will be kept at the flat. She has consented to this referral and to information sharing with her mother. Her GP will review her on 29 October.

Yours sincerely,
Registered Nurse
Medical Ward

Why this letter works

Kept: Risk comes before background: what happened, what she says now, what the nurse must monitor and what is already in place at home.

Left out: The tonsillectomy, netball, the cat, hospital food and the mother's opinion of the ex-boyfriend add nothing to the risk review.

OET Listening Part A - Question Paper

24 questions. Listen once to each extract using the audio on the linked page. Write a word or short phrase in every gap. Practise Listening Part A, then check your answers.

Extract 1: Consultation: recurrent headaches

You hear a GP talking to a patient called Mrs Grace Whitfield. For questions 1-12, complete the notes with a word or short phrase.

Patient: Mrs Grace Whitfield (54)

Presenting complaint

recurrent headaches; onset approx. ___(1)___ ago (after Easter)

bilateral pain around the ___(2)___, 'like a tight band'

frequency: approx. ___(3)___ in the past month

feels ___(4)___ on bad days, with poor appetite; no vomiting

___(5)___ with worse episodes; no visual aura

Background

history of ___(6)___ in her 20s (unilateral, throbbing)

no jaw pain on chewing, no scalp tenderness

periods stopped 18 months ago; not on HRT

Current analgesia

___(7)___, 2 tablets on waking, most days

adds ___(8)___ on bad days

Social

coffee: approx. ___(9)___ a day at work

works as school ___(10)___ (screen-based)

seeing a ___(11)___ for stiff R shoulder since June

Impression and plan

probable ___(12)___ headache; possible underlying tendency given past history

stop regular analgesics; reduce caffeine gradually; headache diary; BP and blood test; review in 2 weeks

Extract 2: Pre-admission clinic: total hip replacement

You hear a pre-admission nurse talking to a patient called Mr Dennis Harrow. For questions 13-24, complete the notes with a word or short phrase.

Patient: Mr Dennis Harrow (68)

Procedure

diagnosis (R hip): ___(13)___; booked for total hip replacement

Allergies and skin

allergy: ___(14)___ (itchy rash) - flag for theatre

___(15)___ on both shins, uses emollient nightly; hip skin intact

Past surgical history

knee arthroscopy

procedure for ___(16)___ (approx. 2015); no anaesthetic problems

Medications

anticoagulant: ___(17)___ 5 mg twice daily (for AF)

timing of last pre-op dose to be advised by ___(18)___

Other medical

sleep apnoea diagnosed after sleep study; has used CPAP for ___(19)___

uses CPAP nightly - bring to hospital

ex-smoker, quit ___(20)___ ago; alcohol minimal

Home situation

lives with wife in a ___(21)___ (bedroom and bathroom upstairs)

wife currently has a ___(22)___, limited lifting

uses a ___(23)___ outdoors

Plan

pre-op referral to ___(24)___ (shower chair, raised toilet seat)

OET Listening Part A - Answer Key

Answer key for the original L01 Part A question paper. Check after finishing. The linked page gives the evidence and explanations. Seeing this key makes a repeat attempt revision rather than a fresh estimate.

1. four months | Accepted: 4 months
2. temples
3. twenty days | Accepted: 20 days
4. queasy | Accepted: nauseous, nauseated, sick
5. light sensitivity | Accepted: photophobia, sensitivity to light
6. migraines | Accepted: migraine
7. paracetamol
8. ibuprofen
9. four or five cups | Accepted: 4 or 5 cups, four to five cups, 4 to 5 cups, 4-5 cups
10. business manager
11. physiotherapist | Accepted: physio
12. medication overuse | Accepted: medication-overuse
13. osteoarthritis
14. chlorhexidine
15. eczema
16. haemorrhoids | Accepted: hemorrhoids
17. apixaban
18. surgical team | Accepted: the surgical team
19. fourteen months | Accepted: 14 months
20. twelve years | Accepted: 12 years
21. townhouse | Accepted: town house
22. broken wrist
23. walking stick | Accepted: walking-stick
24. occupational therapist | Accepted: the occupational therapist

OET Reading Part A - Question Paper

20 questions / 15 minutes. Read Texts A-D, then answer using the group instructions. Practise Reading Part A, then check your answers.

Text A: Clinical assessment of dehydration

Use this table together with the history. Weigh the child undressed on arrival; where a recent weight is available, percentage weight loss is the most reliable estimate of fluid deficit.

Children at increased risk of dehydration

- infants under 6 months, particularly those of low birth weight
- six or more diarrhoeal stools in the past 24 hours
- three or more vomits in the past 24 hours
- unable to tolerate fluids before presentation, or breastfeeding stopped during the illness
- signs of malnutrition

Sign	Mild (< 5%)	Moderate (5-9%)	Severe (>= 10%)
Conscious state	Alert and responsive	Lethargic or irritable	Reduced conscious state
Heart rate	Normal	Normal or mildly raised	Tachycardia
Breathing	Normal	Increased rate	Increased rate; deep acidotic breathing
Blood pressure	Normal	Normal	Hypotension
Skin colour and peripheries	Normal; warm	Normal; warm	Pale or mottled; cold; weak pulses
Eyes and fontanelle	Not sunken	Sunken	Deeply sunken
Mucous membranes	Moist	Dry	Dry
Skin turgor	Instant recoil	Mildly decreased	Decreased
Central capillary refill	Normal	Prolonged	Markedly prolonged

Signs in the severe column, particularly markedly prolonged capillary refill, cold mottled peripheries and reduced consciousness, indicate possible hypovolaemic shock. Severe dehydration requires IV fluids (see Text B).

Suspect hypernatraemic dehydration if the child has jittery movements, increased muscle tone, hyperreflexia, seizures or a doughy feel to the skin, and check serum sodium. Bilious (green) vomiting is not consistent with gastroenteritis and needs urgent surgical review.

Text B: Westbrook Children's Hospital - Rehydration protocol

Mild dehydration

Continue breastfeeding (more often than usual) and usual fluids. Give oral rehydration solution (ORS) in small, frequent amounts, aiming for 10 mL/kg/hour, and offer extra after each loose stool or vomit.

Moderate dehydration

- Oral trial: give ORS by syringe or spoon every few minutes, aiming for 10 mL/kg/hour, and reassess after 1 hour.
- If the oral trial fails (refusal or persistent vomiting), insert a nasogastric tube and give ORS at 10-25 mL/kg/hour for 4 hours (rapid NG rehydration). Many infusion pumps cannot exceed 300 mL/hour.
- Use slow NG rehydration for infants under 6 months and children with significant comorbidities or abdominal pain: replace a 5% fluid deficit over the first 6 hours, then clinically reassess. If further hydration support is required, give the daily maintenance volume over the next 18 hours. Any remaining deficit is reassessed and, if still indicated, replaced in the subsequent 24 hours in addition to maintenance.
- Suspected hypernatraemia is not managed on either NG pathway: check serum sodium and arrange senior paediatric review. Correction must be slower (typically over 48 hours), follow an individualised plan and include serial electrolyte monitoring.
- If vomiting occurs during NG rehydration, slow the fluids temporarily and reassess tolerance. Seek senior clinician review for ongoing vomiting or significant abdominal pain.

Severe dehydration and escalation to IV fluids

- Shock: give a 20 mL/kg bolus of 0.9% sodium chloride IV (or intraosseous) and contact the senior registrar. Repeat the bolus if signs of shock persist.
- Start IV rehydration for all children with severe dehydration, and for those who cannot tolerate NG fluids or whose dehydration worsens despite them.
- For IV rehydration use 0.9% sodium chloride with 5% glucose, and measure electrolytes and blood glucose when the cannula is inserted.

Text C: Medication notes

Ondansetron

A single oral dose (wafer) may be given to children aged 6 months and over who are vomiting and at risk of failing oral rehydration. It is not recommended under 6 months. Give ORS 15-30 minutes after the dose.

Weight	Single oral dose
8 to < 15 kg	2 mg
15 to 30 kg	4 mg
> 30 kg	8 mg

Further doses should be discussed with a senior clinician, as ondansetron can increase stool frequency. Use with caution in children with a known prolonged QT interval or those taking other QT-prolonging medicines.

Antidiarrhoeal agents

Loperamide and other antimotility drugs must not be used in children with acute gastroenteritis. They have little effect on fluid losses and have been associated with paralytic ileus, drowsiness and respiratory depression in young children.

Zinc

Zinc supplementation is recommended by the WHO for children with diarrhoea in low- and middle-income settings, where zinc deficiency is common. It is not routinely used in Australia.

Text D: Parent information - Gastro in children: going home

Drinks and food

- Give small amounts of fluid often - for example, a mouthful every few minutes - even if your child is still vomiting.
- Keep breastfeeding. If your baby is bottle-fed, make up formula at its usual strength. Do not water it down.
- Oral rehydration solution from the pharmacy is the best drink. Avoid undiluted fruit juice, soft drinks and sports drinks: they contain too much sugar and can make diarrhoea worse.

Stopping the spread

- Wash hands with soap and water for at least 20 seconds after nappy changes and using the toilet, and before preparing food. Alcohol-based hand gels do not kill all gastro viruses.
- Keep your child home from childcare, kindergarten or school until 48 hours after the last episode of vomiting or diarrhoea.
- No swimming pools for 2 weeks after the diarrhoea has stopped.

Come back to hospital straight away if your child:

- is drowsy, floppy or hard to wake
- has fewer than 4 wet nappies in 24 hours, or passes very little urine
- vomits green fluid or has blood in their poo
- has severe tummy pain or cannot keep any fluids down

See your GP if your child has diarrhoea for more than 7 days or vomiting for more than 2 days.

Questions 1-7

For each question, 1-7, decide which text (A, B, C or D) the information comes from. You may use any letter more than once.

1. Which text names drugs that should never be given to a child with gastroenteritis? _____
2. Which text lists the factors that make a child more likely to become dehydrated? _____
3. Which text states how long a child should stay away from childcare? _____
4. Which text tells you what to do if a child vomits while receiving fluids through a nasogastric tube? _____
5. Which text describes signs that may indicate an abnormal sodium level? _____
6. Which text explains why certain drinks should not be given? _____
7. Which text refers to a treatment recommended only in certain parts of the world? _____

Questions 8-14

Answer each of the questions, 8-14, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

8. How should a child be dressed when weighed on arrival? _____
9. How is skin turgor described in a child with moderate dehydration? _____
10. What type of vomiting suggests the child's illness is not gastroenteritis? _____
11. What hourly volume of ORS should a child with mild dehydration be aiming to take? _____
12. For how long is rapid NG rehydration given? _____
13. Which fluid is given as a bolus to a child in shock? _____
14. What dose of ondansetron should be given to a child weighing 22 kg? _____

Questions 15-20

Complete each of the sentences, 15-20, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

15. Ondansetron is not recommended for infants younger than ___ .
16. After a dose of ondansetron, ORS should be given ___ later.
17. Ondansetron should be used with caution if a child has a known ___ .
18. Parents of bottle-fed babies should be told not to water down the ___ .
19. Parents should be warned that ___ do not kill all gastro viruses.
20. Parents should take their child to a GP if vomiting continues for more than ___ .

OET Reading Part A - Answer Key

Answer key for the original R01 Part A question paper. Check after finishing. The linked page gives the evidence and explanations. Seeing this key makes a repeat attempt revision rather than a fresh estimate.

1. C
2. A
3. D
4. B
5. A
6. D
7. C
8. undressed
9. mildly decreased
10. bilious | Accepted: bilious (green), bilious (green) vomiting, green
11. 10 mL/kg/hour | Accepted: 10 ml/kg/hour, 10mL/kg/hour, 10 mL/kg
12. 4 hours
13. 0.9% sodium chloride | Accepted: 0.9% sodium chloride IV, 20 mL/kg bolus of 0.9% sodium chloride, 20 mL/kg bolus of 0.9% sodium chloride IV
14. 4 mg | Accepted: 4mg
15. 6 months
16. 15-30 minutes | Accepted: 15-30 minutes
17. prolonged QT interval | Accepted: prolonged QT
18. formula
19. alcohol-based hand gels | Accepted: alcohol based hand gels
20. 2 days

Nursing · Post-operative pain management

SPK-NUR-01 | Original simulated candidate card

Setting: Surgical ward

You are a nurse on a surgical ward. Mr Daniel Brooks, aged 58, is on day 2 after an open bowel resection. He is charted regular paracetamol 1 g four times a day and oral immediate-release oxycodone 5–10 mg every 4 hours as needed, plus regular laxatives. He has refused all oxycodone doses since his epidural was removed yesterday. Overnight staff noted he is reluctant to move, is taking shallow breaths and rated his pain 7/10 when sitting up. The physiotherapist wants him to walk this morning.

Interlocutor: PATIENT

Your tasks

1. Assess Mr Brooks's pain (location, severity, effect on breathing, coughing and moving)

2. Find out why he has been refusing the prescribed pain relief

3. Explain why good pain control is important after surgery (deep breathing, coughing, walking; preventing chest infection and blood clots)

4. Reassure him about his concerns regarding the pain medication

5. Explain the pain relief plan and encourage him to take the medication before the physiotherapy session

Nursing · Community visit: patient removing compression bandages

SPK-NUR-02 | Original simulated candidate card

Setting: Patient's home (community nursing visit)

You are a community nurse. Mrs Beryl Hutchins, aged 79, has a venous leg ulcer above her left ankle that has been present for four months. Her ankle–brachial pressure index is normal, which supported the earlier compression plan; any new cold-toe symptoms still need a current circulation check before reapplication. Two-layer compression bandages were applied at your last visit three days ago, but today you find she has taken them off. The ulcer is not healing and the leg is swollen.

Interlocutor: PATIENT

Your tasks

1. Find out why Mrs Hutchins removed the bandages, in a non-judgemental way; assess the reported cold toes and current foot circulation before considering reapplying compression

2. Explain how compression helps the ulcer to heal and what may happen without it

3. Discuss options to make compression more comfortable (different system, footwear, timing of visits)

4. Advise on other self-care measures (raising the leg, walking, ankle exercises, skin care)

5. Agree a plan with her and check her understanding

Nursing · Bronchiolitis: father wants antibiotics and to take his baby home

SPK-NUR-03 | Original simulated candidate card

Setting: Paediatric ward

You are a nurse on a children's ward. Mia Mensah, aged 7 months, was admitted last night with bronchiolitis. She needs low-flow oxygen through nasal prongs because her oxygen saturation remains persistently at 88–89% in room air, and she is taking less than half her usual bottle feeds. The medical team has suggested a nasogastric tube for feeding. Her father, Mr Ryan Mensah, has just arrived and is asking why she has not been given antibiotics and when he can take her home.

Interlocutor: PARENT

Your tasks

1. Find out what Mr Mensah understands about Mia's illness and what he is expecting

2. Explain bronchiolitis (common viral chest infection in babies, usually worst on days 2–3 of breathing difficulty, improves over 7–10 days)

3. Explain why antibiotics will not help and what the treatment is (oxygen, fluids or feeding support, monitoring, superficial nasal suction only if secretions interfere with feeding or breathing)

4. Explain the nasogastric tube and the criteria for going home (stable breathing and oxygen levels in room air, feeding enough)

5. Respond to his concerns and discuss how he can be involved in Mia's care

Nursing · Discharge after a heart attack: medicines and recovery

SPK-NUR-04 | Original simulated candidate card

Setting: Cardiology ward, Australia

You are a nurse on a cardiology ward. Mr Graham Turnbull, aged 67, is being discharged today, four days after a heart attack treated with a coronary stent. His new medicines are aspirin 100 mg once daily, ticagrelor 90 mg twice daily (for 12 months), atorvastatin 80 mg at night, metoprolol tartrate (immediate-release) 25 mg twice daily and a glyceryl trinitrate (GTN) spray as needed. He has been referred to a cardiac rehabilitation programme. You need to complete his discharge education. His team's written plan says: for angina sit down and use one GTN spray under the tongue, repeat after five minutes if needed, call an ambulance if pain persists ten minutes from the first spray or is severe/worsening; do not use GTN within 24 hours of sildenafil/vardenafil or 48 hours of tadalafil. As a truck driver he must not drive commercially for at least four weeks after the heart attack and needs specialist/licensing assessment before return.

Interlocutor: PATIENT

Your tasks

1. Find out what Mr Turnbull understands about what happened and about his new medicines

2. Explain the importance of taking aspirin and ticagrelor every day and not stopping them without the cardiologist's advice

3. Explain how and when to use the GTN spray, and when to call an ambulance

4. Explain the cardiac rehabilitation programme and the general advice on returning to activity, work and driving

5. Find out if he has any other concerns and check his understanding

Nursing · Postnatal home visit: a mother who is not coping

SPK-NUR-05 | Original simulated candidate card

Setting: Patient's home (child and family health nursing visit)

You are a child and family health nurse. You are visiting Ms Chloe Bennett, aged 29, and her first baby, Leo, aged 7 weeks, for a routine check. Leo is gaining weight well. Ms Bennett completed a postnatal depression screening questionnaire (Edinburgh Postnatal Depression Scale) at the start of the visit and scored 15, which suggests she may have depression. She has answered 'sometimes' to the question about thoughts of harming herself.

Interlocutor: PATIENT

Your tasks

1. Find out how Ms Bennett has been feeling and coping since Leo's birth

2. Ask sensitively about her answer on self-harm, including any thoughts of harming the baby

3. Reassure her that postnatal depression is common and treatable and respond to her worries about asking for help

4. Agree a plan for today (same-day assessment by a GP or perinatal mental health service, someone to be with her)

Nursing · Aged care: son unhappy about his father's modified diet after a stroke

SPK-NUR-06 | Original simulated candidate card

Setting: Residential aged care facility

You are the registered nurse in charge of the shift. Mr Albert Novak, aged 88, moved into the facility six weeks ago after a stroke that left him with swallowing difficulty (dysphagia). The speech pathologist has prescribed a minced and moist diet and mildly thick fluids, with supervision at meals. Two weeks ago he was treated for aspiration pneumonia. Today a care worker found his son, Mr Peter Novak, giving his father a ham sandwich and a cup of tea. You have asked to speak to Mr Novak.

Interlocutor: RELATIVE

Your tasks

1. Find out what Mr Novak understands about his father's swallowing problem and why he brought the food and check his father's immediate safety after eating today

2. Explain the risk of choking and aspiration pneumonia with normal food and thin drinks

3. Acknowledge his concerns about his father's quality of life and enjoyment of food

4. Discuss more appealing modified food and speech pathology/dietitian review; plan a family meeting involving Albert to assess his decision-specific capacity, wishes and informed choices about food and drink

5. Agree on what Mr Novak can safely bring in and how he can help at mealtimes

Nursing · Day surgery: angry patient whose operation is delayed after eating

SPK-NUR-07 | Original simulated candidate card

Setting: Day surgery unit

You are a nurse in the day surgery unit. Ms Natalie Price, aged 38, is booked for a laparoscopic cholecystectomy (gallbladder removal) at 9:30 am. On admission at 8:30 am she told you she had toast and a coffee with milk at 6:30 am. The anaesthetist has reviewed her and decided the operation cannot go ahead at 9:30; she has been moved to a later theatre slot at approximately 1:30 pm. She may have clear fluids until 11:30 am. She is upset.

Interlocutor: PATIENT

Your tasks

1. Acknowledge Ms Price's frustration and find out what she understood about the fasting instructions

2. Explain why her operation has been delayed (risk of stomach contents entering the lungs during anaesthesia)

3. Explain the new plan (new time, clear fluids allowed until 11:30 am and what counts as a clear fluid)

4. Find out about any other concerns and respond to them

5. Check her understanding and explain what will happen next

Nursing · Practice nurse: quitting smoking after a high blood pressure diagnosis

SPK-NUR-08 | Original simulated candidate card

Setting: General practice (practice nurse clinic)

You are a practice nurse. Mrs Sandra Lowe, aged 51, was diagnosed with high blood pressure two weeks ago and started on perindopril by the GP. She smokes about 20 cigarettes a day. The GP has asked you to see her for a lifestyle review and to support her to stop smoking. Her blood pressure today is 146/92 mmHg.

Interlocutor: PATIENT

Your tasks

1. Find out about Mrs Lowe's smoking history, previous quit attempts and how ready she is to stop

2. Explain the benefits of stopping smoking for her heart and blood pressure

3. Explain the support options available (combination nicotine replacement therapy, prescription medication from the GP, quitline counselling)

4. Respond to her concerns about stopping

5. Agree a quit plan and arrange follow-up

Nursing · Emergency: mother frightened after her toddler's first febrile seizure

SPK-NUR-09 | Original simulated candidate card

Setting: Emergency department

You are a nurse in the emergency department. Ms Aroha Leota brought her 2-year-old son in by ambulance after he had a seizure at home lasting about two minutes. He has had a runny nose and cough for two days, and a fever since this morning. The doctor has examined him, diagnosed a simple febrile seizure caused by a viral infection, and says he can go home. He is now alert, drinking well and playing, but his mother is very anxious about taking him home.

Interlocutor: PARENT

Your tasks

1. Find out what Ms Leota understands about what happened and what is worrying her most

2. Explain what a febrile seizure is and reassure her about brain damage and epilepsy

3. Explain what to do if her son has another seizure, including when to get urgent help or call an ambulance

4. Advise how to manage his fever at home (comfort, fluids, medicine for distress)

5. Agree a discharge plan, including when to come back and follow-up with the GP

Nursing · Ward: patient refusing anticoagulant injections after abdominal surgery

SPK-NUR-10 | Original simulated candidate card

Setting: Hospital ward (surgical)

You are a nurse on a surgical ward. Mrs Leila Demir, aged 63, is on day 2 after a laparoscopic bowel resection for recurrent diverticulitis. She is prescribed a daily enoxaparin injection to prevent blood clots, and she has just refused this evening's dose because of bruising on her abdomen. Her observations are stable, her wound is clean and she has been walking to the bathroom and along the corridor with assistance.

Interlocutor: PATIENT

Your tasks

1. Find out why Mrs Demir has refused the injection and what worries her about it

2. Explain why the injections are prescribed after her surgery, even though she is walking

3. Reassure her about the bruising and explain how it can be reduced (e.g. changing injection sites, not rubbing the area)

4. Encourage her to keep moving and explain the other things that help prevent clots (e.g. fluids, leg exercises, stockings if prescribed)

5. Agree a plan for tonight's injection and the signs she should report

Nursing · Home visit: husband caring for his wife with Parkinson's disease

SPK-NUR-11 | Original simulated candidate card

Setting: Home visit (community nursing)

You are a community nurse visiting Mr Joel Quiambao, aged 74, at home. He is the main carer for his wife, aged 71, who has Parkinson's disease; her medication chart lists levodopa tablets four times a day at 8 a.m., 12 noon, 4 p.m. and 8 p.m. She has had two near-falls this week, and the GP has asked you to review her medication routine and falls risk. Mr Quiambao is waiting for you in the kitchen while his wife rests.

Interlocutor: CARER

Your tasks

1. Find out how Mr Quiambao manages his wife's medication routine and what happened during the near-falls (dose times, missed doses, late mornings, dizziness on standing)

2. Explain why her Parkinson's tablets need to be given at her prescribed times (symptom control, possible link to near-falls, other possible causes)

3. Reassure Mr Quiambao that he is not being criticised and acknowledge the care he provides

4. Explain practical ways to reduce her risk of falling (home safety, getting up slowly, what to do if she falls)

5. Agree a plan for medication timing and falls prevention (reminders, carer support, follow-up)

Nursing · Community clinic: young man relying only on his asthma reliever

SPK-NUR-12 | Original simulated candidate card

Setting: Community clinic (general practice)

You are a practice nurse. Mr Javier Castillo, aged 19, is a university student with asthma who has come in for a repeat prescription of his salbutamol reliever (a pressurised metered-dose inhaler). His records show that last year he was prescribed a budesonide preventer dry-powder inhaler to take every morning and every night, but he has not requested a repeat for several months. The GP, who is in clinic today, has asked you to review his asthma before the prescription is written.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Castillo is using his inhalers, how his asthma has been recently and how he is today (reliever use, night symptoms, exercise, breathlessness now)

2. Explain in simple terms the difference between his reliever and his preventer and why relying on the reliever alone is a concern

3. Persuade him to use a preventer every day as the GP advises and respond to his doubts about it

4. Check and correct his reliever inhaler technique (spacer, one puff at a time, slow breath in, breath-hold)

5. Agree a plan, including seeing the GP today before he leaves for a treatment review and written asthma action plan, and when to call an ambulance

Nursing · Aged care: son angry his mother was given a sedative without his knowledge

SPK-NUR-13 | Original simulated candidate card

Setting: Aged care facility

You are the registered nurse in charge at an aged care facility. Mr Ramil Reyes, aged 55, is the son and nominated family representative of an 86-year-old resident with moderate Alzheimer's dementia. At about 2 am she became very distressed, tried to leave the building and struck a carer. For over an hour the night staff tried a quiet room, calm reassurance, walking with her, offering a drink and a snack, and taking her to the toilet. At about 3.15 am the night nurse gave one dose of an as-needed (PRN) antipsychotic medicine charted by her GP, then recorded her observations through the night, but did not contact the family. When you assessed her an hour ago, she woke when spoken to and answered simply, her breathing was normal and her observations were within her usual range, but she was drowsier and more confused than usual. You have asked the GP to see her today and have started regular observations, a food and fluid chart and supervision whenever she walks. Her records contain an admission consent form signed by Mr Reyes, but you cannot yet tell whether it covers this medicine, whether her own ability to make this decision was assessed, or who is legally authorised to consent for her. Mr Reyes has just found her drowsy and has asked to speak to you.

Interlocutor: RELATIVE

Your tasks

1. Acknowledge Mr Reyes's concerns and apologise that the family was not informed

2. Explain what happened overnight and how his mother is this morning (strategies tried, the medicine given, your assessment, monitoring and GP review)

3. Find out about any recent changes in his mother's health and what usually settles her

4. Address his concerns about the medicine (its risks and intended benefit, how consent will be checked, the medication review)

5. Agree how the family will be involved in future decisions and explain his options for making a formal complaint

Nursing · Emergency: man who wants to drive home alone after a head injury

SPK-NUR-14 | Original simulated candidate card

Setting: Emergency department

You are a nurse in the emergency department. Mr Karthik Venkataraman, aged 41, fell about two metres from a ladder at home this afternoon and hit his head. He drove himself to hospital. His CT brain scan is normal and he is alert, but he has a headache and vomited once on arrival. The doctor has cleared him for discharge with verbal and written head-injury advice, provided he does not drive for at least 24 hours and until fully recovered, and has a responsible adult with him for the next 24 hours.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Venkataraman plans to get home and spend tonight (e.g. transport, who lives with him, who could stay, alcohol)

2. Explain why he must not drive or be alone (e.g. concentration and reactions can be affected even with a normal scan; no driving for at least 24 hours and until fully recovered; adult with him for 24 hours; ask the doctor if unsure)

3. Explain warning signs and care at home (e.g. worsening headache, repeated vomiting, increasing drowsiness, confusion, slurred speech, weakness, vision problems, seizure: call an ambulance; no alcohol or sleeping tablets; paracetamol for headache)

4. Respond to his reluctance to ask anyone for help and his worries about work

5. Agree a safe plan (e.g. lift home, adult for the full 24 hours, postpone tomorrow's job, no ladders, electrical work or machinery until recovered, car collection, written advice for him and his supporter; if no one can stay, he remains in hospital)

Nursing · Ward: anxious woman going home with a wound drain after mastectomy

SPK-NUR-15 | Original simulated candidate card

Setting: Hospital ward (surgical)

You are a nurse on a surgical ward. Mrs Belinda Hazeldene, aged 52, had a left mastectomy for breast cancer two days ago. She is recovering well and is being discharged today with one wound drain still in place, which will be removed when the output is low enough. The community nursing team has confirmed daily home visits starting tomorrow morning; if the nurse has not arrived by the afternoon, she should ring the community nursing office. You have written drain-care instructions, an output chart and a contact card listing the breast care nurse (weekdays, office hours), the ward's 24-hour phone line for problems at any other time, and when to call an ambulance.

Interlocutor: PATIENT

Your tasks

1. Find out about Mrs Hazeldene's concerns about going home and the support she has at home

2. Explain how to look after the drain and record the output (keeping the bottle secure and below the wound, avoiding pulling, using the chart provided)

3. Explain the warning signs and who to contact (infection, bleeding, swelling, contact card)

4. Reassure her about managing the drain at home

5. Agree the follow-up arrangements (daily community nurse visits, drain removal, written instructions)

Nursing · Community clinic: father hesitant about his baby's MMR vaccine

SPK-NUR-16 | Original simulated candidate card

Setting: Community clinic (child health / immunisation)

You are a child health nurse running an immunisation clinic. Mr Ferdinand Pascual has brought his 12-month-old daughter for her scheduled 12-month vaccines, which include the measles, mumps and rubella (MMR) vaccine. She is healthy, well today and up to date with all her previous vaccines. Before you start, Mr Pascual tells you he has read online that the MMR vaccine is dangerous and he wants to put it off.

Interlocutor: PARENT

Your tasks

1. Find out about Mr Pascual's concerns about the MMR vaccine and where his information has come from

2. Explain why the MMR vaccine is recommended at 12 months and the risks of delaying it (seriousness of measles, recent outbreaks)

3. Reassure him about the vaccine's safety (e.g. no link with autism, common mild side effects and what to expect)

4. Agree a plan for his daughter's vaccination (e.g. vaccinating today or a follow-up appointment soon)

Nursing · Home visit: older man embarrassed by his new urinary catheter

SPK-NUR-17 | Original simulated candidate card

Setting: Home visit (community nursing)

You are a community nurse. Mr Luke Islington, aged 78, was discharged from hospital four days ago with an indwelling urinary catheter after an episode of acute urinary retention. His discharge summary states that he was started on an alpha blocker, a tablet to relax the prostate, to help the trial without the catheter planned at his urology appointment in two weeks. You are visiting to check how he is managing and to teach him catheter and drainage bag care.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Islington is managing with the catheter at home (daily routine, drinking, any problems)

2. Explain why the catheter needs to stay in until his urology appointment

3. Explain how to look after the catheter and drainage bags, and which warning signs need urgent help

4. Reassure him about his concerns and persuade him not to remove the catheter himself

5. Agree a plan for getting back to his usual activities and arrange follow-up

Nursing · Ward: husband alarmed by his wife's sudden confusion

SPK-NUR-18 | Original simulated candidate card

Setting: Hospital ward (medical)

You are a nurse on a medical ward. Mr Adebayo Abiodun's wife, aged 79, was admitted two days ago with a urinary tract infection and started on antibiotics. Overnight she became confused and agitated, tried to get out of bed and did not know where she was. The medical team has diagnosed delirium. Mr Abiodun, aged 80, has just arrived to visit and is very upset.

Interlocutor: RELATIVE

Your tasks

1. Find out how Mr Abiodun's wife usually manages at home (memory, daily activities, eyesight and hearing) and how she was before admission

2. Explain what delirium is and what the ward is doing to manage it (treating the infection, checking fluids and other causes, keeping her safe)

3. Reassure Mr Abiodun about his belief that his wife now has dementia and will not return home

4. Explain how he and the family can help her recovery (familiar items, glasses and hearing aids, calm reassurance)

5. Agree a plan for his visits and for keeping him informed

Nursing · Emergency: young woman who does not plan to carry her adrenaline autoinjector

SPK-NUR-19 | Original simulated candidate card

Setting: Emergency department

You are a nurse in the emergency department. Ms Xiaoling Mak, aged 24, came in last night with anaphylaxis after eating a restaurant meal that contained peanut sauce. She was treated with intramuscular adrenaline. She has mild asthma, and as a teenager her lips sometimes tingled after eating peanuts. She has recovered fully after observation, and the doctor has discharged her with a prescription for an adult EpiPen adrenaline autoinjector, a written anaphylaxis action plan and a referral to an allergy specialist. The hospital pharmacy can dispense the EpiPen before she leaves, and you have an EpiPen trainer to teach her how to use it.

Interlocutor: PATIENT

Your tasks

1. Find out what Ms Mak understands about last night's reaction and explore any concerns she raises

2. Explain why she needs to carry the EpiPen at all times and why antihistamines are not enough (hidden peanuts, unpredictable reactions, asthma)

3. Explain her action plan (warning signs, lie down or sit with legs out flat, give the EpiPen, call an ambulance, use a second EpiPen if available if there is no improvement after 5 minutes)

4. Demonstrate the EpiPen with the trainer and ask her to practise (pull off the blue safety cap, place the orange end against the outer mid-thigh, push down hard until it clicks, hold for 3 seconds, remove)

5. Reassure her and agree a plan before she leaves (collecting the EpiPen today, allergy specialist appointment, GP review)

Nursing · Aged care: resident refusing to use his walking frame

SPK-NUR-20 | Original simulated candidate card

Setting: Aged care facility

You are a registered nurse at a residential aged care facility. Mr Venkat Thampi, aged 91, has had three falls in the past month. Two were on the way to the dining room and one was in his bedroom early in the morning. He had a bruised hip and a skin tear on his forearm but no fractures. The physiotherapist has recommended he use a four-wheeled walking frame at all times when walking, but staff often see him leave it in his room. You have come to his room to talk with him about his falls.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Thampi feels about his recent falls and why he does not use his walking frame

2. Explain in simple terms why he is at risk of falling and what a serious fall could mean for his independence

3. Respond to his objections to the frame while respecting his right to make his own decisions

4. Discuss practical ways to make walking safer (e.g. physiotherapy review of the frame, footwear, standing up slowly, using the call bell); ask about dizziness or blackouts on standing and arrange supported postural blood-pressure and medical/medicine review when indicated

5. Agree a plan he is willing to follow

Nursing · Returning to work with a colostomy: agree practical support

SPK-NUR-21 | Original simulated candidate card

Setting: Stoma outpatient clinic

You are a stoma nurse seeing Ms Samina Janjua, aged 59, who had a colostomy three months ago and is considering returning to her office job; she is worried that colleagues will smell her pouch. In this fictional case, her surgical team has agreed that she can resume desk work when she feels ready, and you can offer an appliance assessment today and arrange follow-up. General clinical information: a well-fitting pouch normally contains odour, although changing it can release a smell; persistent odour while wearing it can indicate leakage or a filter problem, and leakage or sore skin needs stoma nurse advice. You can assess the seal, filter and surrounding skin with her permission, discuss alternative appliances if appropriate, and help her request practical workplace arrangements without pressuring her to disclose personal details to colleagues.

Interlocutor: PATIENT

Your tasks

1. Find out what worries Ms Janjua about returning to work and how her pouch is currently working, including any odour while wearing it, leakage or skin soreness

2. Explain how the pouch controls odour and how an appliance assessment could address any problems

3. Reassure her without promising that odour can never occur, and explore her preferences about sharing information at work

4. Agree practical support for returning to work, including an appliance check, access to a toilet, spare supplies and follow-up

Nursing · Chronic kidney disease: explain an existing fluid plan

SPK-NUR-22 | Original simulated candidate card

Setting: Renal outpatient clinic

You are a renal nurse seeing Mr Asif Gilani, aged 60, who has chronic kidney disease and is thirsty and worried about dehydration. In this fictional case, his renal clinician's existing written plan is to measure and record his usual drinks and liquid foods, avoid deliberately drinking extra to flush his kidneys, and discuss any fluid restriction with the renal clinician before starting it; no daily fluid maximum has been prescribed, and the clinician can review his concerns today. General clinical information: fluid advice depends on the individual, because impaired kidneys may allow fluid to accumulate, while insufficient fluid can cause dehydration; new breathlessness, markedly reduced urine or dizziness needs prompt clinical assessment, and severe breathing difficulty requires emergency help. Your purpose is to explain this monitoring plan, check whether he has misunderstood it, and arrange review rather than calculate or invent a daily allowance.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Gilani understands and follows his written plan, and whether his thirst is accompanied by new breathlessness, reduced urine or dizziness

2. Explain why fluid advice is individual and clarify that his current plan records intake rather than prescribing a daily fluid maximum

3. Respond to his fear of dehydration and explore a manageable way to record drinks and liquid foods without imposing his own restriction

4. Agree a review with the renal clinician today and explain how to obtain prompt help if concerning symptoms develop

Nursing · Young adult receiving chemotherapy: explain urgent symptom reporting

SPK-NUR-23 | Original simulated candidate card

Setting: Oncology day unit

You are an oncology nurse speaking with Ms Kveta Surbek, aged 49, whose adult daughter is receiving chemotherapy; her daughter has explicitly consented to sharing symptom-reporting and emergency-contact information with her mother, but not other treatment details. In this fictional case, the daughter is comfortable in the unit with no symptoms reported, and her written take-home plan directs her to call the oncology advice line, available day and night, immediately for fever, feeling hot or shivery, or other infection symptoms such as a new cough or painful urination, without waiting until morning or for a thermometer reading; the contact number is printed on her take-home card. The plan also directs her to obtain urgent help through NHS 111 if the oncology service cannot be reached, and to call 999 for severe breathing difficulty, new confusion or collapse. General clinical information: chemotherapy can weaken infection defences, and infections may become serious quickly; Ms Surbek has suggested that a fever could wait until the next day.

Interlocutor: RELATIVE

Your tasks

1. Find out what Ms Surbek understands about symptom reporting and check whether her daughter has any symptoms now, keeping the discussion within her daughter's consent

2. Explain why fever or infection symptoms during chemotherapy require immediate contact rather than waiting until morning

3. Address her reluctance to call overnight and explain the written contact plan, including what to do if the oncology service cannot be reached or emergency symptoms occur

4. Agree how she can support her daughter's use of the plan and check her understanding using a brief overnight-fever example

Nursing · Coeliac disease: discuss practical dietary changes

SPK-NUR-24 | Original simulated candidate card

Setting: Community clinic

You are a community nurse seeing Mr James Amponsa, aged 62, after confirmed coeliac disease; he says that gluten-free food seems expensive and that sharing a kitchen makes the advice difficult. In this fictional case, diagnostic investigations are complete, his treating clinician has advised a lifelong gluten-free diet, and you can offer a referral to a dietitian for affordable meal planning and shared-kitchen advice. General clinical information: gluten in wheat, barley and rye triggers an immune reaction that damages the small bowel, even when symptoms are mild; plain rice, potatoes, vegetables and uncoated meat or fish are naturally gluten-free, while packaged foods need label checking. Gluten can transfer through crumbs and shared preparation equipment, so useful measures include washing surfaces and utensils, protecting spreads from crumbs, and using toaster bags or a separate toaster.

Interlocutor: PATIENT

Your tasks

1. Find out what Mr Amponsa currently eats and which aspects of food costs or sharing the kitchen are making dietary changes difficult

2. Explain why a lifelong gluten-free diet matters and discuss affordable naturally gluten-free choices suited to his usual meals

3. Respond without blame to his difficulties and explain a few practical ways to prevent gluten transferring to his food in the shared kitchen

4. Agree achievable first steps and offer a dietitian referral for individual meal planning and kitchen advice, checking his understanding

Nursing · Pulmonary tuberculosis: discuss isolation and privacy

SPK-NUR-25 | Original simulated candidate card

Setting: Respiratory ward, England

You are a ward nurse in this original independent practice scenario, caring for Mrs Sabina Kaloki, aged 63, admitted yesterday with infectious pulmonary tuberculosis; she is clinically stable and has started prescribed antibiotics. Her treating team's plan is single-room isolation with the door closed, respiratory protection for staff, and a surgical mask for her during essential staff-arranged trips outside the room; the team will review when precautions can end, without promising a date today. TB can spread through the air, and the specialist TB nurse is available today to explain treatment, practical support and contact tracing; active TB requires public health notification in England, and although confidentiality is protected as far as possible, necessary information may need to reach a workplace representative for contact assessment, which the team should discuss with her. Mrs Kaloki feels punished and fears workplace disclosure; ask her to call staff immediately for new breathlessness or coughing blood, and recognise that a complete ongoing clinical assessment may continue after this focused conversation.

Interlocutor: PATIENT

Your tasks

1. Explore Mrs Kaloki's understanding of isolation, her main privacy concern and whether she intends to leave the room now

2. Explain how the current precautions reduce airborne spread and how the treating team will review them

3. Clarify confidentiality and its limits, including public health notification and possible workplace contact assessment

4. Respond to her feeling of being punished and offer practical support from the specialist TB nurse

5. Agree an immediate plan for precautions and a private TB-team discussion; check understanding and explain when to call ward staff

Nursing · Prescribed home oxygen: agree a safe home plan

SPK-NUR-26 | Original simulated candidate card

Setting: Home oxygen assessment clinic

You are a respiratory nurse in this original independent practice scenario, seeing Mr Elmer Vergara, aged 64, for a safety review after prescribed home oxygen was installed last week; he is currently comfortable, and no change to his prescribed oxygen settings or schedule has been authorised. He does not smoke, but wants visitors to smoke in another room; oxygen makes fires start more easily and burn more fiercely, so visitors must smoke outside, away from him and the equipment, rather than anywhere inside his home. Turning down or stopping prescribed oxygen to accommodate smoking is not a safe solution, and the oxygen team is available today to review any difficulty making the home safe before he leaves the clinic. Agree a smoke-free indoor plan, offer a home fire-safety assessment and check working smoke alarms; unresolved smoking risk requires prompt oxygen-team review, while a fire requires getting to safety and calling emergency services, and a complete ongoing assessment may continue after this focused conversation.

Interlocutor: PATIENT

Your tasks

1. Explore Mr Vergara's proposed arrangements for visitors and whether smoking has already occurred indoors since oxygen was installed

2. Explain why smoking in another room or reducing oxygen does not provide a safe solution

3. Respond to his concerns about visitors and help him identify a workable smoke-free indoor arrangement

4. Agree the home plan and any oxygen-team review needed today, including fire-safety support; check his understanding and invite questions

Nursing · Neonatal jaundice receiving phototherapy: explain care and involvement

SPK-NUR-27 | Original simulated candidate card

Setting: Postnatal ward

You are a nurse on a postnatal ward in this original independent practice scenario, speaking with Mrs Iyadunni Edun, aged 29, whose three-day-old baby, born at term, is clinically stable and started standard overhead phototherapy today because a blood test showed bilirubin requiring treatment. The special light helps the body remove bilirubin, the substance causing jaundice, and the treating team's plan is bedside treatment with eye protection, repeat bilirubin blood tests to assess response and a further check after treatment stops, alongside temperature and hydration monitoring using feeding, wet nappies and weight. The team permits short staff-agreed breaks for breastfeeding, nappy changes and cuddles, with feeding support and help waking the baby for feeds if sleepy but readily rousable; longer interruptions or changes to this plan require review, and no stopping time has been promised. Mrs Edun fears losing the chance to bond; ask about feeding and alertness now, advise her to call ward staff immediately if the baby becomes difficult to wake, stops feeding or has breathing difficulty, and explain that a complete ongoing clinical assessment may continue after this focused conversation.

Interlocutor: RELATIVE

Your tasks

1. Explore Mrs Edun's understanding and bonding concerns, then check how her baby has been feeding and waking

2. Explain the purpose of phototherapy and how the team will monitor its effect and her baby's wellbeing

3. Reassure her about opportunities to participate, explaining this baby's agreed feeding and short-break plan

4. Agree how she will take part in the next feed and care period; check understanding and explain when to call staff immediately

Nursing · Iron-deficiency anaemia: explore refusal of prescribed iron infusion

SPK-NUR-28 | Original simulated candidate card

Setting: Infusion day unit

You are an infusion-unit nurse in this original independent practice scenario, speaking with Mr Jaidyn Morrison, aged 66, who has confirmed iron-deficiency anaemia and is declining his prescribed intravenous iron because he believes it is a blood transfusion; no cannula has been inserted and no treatment has started. His prescriber recommended intravenous iron after iron tablets caused persistent nausea and constipation, and investigations into the cause of his deficiency are already being arranged separately; the proposed infusion supplies iron medicine through a small tube into a vein, contains no donor blood, and helps replace the iron needed to make red blood cells. Staff monitor patients during and after infusion because reactions can occur, including rare serious allergic reactions, while leakage around the cannula can cause lasting skin staining; breathing difficulty, swelling or feeling faint require immediate staff attention, as does pain or burning at the cannula site, with treatment stopped and urgent clinical help obtained for a suspected serious reaction. He may decline or postpone without pressure, and the prescriber is available today to discuss alternatives, including whether a different oral-iron approach is suitable; this focused conversation does not replace the full pre-infusion assessment, product-specific consent discussion or ongoing clinical assessment.

Interlocutor: PATIENT

Your tasks

1. Explore Mr Morrison's understanding of the proposed treatment and the reasons for his refusal

2. Explain why intravenous iron was recommended in his case and how it differs from a blood transfusion

3. Describe the procedure, key risks and monitoring in plain language, checking what further explanation he needs

4. Acknowledge his concerns and clarify his right to decline or postpone without pressuring him to consent

5. Agree his preferred next step, offering a discussion with the prescriber about alternatives and follow-up

Nursing · Haemodialysis fistula: explain fistula protection

SPK-NUR-29 | Original simulated candidate card

Setting: Renal outpatient clinic

You are a renal nurse in this original independent practice scenario involving Ms Orah Naylor, aged 67, whose healed left-arm fistula is used for haemodialysis. She wants advice before attending another clinic because she feels embarrassed about reminding staff which arm to avoid. For this fictional case, her renal team's documented plan is to use her right arm for routine blood pressure measurements, blood samples and cannulas, reserve fistula needling for the dialysis team, avoid tight clothing or direct pressure over the fistula, and check its usual vibration daily. You can demonstrate this check and provide written instructions and the renal unit's contact details; a complete ongoing clinical assessment may continue after this focused conversation.

Interlocutor: PATIENT

Your tasks

1. Find out what Ms Naylor understands about protecting her fistula and briefly check whether she has noticed any current change in its vibration, appearance or comfort

2. Explain that the fistula provides access for dialysis and discuss her renal team's protection plan

3. Reassure her that reminding staff is appropriate and rehearse a question she feels comfortable using before a blood pressure check or needle procedure

4. Advise her to contact the renal unit urgently if the vibration disappears, the area becomes painful, red or swollen, or her hand becomes cold or numb; explain that bleeding outside supervised dialysis care requires calling 999 immediately and applying firm direct pressure to the bleeding point with clean gauze while awaiting help

5. Agree how she will identify her fistula arm, follow her renal team's instructions and obtain help; check her understanding

Nursing · Hearing loss: agree accessible care communication

SPK-NUR-30 | Original simulated candidate card

Setting: Community home visit

You are a community nurse in this original independent practice scenario, visiting Mr Adelardo Buendia, aged 38, to review how he receives information during home care. He reports longstanding hearing difficulty, has not had a recent hearing assessment and has sometimes nodded without catching what staff said. General communication options include reducing background noise, facing him, speaking clearly at a pace he prefers, rephrasing and providing written information; gradual hearing difficulty warrants GP assessment, with hearing-service referral if appropriate, whereas sudden loss, rapid deterioration, ear pain or discharge requires urgent GP or NHS 111 advice. You can record agreed communication preferences and, with his permission, contact his GP to request assessment and consideration of an audiology referral; a complete ongoing clinical assessment may continue after this focused conversation.

Interlocutor: PATIENT

Your tasks

1. Find out when communication is difficult, what has helped and whether his hearing has changed suddenly or recently, or is accompanied by ear pain or discharge

2. Explore his habit of nodding when he has missed information, acknowledge any embarrassment and establish how he would prefer staff to check understanding

3. Explain and try suitable communication adjustments, including written information, pausing to use his feedback

4. Offer to contact his GP with permission for assessment of his hearing difficulty and consideration of audiology referral; explain when urgent advice would be needed instead

5. Agree a communication plan for future visits, including his preferred contact method, and check his understanding

Nursing · Ankle fracture in a cast: arrange reassessment and address work concerns

SPK-NUR-31 | Original simulated candidate card

Setting: Emergency discharge area

You are an emergency nurse in this original independent practice scenario involving Ms Sarah Crampsie, aged 39, whose left ankle fracture was treated in a plaster cast today; she now reports increasing tightness while preparing to leave for work. Discharge must pause so you can check her foot and arrange prompt reassessment by the emergency clinician, with orthopaedic input if needed. Her existing orthopaedic plan is no weight through her left foot, use of the crutches already fitted and taught, and fracture-clinic follow-up confirmed before discharge. Prioritise reassessment and her work concern, briefly explain essential cast care and the existing plan, and make clear that home advice applies only if she is cleared to leave.

Interlocutor: PATIENT

Your tasks

1. Establish how the tightness and pain have changed and ask briefly about toe colour, sensation and movement

2. Explain why she must stay for a foot check and prompt clinical reassessment now; ask her to alert you immediately if pain worsens, her toes become blue, white or numb, or she has difficulty moving them

3. Explore her concern about missing work, acknowledge the practical pressure and offer help with work documentation to support her staying

4. Summarise the existing plan and essential care for after discharge, if authorised: no weight through the left foot, use the fitted crutches, confirm fracture-clinic follow-up before leaving, keep the cast dry and raise the leg when resting. Do not put anything inside the cast. Do not cut the cast yourself.

5. Agree that she will remain while you contact the clinician; check her understanding of the immediate next step and that home advice applies only after clearance

Nursing · Urinary incontinence: explore confidentiality and access

SPK-NUR-32 | Original simulated candidate card

Setting: School health clinic

You are a school nurse in this original independent practice scenario, seeing Mr Jesus Panganiban, aged 15, who reports daytime urine leakage and avoids drinking water at school to reduce toilet visits. Explain that personal information is kept private and shared only as necessary for care, but information may need to be shared to protect him or someone else from serious harm or where legally required, discussing this with him first wherever possible. General advice is to drink regularly rather than deliberately restrict water and to have prompt toilet access; pain when passing urine or fever needs urgent GP advice, and new marked thirst with passing much more urine needs urgent assessment. In the context of new marked thirst and passing much more urine, rapid deterioration or any one of vomiting, drowsiness, confusion or rapid, deep breathing requires immediate emergency help: call 000 in Australia and do not wait for routine GP or school follow-up. For this fictional school, you can seek his permission to discuss a discreet toilet-access arrangement with the designated staff member and help him arrange a GP assessment of the leakage; a complete ongoing clinical assessment may continue after this focused conversation.

Interlocutor: PATIENT

Your tasks

1. Explain confidentiality and its limits in age-appropriate language, and ask what he is worried might be shared

2. Find out about the leakage, his drinking and access to school toilets, briefly checking for pain, fever or new marked thirst with passing much more urine

3. Reassure him without blame and explain why avoiding water is not a suitable solution; discuss regular drinks and prompt toilet access without prescribing a fixed fluid amount

4. Offer help arranging GP assessment to investigate the leakage, explaining when urgent help would be needed instead

5. Agree what practical school support he wants, who may receive the minimum necessary information and how you will follow up; check his understanding

Nursing · Reduced intake near end of life: discuss comfort-focused care

SPK-NUR-33 | Original simulated candidate card

Setting: Palliative care ward

In this original independent practice scenario, you are a nurse speaking with Ms Soraia Puig, aged 45, about her mother. Fictional case facts: her mother has advanced cancer, the treating team believes she is entering her last days, and she is increasingly sleepy, taking occasional sips and declining most food; when awake, she can express her wishes and has agreed to her daughter's involvement. The team's individual plan is to offer food and small drinks when she wants them and is awake enough to swallow comfortably, provide frequent gentle cleaning and moistening of her mouth and lips, and review discomfort or swallowing changes; you can demonstrate mouth care and request a doctor review today. General clinical background: appetite commonly decreases near death, food should not be forced, and coughing or distress during intake requires stopping the attempt and calling the nurse immediately; hydration decisions remain individual and require review.

Interlocutor: RELATIVE

Your tasks

1. Find out what Ms Puig understands about her mother's reduced intake and what she hopes feeding will achieve

2. Explain why appetite can decrease near death and how care will continue while respecting her mother's wishes

3. Explain the team's mouth-care and comfort-feeding plan, including what to do if swallowing causes coughing or distress

4. Respond to her belief that not forcing food means neglect and invite her reaction to the explanation

5. Agree how she would like to help, offer the doctor review today and check her understanding of the immediate plan

Nursing · Possible wound infection: arrange prompt reassessment

SPK-NUR-34 | Original simulated candidate card

Setting: Surgical outpatient clinic, telephone consultation

In this original independent practice scenario, you are a surgical outpatient nurse telephoning Mr Friedemann Ortmann, aged 42, after a missed wound-review appointment. Fictional case facts: he had hernia surgery eight days ago, missed yesterday's appointment when his arranged transport failed, and has reported increasing wound soreness, redness and yellow discharge without an examination yet. The duty surgical team has offered reassessment in the clinic today; you can confirm attendance with them and ask the clinic coordinator to investigate suitable transport, but transport is not guaranteed, so any access failure must be discussed with the duty team to secure an alternative same-day assessment. General clinical background: these wound changes may indicate infection and need prompt review; new confusion, severe breathing difficulty or rapid serious deterioration require an ambulance via 999 rather than waiting for transport.

Interlocutor: PATIENT

Your tasks

1. Find out how the wound has changed and how he feels now, checking for fever or shivering and emergency warning signs

2. Explore what prevented attendance and what practical barriers could prevent assessment today, without blame

3. Explain why examination today is needed while making clear that infection has not yet been confirmed

4. Respond to his concerns about another failed journey and explain what access support you can investigate

5. Agree a workable same-day assessment plan, including the duty-team fallback if transport fails and when to call 999

Nursing · Shingles: explain contact precautions

SPK-NUR-35 | Original simulated candidate card

Setting: Community home visit

In this original independent practice scenario, you are a community nurse visiting Ms Angella Daniels, aged 43, whose GP diagnosed shingles yesterday. Fictional case facts: the rash is confined to one side of her trunk, some blisters are still weeping, it can be covered with loose clothing, and her pregnant daughter wants to visit; no advice specific to this visit has yet been given. General clinical advice: blister fluid can transmit chickenpox to susceptible people, covering the rash reduces exposure but does not establish a pregnant contact's immunity, and a pregnant person with possible exposure should contact their midwife or GP urgently. Your immediate plan is to clarify previous clinical advice and contact, help her cover the rash without adhesive touching the blisters, postpone the proposed visit while immunity and exposure advice are clarified, and advise urgent GP or NHS 111 assessment if she develops a rash near the eye or nose or changes in vision.

Interlocutor: PATIENT

Your tasks

1. Find out what clinical advice Ms Daniels has received, how she covers the rash and what she knows about her daughter's chickenpox history or vaccination

2. Check whether her daughter has already visited or had contact with the rash, and arrange urgent maternity or GP advice if exposure has occurred

3. Explain how shingles can transmit chickenpox and how rash coverage and avoiding susceptible contacts reduce risk

4. Respond to her disappointment about postponing the visit without guaranteeing that her daughter or the baby is safe

5. Agree a practical contact plan, check her understanding and explain when she should obtain urgent help for eye-related symptoms

Nursing · Type 1 diabetes and religious fasting: agree specialist planning

SPK-NUR-36 | Original simulated candidate card

Setting: Community diabetes clinic

In this original independent practice scenario, you are a nurse seeing Mr Ephantus Jeptoo, aged 44, who has type 1 diabetes and wants to undertake a religious fast beginning tomorrow. He uses background and mealtime insulin, has no individual fasting plan and proposes omitting his background insulin because he will not be eating. You have already confirmed that he feels well, has taken his usual insulin and has not started fasting or changed treatment; a diabetes specialist nurse can see him today before he leaves. Your focus is to address his misunderstanding and agree that next step: the specialist will undertake the detailed risk assessment, treatment planning and safety education.

Interlocutor: PATIENT

Your tasks

1. Find out what the fast involves and what matters most to him about observing it

2. Explain briefly why background insulin is still needed without food and why fasting needs individual specialist advice

3. Explore his concern about specialist involvement and reassure him that the discussion will take his beliefs and priorities seriously

4. Agree that he will stay for today's specialist discussion and postpone fasting and self-directed insulin changes until an individual plan is agreed, then check his understanding

Nursing · Constipation while using prescribed opioids: discuss a documented bowel plan

SPK-NUR-37 | Original simulated candidate card

Setting: Postoperative ward

In this original independent practice scenario, you are a ward nurse caring for Ms Lindah Sitienei, aged 45, who is recovering from knee surgery and receiving prescribed opioid pain relief; she has quietly mentioned difficulty opening her bowels. Fictional case information: the treating team has documented offering her already-prescribed oral laxative, recording bowel movements and symptoms, and reviewing her constipation during the ward round; she may drink normally and mobilise with the assistance already arranged for her recovery, but you do not yet know whether she has taken the laxative. Clinical information: opioids, reduced movement and changes in routine can contribute to constipation; severe or worsening abdominal pain, vomiting, increasing abdominal swelling or inability to pass wind require immediate assessment and urgent medical review rather than routine constipation advice. You can arrange a private conversation and toilet access; explain the existing plan without selecting or changing medicines, and recognise that a complete clinical assessment may continue after this focused conversation.

Interlocutor: PATIENT

Your tasks

1. Find out about Ms Sitienei's bowel difficulties and privacy needs, including what she has already taken or tried.

2. Check for urgent abdominal symptoms and explain that any concerning findings require immediate assessment by the treating team.

3. Explain possible contributors to constipation and the documented bowel plan without prescribing or changing treatment.

4. Respond sensitively to her embarrassment and discuss practical support with privacy, drinks and assisted movement.

5. Agree the next steps for the prescribed treatment and ward-round review, checking understanding and inviting questions.

Nursing · Pressure injury prevention: agree shared care support

SPK-NUR-38 | Original simulated candidate card

Setting: Home nursing visit

In this original independent practice scenario, you are a community nurse visiting Mr John Boetet, aged 46, who cares for his father at home following a stroke; his father cannot change position independently, and Mr Boetet believes the newly supplied pressure-relieving mattress makes repositioning unnecessary. Fictional service arrangements: with his father's agreement, you can assess skin, pressure-injury risk and moving needs during this visit, develop an individual written prevention plan, and contact the community care coordinator to request additional assistance, although extra visits are not yet confirmed. Clinical information: the mattress helps reduce pressure but does not replace regular changes of position or daily skin checks; the positioning method and frequency must suit the individual assessment, and Mr Boetet should not attempt lifting or moving that he cannot safely manage. New discolouration, soreness or broken skin needs prompt assessment, while associated heat, swelling, pus, fever or severe or worsening pain needs urgent medical advice; a complete ongoing assessment and support planning may continue after this focused conversation.

Interlocutor: RELATIVE

Your tasks

1. Find out how Mr Boetet is managing his father's care, what he understands about the mattress and whether he has noticed any skin problems.

2. Explain why the mattress supports rather than replaces changes of position and skin checks.

3. Acknowledge his exhaustion and discuss an individual assessment and shared support without expecting unsafe lifting.

4. Agree the immediate assessment and request for practical help, including which skin changes need prompt or urgent advice, and check understanding.

Nursing · Chlamydia: discuss follow-up and partner support

SPK-NUR-39 | Original simulated candidate card

Setting: Sexual health clinic

In this original independent practice scenario, you are a sexual health nurse speaking privately with Ms Michaele Cormier, aged 47, after the clinician has explained her positive genital chlamydia result and assessed her as having uncomplicated infection; pregnancy has been excluded and she remains symptom-free. Her documented plan is to complete the supplied seven-day doxycycline course exactly as labelled, avoid vaginal, anal and oral sex until she has completed treatment, symptoms have resolved and partners have been tested and treated if necessary, and return for a self-collected vaginal swab at three months to look for reinfection rather than immediate proof of cure; she has not started the tablets yet. The clinician has already explained this plan and symptom safety advice, provided written instructions and checked her understanding, so briefly relate the plan to her concerns without repeating detailed counselling or taking a detailed sexual history. A health adviser is available before she leaves to discuss safe partner notification, including contacting partners without naming her, although a partner may infer her identity.

Interlocutor: PATIENT

Your tasks

1. Explore Ms Cormier's main worry about who might learn about her result.

2. Reassure her without judgement and explain confidentiality briefly, including that family or her GP are not routinely informed without permission and that limited legal or serious safety-related exceptions apply.

3. Briefly explain her documented treatment and follow-up plan, linking partner testing and treatment to preventing reinfection and clarifying the purpose of the three-month test in relation to her concerns.

4. Explore whether contacting partners would feel safe and explain the clinic's supported notification option, including its privacy limits and the need for partners to have testing and treatment if indicated.

5. Agree a next step with the health adviser and a safe way for the clinic to contact her, then check her understanding and invite questions.

Nursing · Communication through an interpreter: agree supported communication

SPK-NUR-40 | Original simulated candidate card

Setting: Preoperative clinic

In this original independent practice scenario, you are a preoperative nurse speaking with Ms Ataahua Henare, aged 42, whose mother is awaiting a non-emergency surgical consent discussion and needs language support; her mother has agreed that you may discuss communication arrangements with her daughter. Fictional service arrangements: the clinic can request a professional telephone or video interpreter without charge after confirming the patient's preferred language and dialect, and the surgeon will conduct the subsequent consent discussion; the patient's preferences about interpreting and her daughter's presence have not yet been checked directly. Consent must be informed and voluntary, and limited English does not itself mean lack of decision-making capacity; professional interpreting supports accurate, impartial communication and confidentiality, while a daughter can remain a valued supporter if the patient wishes. If her mother prefers family interpreting or declines the offered service, arrange an independent supported discussion of that preference and senior review of how understanding can be established, rather than assuming consent or treating the daughter's agreement as the patient's decision; this conversation concerns communication arrangements, and the full clinical assessment and surgical consent discussion will follow separately.

Interlocutor: RELATIVE

Your tasks

1. Find out why Ms Henare wants to interpret and what concerns she has about professional interpreter support.

2. Explain why the team offers professional interpreting for an informed, voluntary consent discussion while recognising her knowledge of her mother.

3. Discuss checking her mother's own communication preferences and how Ms Henare could remain involved with her mother's permission.

4. Agree the next steps for interpreter support and the later surgeon-led discussion, including what happens if her mother declines, and check understanding.

Nursing · Daily weight monitoring: agree a feasible monitoring routine

SPK-NUR-41 | Original simulated candidate card

Setting: Community heart-failure clinic, England

This is original independent practice material; the patient history, individual care plan and equipment availability are fictional case facts. You are a nurse seeing Ms Eve Sharpe, aged 49, who has heart failure and has brought an empty weight record despite her team's agreed daily-monitoring plan. Her existing response plan is to contact the heart-failure team promptly for sudden weight gain or new or worsening breathlessness or swelling, seek an urgent GP appointment or NHS 111 advice if the team cannot be reached, and call 999 for severe difficulty breathing, such as gasping or being unable to get words out. A talking scale is available to try and borrow today, and you can provide an audio version of her response plan.

Interlocutor: PATIENT

Your tasks

1. Explore Ms Sharpe's experience of weighing and recording, what has made this difficult, and whether she has any new symptoms.

2. Explain how weight monitoring can help identify fluid build-up and guide her care, responding to her concerns without judgement.

3. Discuss accessible ways to obtain and record readings, offering a trial of the talking scale and asking what she would prefer.

4. Clarify her team's existing response plan, including how to obtain urgent help without waiting for a weight reading.

5. Agree a feasible daily routine, an accessible record and response plan, and how the clinic will check whether these arrangements work; check her understanding.

Nursing · Communication after aphasia: agree a patient-led rehabilitation goal

SPK-NUR-42 | Original simulated candidate card

Setting: Stroke rehabilitation ward

You are a nurse in this original independent practice scenario, speaking with Mr Munyoki Wanjiku, aged 50, whose partner, aged 49, had a stroke three weeks ago and has aphasia. In an earlier supported discussion, she repeatedly selected sharing news with her daughter as her first communication goal, rather than practising work telephone calls, which Mr Wanjiku favours. Her speech and language therapist has established that she can communicate choices using photographs, short written keywords and pointing, with one idea presented at a time and time to respond; her proposed first step is to share one event from her day using her photograph booklet. She has agreed to this discussion with her partner while she rests, and the team's plan is to confirm the goal directly with her before recording it, provide her with an accessible copy and review progress at the next rehabilitation meeting.

Interlocutor: RELATIVE

Your tasks

1. Find out why Mr Wanjiku prioritises work telephone calls and what he understood about his partner's expressed preference.

2. Explain how aphasia can affect communication without, by itself, showing that someone cannot make decisions; describe how his partner's preference was established.

3. Acknowledge his concerns and explain how her chosen everyday activity can be a meaningful rehabilitation goal without promising a particular recovery outcome.

4. Agree how to confirm the goal directly with his partner using her established communication supports, record her confirmed preference and support practice with her agreement; check his understanding.

Nursing · Stopping smoking before surgery: explore readiness and support

SPK-NUR-43 | Original simulated candidate card

Setting: Preoperative assessment clinic, England

This is original independent practice: you are a nurse seeing Ms Agnes Satterfield, aged 51, before planned gallbladder surgery. In this fictional case, she has disclosed that she still smokes and asks whether this means her operation will be cancelled. No individual smoking instructions or decision about postponement have yet been provided by the surgical or anaesthetic team. You can contact that team today to clarify her advice, offer referral to a local NHS stop smoking service with her agreement, and arrange a follow-up call to discuss the team's response.

Interlocutor: PATIENT

Your tasks

1. Explore her fear about disclosing smoking, her current smoking pattern and how ready she feels to stop.

2. Explain briefly why accurate information helps the team plan safe care and how stopping smoking can support recovery.

3. Reassure her that your discussion and referral offer are supportive; explain that you must obtain the surgical team's individual advice rather than promise whether surgery will proceed.

4. Agree a manageable next step, including her preferred support, clarification from the surgical team and how you will follow up.

Nursing · Psoriasis treatment at home: explore practical treatment barriers

SPK-NUR-44 | Original simulated candidate card

Setting: Dermatology nurse clinic

You are a dermatology nurse seeing Mr Carlos Sumulong, aged 52, who reports difficulty applying his prescribed topical psoriasis treatment to his back. Today's consultation concerns practical support; no medicine regimen is supplied or needs to be explained, and questions about application instructions must be referred to the pharmacist or prescriber. You can offer a private assessment, request pharmacist advice about a suitable application aid and arrange a further nurse review; home nursing support would require assessment and cannot be guaranteed. This is original independent practice: all patient details and clinic arrangements are fictional, while general clinical information is drawn from the NHS psoriasis source.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Sumulong manages treatment at home, which areas he cannot reach and what makes asking for help difficult.

2. Explain briefly how treatment can help manage psoriasis symptoms and explore his understanding of whether another person could catch it.

3. Reassure him without judgement and discuss practical options, including checking whether an application aid is suitable or involving a trusted person with his permission.

4. Agree a support plan that respects his privacy, clarify consent before involving anyone else and check his understanding of the next steps.

Nursing · Gastroenteritis recovery: explain the documented oral-fluid plan

SPK-NUR-45 | Original simulated candidate card

Setting: Children's ward, England

You are a nurse in this original independent practice scenario, preparing Ms Risper Mutahi, aged 42, for her daughter's discharge following gastroenteritis. Her 10-month-old daughter was admitted yesterday; the treating clinician has reviewed her today and authorised discharge because she is alert, tolerating formula feeds and no longer clinically dehydrated. She has not vomited since yesterday evening but still has loose stools, and Ms Mutahi believes all milk should stop until these settle. The documented discharge plan is to continue her usual formula at its normal strength, offer smaller feeds more frequently while she is recovering, offer small sips of water between feeds, offer her usual age-appropriate foods when she wants them, and avoid fruit juice and fizzy drinks.

Interlocutor: RELATIVE

Your tasks

1. Find out what Ms Mutahi plans to offer at home, how her daughter is currently tolerating feeds and what her main feeding concern is; explore further according to her responses.

2. Explain her daughter's documented fluid and feeding plan in plain language, clarifying that the team has advised continuing her usual formula at normal strength rather than stopping or diluting it.

3. Respond to her feeding concerns without blame, acknowledging her observations and avoiding a guarantee that milk can never cause symptoms.

4. Explain when to obtain help after discharge: call NHS 111 if she remains worried about her baby, who is under 12 months; contact the GP urgently or call NHS 111 if her daughter stops feeding, has fewer wet nappies or repeatedly vomits and cannot keep fluids down; call 999 immediately if she is not responding as usual, becomes unresponsive or has severe difficulty breathing.

5. Agree how she will manage the next feed and feeds at home, check her understanding and offer treating-team clarification if concerns remain. If new deterioration is reported or observed during the discussion, pause discharge and arrange prompt clinical reassessment, activating the ward emergency response for emergency signs.

Nursing · Pelvic floor exercise support: agree private practical follow-through

SPK-NUR-46 | Original simulated candidate card

Setting: Community continence clinic

You are a nurse in a community continence clinic in this original independent practice role-play. Mr Madushan Liyanage, aged 54, has had small urine leaks when coughing or lifting for six months and believes this is simply part of getting older. In this fictional case, his GP assessed him last week and recommended specialist teaching to help him learn pelvic floor exercises, but he has not arranged this. You can offer a referral for an individual appointment with a continence physiotherapist, record his communication preferences and arrange a follow-up nursing appointment; no individual exercise programme has yet been prescribed.

Interlocutor: PATIENT

Your tasks

1. Find out how leakage affects his daily life, what he understands about pelvic floor exercises and what has prevented him from arranging teaching.

2. Explain that leakage is not an inevitable part of ageing and that pelvic floor exercises strengthen muscles involved in bladder control and may help.

3. Explore his embarrassment and privacy preferences, explaining the option of individual specialist teaching without promising a cure.

4. Agree a practical next step, including whether he accepts the referral, his preferred contact arrangements and nursing follow-up; check his understanding.

Nursing · Walking after hip replacement: address fear of movement

SPK-NUR-47 | Original simulated candidate card

Setting: Orthopaedic rehabilitation ward

You are a nurse in this original independent practice scenario; the patient details and individual treating-team plan are fictional case facts. Ms Songul Lochel, aged 55, had a left total hip replacement for osteoarthritis three days ago and is refusing mobilisation after reading about dislocation online. Her documented plan permits weight-bearing as comfortable, using her fitted walking frame with one staff member beside her for a short walk from the bed to the raised armchair; her individual precautions are to avoid crossing her legs, bending her hip beyond a right angle and sudden twisting, and to stop for ward assessment if pain increases or dizziness develops. She previously completed this route with the physiotherapist, reports unchanged mild soreness today, and has no discharge date agreed; the physiotherapist is available to review any uncertainties before practice.

Interlocutor: PATIENT

Your tasks

1. Explore what Ms Lochel read, what she fears will happen and whether her hip symptoms have changed.

2. Explain how supported walking helps recovery and clarify her documented walking plan and precautions.

3. Acknowledge her fear and explain that dislocation is possible but uncommon, without promising that movement is risk-free.

4. Agree a manageable next step with her consent, offering physiotherapy review if needed; check her understanding of the support and when to stop.

Nursing · Distress during personal care: agree person-centred support

SPK-NUR-48 | Original simulated candidate card

Setting: Dementia community clinic

In this original independent practice role-play, you are a community dementia nurse. Mrs Wendy Prempeh, aged 56, supports her 80-year-old mother, who was diagnosed with Alzheimer's disease three years ago and lives with her. Her mother is with a support worker in the waiting area and has agreed that her daughter can discuss difficulties with washing. Mrs Prempeh reports increasing distress during morning showers over the past month and believes her mother is deliberately making care difficult; no personal-care assessment has yet been completed.

Interlocutor: RELATIVE

Your tasks

1. Explore one recent washing episode and what usually works, including her mother's preferences, abilities and any discomfort or sudden change.

2. Explore how the difficulty affects Mrs Prempeh and why she feels her mother's response is deliberate.

3. Explain possible reasons for distress using the episode, responding sensitively to Mrs Prempeh's concerns.

4. Discuss one or two changes matched to her mother's preferences and abilities, including asking permission and pausing if she becomes distressed.

5. Agree which change to try first and a clinic review to assess the washing difficulties, and check Mrs Prempeh's understanding.

Nursing · HIV testing: clarify a voluntary disclosure request

SPK-NUR-49 | Original simulated candidate card

Setting: Sexual health follow-up clinic, England

You are a nurse in a sexual health follow-up clinic in this original independent practice scenario; all patient details and clinic arrangements are invented case facts. Ms Aurelia Hurtado, aged 57, has already discussed her negative HIV test result with the clinician and now asks you to send the result to her employer. Nothing has been sent, and you have not yet clarified why she wants this disclosure. For this case, the clinic can provide a general medical attendance letter showing her name and attendance date without naming the specialty or test; any requested result disclosure requires clarification and documentation of her voluntary permission, the exact information, the recipient and an approved secure delivery method.

Interlocutor: PATIENT

Your tasks

1. Explore why Ms Hurtado wants her employer to receive the result and whether anyone has asked for it or made her feel under pressure.

2. Clarify what she wants to demonstrate, the minimum information she wishes to share and who would receive it.

3. Explain how permission for this employer disclosure would be agreed, including the information and recipient, without promising control over subsequent sharing.

4. Reassure her that you will respect her informed choice and discuss the available attendance letter as an alternative.

5. Agree what, if anything, will be prepared or disclosed, confirm the next steps and check her understanding.

Nursing · Fatigue after Guillain-Barré syndrome: agree pacing under the rehabilitation plan

SPK-NUR-50 | Original simulated candidate card

Setting: Neurological rehabilitation unit

You are a nurse in a neurological rehabilitation unit in this original independent practice role-play. Mr Oba Ajewole, aged 58, is recovering from Guillain-Barré syndrome diagnosed six weeks ago; he is medically stable but experiences fatigue and needs assistance when walking with his frame. His individual rehabilitation plan specifies walking practice with the physiotherapist or an assisting nurse, seated washing and dressing in stages with rests between stages, and no additional walking laps or increases in exercise until therapist review. He has been adding extra walking laps because he feels resting is lazy; the physiotherapist and occupational therapist are available to review his programme today.

Interlocutor: PATIENT

Your tasks

1. Find out how fatigue affects Mr Ajewole's activities, what extra practice he has been doing and what resting means to him; briefly check for new or worsening symptoms.

2. Explain that fatigue can persist during recovery from Guillain-Barré syndrome and does not mean he is lazy; avoid promising a recovery date.

3. Explain his individual rehabilitation plan and how to apply its activity and rest arrangements to washing, dressing and walking.

4. Acknowledge his determination and concerns about progress; encourage him to discuss his goals with the therapists rather than increasing activity himself.

5. Agree today's activities and therapist review; advise calling ward staff immediately for new or worsening weakness, breathing or swallowing difficulty. Explain that breathing or swallowing difficulty needs urgent clinical assessment, without waiting for therapist review or treating it as ordinary fatigue; check his understanding.

Nursing · Teenager seeking more independence: negotiate supported self-management

SPK-NUR-51 | Original simulated candidate card

Setting: Paediatric diabetes clinic

You are a nurse in a paediatric diabetes clinic; this is an original independent practice scenario with fictional patient-specific facts. Ms Veronica Tarchetti, aged 42, is attending with her 15-year-old son, who has had type 1 diabetes for three years and is well today; he has agreed that you may discuss shared care with his mother before he joins the conversation. His documented education assessment confirms that he can check his blood glucose, record the result and demonstrate insulin pen technique, but his mother continues to perform all these tasks and he wants more involvement. The treating team proposes starting with him performing a glucose check and recording the result at home while his mother is nearby and reviews the record with him, with existing insulin arrangements unchanged; you can bring him into the discussion today and arrange diabetes-team support if either needs further help.

Interlocutor: RELATIVE

Your tasks

1. Find out which care tasks Ms Tarchetti currently performs, what her son has asked to do and what worries her about sharing responsibility.

2. Explain how supported involvement can recognise her son's demonstrated skills while retaining her practical support.

3. Clarify the team's proposed first step and reassure her that this discussion does not change insulin doses, treatment instructions or existing insulin responsibilities.

4. Respond to her concerns without blame or promising that training removes all risk, and explore what would make a small first step acceptable.

5. Agree a provisional division of responsibilities to discuss with her son today, including how they will ask for help and review whether the arrangement is working.

Nursing · Requested urine collection for stone assessment: agree a workable collection plan

SPK-NUR-52 | Original simulated candidate card

Setting: Urology outpatient clinic

In this original independent practice role-play, you are an outpatient urology nurse seeing Mr Akwesi Oppong, aged 60. Following his second kidney stone episode six weeks ago, the urologist has requested one 24-hour urine collection to investigate factors contributing to his stones; he feels well, has not started collecting and proposes collecting only outside his driving shifts. For this case, the supplied laboratory instructions specify: empty the bladder into the toilet on waking and record the start date and time; collect all subsequent urine throughout the day and night using a clean, dry plastic jug and transfer it carefully into the supplied collection container; exactly 24 hours after starting, empty the bladder again and include this final urine, then record the finish date and time; keep the container cool and tightly closed, complete the identity label and return it with the request form promptly; if any urine is missed or spilled, stop and contact the laboratory for a fresh container and restart instructions rather than submitting an incomplete collection. You can telephone the laboratory with him today to clarify kit handling, storage, return arrangements and replacement supplies before he starts; no special dietary or medicine changes are documented, and any questions about these must be checked with the laboratory or prescriber.

Interlocutor: PATIENT

Your tasks

1. Find out what Mr Oppong understands about the collection, what he intends to collect and how his work could make it difficult.

2. Explain the purpose of a complete timed collection and talk him through the supplied instructions in manageable steps.

3. Acknowledge his work pressures and address his belief that a partial collection will be sufficient, without blaming him.

4. Agree a practical collection plan, offer to contact the laboratory together about outstanding arrangements and check his understanding.

Nursing · Chemotherapy-related mouth soreness: plan timely symptom support

SPK-NUR-53 | Original simulated candidate card

Setting: Oncology ward

You are a nurse on an oncology ward in this original independent practice scenario. Ms Rosario Manansala, aged 61, is an inpatient whose most recent chemotherapy was a week ago; she has just mentioned mouth soreness that began yesterday. You have not yet assessed her mouth or intake, and no treatment has been prescribed for this new symptom. You can assess her mouth and observations and contact the ward oncology clinician now for review and symptom support; decisions about further chemotherapy belong to the treating team.

Interlocutor: PATIENT

Your tasks

1. Find out about her mouth soreness, its effect on eating and drinking, and any difficulty swallowing, fever, shivering or feeling unwell.

2. Explain that chemotherapy can cause mouth soreness and that reporting symptoms allows the team to assess the problem and offer support.

3. Explore her worry about reporting pain and reassure her without promising that chemotherapy will continue unchanged.

4. Explain the proposed assessment and request for symptom relief, including review of her ability to eat and drink.

5. Agree to contact the oncology clinician now, check her understanding and explain how to obtain immediate help if her condition worsens.

Nursing · Accessible follow-up after discharge: agree a partly private accessible consultation

SPK-NUR-54 | Original simulated candidate card

Setting: Community learning-disability service

You are a community learning-disability nurse conducting an original independent practice consultation with Mr Robert Drummond, aged 62, his adult son's agreed carer and father. His son, aged 31, has attended a follow-up after hospital discharge six days ago and is waiting in an adjoining consultation room. In a brief private conversation today, his son requested that his father join the discussion about transport and support with daily routines, while other personal health matters remain private. His son prefers short spoken explanations, pictures, one question at a time and time to respond; you will confirm his choices with him again before starting the shared discussion.

Interlocutor: RELATIVE

Your tasks

1. Find out what concerns Mr Robert Drummond about joining only part of the consultation and what support he currently provides.

2. Explain the limits of the permission his son has given, making clear that needing communication support does not automatically mean being unable to make decisions.

3. Describe an accessible consultation in separate segments: a shared discussion of agreed practical topics, a private conversation with his son and an optional shared summary containing only information his son agrees to share.

4. Reassure Mr Robert Drummond that his contribution is valued and explore how his son can receive communication support during the private segment.

5. Agree a proposed arrangement to confirm with his son, including how to check permission before sharing any additional information and how his father can offer relevant observations.

Nursing · Feeding with mastitis: respond to fear and arrange support

SPK-NUR-55 | Original simulated candidate card

Setting: Postnatal ward

In this original independent practice role-play, you are a nurse caring for Ms Else Faulkner, aged 32, who wants to stop breastfeeding immediately because she believes her milk is unsafe. She was readmitted eight days after giving birth, has been assessed by the doctor as clinically stable with left-sided mastitis, and has a healthy, term baby. Her documented individual feeding plan is to continue breastfeeding from either breast according to her baby's cues if she wishes; if feeding is too painful, help her hand express enough milk for her baby, without additional pumping to empty the breast. A breastfeeding specialist can assist with her next feed, the doctor will reassess her later today before discharge is considered, and she should alert ward staff immediately if she feels worse.

Interlocutor: PATIENT

Your tasks

1. Find out what Ms Faulkner believes about her milk, how feeding is going and what she would like to do about breastfeeding.

2. Explain her clinician's individual feeding advice, including the option of supported hand expression if feeding is too painful.

3. Respond to her fear of harming her baby and explain why stopping suddenly is discouraged (milk can build up, increasing breast fullness and discomfort), while respecting her feeding choices and offering team support for a gradual change if she chooses to stop.

4. Agree support for the next feed and today's review; check her understanding and explain when to call ward staff.

Nursing · Early mobilisation and clot prevention: agree an acceptable mobilisation assistant

SPK-NUR-56 | Original simulated candidate card

Setting: Surgical ward

In this original independent practice role-play, you are a nurse on a surgical ward. Mr Ancil Farrell, aged 64, is recovering from abdominal surgery yesterday; he feels well enough to walk and accepts the mobilisation plan, but has declined help from the female healthcare assistant currently available. His individual physiotherapy-assessed plan is a short walk beside his bed using the fitted walking frame with one trained staff member assisting; he must not get up alone, and any new pain, dizziness or difficulty requires reassessment before proceeding. The female healthcare assistant is trained to assist, a male nurse may be available after his current duties but this must be checked, and pyjama trousers, an additional gown and bedside screens are available to support privacy.

Interlocutor: PATIENT

Your tasks

1. Explore why Mr Ancil Farrell declined the offered assistant, what would help him feel comfortable and whether anything about his condition has changed since assessment.

2. Explain briefly how walking can help reduce the risk of blood clots after surgery and clarify his individual assessed assistance plan.

3. Acknowledge his privacy concerns and discuss feasible choices, including checking for a male staff member and offering suitable clothing and privacy screens without pressuring him.

4. Agree an acceptable next step, including how you will confirm staffing and update him; check his understanding that he should use the call bell and wait for trained assistance.

Nursing · Multiple sclerosis fatigue at work: agree boundaries for a workplace support letter

SPK-NUR-57 | Original simulated candidate card

Setting: Neurology community clinic

You are a community neurology nurse seeing Mrs Everlyne Esinyen, aged 65, in this original independent practice scenario. She has multiple sclerosis and works in office administration; her treating team reviewed her longstanding fatigue last week, with no new symptoms reported. Her employer has requested a letter containing her diagnosis and medical history, but she currently authorises disclosure of functional limitations only. The clinic's process is to clarify her requested adjustments and consent, then contact the specialist MS nurse to coordinate occupational therapy advice and an appropriately authorised support letter; she can review the proposed wording before deciding whether it may be released.

Interlocutor: PATIENT

Your tasks

1. Find out how fatigue affects her work, what adjustments she wants and what worries her about the employer's request.

2. Explain how practical changes to work patterns may help manage fatigue, relating possible adjustments to her priorities without promising their effectiveness or the employer's agreement.

3. Clarify exactly what information she permits in the letter, who may receive it and whether she wants to review it before release.

4. Reassure her that the employer's request does not itself authorise disclosure of her diagnosis or medical history, while acknowledging that limited information may lead to further questions.

5. Agree what you may discuss with the specialist MS nurse, document the external disclosure boundary and arrange a follow-up discussion about the proposed letter; summarise her wishes and invite correction.

Nursing · Methotrexate monitoring: resolve uncertainty about a written monitoring schedule

SPK-NUR-58 | Original simulated candidate card

Setting: Rheumatology day clinic

You are a nurse in this original independent practice scenario. Mr Njeru Mahat, aged 66, takes prescribed once-weekly methotrexate for rheumatoid arthritis and has brought his written monitoring schedule because his work shifts prevent him attending the booked blood test. His individual written plan states: 'Blood test tomorrow morning; contact the rheumatology day clinic if unable to attend'; these appointment details are fictional patient-specific facts, not a general monitoring guideline. The duty rheumatology clinician is available to discuss the problem today before he leaves and can confirm alternative testing arrangements and any medication instructions; no replacement appointment or medication change has yet been authorised.

Interlocutor: PATIENT

Your tasks

1. Find out what Mr Njeru Mahat understands about his written schedule, how his shifts affect attendance and whether he feels unwell today.

2. Explain the purpose of methotrexate blood monitoring in plain language, distinguishing the blood-test appointment from his weekly medication schedule.

3. Clarify the instruction to contact the clinic if unable to attend, explaining that alternative testing arrangements and any medication questions need confirmation from the treating team.

4. Respond to his concerns about attending tests around work and reassure him that discussing the difficulty is appropriate.

5. Agree to contact the duty clinician with him before he leaves, identify workable appointment options and check his understanding of what remains to be confirmed.

Nursing · Falls alarm use: agree a realistic falls-alarm response plan

SPK-NUR-59 | Original simulated candidate card

Setting: Community home visit, England

In this original independent practice scenario, you are a community nurse visiting Ms Debolina Sengupta, aged 67, who lives alone and was assessed by her GP after a fall without injury last week; she reports no further falls or new symptoms. Her pendant alarm connects to a monitoring centre day and night, but her daughter is the only listed responder, and Ms Sengupta now says that her daughter cannot always attend. For this case, the provider has confirmed that her existing funded package includes a trained responder service for non-emergency assistance, with no additional charge, but it has not been activated; the coordinator can clarify the response pathway, consent, authorised access using her existing key safe and any interim arrangements. Neither the alarm nor the responder service guarantees immediate attendance, although the monitoring centre can contact emergency services when needed; your task is to agree a joint call with Ms Sengupta and identify what still needs confirmation, with the call taking place after the role-play.

Interlocutor: PATIENT

Your tasks

1. Find out how Ms Sengupta expects the alarm to work and when her daughter can realistically answer or attend, including any other support she would consider.

2. Explain the gap in the current arrangement and the responder option included in her individual package, distinguishing monitoring from someone attending.

3. Explore her concerns about changing the arrangement and reassure her that planning reliable help can support her wish to remain independent.

4. Explain when emergency help is needed after a fall: call 999 if she cannot get up or may have injured her head, back, neck or hip; use her reachable alarm to summon help if she cannot reach a phone.

5. Agree her consent to a joint call to the coordinator after the role-play to clarify the response pathway, responder availability, authorised home access and any interim arrangements needed before activation; summarise what remains unconfirmed and check her understanding.

Nursing · Anticipatory care planning: explore fears about documented symptom medicines

SPK-NUR-60 | Original simulated candidate card

Setting: Palliative home visit, England

In this original independent practice role-play, you are a community nurse visiting Mr Clemente Checa, aged 38, whose wife, aged 40, has advanced incurable cancer and has consented to you discussing her care with him. She is comfortable today and wants the individually prescribed anticipatory medicines available at home, but he worries that accepting them means giving up. Her documented plan is for a trained nurse to assess symptoms, agree treatment with her, give an injection only if needed under her prescription and review its effects. You can give him the community palliative care service's round-the-clock contact details.

Interlocutor: RELATIVE

Your tasks

1. Find out what Mr Checa understands about keeping the medicines at home and what worries him most.

2. Explain their purpose and the short sequence before and after use: nurse assessment, agreement with his wife, treatment if needed and review.

3. Reassure him about his main concern, explaining how preparing for symptom relief supports his wife's care and choices.

4. Agree a simple plan for contacting the community palliative care service if symptoms develop or concerns remain.

Nursing · Cellulitis treatment follow-up: resolve a documented appointment-system error

SPK-NUR-61 | Original simulated candidate card

Setting: Discharge lounge

In this original independent practice scenario, you are a nurse in a hospital discharge lounge speaking with Ms Similoluwa Oyaifo, aged 39. Her discharge record documents treatment for left lower-leg cellulitis with an oral antibiotic started three days ago, instructions to complete the prescribed course and a review appointment today. Her appointment confirmation and check-in record show that she attended on time, but a booking-system error marked her as absent; reception refused her review, and she has asked you for help because her leg is still painful. The duty clinician is available to reassess her today: your immediate plan is to assess her current condition and contact that clinician without waiting for the bookings team to correct the attendance record, escalating immediately through the hospital emergency response if she is acutely unwell.

Interlocutor: PATIENT

Your tasks

1. Acknowledge her experience, apologise for the documented error and invite her account of what happened.

2. Find out how her leg and general health have changed since treatment began, whether she has taken the antibiotic as prescribed and what is worrying her most.

3. Explain why current clinical reassessment is needed and reassure her that correcting the booking record will not be a condition of receiving care.

4. Explain how you will ask the bookings team to correct the inaccurate attendance entry and confirm the outcome with her, responding to any concerns about raising the error.

5. Agree that she will stay for assessment and today's clinician review; explain that she should report any deterioration immediately, then check her understanding and invite questions.

Nursing · Needle anxiety: agree a supported vaccination discussion

SPK-NUR-62 | Original simulated candidate card

Setting: Immunisation clinic

You are a nurse in an original independent practice scenario; all patient details and local arrangements below are fictional case facts. Mr Gianni Scamarcio, aged 40, has attended a routine vaccination appointment, but says he has fainted during a previous needle procedure and wants to leave immediately; no vaccine has been given. For this case, the clinic's local policy provides for people with a fainting history to receive vaccination lying on an examination couch, with staff observation afterwards, and a private room is available for discussion without proceeding to vaccination. You can offer a discussion today or arrange another appointment with a support person; vaccination would require the usual screening, vaccine-specific information and his voluntary consent.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Scamarcio feels now, what happened when he fainted previously and what worries him most about today's appointment.

2. Acknowledge his request to leave and explain that vaccination is his choice; ask whether he would like a brief discussion without any procedure.

3. Explain the available positioning and support options, including lying on the couch because of his fainting history, privacy and keeping equipment out of view.

4. Explore what would help him feel in control, including his preferred explanations and an agreed signal to pause or stop.

5. Agree his preferred next step, which may be discussion only, another appointment or leaving today; check his understanding and explain that any new faintness needs immediate staff attention.

Nursing · Tonsillectomy recovery: check confidence with home care

SPK-NUR-63 | Original simulated candidate card

Setting: Paediatric ENT discharge area, Australia

This is original independent practice: you are a nurse preparing Ms Seanan Quinney, aged 42, to care for her eight-year-old daughter following a tonsillectomy yesterday. In this fictional case, her daughter has been cleared for discharge, is drinking, has manageable pain and has no bleeding; Ms Quinney says she cannot remember all the instructions. The fictional treating-team plan is to give the supplied prescribed pain medicines regularly according to their pharmacy labels, record each administration, avoid additional medicines or dose changes without professional advice, encourage frequent drinks and contact the ENT team for pain not controlled by the prescribed treatment; the pharmacist has already checked the labelled doses and schedule with her, and no numerical dosing recall is required here. The supplied escalation plan is to attend the nearest emergency department immediately for fresh blood from the mouth or nose, blood in vomit or new repeated swallowing suggesting bleeding, even if visible bleeding stops; call 000 for heavy bleeding, breathing difficulty or collapse, obtain urgent assessment if she cannot drink, and use the ENT discharge contact for other recovery concerns.

Interlocutor: RELATIVE

Your tasks

1. Find out which instructions Ms Quinney finds confusing, what she currently understands and whether she has practical support at home.

2. Explain the supplied pain-management and drinking plan in small sections, then ask her to describe how she will manage medicines at home.

3. Explain the supplied bleeding and emergency plan, then ask what she would do if her daughter spat out fresh blood that subsequently stopped.

4. Reassure her that asking for repetition is appropriate, respond to any misunderstanding without blame and explain the relevant point again.

5. Agree a manageable home-care plan, confirming access to the written instructions, discharge contact and emergency transport; check any remaining questions before discharge.

Nursing · Inhaler technique review: explore difficulty without blame

SPK-NUR-64 | Original simulated candidate card

Setting: Respiratory outpatient clinic

You are a respiratory nurse in this original independent practice role-play. Mr Shep Frami, aged 42, has diagnosed COPD and attends a routine review after receiving a prescribed maintenance pressurised metered-dose inhaler three weeks ago; he says everything is fine. He appears comfortable at rest and has brought his inhaler, but you have not yet assessed his current symptoms or observed him using the device. For this fictional case, the treating team's plan is for you to assess practical difficulties, offer observed teaching using the matching non-medicinal demonstration device and its instructions, and arrange review by the respiratory prescriber available today if he cannot use his inhaler reliably; you must not independently change his medicine or device.

Interlocutor: PATIENT

Your tasks

1. Find out how Mr Frami has been managing his inhaler, including any missed doses, practical difficulties and changes in his breathing.

2. Explore his reluctance to mention difficulties without blame, acknowledging any concerns about being judged.

3. Explain why being able to operate the device matters and ask permission to observe him handling the matching demonstration device without forcing painful movements.

4. Offer supported teaching and explain why persistent difficulty needs a prescriber-led device review rather than simply more practice.

5. Agree an immediate plan for today's review and check his understanding of the next steps without recommending an independent treatment change.

Nursing · Sickle cell pain care: repair trust and agree timely help-seeking

SPK-NUR-65 | Original simulated candidate card

Setting: Haematology day unit, UK

In this original independent practice role-play, you are a nurse seeing Ms Amparo Schumm, aged 43, for a planned sickle cell care review. She is currently pain-free and feels well, but says she may avoid seeking help during another painful episode because she felt dismissed during a previous emergency department visit. For this fictional case, her treating team has documented this individual help-seeking plan: contact the haematology advice service, available day and night, for non-severe pain that is worsening or not settling; if the service cannot be reached, seek urgent medical assessment rather than wait for a routine appointment; call 999 for severe pain, breathing difficulties or vomiting during a suspected crisis, or for a high temperature, without waiting for a callback or driving herself to hospital. The plan also records that staff should listen to her account, ask what treatment she has already used and what has helped previously, assess her promptly and reassess her response to treatment; you can provide a paper copy and save the advice-service contact in her phone today.

Interlocutor: PATIENT

Your tasks

1. Find out what happened during Ms Schumm's previous encounter, how it affects her willingness to seek help and whether she has any symptoms now.

2. Acknowledge the impact of feeling dismissed, apologise for her experience and explain that her knowledge of her own pain matters.

3. Explain her team's individual help-seeking and assessment plan, inviting her views about whether it addresses her concerns.

4. Explain which symptoms require calling 999 immediately rather than waiting to speak to the haematology service.

5. Agree practical steps to make the plan accessible, and check her understanding using a brief example of another painful episode.

Nursing · Obstructive sleep apnoea and CPAP: clarify equipment and team communication

SPK-NUR-67 | Original simulated candidate card

Setting: Preoperative clinic

You are a nurse in a preoperative clinic in this original independent practice case. Mrs Evelina Vuk, aged 45, is preparing for an elective hernia repair next week; she has obstructive sleep apnoea treated with CPAP and believes hospital oxygen means she can leave her machine at home. In this fictional case, her documented preoperative instructions are to continue her usual prescribed CPAP at home and bring her machine, mask, tubing and power cable to hospital, together with her sleep-service treatment information if available. Her individual anaesthetic, postoperative CPAP and monitoring arrangements have not yet been confirmed; the anaesthetist is available for discussion today, and you must not change her settings or promise a particular recovery arrangement.

Interlocutor: PATIENT

Your tasks

1. Find out what Mrs Vuk understands about CPAP and hospital oxygen, how she currently uses her machine and what might prevent her bringing it.

2. Explain the difference between CPAP and supplemental oxygen in simple terms, clarifying why oxygen does not replace the pressure that keeps her airway open.

3. Explain her documented equipment instructions and why the anaesthetic team needs to know about her sleep apnoea and usual treatment.

4. Explore and respond to her concerns about bringing the machine and involving the anaesthetist, without promising that surgery will proceed unchanged.

5. Agree an equipment checklist and a discussion with the anaesthetist today to confirm her individual plan; check her understanding and leave her prescribed settings unchanged.

Nursing · Scabies treatment follow-through: agree support after contacts decline treatment

SPK-NUR-68 | Original simulated candidate card

Setting: Community skin clinic

In this original independent practice scenario, you are a nurse seeing Mr Dara Bernie, aged 46, who was diagnosed with scabies yesterday and completed his first prescribed cream treatment as instructed. He has already informed his two adult housemates, but both decline the recommended pharmacy assessment and coordinated treatment because neither has symptoms. His treating team's written plan is to repeat his prescribed treatment seven days after the first application, avoid sexual and close skin contact until the course is complete, avoid sharing bedding, clothes or towels, wash bedding and clothing at 60°C or higher on the first treatment day, and seal items that cannot be washed in a bag for at least three days. The plan also directs him to contact this clinic if household treatment cannot be coordinated: you can request a prescriber review today, provide written information for him to offer his housemates and arrange a nurse telephone follow-up tomorrow, without independently changing his treatment.

Interlocutor: PATIENT

Your tasks

1. Find out what happened when Mr Dara Bernie spoke with his housemates, how he has followed his own plan and what support he wants now.

2. Explain why contacts without symptoms still need treatment and how untreated contacts can lead to reinfestation, linking this to his written plan.

3. Acknowledge his frustration, distinguish his own actions from his housemates' choices and discuss the clinic support available without pressuring him to persuade them.

4. Agree practical next steps, including today's prescriber review request and tomorrow's telephone follow-up; check his understanding of his own treatment and precautions.

Nursing · Return to study after concussion: negotiate graded cognitive activity

SPK-NUR-69 | Original simulated candidate card

Setting: Rehabilitation outpatient clinic, UK

In this original independent practice scenario, you are a rehabilitation nurse seeing Mrs Deepali Bendre, aged 47, one week after a diagnosed concussion. Today's clinician review found overall improvement, although prolonged reading still causes a mild headache and difficulty concentrating. She plans to study all night to catch up; the clinician recommends short reading sessions, quiet breaks, normal sleep and gradual increases that cause no more than mild, brief symptom worsening. You can arrange a telephone review with the same clinician in three days, provide the clinic's working-hours advice number and request course-support documentation with her permission.

Interlocutor: PATIENT

Your tasks

1. Find out how Mrs Bendre feels now, how reading affects her and what worries are driving her all-night study plan.

2. Explain how to adjust study to symptoms: mild, brief increases can be tolerated; greater increases mean pausing, resting and trying a shorter or easier task once settled.

3. Acknowledge her concerns and negotiate an alternative to studying all night: a manageable reading task, quiet breaks and normal sleep. Offer support with requesting course adjustments.

4. Explain when to seek help: persistent deterioration needs prompt clinic advice, or NHS 111 if unavailable; severe or progressively worsening headache or repeated vomiting needs urgent A&E assessment; a seizure, inability to stay awake or new weakness requires 999. Advise her not to drive herself to emergency care or wait for the review.

5. Agree her next study step and telephone review, then ask her to explain the plan and safety advice in her own words and invite questions.

Nursing · Ileostomy care: balancing partner support with patient privacy

SPK-NUR-70 | Original simulated candidate card

Setting: Postoperative ward

In this original independent practice scenario, you are a ward nurse speaking privately with Mr Evan Roden, aged 48, whose adult partner had surgery to form an ileostomy six days ago and is recovering well. Mr Roden wants to learn to perform every pouch change, but his partner wants to participate in her own care and begin today's stoma-nurse teaching without him present. She has authorised you to discuss her teaching preferences, privacy wishes and possible practical support with him, but not other clinical details. Today's teaching can include demonstration equipment and supervised practice at her pace; any later involvement by Mr Roden requires her agreement.

Interlocutor: RELATIVE

Your tasks

1. Explore why Mr Roden wants to perform every pouch change, what he has already observed and how he understands his partner's wishes.

2. Explain how supervised teaching can help his partner take part in pouch care at a manageable pace, with nursing help available.

3. Acknowledge his wish to help and encourage him to support her learning and privacy rather than take over.

4. Clarify that permission to discuss teaching does not permit attendance or hands-on assistance, and explore support he could offer within her chosen boundaries.

5. Agree a proposed arrangement for today's private teaching and any later involvement, subject to his partner's agreement, then check his understanding.

OET vocabulary and spelling list

Words to spell correctly in Listening Part A and in letters, grouped by profession. Cover the term, listen to it or say it aloud, write it, then check.

Nursing

Word	Note
haemorrhage	British haem-; double r, then silent h: haemorrhage.
oedema	British spelling begins oe-; swelling from fluid in tissues.
diarrhoea	British ending -rrhoea: double r, h, then o-e-a.
dyspnoea	Shortness of breath; British spelling ends -oea.
catheterisation	British -isation ending; 'catheter' has th, not t.
sphygmomanometer	Blood pressure cuff; starts s-p-h-y-g-m-o.
paediatric	British spelling keeps ae: paediatric, paediatrician.
anaesthetic	British ae: anaesthetic, anaesthetist.
pressure injury	Australian term; UK nurses often say pressure ulcer.
nil by mouth	NBM; no food or drink, usually before a procedure.