OET WRITING CORRECTION REPORT

Report #190 • Sub-Test: NURSING

STUDENT INFORMATION

Student	Not provided
Task	Discharge letter requesting ongoing stoma care and wound review (Nursing)
Patient	Mr Rangi Waititi, 67 years, married; discharged 31/05/2025 following emergency Hartmann's procedure for perforated diverticulitis
Recipient	Ms Eleanor Pike, Stomal Therapy Nurse, Community Nursing Service, 45 Antigua Street, Christchurch 8011
Word count	≈314 words (target: 180–200) — substantially over target (approximately 57% above the upper limit)
Source notes	Verified

SCORE COMPARISON

CURRENT SCORE	PROJECTED SCORE
303 /500	**395** /500
Grade C+	Grade B+

INDIVIDUAL CRITERIA SCORES

Purpose	Content	Conciseness & Clarity
3/3	**4**/7	**3**/7
Band 3	*Band 4*	*Band 3*
Genre & Style	**Organisation & Layout**	**Language**
5/7	**5**/7	**3**/7
Band 5	*Band 5*	*Band 3*

Scoring scale: Purpose is marked out of 3; all other criteria out of 7. Total = (sum of raw scores ÷ 38) × 500. Raw total here = 23 → 303/500 (Grade C+).

ASSESSMENT SUMMARY

This is a well-shaped letter written by a candidate who clearly understands what a community stomal therapy nurse is being asked to take on. The purpose is established in the opening two sentences — "He is being discharged today and requires ongoing stoma care and a wound review" — and it is then genuinely expanded, first through a detailed request paragraph and then through the closing appeal for "ongoing care and management". That two-part construction is exactly what Band 3 Purpose requires, and it is the strongest feature of the letter. The five-paragraph architecture is logical and easy to follow: introduction, background, postoperative course, nursing instructions, closing request. Nothing forces the reader to hunt. Several individual selections show real clinical judgement. Naming type 2 diabetes alongside a wound healing by secondary intention lets the reader reason about delayed healing without being told to. Carrying "has no known allergies" into the letter is precisely the item most candidates lose, and it is here. The distinction drawn between what Mr Waititi can do alone and what he cannot — "able to... empty his stoma bag, however, he requires supervision for a full appliance change" — is the single most useful sentence for a stomal therapy nurse planning her first visit, because it tells her exactly where to pitch the teaching. The ongoing nursing requirements are transferred in full and none is dropped: second-daily packing, weekly cavity measurement, stoma and peristomal monitoring, escalation criteria, supplies, support group, outpatient review. Signing with the role rather than a personal name correctly preserves OET anonymity, and the register throughout is polite, factual and free of personal opinion.

Three things hold the score down. First and most seriously, four of the five discharge medications are missing. Only metformin is named, and without a dose. A community nurse visiting a new colostomy patient every second day needs to know he is taking oxycodone 5 mg as required up to four times daily — an opioid that constipates, sedates and contributes to the fatigue the letter also omits — and that docusate with senna two tablets nocte is being used to keep the stomal output soft and formed. Paracetamol 1 g four times daily and perindopril 5 mg daily also bear on the escalation instructions, since perindopril and a high-output stoma together raise dehydration risk. Omitting the drug chart from a discharge handover leaves the receiving nurse unable to interpret the very deterioration she is being asked to detect. Second, the letter reports actions without their reasons. "Please refer him to a stoma support group for emotional support" arrives with no mention that Mr Waititi has been tearful on two occasions and states he feels "less of a man" — the instruction survives, but the clinical picture that makes it urgent does not. Likewise, the peristomal skin monitoring is requested, yet the 29/05 leak is reported only as a leak: the excoriation it caused, now improving, is absent, so the reader has no baseline for the skin she is being asked to watch. The wife's role is similarly stripped — Hine is unnamed, her observation of two appliance changes is unrecorded, and her anxiety about odour and night leakage is lost, though it is the reason the teaching must include her. Third, at roughly 314 words the letter is over half again its target while still omitting this material. The excess comes from eight consecutive sentences each beginning "Please", where grouped instructions would have done the same work in half the space. Language accuracy compounds it: reqiures, ongong, illiac, outout, aplliance, measuare, techniquea, indapendent, monito, sugical, wekks and Registred are all misspellings on one page. None obscures meaning, but the density creates the minor strain that fixes Language at Band 3.

CRITICAL ERRORS / AREAS FOR IMPROVEMENT

#	ERROR	IMPACT
1	Four of five discharge medications omitted — ~~He is currently taking metformin for his diabetes~~ → **Discharge medications: paracetamol 1 g four times daily; oxycodone immediate release 5 mg as required, maximum four doses daily; docusate with senna two tablets nocte; metformin 500 mg twice daily; perindopril 5 mg once daily**	The community nurse is asked to detect high output and dehydration but is not told the patient is on an opioid that constipates and sedates, an aperient that softens stomal output, or an ACE inhibitor that compounds dehydration risk. Without the drug chart she cannot interpret a change in output or a drop in alertness. Metformin is named without a dose, which is not a usable medication record.

#	ERROR	IMPACT
2	Psychological distress omitted — support group referral given without its reason — ~~Please refer him to a stoma support group for emotional support.~~ → **Mr Waititi has been tearful on two occasions and states he feels "less of a man" since surgery; emotional support and referral to a stoma support group are recommended.**	A referral instruction without its rationale cannot be prioritised. The distress is a documented, quoted finding in a man with a new permanent-appearing stoma awaiting reversal discussion, and it directly affects his willingness to learn appliance changes. Stripped of the reason, the reader may treat the referral as routine paperwork rather than an active clinical need.
3	Peristomal skin excoriation following the 29/05 leak omitted — ~~On 29/05 , he reported that the stoma bag had leaked.~~ → **One leakage episode on 29/05 caused peristomal skin excoriation, which is now improving.**	The letter asks the nurse to monitor peristomal skin integrity but gives her no baseline against which to judge it. Excoriated skin in a diabetic patient with a fresh stoma is the commonest cause of appliance failure and recurrent leaking. Without the finding, deterioration on the first visit could be mistaken for a new problem rather than a relapse.
4	Wife Hine's carer role and specific anxieties omitted — ~~Mr. Waititi lives with his wife and is retired.~~ → **His wife Hine (64) will assist with his care; she has observed two appliance changes and is anxious about odour and leakage at night.**	The letter instructs the nurse to reinforce technique "with him and his wife" but never identifies her, states how far her training has progressed, or names her specific fears. The stomal therapy nurse would arrive without knowing whom she is teaching, at what stage, or which two concerns must be addressed first to prevent carer breakdown at home.
5	Dietitian review and supplement drinks omitted alongside the 6 kg weight loss — ~~During his hospital stay , he lost 6 kg.~~ → **He lost 6 kg during admission; the dietitian has reviewed him and supplement drinks have been commenced.**	A 6 kg unintentional loss reported with no accompanying management implies nutrition is unaddressed, and the community nurse may duplicate a referral already made. More importantly, protein-energy deficit directly delays healing of a 2 cm wound cavity by secondary intention, so the reader needs to know supplementation is already running and requires monitoring rather than initiation.

KEY AREAS FOR IMPROVEMENT

AREA	PRIORITY	RECOMMENDATION
Discharge medication list	**HIGH**	Never send a nursing discharge letter without the full drug chart. Set the list out on its own line with drug, dose, route where relevant and frequency for every item. Here that is paracetamol 1 g QDS, oxycodone IR 5 mg PRN (max four daily), docusate with senna two tablets nocte, metformin 500 mg BD and perindopril 5 mg daily. Five drugs cost you under thirty words.
Carry the reason with the action	**HIGH**	Every instruction you transfer from the plan should travel with the finding that generated it. Support group referral travels with the tearfulness and the quoted "less of a man". Peristomal skin monitoring travels with

AREA	PRIORITY	RECOMMENDATION
		the 29/05 excoriation. Appliance teaching travels with Hine's two observed changes and her fear of night leakage. Pair them and your Content rises without your word count doing so.
Length and summarising	**HIGH**	You wrote roughly 314 words for a 180–200 word task while still omitting the drug chart. Eight sentences beginning "Please" is the culprit. Group them: "Please redress the wound second-daily, measure the cavity weekly, and monitor stoma colour, output and peristomal skin, escalating high output, dehydration or wound deterioration to the surgical team." One sentence, four instructions, forty words saved.
Spelling accuracy	**MEDIUM**	Twelve misspellings appear on one page: reqiures, ongong, illiac, outout, aplliance, measuare, techniquea, indapendent, monito, sugical, wekks, Registred, plus Chrischurch in the recipient's address. None changes meaning, but the density holds Language at Band 3. Budget ninety seconds at the end purely for a spelling sweep of clinical nouns and the address block.
Layout conventions	**MEDIUM**	Add a date line beneath the recipient's address — 31 May 2025 — because a discharge letter without a date cannot be filed against the episode. Also close the gap in "Ms.Pike", remove the spaces before commas in "On 29/05 ," and "hospital stay ,", and delete the double space in "for a full". These are Organisation marks, not Language ones.
Purpose framing and role signature — protect this	**LOW**	Your opening states the request in two sentences and your closing expands it, which is exactly what Band 3 Purpose requires; keep that shape. Signing "Registered Nurse, Colorectal Surgical Ward" rather than a personal name correctly preserves anonymity. Change only "refer" to "hand over the care of", since this is a discharge handover, not a specialist referral.

CORRECTED LETTER WITH ANNOTATIONS

~~Ms.~~**Ms** Eleanor Pike *[British convention omits the full stop after Ms and Mr — a minor layout point applying throughout the letter]*

Stomal Therapy Nurse

Community Nursing Service

45 Antigua Street

~~Chrischurch 8011, New Zealand~~**Christchurch 8011, New Zealand** *[the recipient's city is misspelt — marked under Organisation & Layout, not Language]*

[no date line — a discharge letter must carry its date, 31 May 2025, so the receiving service can file it against the episode; no text supplied here, see Key Areas]

Dear ~~Ms.Pike,~~**Ms Pike,**

Re: Mr~~.~~ Rangi Waititi✓ *[good — a clear Re: line naming the patient at the top of the page]*

Age: 67 years ~~old~~

I am writing to ~~refer~~**hand over the care of** *[this is a discharge handover to a community service, not a specialist referral; the verb should match the genre]* Mr Waititi, who is recovering from a Hartmann's procedure. He is being discharged today and ~~reqiures ongong~~**requires ongoing** stoma care and a wound review.✓ *[the purpose is apparent within two sentences — exactly the early statement Band 3 Purpose requires]*

Mr Waititi lives with his wife *[CRITICAL — his wife Hine (64) is the designated carer, has observed two appliance changes and is anxious about odour and night leakage; that belongs here — see Critical Errors #4. No text supplied.]* and is retired. He was admitted to hospital on 18/05/2025 and underwent a Hartmann's procedure for perforated diverticulitis on 19/05/2025. *[the notes specify an emergency Hartmann's — the urgency is worth preserving]* He has a medical history of type 2 diabetes, hypertension and diverticular disease.✓ *[well selected — diabetes is directly relevant to a wound healing by secondary intention]* He is currently taking metformin for his diabetes *[CRITICAL — metformin appears without a dose and the other four discharge medications are absent entirely; see Critical Errors #1. No text supplied.]* and has no known allergies.✓ *[excellent — the nil-known-allergies statement is the single most omitted item across our marked scripts and you have carried it across]*

Post-operatively, he stayed in the high dependency unit for two ~~night~~**nights**. On day 6, his wound became infected and he was prescribed ~~Flucloxacillin~~**flucloxacillin** for seven days. *[the swab grew Staphylococcus aureus — naming the organism matters if the wound deteriorates in the community]* His wound is healing by secondary intention with a 2 cm cavity and measures 14 cm. *[the notes specify secondary intention at the lower third only]* The end colostomy is located in the left ~~illiac~~**iliac** fossa. The stoma is pink, with an ~~outout~~**output** of 400–600 mL daily. *["budded", and output described as soft and formed, are omitted — both are baseline descriptors the stomal therapy nurse will compare her own findings against]* He is able to mobilise independently and empty his stoma bag, however, he requires supervision for~~–~~ a full ~~aplliance~~**appliance** change.✓ *[the most useful sentence in the letter — distinguishing independent emptying from supervised appliance change tells the reader exactly where to pitch her teaching. The fatigue and twice-daily rests are omitted, though, and they affect visit timing.]* On ~~29/05 ,~~**29/05,** he reported that the stoma bag had leaked. *[CRITICAL — the leak caused peristomal skin excoriation, now improving; without it your later instruction to monitor peristomal skin has no baseline — see Critical Errors #3. No text supplied.]* During his hospital ~~stay ,~~**stay,** he lost 6 kg. *[the dietitian review and the supplement drinks already commenced are omitted — see Critical Errors #5. No text supplied.]*

Please change the wound packing and dressing every second day and ~~measuare~~**measure** the cavity weekly. Please provide him and his wife with information on appliance changing ~~techniquea until he become indapendentt~~**technique until he becomes independent**. Please continue to ~~monito~~**monitor** the stoma colour, output volume and peristomal skin integrity. Please inform the ~~sugical~~**surgical** team immediately if you notice high output, dehydration or wound deterioration.✓ *[good — every item of the ongoing nursing requirements has been transferred; nothing from the plan has been dropped]* Please remind him that he has been provided with two ~~wekks~~**weeks** of stoma supplies and that the ordering process has been explained. Please refer him to a stoma support group for emotional support. *[CRITICAL — the reason is missing: he has been tearful on two occasions and states he feels "less of a man" — see Critical Errors #2. No text supplied.]* Please remind him of his surgical outpatient review scheduled for 21/06/2025, ~~when stoma reversal will be discussed at six months~~**and reversal will be discussed at six months** *[as written, the two events are conflated: the review is on 21/06/2025, whereas reversal is to be discussed at six months — separate timepoints]* *[eight consecutive sentences beginning "Please" — grouping these into two or three sentences would recover around forty words for the missing drug chart]*

In view of the above, it would be greatly appreciated if you could provide ongoing care and management for Mr Waititi.✓ *[a courteous closing that expands the opening request — this is what lifts Purpose to Band 3]*

Yours sincerely,

~~Registred~~**Registered** Nurse✓ *[correct — signing with the role rather than a personal name preserves OET anonymity]*

Colorectal Surgical Ward

Christchurch Hospital

2 Riccarton Avenue

Christchurch 8011, New Zealand

Key: ~~red strikethrough~~ = error to remove / ✓ = strength to keep | **green bold** = correction | blue superscript = examiner note | corrected line-by-line in the student's own order

DETAILED ERROR ANALYSIS

ORIGINAL	CORRECTED	ERROR TYPE	SEVERITY
He is currently taking metformin for his diabetes	**Discharge medications: paracetamol 1 g four times daily; oxycodone IR 5 mg as required, maximum four doses daily; docusate with senna two tablets nocte; metformin 500 mg twice daily; perindopril 5 mg once daily**	Content omission — discharge drug chart absent; metformin given without dose	**Critical**
Please refer him to a stoma support group for emotional support.	**He has been tearful on two occasions and states he feels "less of a man" since surgery; emotional support and stoma support group referral are recommended.**	Content omission — instruction transferred without its clinical rationale	**Critical**
On 29/05 , he reported that the stoma bag had leaked.	**One leakage episode on 29/05 caused peristomal skin excoriation, now improving.**	Content omission — consequence of the leak removed, leaving skin monitoring without a baseline	**Critical**
Mr. Waititi lives with his wife and is retired.	**His wife Hine (64) will assist with care; she has observed two appliance changes and is anxious about odour and night leakage.**	Content omission — carer identity, training stage and specific concerns absent	**Critical**
when stoma reversal will be discussed at six months	**and reversal will be discussed at six months**	Accuracy — the 21/06/2025 review and the six-month reversal discussion conflated into one event	**Critical**
reqiures, ongong, illiac, outout, aplliance, measuare, techniquea, indapendent, monito, sugical, wekks, Registred	**requires, ongoing, iliac, output, appliance, measure, technique, independent, monitor, surgical, weeks, Registered**	Spelling — twelve errors on one page; meaning preserved but cumulative strain	**Minor**
Chrischurch 8011 / Dear Ms.Pike, / On 29/05 , / hospital stay , / for a full / no date line	**Christchurch 8011 / Dear Ms Pike, / On 29/05, / hospital stay, / for a full / 31 May 2025**	Layout — recipient's city misspelt, spacing faults, date line absent (Organisation & Layout)	**Minor**
for two night ... until he become indapendent	**for two nights ... until he becomes independent**	Grammar — plural agreement and subject–verb agreement	**Minor**

ORIGINAL	CORRECTED	ERROR TYPE	SEVERITY
≈314 words; eight consecutive sentences beginning "Please"	**180–200 words with the plan grouped into two or three combined instructions**	Conciseness — over target by 57% while key content is omitted; summarising only partially successful	**Minor**
and has no known allergies	**Retained as written**	Content — nil-known-allergy statement correctly carried into the letter	**Positive**
He is able to mobilise independently and empty his stoma bag, however, he requires supervision for a full appliance change.	**Retained as written**	Content — precise self-care baseline; tells the reader exactly where teaching must begin	**Positive**
He is being discharged today and requires ongoing stoma care and a wound review. ... In view of the above, it would be greatly appreciated if you could provide ongoing care and management	**Retained as written**	Purpose — early statement plus later expansion, the full two-part Band 3 requirement	**Positive**
Registered Nurse / Colorectal Surgical Ward / Christchurch Hospital	**Retained as written**	Genre — role signature preserves OET anonymity; polite, factual register maintained throughout	**Positive**

MODEL LETTER — BAND A

Ms Eleanor Pike

Stomal Therapy Nurse

Community Nursing Service

45 Antigua Street

Christchurch 8011

31 May 2025

Dear Ms Pike,

Re: Mr Rangi Waititi, aged 67 — discharge 31/05/2025

I am writing to request ongoing stoma care and wound review for Mr Waititi, discharged today after an emergency Hartmann's procedure on 19/05/2025 for perforated diverticulitis. He has type 2 diabetes and hypertension, and no known allergies.

A day-6 Staphylococcus aureus wound infection was treated with flucloxacillin for seven days. The 14 cm midline wound is healing by secondary intention, cavity 2 cm. His end colostomy (left iliac fossa) is pink and budded, output soft and formed, 400–600 mL daily. A leak on 29/05 caused peristomal excoriation. He lost 6

kg; supplements were started. He mobilises independently but tires quickly.

Discharge medications: paracetamol 1 g QDS; oxycodone 5 mg PRN, maximum four daily; docusate with senna two tablets nocte; metformin 500 mg BD; perindopril 5 mg daily.

Please redress the wound second-daily, measure the cavity weekly, and monitor stoma colour, output and peristomal skin; escalate high output, dehydration or wound deterioration to the surgical team. Reinforce appliance technique with Mr Waititi and his wife Hine, who is anxious about odour and night leakage. He has been tearful, feeling "less of a man"; emotional support and a support group referral are advised. Two weeks' supplies were provided. Outpatient review is 21/06/2025.

Yours sincerely,

Registered Nurse

Colorectal Surgical Ward

Christchurch Hospital

SCORE IMPROVEMENT GUIDE

TIP 1: Protect your purpose framing

Your opening two sentences and your closing request together satisfy both halves of the Purpose criterion, which is why you scored the full three marks there. Many candidates open well and then let the letter drift to a stop. You did not. Keep this shape in every letter: state the request immediately, then expand it into something specific at the close. Change only "refer" to "hand over the care of", since this is a discharge, not a referral.

TIP 2: Never omit the drug chart from a nursing discharge

You gave the community nurse escalation criteria for dehydration and high output, then withheld the oxycodone, the docusate with senna and the perindopril that bear directly on both. Set discharge medications out as their own short block: drug, dose, frequency, one after another. Five drugs cost you fewer than thirty words, and they are the words the receiving nurse will read first when she plans her visit.

TIP 3: Attach the finding to the instruction

Three of your requests arrived without the evidence behind them. Monitor peristomal skin — because a leak on 29/05 excoriated it. Refer to a support group — because he has been tearful twice and feels "less of a man". Teach the wife — because Hine has watched only two changes and fears night leakage. Pair each action with its finding and your Content band rises without your word count moving at all.

TIP 4: Group your instructions into fewer sentences

Eight sentences beginning "Please" pushed you to roughly 314 words for a 180–200 word task. Combine them: "Please redress the wound second-daily, measure the cavity weekly, and monitor stoma colour, output and peristomal skin, escalating high output, dehydration or wound deterioration to the surgical team." That single sentence carries four of your eight requests and frees the forty words the medication list needed. Conciseness is about summarising, not deleting.

TIP 5: Sweep for spelling and layout separately

Twelve misspellings appear here, including the recipient's own city as "Chrischurch". None changes meaning, but density alone fixes Language at Band 3. Reserve the final ninety seconds for two passes: one reading only clinical nouns and drug names, one reading only the address block, date line, salutation and Re: line. Add the date, 31 May 2025 — a discharge letter without one cannot be filed against the episode.

TIP 6: You are closer to B+ than the score suggests

The architecture, the plan transfer, the allergy statement and the self-care baseline are all already at the standard required. What you are missing is a medication block and three short clauses of rationale — perhaps fifty words in total, comfortably affordable once the eight "Please" sentences are grouped. Make those two changes and clean the spelling, and this letter sits at approximately 395, a solid B+.

EXAMINER COMMENT

EXAMINER COMMENT

This is a genuinely competent discharge handover from a candidate who understands the receiving nurse's job. Your purpose is apparent within two sentences and expanded at the close, earning full marks on that criterion. The five-paragraph structure is logical, the register is polite and clinical throughout, the entire ongoing nursing plan is transferred without loss, the nil-known-allergies statement is present — the item most often dropped — and your sentence distinguishing independent bag emptying from supervised appliance change is precisely what a stomal therapy nurse needs before her first visit. Signing with your role rather than a name is correct. What holds the letter at Grade C+ is the combination of a missing drug chart and instructions sent without their reasons. You ask Ms Pike to escalate high output and dehydration, yet withhold the oxycodone, the docusate with senna and the perindopril that shape both. You ask her to monitor peristomal skin without telling her the 29/05 leak excoriated it, and to arrange a support group referral without mentioning the tearfulness or the quoted "less of a man". Hine is never named. Meanwhile the letter runs to some 314 words against a 180–200 target, because eight successive sentences each begin "Please" — the space for the missing material was there. For your next draft, do one thing: write the medication block first, before anything else, then group the plan into three sentences. That single discipline lifts this letter into B+ territory. — Dr Nasir Academy Assessment Team

— Dr Nasir Academy Assessment Team