Bronchiectasis after an exacerbation: discharge

Original independent practice. The patient details, observations and individual care arrangements are fictional. Assume that today's date is 3 November 2026. Mr Ropata is returning to his aged care facility today. Allow 45 minutes: 5 minutes reading and 40 minutes writing. You are a registered nurse on the respiratory ward. Using the case notes, write to Ms Hinemoa Poutama, the residential care nurse, handing over Mr Ropata's changed sputum-clearance support needs and escalation plan. Address the letter to Ms Hinemoa Poutama, Residential Care Nurse, Residential Care Nursing Office, 26 High Street, SW19 1AA, United Kingdom. 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.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Mr Hone Ropata	☐	☐	☐
2. DOB: 19/06/1942 (84 yrs)	☐	☐	☐
3. Admitted 21/10/26; discharge 03/11/26	☐	☐	☐
4. Resident: aged care facility, 26 High Street, SW19 1AA, UK	☐	☐	☐
Social background and pre-illness routine			
5. Staff administer medicines and assist with washing	☐	☐	☐
6. Before illness: small amount pale sputum; coughed it up unaided	☐	☐	☐
7. Previously completed daily breathing exercises independently; no nursing prompts	☐	☐	☐
8. Daughter visits weekly; aware of planned return	☐	☐	☐
9. Prefers sitting in chair rather than lying for exercises	☐	☐	☐
10. Complained about another resident's visitors; asks nurse to confront them	☐	☐	☐
Medical history			
11. Bronchiectasis diagnosed 2018; respiratory team follow-up	☐	☐	☐
12. Hearing impairment; hearing aids improve ability to follow instructions	☐	☐	☐
13. Cataract surgery 2021; no current eye symptoms	☐	☐	☐
14. Never smoked; no home oxygen	☐	☐	☐
Admission and treatment			
15. 21/10: fever, ↑ breathlessness and ↑ sputum → admission	☐	☐	☐
16. Sputum sent for culture; antibiotic course completed 03/11	☐	☐	☐
17. Initially tired; struggled to cough sputum out without help	☐	☐	☐
18. 30/10: respiratory physiotherapist retrained active cycle of breathing technique	☐	☐	☐
Admission and treatment			
19. Taught sequence: upright sitting → relaxed breaths → deeper breaths → relaxed breaths → huff/cough as needed	☐	☐	☐
20. Rest with relaxed breathing between active stages; avoid forceful repeated coughing	☐	☐	☐
Current progress			
21. 02/11: clears sputum better with prompting; still omits steps independently	☐	☐	☐
22. 03/11: afebrile; breathlessness at baseline; no supplemental oxygen	☐	☐	☐
23. Sputum now smaller amount and paler than on admission	☐	☐	☐
24. Walking to dining room with frame; rests when tired	☐	☐	☐
Documented individual discharge plan			
25. Discharge plan: nurse supervises/prompts exercises daily, including when cough improves	☐	☐	☐
26. Record sputum amount/colour and changes in breathlessness	☐	☐	☐
27. Urgent GP assessment if no ambulance criteria below: fever, ↑ breathlessness/sputum, or blood confined to a few spots/streaks in sputum	☐	☐	☐
28. Call ambulance: severe breathing difficulty; blood exceeding a few spots/streaks; any blood with breathing difficulty, chest/upper back pain or very fast heartbeat. Ambulance criteria take priority regardless of blood amount	☐	☐	☐
29. Physiotherapy review booked 10/11; facility to facilitate attendance	☐	☐	☐
30. No rescue antibiotics prescribed; seek medical assessment for deterioration	☐	☐	☐
31. Appetite improved; usual meals and drinks resumed	☐	☐	☐