Stroke with expressive aphasia: discharge

Assume that today's date is 5 November 2026. Mr Adebiyi Babtunde is being discharged home this afternoon. This is an original independent practice task. Allow 45 minutes: 5 minutes for reading and 40 minutes for writing. You are a registered nurse on a stroke unit. Using the case notes, write a discharge letter to Ms Wuraola Ogunbo, Stroke Early-Supported-Discharge Nurse, Home Rehabilitation Service, 24 Park Road, SW1V 2RF, United Kingdom. Request continued home rehabilitation, explaining Mr Babtunde's communication and assistance needs and the documented assessment of his capacity regarding discharge. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

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 Adebiyi Babtunde	☐	☐	☐
2. DOB: 12/03/1958 (68 yrs)	☐	☐	☐
3. Home: 18 Park Road, SW1V 2RF, United Kingdom	☐	☐	☐
4. Admitted 24/10/26; discharge home 05/11/26	☐	☐	☐
Social background			
5. Lives with wife; available throughout initial recovery	☐	☐	☐
6. Previously independent; retired accountant	☐	☐	☐
7. Enjoys gardening and radio quizzes	☐	☐	☐
8. Daughter's private financial dispute discussed with staff	☐	☐	☐
Medical history			
9. Hypertension; hypercholesterolaemia	☐	☐	☐
10. Appendicectomy 1980; no ongoing problems	☐	☐	☐
Assessment and communication			
11. 24/10: left hemispheric ischaemic stroke	☐	☐	☐
12. Initially R arm weakness + marked word-finding difficulty	☐	☐	☐
13. 05/11: expressive aphasia persists; short phrases, gestures	☐	☐	☐
14. SLT: understands short spoken sentences; lengthy explanations difficult	☐	☐	☐
15. SLT plan: quiet setting; one short question; allow response time; do not finish sentences	☐	☐	☐
16. SLT plan: picture board/gestures; confirm intended meaning; board supplied	☐	☐	☐
17. Reading: single familiar words; paragraphs difficult	☐	☐	☐
Assessment and communication			
18. 04/11 supported assessment: understood, retained/weighed home-discharge options; communicated choice by pointing; capacity for this decision documented	☐	☐	☐
19. Patient requests direct involvement; wife may support, not answer automatically	☐	☐	☐
20. Frustrated when rushed; settles with time	☐	☐	☐
Treatment and progress			
21. Independent bed/chair transfers, toileting and indoor walking; no aid	☐	☐	☐
22. Home assessment: level access; shower chair installed	☐	☐	☐
23. OT plan: wife assists showering, upper-body dressing and hot-meal preparation; R hand remains weak	☐	☐	☐
24. Wife demonstrated agreed assistance safely	☐	☐	☐
25. Regular diet, normal fluids; independently feeds himself	☐	☐	☐
26. Fatigue ↑ after lengthy conversations; prefers morning visits	☐	☐	☐
Discharge plan			
27. Home rehabilitation accepted; patient agrees	☐	☐	☐
28. SLT home visit booked 06/11; continue communication practice	☐	☐	☐
29. Nursing visit agreed 06/11: review assistance arrangements, reinforce communication strategies, coordinate rehabilitation goals with patient	☐	☐	☐
30. Patient's goal: express daily needs independently	☐	☐	☐
31. Complained that ward television programmes were boring	☐	☐	☐
32. Team safety advice: sudden new/worsening face weakness, arm weakness or speech difficulty → call 999 immediately, even if transient	☐	☐	☐

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