Robert Smith is a 66 year old man who lives with his wife in a three bedroomed mid terraced house. He is a retired electrician.

He has a past medical history of COPD and hypertension.

He was referred to Hospital X MAU by his GP and subsequently admitted on the 15th April 2016. He had a 3 day history of increasing breathlessness, wheeze and a cough productive of yellow sputum. He had a low grade temperature of 37.7 degrees Celsius on admission.

His CXR showed hyperinflated lungs consistent with COPD but no consolidation. His CRP was raised at 57 but his WBC was normal. His SpO2 was 96% on room air.

He was treated for an infective exacerbation of COPD and received nebulised salbutamol and ipratropium bromide for 24 hours, oral prednisolone and began a course of doxycycline.

Following initial assessment on the MAU he was transferred to Ward Z at Hospital X under the care of Dr Brown, Consultant in Acute Medicine.

His medications on admission were:

Salbutamol 100 micrograms 2 puffs, inhaled PRN
Beclomethasone 100 micrograms 2 puffs BD
Amlodipine 5mg OD

He reported a previous allergy to Penicillin, experienced more than 20 years ago, causing a widespread rash.

During his admission the Beclomethasone was stopped and replaced by Symbicort. His amlodipine was increased to 10mg OD as his BP was persistently elevated.

He made a rapid improvement, did not require any nebulised treatment on day 2 of his admission and was therefore discharged home on the evening of 16th April 2016.

His medication on discharge was

Salbutamol 100 micrograms 2 puffs, inhaled PRN
Symbicort 200/6 dry powder inhaler T BD
Prednisolone 30mg OD for 3 days
Doxycycline 100mg OD for 5 days
Amlodipine 10mg OD

No hospital follow up has been arranged but a referral was sent to the community COPD Specialist Nurse who will arrange to visit him in the next week.

His GP was asked to review his BP a week after discharge.