



HOME BLOOD PRESSURE MONITORING

REASONS FOR THE PROJECT

- High blood pressure was identified by The National Stroke Service Model 2021 as a major risk factor to health and is a national prevention priority under the Core20PLUS5.
- Recent National Clinical Guidelines for stroke¹ recommendations make reference to the need for long term prevention management including blood pressure as it's estimated to cause 50% of ischaemic strokes.
- Overall, a 10 mmHg reduction in systolic BP reduced the risk of cardiovascular disease by 20% and stroke by 27% (Ettehad et al, 2016).²
- It aids continuity of care for the patient in partnership with healthcare professionals and influences patients to take ownership of their own health in their own environment.
- It provides a MDT approach to supporting blood pressure management as well as being cost effective e.g. reduces amount of GP appointments.

PROJECT ACTIONS

- 7 community stroke services across the East Midlands participated in a 12 month programme
- After hospital discharge, patients receive a comprehensive assessment. If high blood pressure is detected, the patient is informed of the risk associated with hypertension and invited to join the home blood pressure monitoring program.
- Patient is loaned a calibrated machine and provided a recording sheet, information and contact details.
- This program involves monitoring blood pressure over four days and liaising with the patient's GP to review medication where necessary.
- This process will be repeated for up to seven cycles where necessary to bring BP within recommended limits.
- Where possible patients are recommended to purchase their own monitor to continue long term management.

Demographics

Of the 887 patients who joined the programme



58.1% patients were male, 41.2% were female and 0.7% patient did not provide information.



75.7% patients were 60 or older, 23.1% were under the age of 60 and 1.2% patient did not provide information.



69.1% patients were white, 4.7% were Asian, 1.5% were Black, African, Caribbean or Black British, 0.7% patient were of Mixed /Multiple ethnicity and 24% did not provide information.

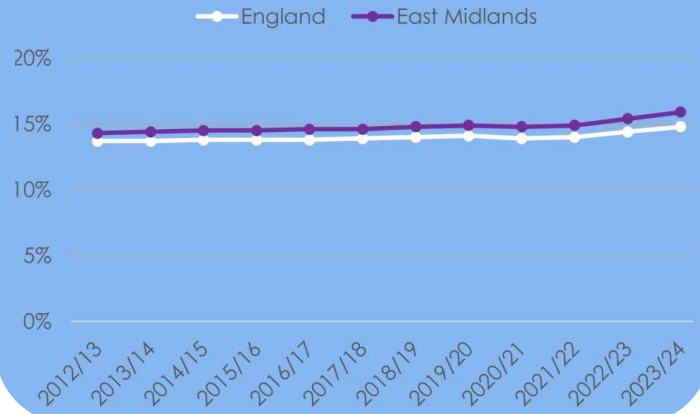


10.7% patients had previously diagnosed atrial fibrillation, 83.8% did not have AF and 5.5% did not provide information.

PATIENT FEEDBACK

"Understanding more about how I can check my blood pressure has helped me to feel more in control of managing something that might cause me to have another stroke. It is so hard to get into see a doctor, so I think this may not have been checked otherwise"

East Midlands Region - QOF Hypertension



28%

East Midlands responders to PREMS³ (Patient Related Experience Measures) would like advice and support with monitoring their blood pressure independently.

Audit Results

1236 patients had a reading at their comprehensive assessment.



887

patients were identified and joined the programme.



75

patients were found to have dangerously high hypertension needing immediate action.



658

patients were hypertensive after the first week of BP@Home readings.



411

patient's GP were contacted by their community team



148

patients were discharged to GP by the community team



54%

of patients were discharged after 1 cycle in the programme



4.5%

of patients were part of the programme for the full 7 cycles



10.5

mmHg is the average reduction in the systolic blood pressure across the BP@Home programme