BROMLEY BP@HOME PROTOCOL FOR FIRST APPOINTMENT

Benefits of using this protocol:

- Consistent, evidence-based approach across Borough
- Ensures flexibility for practices to use clinical or non-clinical staff and give non-clinical staff confidence to engage with patients
- Opportunity for healthy lifestyle promotion independent of engagement with BP@home project
- Opportunity to update patient information
- Provide standard information to patients, yet allowing production of customised information pack tailored to patient needs

Resource Pack:

- BP@Home List of approved patient information sources including video links:
  - https://www.nhs.uk/better-health/
  - Join the Movement | Sport England – direct link to exercise at home
  - https://www.bhf.org.uk/informationsupport/support/healthy-living
  - Manage your blood pressure at home - British Heart Foundation (bhf.org.uk)
- Motivational interviewing for BP@home summary sheet
- NICE Guideline PH49 Behaviour change: individual approaches
- Printed physical activity infographics for adults, disabled adults, pregnant & postpartum women: https://www.gov.uk/government/publications/physical-activity-guidelines-infographics
- Appendix 1 – Flow chart
- Appendix 2 – Reducing salt in your diet
- Appendix 3 – Alcohol chart
- Appendix 4 – Weight management pathway
- Appendix 5 – RAG chart
- Appendix 6 – Health coaching information

FIRST APPOINTMENT CONVERSATION PROTOCOL

Activate Bp @ Home template

Intro section - Beginning the conversation

- Introduce self, role and practice/PCN details.
- Confirm patient ID.
- Confirm today's appointment is to discuss BP and why – e.g. patient on meds/previous high readings.
- Check demographics – smoking & alcohol status, ethnicity if not recorded.
- Did you bring your own blood pressure monitor with you today?

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Section 1 – Blood pressure conversation

Section 1a – Blood pressure knowledge

- Explore what patient understands about blood pressure and why good control is beneficial.
- Open questions:
    - "What do you already know about high blood pressure and why it requires treatment?"
- If patient has incorrect/insufficient knowledge, ask permission to educate – refer to patient education leaflets and videos.
- Ensure patient understands that if BP is controlled in normal range via medication, this still means they have a diagnosis of high blood pressure.

1b – Medication compliance

- If patient on medication, explore compliance with open questions e.g. "many people find it difficult to remember to take pills every day, how do you find it?"
- If patient struggles with medication compliance, deliver brief intervention using motivational interviewing techniques to encourage patient to identify barriers to medication compliance and find solutions to these barriers.
- If patient has queries about their medication, offer appointment with pharmacist/nurse as appropriate for your practice.

Check for any questions before moving on to next section.

Section 2 – Lifestyle intervention conversation

"A healthier lifestyle can also contribute to maintaining good blood pressure. Even a couple of simple changes can have significant benefit. Are you interested in briefly discussing these?

If patient not interested – "you will find a leaflet on healthy lifestyle in your information pack" and move to section 3.

2a – Weight management and diet

- Briefly describe how healthy eating reducing salt intake etc. benefits blood pressure and also reduces risk of developing other chronic diseases.
- Salt intake awareness - https://www.bhf.org.uk/informationsupport/support/healthy-living/healthy-eating/salt; Appendix 1
- Simple diet improvements: increase fruit and vegetable intake, decrease intake of ultra-processed food, change to healthier snacks, increase fluid intake.
- Ask permission to weigh and measure height if no recent BMI recorded.
- If patient overweight, mention that whilst preventing further increase is beneficial, losing just 5% body weight loss also significantly reduces long-term risk of disease.
- If have recent weight, calculate how many lbs/kgs is required for 5% weight loss.
- With permission, use motivational interviewing approach for a brief intervention on diet improvement and weight loss.
- Is this person sufficiently motivated to engage in a weight loss programme? If yes, refer to appropriate weight management services.

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2b – Physical activity

- Introduce regular physical activity as helpful to managing blood pressure and general health using appropriate NHS physical activity infographic leaflet.
- Explore patient's current level of physical activity.
- If appropriate offer brief intervention on physical activity, supported by https://www.nhs.uk/better-health/get-active/.

2c – Smoking

- If patient smokes, introduce stopping as helpful to managing blood pressure and general health. https://www.nhs.uk/better-health/quit-smoking/
- If appropriate, use motivational interviewing approach for brief intervention on smoking cessation including information on how to self-refer to smoking cessation service.

2d – Alcohol

- If patient drinks alcohol explore their understanding of recommended weekly intake and alcohol content of their usual drinks, linking remaining within the guidelines as helpful to managing blood pressure and general health. https://www.nhs.uk/better-health/drink-less/ Appendix 2.
- If appropriate, use motivational interviewing approach for brief intervention on alcohol reduction and including information on how to self-refer for support.
- If patient advises that drinks regularly >30 units per week, advise against stopping suddenly without professional support and seek advice from clinician

Check for any questions before moving on to next section.

Section 3 – Introduce the BP@home service

3a – Potential benefits of BP monitoring

- Taking your blood pressure at home regularly has been shown to help many people manage their blood pressure better.
- This practice is offering a service to support you with this which involves sending in your results to us every so often. We will then contact you to advise you whether to carry on as you are or to see a healthcare professional to review you and possibly adjust your medication.

3b – What is involved in BP@home

- You will take your blood pressure at home X times per day/week and send the results back to us. Explore how patient would like to send results back: accurx texts, email, telephone appointment, f2f appointment (if appropriate)
- If they are within the target range we will text you back/call you and ask you to send results again in X weeks.

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- If you results are outside the target range they will be reviewed by a qualified health care professional, who will decide whether or not you need to come in for a review and we will text/call you to arrange this.
- We may ask you to send in your result more or less often depending on the readings you send us.
- If you have any questions at any time you will be able to contact me by emailing the practice to request a support call.
- Would you like to take part in this?
- If no, offer information pack and open offer to return

Section 4 – Details of BP@Home

4a– Blood pressure monitoring

- Do you have a blood pressure monitor at home and did you bring it with you?
- Check that monitor is on approved list and less than 5 years old.
- Measure patient's arm circumference to check cuff correct size.
- If no monitor or unsuitable/cuff wrong size, tell patient that practice will provide monitor.

4b– Demonstration

- Demonstrate how to use BP monitor – advise can text/email BHF video and link also in info pack.
- Manage your blood pressure at home - British Heart Foundation (bhf.org.uk)
- Demonstrate how to record results on recording sheet (record lowest of 3 measurements) - advise details and blank sheets in info pack.
- You can then email or text us your results. For your first set of home readings, I can call

4c– Results review system

- The results you send us will be coded Red, Amber or Green according to whether they are within your target range or not. Your qualified health professional may set your personal target BP readings in a different range than the standard target of 120/80 that you see in the information leaflets.
- Green means your blood pressure readings are satisfactory. We will contact by text or email to confirm this and state when you should next send your readings in.
- If your readings are amber or red, your qualified health professional will decide whether you should increase how often you take readings, or if you need medication adjusted, or to come in for an appointment. We will contact you to advise you what to do.
- If you are unable to get a BP reading on your monitor, please contact the surgery for advice.

Section 4 – Book follow up appointment

- Give customised information pack +/- monitor with correct cuff size.
- Agree results schedule and method of sending them in.
- Book follow up telephone/F2F appointment to go through first set of BP readings.
- Ask patient if they have any questions.
- Advise patient "You can email me with any queries you have or to request a telephone or face to face appointment if you feel you need more support".

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After patient leaves:

Complete BP@Home template on EMIS.
Make diary entry to follow up
Code any advice given or referrals made not included on template.
Complete and code any referrals.

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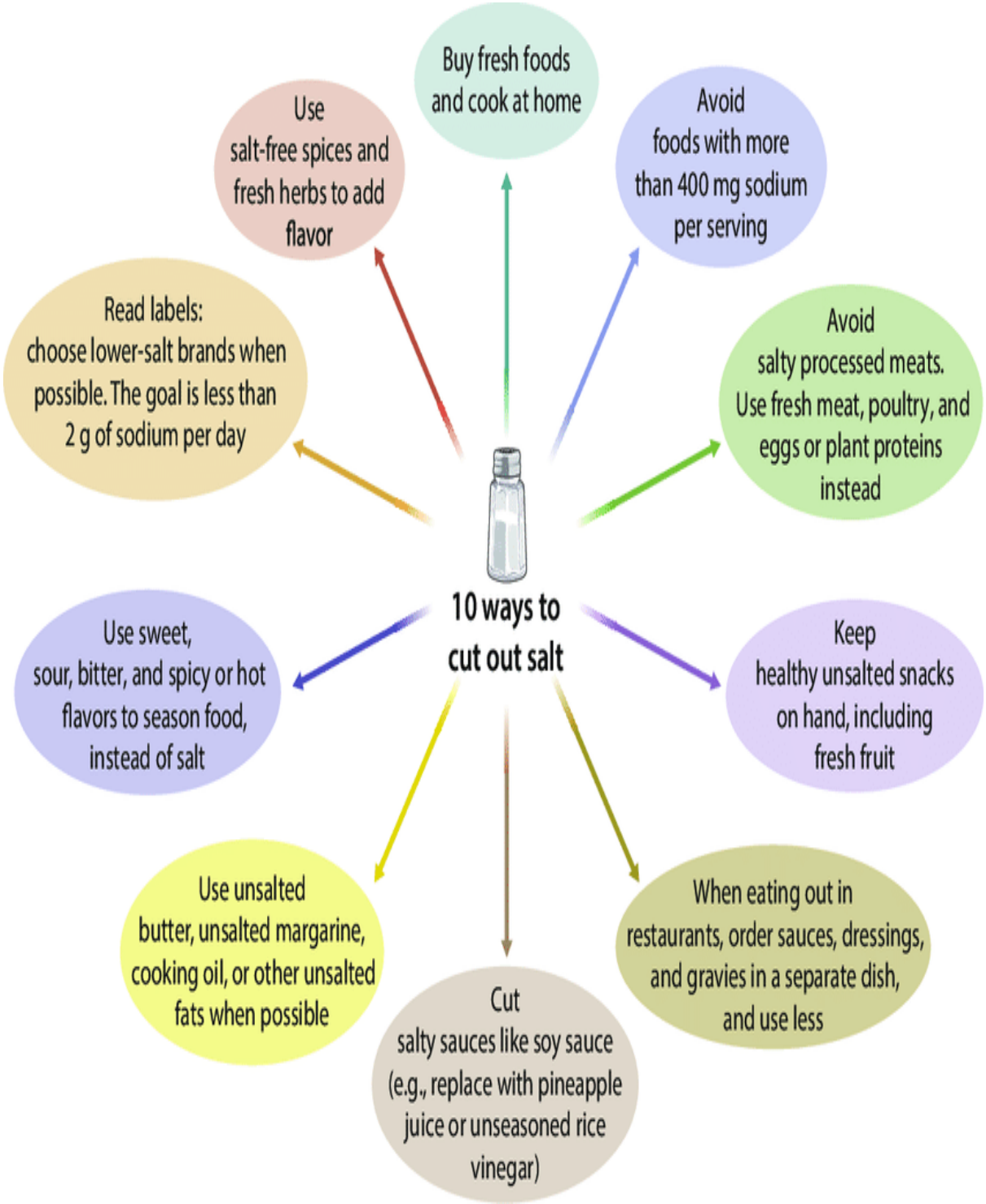
Appendix 2 10 ways to cut out salt



Appendix 4 Alcohol chart

Appendix 6

A health coaching approach to BP@Home

A health coaching approach and motivational interviewing techniques are simple and evidence-based ways to support patient health behaviour change. They are easy to integrate into the consultation conversation. Assisting a patient to identify and overcome their personal barriers to behaviour change has been demonstrated to be far more effective than simply telling the patient what they should do or giving them an information leaflet.

Principles:

- The patient is the expert in their own life
- Listen to the patient and reflect back their concerns
- Resist the righting reflex - avoid suggesting a patient must or should make a change or do things a particular way
- Encourage change talk – ask open questions to encourage the patient to think about how to make small healthy changes and how this would benefit them
- Encourage patient to identify potential barriers to making their desired change and think of ways to overcome them
- Ask permission to give information

Using medication compliance as an example:

"Many people find it difficult to remember to take pills every day, how do you find it?"

"You do want to take your pills every morning as it is important to you to control your blood pressure, however you often get to work and realise that you've forgotten to take them."

"Can you think of anything you could do in the morning which might make it easier remember?"

"May I suggest some methods other patients have found helpful – some might appeal to you?"

"Thank you. Some people find attaching taking their medication to an already established habit works for them, for example putting the box in front of the kettle or sitting their toothbrush on the box. Is that something that might work for you?"

"So there is chance that another family member might move the box from this place – can you think of any ways around that?"

Useful questions:

- What changes would you most like to talk about?
- How important is it for you to change?
- How do you see the benefits of…?
- How do you see the drawbacks of…?
- How might things be different if…?
- How confident do you feel about making this change, on a scale of 1-10. Why 5, why not 7 or 8? What would you need to do to reach 8?

Source: Palmer, S, The Health Coaching Toolkit Part 2, Coaching at Work, 2012, 7, 4. P34. www.coaching-at-work.com

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Flow chart – needs to go in as appendix 1
Weight management pathway – needs to go in as appendix 3

RAG –needs to in as appendix 5

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