For the attention of HM Senior Coroner M E Hassell

Response to prevention of future deaths report issued on 5th April 22

10th May 2022

Following the Inquest outcome the practice had already discussed the issue of the missing blood pressure reading in the practice meeting on 5th April 22. In that meeting staff were asked to clarify their current protocol on recording blood pressure readings submitted by patients using the machine in the reception area. They confirmed that they ask patients to give them the slip with the blood pressure reading from the monitor once they have checked it, they also confirmed that they record this reading in the records and inform the doctor by screen message. They also confirmed that if the blood pressure reading was high they would ask the patient to recheck their blood pressure. They would then submit these readings to the doctor.

The practice manager also individually questioned the healthcare assistant and the reception staff that were working in reception on 13th of October 2021 if they had any recollection of this patient submitting this high blood pressure reading to them. The photo of the blood pressure reading submitted by the patient's mother had a time stamp of 13.36. The patient attended for an appointment (to collect a self smear pack) with the Healthcare assistant at 14.35. (The time discrepancy has been found to be due to the clocks going forward and the blood pressure monitor needing to be manually updated). Unfortunately due to the length of time lapsed since the incident none of the staff members could recall seeing the patient, however they were all able to confirm that if they had been presented with a blood pressure reading as high as this they would have asked the patient to repeat their blood pressure and as per routine practice informed the doctor of the reading.

As a result we are unable to clarify events of that day and how exactly this blood pressure reading was unfortunately missed.

We have now created a sign and displayed it above the blood pressure monitor. It states to the patient to give their blood pressure reading to the receptionist.

We have also created a protocol for blood pressure monitoring in the reception area for staff to follow, this clearly highlights the role of the receptionist in the monitoring process, guidelines for informing the doctor, abnormal values.

The machine is calibrated annually to ensure accurate measurement of blood pressure.

A significant event analysis meeting was also held on 20th April 2022. This included doctors, practice manager and reception staff. We discussed possible options to prevent this scenario recurring and have actioned the most feasible options. Wherever possible, the receptionist should remain with the patient and supervise the blood pressure monitoring, ensuring the reading is brought to the attention of the doctor. This of course may not be possible when short staffed or during busy periods, however staff to remain vigilant of any patients using the machine to ensure they do not leave before submitting a reading.

We have also concluded to send an Accurx text message to any patient being started on combined hormonal contraceptives to recheck their blood pressure in a month, scheduling a reminder text message after a month prompting the patient to submit a reading. Whilst there is no faculty guidance on this, we believe learning from this incident could prevent future deaths.

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Partners, Lathom Road Medical Centre

Appendices

1. Practice protocol for blood pressure monitoring in reception
2. Signage in reception
3. Significant Event Analysis meeting minutes