

## Significant event analysis

LATHOM ROAD MEDICAL CENTRE

Event Title	Missing blood pressure reading
Date of significant event	13/10/21
Date of significant event meeting	21/4/22
Name of reporter	[REDACTED]
Position of reporter	GP
Staff Present at meeting	[REDACTED] [REDACTED] [REDACTED]

### What happened?

(Describe what actually happened in detail. Consider for instance, how it happened, where it happened, who was involved, and what the impact or potential impact was on the patient, the team, organisation and/or others)

A 27yr old patient tragically died on 23/10/21. She had been started on the contraceptive pill 3 months prior. Post mortem revealed she died of Myocardial Infarction likely due to vasospasm from underlying hypertension. The patient was not known to have high blood pressure. The mother of the patient found a photo of a blood pressure reading taken at our surgery on the patient's phone post mortem, it was dated 13/10/21 and the reading was 166/90. This reading was not entered in the records and not brought to the attention of any clinician.

### Why did it happen?

(Describe the main and underlying reasons – both positive and negative- contributing to why the event happened. Consider for instance the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event)

According to the records the patient did attend the surgery on 13/10/21 to see the HCA to collect a self-test smear pack. She had not been booked for a blood pressure check with the HCA.

The patient was started on the pill in July and she was asked to recheck her blood pressure in reception after a month. She may have come to check it for that reason in October. It is not clear why the blood pressure reading was not recorded - staff members present on the day could not recall seeing the patient or being given a blood pressure slip of a high reading but as it was 6 months ago it is difficult to recall. Staff members confirmed their usual practice is to record blood pressure readings into records and inform the doctor.

Therefore we cannot clarify why this happened - if the patient did not submit the reading to a member of staff or if she did submit it and it was overlooked.

### What has been learned and what changes should be made

(Demonstrate that reflection and learning that has taken place on an individual or team basis and that relevant team member have been involved in the analysis of the event. Consider, for instance, a lack of education and training; the need to follow systems and procedures, effective communication) Also outline the actions that should be implemented, how the event not reoccurring can be monitored)

We have learnt that more robust protocols need to be in place to prevent this from happening again. Reception staff are all already aware to record blood pressure readings in the patient records and inform the doctor of the reading on the same day. However, at busy times when there are a few patients in the waiting room and the phone is ringing or if a receptionist has been called away then it

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is difficult to keep track of all patients coming to use the machine, we can try to safeguard against this by ensuring patients are given clear advice before they sit down to check their blood pressure.

A protocol has been created with clear guidance for staff – only adjustments to be made to it is for patient to wait 2 minutes before repeating the blood pressure if the 1<sup>st</sup> reading is raised and for staff to highlight to the doctor if the pulse is <60 or >100bpm. This will be placed in clear sight in the reception office.

A sign has been placed above the blood pressure machine guiding patients to hand the reading to the receptionist once checked.

Staff to remain vigilant of any patients using the machine to ensure patients do not leave without submitting a reading.

Further suggestions were made by staff at the meeting:

1. Re-site the machine closer to the reception desk so staff can keep a closer eye on the patients using the machine, the only problem with this is that it can't be placed right next to the reception desk as it would raise confidentiality issues with the patients already queuing at the front desk. Reception staff suggested to place the machine on the opposite wall of the reception area where they would have better oversight of the patient – we shall try this.
2. Dr █████ suggested we could place the machine in the far corridor away from the reception desk, however again there would be confidentiality issues as that corridor space is between 2 consulting rooms and patients could potentially be sitting by the bp machine for up to 15min therefore overhearing consults going on in the adjacent rooms. Except for this area there isn't any other space on the ground floor for the machine to be placed whilst maintaining confidentiality and keeping fire exits clear at the same time.
3. Dr █████ suggested we could have a list of specific criteria for which patients are allowed to check their blood pressure and not allow access to all patients. Reception staff were concerned they would have to face irate patients who are being turned away. Also as the machine was initially procured to help with opportunistic blood pressure screening, Dr █████ felt it would not serve that purpose if we only allowed certain patients to use it.
4. █████ suggested contacting the bp machine company to see if they operate any coin slot system whereby the patient needs to be given a coin to enter in the machine to be able to use it, thereby keeping a closer track on who is using it and returning readings – she will contact the company.
5. Dr █████ suggested having a dedicated member of staff to supervise each patient checking their blood pressure throughout the process. █████ mentioned that this is not always going to be possible as staff are already busy at the front desk and wouldn't always have time to supervise every patient. We agreed that if staff members are free then they should try to stay with the patient though the monitoring process, failing that they should give the patient clear instructions to submit their readings to the front desk.