

Patients' and clinicians' views on the optimum schedules for self-monitoring of blood pressure

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What this study adds:

- Self-monitoring of blood pressure is common but guidance on how it should be carried out varies and it is currently unclear how such guidance is viewed.
- This qualitative study highlights patient and professional opinion on operationalising the use schedules for self-monitoring.
- Clinicians and patients largely favoured the move towards using a schedule for SMBP however described practical difficulties in terms of implementation.
- An educational approach outlining to patients how to measure BP correctly, under what conditions (e.g. seated, after 5 minutes of rest) and specific detail whereby patients are asked to complete the minimum number of readings required for accurate BP estimation in a flexible manner, seems most likely to succeed.

Abstract

Background

Self-monitoring of blood pressure is common but guidance on how it should be carried out varies and it is currently unclear how such guidance is viewed.

Aim

To explore patients' and health care professionals' (HCPs) views and experiences of the use of different self-monitoring regimes, to determine what is acceptable and feasible and to inform future recommendations.

Design and Setting

Thirteen focus groups plus four HCP interviews were held, total of 66 participants (41 patients, 25 HCPs) from primary and secondary care with and without experience of self-monitoring.

Method

Both standard and shortened self-monitoring protocols were considered. Focus groups and interviews were recorded, transcribed verbatim and analysed by constant comparative method.

Results

Patients generally supported structured schedules but with sufficient flexibility to allow adaptation to individual routine. They preferred a shorter (3-day) schedule to longer (7-day) regimes. Whilst HCPs could describe benefits for patients of using a schedule, they were reluctant to recommend a specific schedule. Concerns surrounded the use of different schedules for diagnosis and subsequent monitoring. Appropriate education was seen as vital by all participants to enable a self-monitoring schedule to be followed at home.

Conclusions

There is not a 'one size fits all approach' to developing the optimum protocol from the perspective of users and those implementing it. An approach whereby patients are asked to complete the minimum number of readings required for accurate BP estimation in a flexible manner seems most likely to succeed. Informative advice and guidance should incorporate such flexibility for patients and professionals alike.

Introduction

Self-monitoring of blood pressure (SMBP) provides a better estimation of underlying BP than measurements taken in the clinic for the diagnosis and management of hypertension.¹⁻³ A previous survey highlighted an increasing number of hypertensive individuals undertaking SMBP in the UK⁴ and many prefer it, primarily because it promotes independence and control over an individual's own health.⁵⁻⁷ However, self-monitoring largely takes place within the privacy of the patient's home, and thus can be hidden from the patient's clinical care provider.⁸

Whilst National Institute of Clinical Excellence (NICE)¹ and international guidelines^{3,9} recommend a week of readings for diagnosis, most primary care HCPs use self-monitoring for ongoing management,¹⁰ for which there are no evidence-based recommendations on what type of self-monitoring schedule to implement. Consequently there is wide variation in practice has been reported by both patients and HCPs.^{4,10} This includes the interpretation of self-monitoring results which may be haphazard.^{10,11} Previous work suggests only small incremental benefit in terms of prognostic ability from longer schedules of self-monitoring.¹² Little qualitative data exists regarding what patients think of different monitoring routines, perhaps because they are generally only exposed to one regime, and professionals have previously reported uncertainty as to the optimum schedule.^{13,14} This study aimed to explore attitudes towards an 'optimal' schedule for home monitoring BP from the perspectives of primary care patients and HCPs what is the most acceptable and feasible BP home monitoring schedule to use in clinical practice.

Methods

Participants and recruitment

Patients and HCPs at primary and secondary care sites in Birmingham, UK were invited to take part in this focus group study. Primary care participants were recruited via general practices from a pool of individuals who had taken part in a previous trial (including people in both intervention and usual care groups) investigating the self-management of hypertension.¹⁵ Clinical staff attached to these practices were also invited to take part. Secondary care patients and HCPs were recruited using convenience sampling¹⁶ through verbal invitation at specialist hypertension clinics at a teaching hospital. Patients agreeing to take part were grouped based on the following attributes: setting (primary or secondary care), socio-economic status¹⁷ (by IMD score of practices postcode) and experience of SMBP.(Figure 1)

Focus groups were held in patients' and HCPs' own general practice/hospital clinic sites to ensure that participants could easily attend.¹⁸ Face to face interviews were offered where logistics precluded participation in focus groups.

Topic guide and procedure

A structured topic guide was developed, informed by the literature (Appendix 1 and 2). Two potential self-monitoring schedules were discussed, i.e. a longer one based on current NICE/European Society of Hypertension (ESH) clinical guidance ^{1,2}(twice daily monitoring for a week) and a shorter one based on the minimum data required for accuracy¹⁹ i.e. for at least 3-4 days). Discussions were facilitated using Emoji visual aids.²⁰ The topic guide was adjusted depending on participants' attributes i.e. primary/secondary; patient/HCP; experience of SMBP/no experience.

Each focus group was facilitated by 2 people (typically SG, SF or JH, all non-clinical researchers), with one leading the discussion and another note-taking, and lasted approximately 1.5 to 2 hours; interviews lasted 45 to 60 minutes and were led primarily by SG.

Both focus groups and interviews were digitally recorded and transcribed verbatim along with contemporaneous field notes.

Analysis

Data were analysed using a constant comparative method, whereby a coding frame was inductively constructed and systematically applied to the data.²¹ Data from focus groups and interviews were analysed concurrently using the same methodology, i.e. data were extracted from the transcripts and relevant field notes and placed on charts according to emergent thematic references, so enabling analysis of the similarities and differences within and between each focus group and interview. All data were managed using NVivo software, Version 10.0.

Members of the research team from different clinical (UM) and non-clinical disciplines (SG [a health psychologist], JH, SGr [both sociologists], and SM) individually read and reread two transcripts each. These were then independently coded and after collaborative discussion codes were further developed from the data. Following this, the team collectively developed higher level codes. This process of investigator triangulation increases internal validity.²² Subsequent coding was then undertaken primarily by SG, with support from SM.

Results

Participant characteristics

Eighteen of the 24 practices participating in the original trial¹⁵ were approached. Six were excluded due to geographical distance from the research team. Eleven agreed to participate; however it was not necessary to extend recruitment beyond 9 practices as, by this point, data saturation had been achieved.²³ Participants, as previously identified in the original trial, were all patients with hypertension, treated with at least one or 2 anti-hypertensives.¹⁵ Participants from these practices formerly agreeing to take part in further research were identified and initially invited (n=155). Of these, 42 declined, 64 did not reply, 18 participants replied 'yes' but were subsequently not contactable, resulting in a sample of 31 patients. Of 78 primary care HCPs employed within these practices and invited to participate, 11 declined, 50 did not reply, resulting in a sample of 17 (13 GPs, 3 practice nurses, 1 health care assistant). In secondary care, 17 patients were invited to take part, of which 10 agreed to participate, 7 declined. All of the eight secondary care professionals (5 Specialist Nurses, 1 Consultant Physician, 1 Renal Registrar and 1 Consultant Nephrologist) verbally invited took part.

Focus Groups

Thirteen focus groups were held in total, with between three and nine participants. The baseline characteristics of patients and HCPs are given in Table 1. Half of the participants (primary and secondary) were female and nearly two thirds were self-monitoring or (28/41[68%]) had some self-monitoring experience. Four interviews were held with HCPs (one primary care, three secondary care) resulting in a total of 66 participants (41 patients, 25 HCPs).

Analysis revealed a series of themes from patients and HCPs that emerged from the interviews and focus groups, some of which were shared, others unique to a particular group or setting. (Box.1).

Positive views for using a schedule vs. ad hoc monitoring

Patients in both primary and secondary care considered that self-monitoring schedules improved adherence to medication and allowed understanding of BP variability.

I've become even more, almost regimented about it, so I can actually have a better pattern as to what is working and what isn't working and which tablets I'm taking might be working and which aren't working"

(FG2 Patients, SC)

Similarly, HCPs supported the use of a schedule on the basis of allowing patients to take greater ownership of their condition; increasing adherence to regular monitoring and subsequently facilitating treatment decisions. Implementing a schedule therefore appeared well supported.

MF: "It [monitoring with a schedule] gives them some ownership of the problem and they tend to actually find it interesting...what the medication is doing, and...helps them to appreciate the variability of BP that one minute it might be slightly high and then it might go down again when you repeat the testing, which is sometimes reinforcing what we are doing when we are rechecking the pressures in the surgery and seeing it come down for the second or third week".

(FG12, HCP, PC)

Determining a more accurate estimate of BP through more readings was perceived as an advantage for both the patient and the health professional alike.

HE: "If you know...I think it would help, if you can get them to follow it and they are willing to do it then I think it could help patients because you know it's got more readings"

(Interview 17, SC, Specialist Consultant)

In contrast to secondary care clinicians, those in primary care considered the negative impacts of a schedule.

LM: "... these people do panic about one-off readings, if they had that in front of them and said okay, if you get a high reading, do another six days of readings before you contact us. that might actually stop their panic and reduce that workload potentially...therefore, I've got to do seven days now...'

AJ: Or they get six more days of panic".

(FG10, HCP, PC)

A number of patient focus groups agreed with HCPs views that complying with specific instructions regarding home measurements could cause more anxiety, making it no different to the anxieties experienced within the clinic.

DR: I think I'd prefer to [not monitor on a set day]. As I say, I just do it and, you know, I think if it's not right, you've got to do it a certain day at a certain time. You can get more agitated.

SS: Or if your wife's gone shopping you think I'm reading a book, I'll take my [BP] ...

DR: I think half of its [preference for home monitoring] because they [the doctor] tell you to sit it up on your table, because you're going to have your arm like this, certain height, your wrist, wrist certain height, level you've got to be sitting comfortable and this and that

AW: 'No talking'.

DR: ...all that's more stressful"

(FG1 Patient, PC)

Flexibility

Finding a balance combining rigour with a degree of flexibility within a schedule was discussed across more than half of the 13 patient focus groups in both primary and secondary care. Patients mentioned a range of issues about fitting self-monitoring within their daily life. Those with more spare time, felt scheduling monitoring could undermine 'free time' when they were at their most relaxed. Unpredictable situations were also

considered such as illness, when they might want to increase the frequency of the measurements.

LB: "...you would have to look at your own circumstances really because with some people it would work for three days, some people work it every other day, some people you need to review it every day, especially if your medication has just been changed and you want to see if it's working but then at the same time, depending on how you react to the results"

(FG2, Patient, SC)

GF: "it depends on your lifestyle. Sometimes it might be difficult, I have a four year old grandson that I have occasionally, it wouldn't really be practical when he's around because it's not always that easy really".

(FG9, Patient, PC)

Through further discussion questions were raised concerning how or if, a rigid schedule should be followed during more relaxed time periods e.g. holidays and weekends.

MB: "What if you're on holiday and...stuff, are you still able to do that?"

DM: In terms of the internet, you can still connect from anywhere.

PO: ...you wouldn't want to do it on holiday though.

DM: That's correct, but you might be more relaxed.

MB: ...if you were doing it for 'x' amount of months and you were on holiday during that period, what would you do?"

(FG 14, Patient, SC)

Patients felt measuring BP at home should allow for flexibility rather than complying with a strict imposition of rigid times, though some alluded to how such measurement variation might influence results. Work and family were perceived to influence ability to monitor with a degree of rigour:

JW: "...you get up in the morning at a certain time... you can monitor then and lunchtime if you've got time, but obviously for those people who work may not be in a position to do that"

(FG 2, Patient, SC)

IR: "It just depends on your circumstances, doesn't it, whether you go to work or whether you've got a family, if it's young children and dealing with children, you know, it depends..."

JF: ...it depends if it's taken the same time every day or in the evening...would it work if one night you took it at 7:00 [pm], because you know you're going out and you'd have a late night...But the next night... you stay in and you do it at 10:00 at night"

(FG11, Patient, PC)

For HCPs, consideration of whether a schedule was feasible related to what was 'doable' for the patient and this varied between patients. Factors brought up included people's personal routines, carer responsibilities, job patterns, along with each individual's attitude to their own health.

CB: "It completely depends on their social...whether they've got four, five kids, whether they've got a job they need to be at six o'clock in the morning, whether they work nights, it's all very subjective to what ... I think it [following a schedule] is doable."

(FG7, HCP, SC)

RI: "...it depends on the patient how you feel in their consultation how comfortable they are".

(FG 10, HCP, PC)

Variation in practice

Capturing current home monitoring experiences revealed substantial variation amongst both patients and HCPs. Some expected individual differences in the number and times of day measurements were taken and in logging readings were described. There were also some unexpected accounts.

GM: *"I usually disregard the highest reading; I do it three times and disregard the highest reading than the other two.*

DG: *If I do mine, I take the best of three, a good average".*

(FG3, Patient, PC)

SH: *"I take measurements in just one arm.*

AG: *I do both [arms].*

SH: *Yeah. Um, one would be higher, one would be lower.*

AG: *And I'd always, look at the higher one because that's normal for me".*

(FG 4 Patient, SC)

Across primary and secondary care sites, HCPs described variability in the advice they gave to patients. 'Eyeballing averages' appeared to be the most common technique described.

MF: *"I will tend to try and work out a ballpark average by eyeballing the figures... I will look at them and see if there are several over ninety [diastolic BP] or if there are others that are sort of within the normal range then I will be more comfortable, but I would be looking at a pattern of generally lower BP than before and managing a patient on treatment...I will often say two or three times a week is a reasonable amount and then assessing in a month's time that gives you enough readings to make a judgement"*

(FG12, HCP, PC)

JC: *...as long as you give them a general view about the volume of readings, you know, that you feel would be helpful to ... you know, for, for them and us to manage their BP, then that's usually fine".*

(Interview 15, SC, Consultant Physician)

These behaviour patterns were corroborated by patients' accounts. Other guidance given to patients was around aspects of measurement, e.g. discarding readings, length of time between measurements, whether to measure before or after BP medication, and measurement technique, again with little consensus on a unified recommendation.

CB: "I think to do it properly they need to be sitting down with the cuff on for 5 minutes at rest, and then obviously take a measurement, a minute, take a measurement, a minute, and if you're going to do a third, another minute. I tend to say before medication, before they've taken the tablets, sort of first thing.

(FG7, HCP, SC)

Not surprisingly, clinicians appeared to draw on national guidelines as their primary source of guidance when interpreting SMBP data.

LD: "I tend to ignore the first couple of readings to be honest because they usually tend to be a bit higher, so I actually tend to ignore the first few and then take the average and the rest of the readings.

ST: Yes and then when I get the results I exclude the first day and work out the readings from the remaining six.

(FG12, HCP, PC)

Guidelines appeared to give clinicians a basic framework from which to provide advice.

CB: "I think since the NICE 2011 [guidelines] that sort of gave healthcare practitioners a bit more of a definitive sort of thing to tell patients. Because up until then it was very much ad hoc, and there was less sort of stringent guidelines. But I've found that's a useful tool, you know, telling them exactly how to do it in NICE, as per the diagnostic criteria."

(FG7, HCP, SC)

Length of protocol

Longer and shorter schedules were presented to participants as seen Appendix 1 and 2.

Comparison of patients' and HCPs' discussions revealed a key difference of opinion on implementing each of the schedules. Clinicians within both primary and secondary care felt the need for clarity about whether SMBP was being used for diagnostic purposes or for ongoing management as these would involve using different schedules.

MM: “With the diagnosis there’s a root work that would have to be followed, and you discard the first days’ readings and then average up the rest basically and then do it over a week, twice daily, so there’s a different process to ongoing monitoring which can be very ad hoc and just you look at the lowest reading I think, because that probably correlates best with the average doesn’t it?”

(FG6, HCP, PC)

Some HCPs suggested a longer monitoring schedule with more frequent measurements over a week would be needed for diagnostic purposes, and a 3-day home monitoring schedule would be sufficient for longer term monitoring. Others felt that the evidence base for this was lacking, whilst most secondary care clinicians stated that this was a standard recommendation to patients.

NC: “what we’re probably saying is seven days for diagnosis and three days for monitoring, aren’t we really”.

(Interview 13, PC, General practitioner)

CB: “three days would be great for the patients but if you want to get a true, accurate reflection of the BP probably seven days is more appropriate, if you’re treating them... this is the problem as a clinician, because the evidence base is not there to say well, actually, if you monitor for three days this month the reading ... it equates to monitoring for seven days over this amount of ... you know, so you know, as a clinician it’s very hard to just rely on those three days of ... of monitoring.

(FG 7, HCP, SC)

Preferred monitoring regime

Whilst the focus for the HCPs was on matching schedules to the type of clinical decision being made, patients (both in primary and secondary care) focused more on feasibility, whether a protocol was easy to implement in daily life. On this basis the 3-day schedule was preferred.

GM: "Those three days are more convenient than the seven for obvious reasons. It's time isn't it?"

(FG 3, Patient, PC)

DM: "...three days two readings, I'd be happy to kind of wrap it up and get it sorted rather than stretch it out over seven days a week".

(FG 14, Patient, SC)

For many of the secondary care patients, the shorter schedule was already recommended by their HCP. Benefits of the 7-day schedule were discussed by all, with willingness expressed by patients in primary care to comply with monitoring over 1 week if a clear clinical reason for doing so was given. Amongst our sample, if instructed to do so by a HCP, patients would generally comply with a 7-day schedule.

JF: "So if somebody said, "Well, it's best to do it every morning for three days," ...I would probably fit in with whatever I was told would be best".

(FG11, Patient, PC)

WT: "I'd probably say yes if it was one week a month because you could plan around that week"

(FG 8, Patient, PC)

Initiation of monitoring

Starting to self-monitor in primary care tended to be an individual decision, with patients devising their own regime for measuring BP. For the majority, monitoring BP independently was something they felt comfortable with. A few primary care patients were reluctant to change schedule having established a routine.

JM: "I take medication twice a day and I take it first thing in the morning and middle of the evening. So we're used to that sort of routine, it's just that I don't want to do more [measurements] in terms of this sort of thing, where I'm satisfied with what I do at the moment.

PW: The trouble is now, I'm quite happy with routine, I take it [measuring BP] once a fortnight and it's kept me going for fifteen years...."

(FG9, Patient, PC)

In secondary care, monitoring with some degree of schedule was commonly advised therefore patients appeared more informed about the reasons for adopting a schedule.

LB: "This is...another reason why it's important to home monitor because at least you can get an accurate picture of when you're watching... you can identify the times when it is not okay then you and the GP or Doctor X [Hypertension consultant] can discuss that and then address how you can control that".

(FG2, Patient, SC)

Education Needs

A number of other issues arose as a result of discussing the use of schedules. Patients felt that understanding the rationale behind the basic instructions for SMBP needed to be improved.

TW: I mean, I never ... I never quite understand why they do the best of three and record the best of three.

(FG 8, Patient, PC)

Some appeared confused about their own BP thresholds and identified that education was needed regarding interpreting SMBP results.

AG: *“That's the problem. I mean, the doctors say 200 and above is very, very high and I think it's normal for me. So when it's 180 at home, I'm worried that something is wrong*

HG: *I think it could be very useful, indeed...you know, educating the patient. Making sure they're aware of [schedules], you know, what they're doing, how to do it, and what to do with the information.”*

(FG4 Patient, SC)

When discussing morning and evening BP measurement, some indicated a preference regarding the time of day, most notably evenings.

KR: *I tend to take mine of an evening,*

RA: *Apparently it naturally changes throughout the day, doesn't it, there's like a peak and a trough, isn't there?*

KR: *I'm not good in the mornings, I'm better at night time. I'm more of a night person, I'm more relaxed at night. I'm a natural night worker I used to be, you know, so I tend to do anything complicated then”.*

(FG 5, Patient, PC)

Reflected in both primary and secondary care, was the consensus that a clearer understanding of the basic elements of BP measurement and how to accurately interpret and act on BP results was necessary before any additional guidance could be absorbed. Provision of such education from the patients' perspective was viewed as the HCPs' responsibility.

MB: *“Yes. I mean to me I wouldn't know, because I'm new to it, when to do it, what number is particularly high, what number I should be at, you know.*

DM: *Something would have to be defined per person, I think, to do it.*

PO: *Give some guidance as to what's your norm”.*

(FG 14, Patient, SC)

Patient and HCPs focus groups revealed synergy between the lack of education patients described and gaps in HCPs knowledge regarding SMBP. Clinicians felt that, although there was national guidance available on how patients should self-monitor for diagnostic purposes, there was a lack of guidance regarding longer term management. A central problem was that every patient was different and therefore there was no universal rule of thumb when it came to SMBP.

CB: "it's patient education and if we don't educate them then it's down to them knowing what to do and how to do it, I guess... it is difficult to know where to start

GH: ...the people who'll search the web for these sites are the ones that are going to be more proactive and engaged in their care, it's the ones that haven't got access to internet and haven't got access to this and that equipment are the ones that you need to focus on more, really"

(FG 7, HCP, SC)

Consequently, clinicians felt there should be more informative guidelines provided on all aspects of home monitoring, but more so if a schedule was implemented. Descriptions of the reference sources for guidance on SMBP appeared to vary from clinician to clinician and within primary care even within the same practice.

CB: "...the Trust here, it's very sort of ad hoc...There's no sort of indication a) is it a validated monitor, or when are you doing it...So I think there is a huge sort of disparity around with what actually sort of advice is given and there's no sort of real check".

(FG 7, HCP, SC)

VR: I think there's something online and even on Facebook about self-monitoring and you can print out a chart for patients but no substantial guidance for us.

(FG 6, HCP, PC)

I mean I think these days the world runs on guidelines really and actually the more explicit and the more clear and evidence based our guidance is the better... so yes more structured guidance is really important here...

(Interview 15, HCP, SC)

Discussion

Summary

This study draws together for the first time opinion from patients and HCPs across primary and secondary care about the use of a defined schedule for SMBP. Patients were inclined towards some form of self-monitoring schedule rather than ad hoc monitoring believing it to aid adherence to medication and allow understanding of BP variability, though with a caveat to remain flexible and sensitive to patients' lifestyles. HCPs also supported the use of a schedule believing this could allow patients to take greater ownership of their condition; potentially increasing adherence to regular monitoring and subsequently facilitating treatment decisions. Devising an optimal schedule combining rigour with flexibility and consideration of a patient's individual own backgrounds was an equally recognised as a challenge by health professionals and patients. In primary care, HCPs and patients in primary care considered that overly rigid regimes were likely to lead to increased anxiety. Such disturbance of usual routines for home monitoring could have the potential for transferring patient anxieties about clinic BP evaluations into the home, and is an area for further study.

Whilst both groups considered a shorter schedule most practicable, clinicians favoured longer periods of monitoring, particularly for diagnosis. Though both schedules considered were compliant with current national (NICE) guidance and supported by the literature,¹ the longer schedule was more prominent in current UK guidance which probably explains why primary care clinicians in particular favoured it.

For the majority of patients and HCPs the idea of using a schedule seemed logical, but there were practical difficulties raised in terms of implementation. This study highlights HCPs felt challenged in deciding who to suggest home monitoring to, and indeed who might be able to comply. It could be argued that a standardised approach could address this; however, clinicians have to take into consideration the needs and abilities of their patients. Given no clear consensus on the optimal approach to home monitoring it appears that this makes it then harder for HCPs to train their patients.

Strengths and limitations

To the authors' knowledge, this is the first qualitative study combining the views of clinicians and patients, with and without experience of SMBP, about using schedules to operationalise self-monitoring. The study had good representation of participants in terms of both gender and diversity in socio-economic status. However, two thirds of potential participants for this study either refused to be interviewed or were not contactable, and it may be that non-participants had divergent views.

Whilst a range of settings and experience were included, participating primary care patients and HCPs had previously taken part in a trial of self-management¹⁵ which might have influenced results, although the heterogeneity in monitoring regimes which emerged suggested that the trial which reported in 2010 had not overly influenced participants' subsequent behaviour. Furthermore, study personnel facilitating the focus groups and interviews were not familiar with the patients or professionals. In terms of secondary care, participants were drawn from one teaching hospital and hence might be expected to have

more uniform views than more dispersed sampling. Overall, the use of thirteen groups with sixty six participants and achieving theoretical saturation is reassuring in this regard.²³

Only two regimes were discussed, a decision made for logistical reasons, and it may be that other suggestions would have given different responses. The choice of regime was made based on data from the literature (and from the NICE guidance) that shorter than currently recommended schedules have similar ability to capture mean BP than longer schedules.¹⁹

Comparison with existing literature

There is a sizeable amount of evidence from clinical trials and qualitative studies showing that self-monitoring with clinician involvement is effective in the management of hypertension,^{15,24} but there are few studies specifically looking at preferences for and the acceptability of using a home BP schedule. The key original finding from the current study is in identifying that using a schedule was for the majority of primary care patients largely acceptable with particular schedules favoured over others. Secondary care patients appeared to be already complying with some sort of schedule.

Clinical Implications

For a schedule to be implemented into clinical practice it is important to consider why it is needed, and to ensure that it is accepted and useable by both HCPs and patients.

Implementation of a schedule for home monitoring whether for diagnosis or for ongoing monitoring appears to be, for some HCPs, a preferable solution to the unguided haphazard routines currently performed by patients. Shorter schedules of monitoring were the

preferred option by patients in this study. Given evidence that little additional data are gained from longer regimes,¹² coupled with evidence that patients may drift from pre-specified advice,⁸ a simpler approach might be appropriate. Rather than asking for 28 readings taken at specific times (i.e. two in the morning and evening twice daily over 7 days; GPs might gain better adherence by emphasising that a flexible regime will give similar data provided that at least 3 days of self-monitoring are included.

The present study suggests using a schedule could result in more patient centred encounters between the patient and the professional, which could in turn lead to improved adherence to medication and ultimately BP control. The vital ingredient however appears to be education. This is necessary for those HCPs who are in a state of flux between adhering to guidelines and being receptive to those patients who welcome a sense of empowerment in managing their health needs. Likewise, patients need specific instruction if they are to adhere to any stated BP measurement regime including technical instruction, how to measure BP and under what conditions i.e. seated, after 5 minutes rest period and clarity over how essential it is to monitor at specific times of day and whether to discard first readings. Effective education could reassure patients that a schedule would not eliminate flexibility and would be adaptable to suit the lifestyle and existing routines of the individual. Joint decision-making involving patients has been shown to increase the likelihood of compliance²⁵ with clinical recommendations and self-managing BP utilising a pre-specified protocol, previously trialled with success.^{15,26} Clear and simple education for HCPs to feel confident about what schedule to implement for which type of patient will be crucial to effectively implementing this in real practice. Measuring BP at home is potentially a powerful tool; but maximum impact requires proper interaction between HCP and patient.

Such an evidence based practical guide with resources for patients and doctors on how to measure home BP has been developed in Australia;²⁷ similar materials are available in the UK via the British Hypertension Society. <http://bhsoc.org/resources/hbpm/> Both could potentially be adjusted to add the flexibility discussed above.

Conclusions

Though patients and HCPs largely favour moving towards the use of schedules for SMBP, there is not a 'one size fits all approach' to developing the optimum protocol. The approach that seems most likely to succeed and provide good quality clinical data is one where patients are asked to complete at least the minimum number of readings required for accurate BP estimation (ie 12 or more) within a specific timeframe e.g. 1-2 weeks, but how this is organised should be left flexible and up to the patient themselves.

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Ethical Approval

The study was approved by NRES Committee Southampton A, 13/SC/0054, and informed consent was given by all participants.

Provenance

Freely submitted, externally peer reviewed

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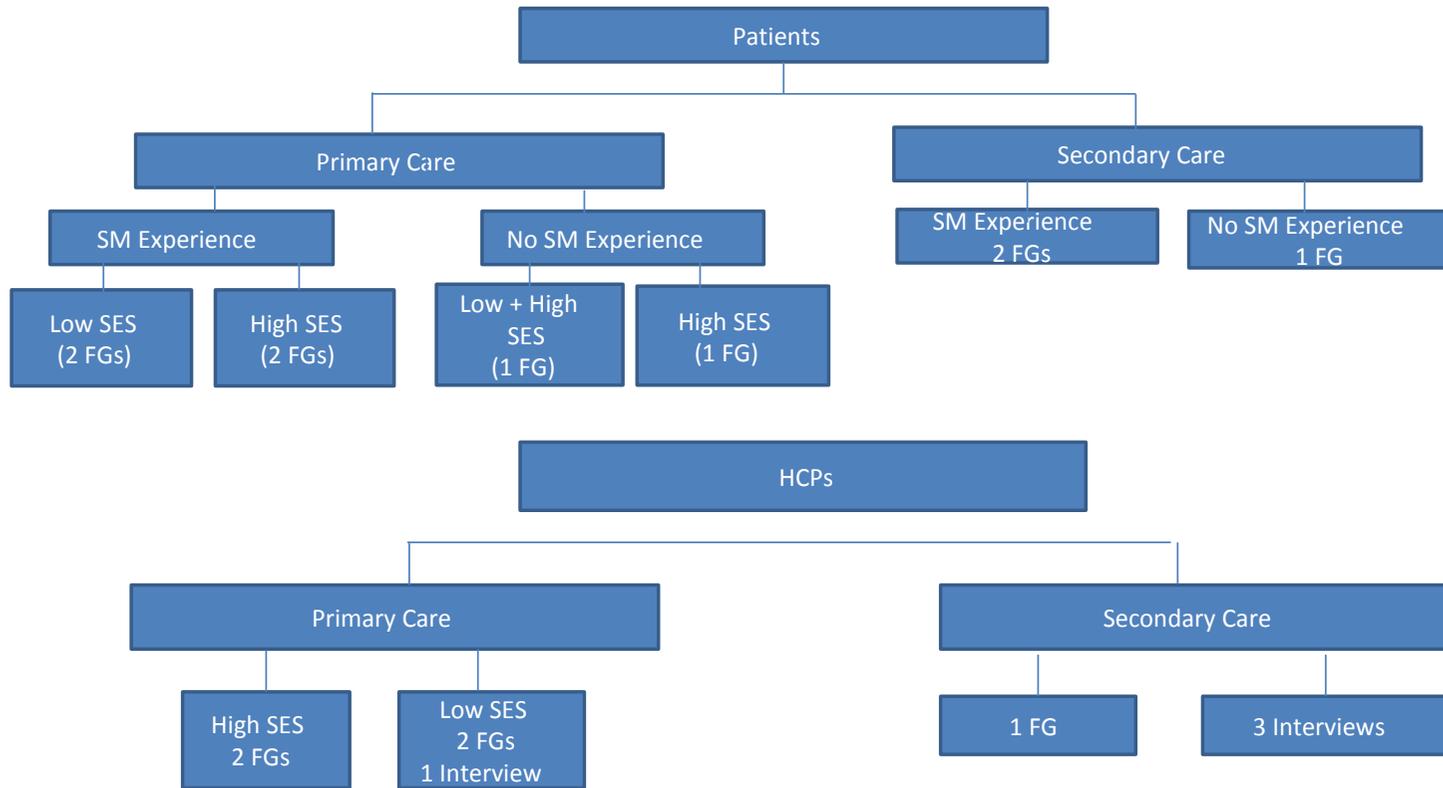
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Competing interests

The authors have no conflicts to declare

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SM Self-monitoring; SES Socio Economic Status; FGs Focus Groups; HCPs Health Care Professionals

Figure 1 Sampling Flowchart

Table 1: Participant characteristics

Focus group type	Health care level	Self-Monitoring Experiences	Socio Economic Status**	Focus group / Interview	Focus Group/ Interview Identification Number	N (male, female)	Occupation		
Patients	Primary	Yes	High	Focus Group	5	5(2,3)	-		
			Low	Focus Group	9	9(5,4)			
		No	Low	Focus Group	1	3(2,1)			
			High	Focus Group	3	4(3,1)			
			High	Focus Group*	11	4(1, 3)			
	Secondary	Yes	-	Focus Group	2	4(2,2)		-	
			-	Focus Group	4	3(0,3)			
		No	-	Focus Group	14	3(1,2)			
			-	Focus Group	6	6(3,3)			6 GP
			-	Focus Group	10	6(4,2)			5 GP, 1PN
Health Care Professionals	Primary	-	High	Focus Group	12	4(1,3)	1 GP, 2PN, 1 HCA		
			Low	Interview	13	1(1,0)	GP		
			High	Focus Group	7	5(0,5)	5 SN		
			Low	Interview	15	1(1,0)	CP		
	Secondary	-	-	High	Interview	16	1(1,0)	RR	
				Low	Interview	17	1(0,1)	CN	

*combined focus group n=4 (2 participants high SES, 2 participants low SES)

GP General Practitioner, PN Practice Nurse, HCA Health Care Assistant, SN Specialist Nurse, CP Consultant Physician, RR Renal Registrar, Consultant Nephrologist

**IMD score based on threshold of 15% most deprived LSOAs nationally vs. practices in the 85% least deprived according to IMD 2010¹⁷ High SES=Least Deprived; Low SES=Most Deprived

Box 1 Series of themes similar or different within Clinician and Patient focus groups

Theme	Clinician*	Patient*
Positive views for using a schedule vs ad hoc monitoring	Y	Y
Flexibility	Y	Y
Variation in practice	Y	Y
Education Needs	Y	Y
Length of protocol	Y	
Preferred monitoring regime		Y
Initiation and change of monitoring		Y

*Focus groups and interviews; Y Theme applies to: Green: clinician and patient; Red: clinician only; Blue: patient only