A qualitative study on the practicality of guideline recommended office blood pressure measurement in primary care

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Background and objective
For accuracy, clinic blood pressure (BP) must be measured using a standardised, guideline-recommended protocol. Practicality of this has not been examined, which was the aim of this study.

Methods
Across Tasmania, Australia, 16 co-design workshops were undertaken with primary care health professionals who perform BP measurement (n = 63) and community members (n = 47). Workshops discussed whether the guideline-recommended BP measurement protocol was adhered to.

Results
There was awareness among health professionals of the recommended way to measure BP. However, none reported measuring BP strictly according to the protocol, instead advising this was not practical. The most common reasons given for this were time constraints and competing clinical priorities. Community members reported never having received protocol-driven BP measurements from a health professional, also citing perceived time constraint as a reason.

Discussion
The guideline-recommended protocol for measuring BP is seen as impractical for health professionals to undertake in routine primary care.

HIGH BLOOD PRESSURE (BP) is the most prevalent modifiable risk factor for cardiovascular disease.[1] To ensure correct diagnosis and clinical care, it is essential that BP is measured using a standardised protocol.[2] For clinic BP measurement, the recommended protocol involves the person being seated with their back supported, feet flat on the floor and arm supported with the cuff at heart level.[3] Several BPs are then recorded at set intervals, commencing after resting for 3 to 5 minutes, and the average of two or more BP readings is taken as the person's BP. This must be done without talking and takes a minimum of 10 minutes. Failure to follow any of these standardised conditions can induce error and contribute to misclassification of risk or impede BP management to target levels.[4,5]

Hypertension screening mostly occurs in primary care, with subsequent management most frequently undertaken by general practitioners (GPs).[6,7] GP consultations are complex interactions where patients commonly have multiple health problems.[8] Balancing condition management and achieving high-quality BP measurement might be difficult within relatively short consultation times.[9,10] Overall, there appears to be discordance between the expectations of guideline BP measurement and the feasibility to undertake this in real-world practice. To our knowledge, the practicality of clinic BP measurement using a standardised, guideline-recommended BP protocol has never been determined. This study aimed to examine this among Australian primary care health professionals and community members.

Methods

Study overview

Sixteen workshops were conducted using design thinking methodology[11] with separate groups of health professionals and community members in 14 towns across three regions of Tasmania, Australia. Design thinking is a human-centric collaborative approach, and draws on principles of co-design to develop solutions with community.[11] The workshops discussed the guideline-recommended protocol for BP measurement (as described above),

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including whether health professionals adhered to the protocol (and the barriers to its use), and if community members' BP measurements had been taken using the protocol (and if not, why did they perceive the protocol was not being followed). Three researchers were involved with data collection (JS, SW, LS) and four in the analysis (JS, SW, LS, AW). The researcher who developed and facilitated workshops (SW), and researcher LS who co-facilitated the workshops, were experienced in community-based participatory research approaches, not in the field of BP. While co-facilitator JS is a BP expert, possible influence of how questions were asked was mitigated through semi-structured data collection to avoid prompting. Researchers involved in the analysis had experience in primary healthcare (JS, SW, LS, AW) and mixed methods research methods (SW, LS, AW). Participants provided written informed consent, and the study was approved by the University of Tasmania Human Research Ethics Committee (ID 28339).

Study population and recruitment

Health professionals were those who routinely measured BP in primary care, including GPs, general practice nurses and other general practice staff, pharmacists and other healthcare workers. Community members were adults aged over 18 years, with lived experience of hypertension and/or BP measurement in a primary care setting. Purposive sampling, including a snowball approach, was used to recruit participants to ensure the targeted study population were from across rural and regional areas. Sampling saturation was reached through data and geographical saturation.

Design thinking methodology and workshops

The design thinking framework and co-design principles[12] were used to guide the workshops held in person and online. Design thinking is an iterative process to create solutions collaboratively with stakeholders. A standard PowerPoint (Microsoft Corporation) presentation was delivered to provide consistency across all workshops. Basic demographic information was collected from community, whereas occupation was the only additional information collected from health professionals. In larger workshops, participants were divided into smaller focus groups to facilitate discussion. Community members were invited to share their experiences with BP measurement and were prompted to identify any challenges or supports that influenced their access, understanding or comfort with different BP measurement approaches. Health professionals were asked two additional questions about needs and challenges associated with implementing standardised BP measurement in clinical practice. In each workshop, priorities considered by all participants to be of greatest need or importance were ranked by participants. Workshops were audio recorded and transcribed. Workshop data was deidentified and coded as a group (workshop 1, 2 etc), with key quotes coded as community member, GP or other health professional 1, 2, 3 etc.

Data analysis

Summative content analysis was used to combine and rank the answers from the voting activity.[13] Transcripts were de-identified, proofread and analysed using NVivo (Lumivero) for qualitative analysis using a deductive conventional content analysis to develop themes.[13] The deductive thematic analysis focused on challenges expressed by community and health professionals associated with adherence to standardised BP protocols. To strengthen trustworthiness, triangulation was achieved using the ranking data and a thematic analysis to look for overlapping concepts with three researchers (SW, LS, AW) analysing and interpreting the data.

Results

Ten workshops, including two online, with health professionals (n = 63), and six workshops with community (n = 47), were conducted between June and September 2024. A total of 47 (75%) of the health professionals were female, and their occupations are described in Table 1. Characteristics of the community members are provided in Table 2. The three themes below capture key perspectives.

Table 1. Occupations of the 63 participating health professionals

Occupation	n (%)
General practitioner	34 (54)
General practice staff	15 (24)
Pharmacist and pharmacy staff	7 (11)
Other (rural health staff member, exercise physiologist, cardiac rehabilitation nurse, Aboriginal Health Worker)	7 (11)

Table 2. Characteristics of 47 participants from the community

Variable	n (%) or mean ± SD
Age (years)	63.1 ± 13.6
Female	21 (45)
Diagnosed with hypertension[A]	32 (68)
Taking antihypertensive medications[B]	28 (60)
In paid employment	12 (26)
Highest education level	
• Finished Year 10	13 (28)
• Vocational education/training	13 (28)
• University undergraduate	5 (11)
• University postgraduate	10 (21)

[A]Three and [B]seven participants were unsure or did not answer.

SD, standard deviation.

Minimal adherence to standardised clinic blood pressure protocol

While there was general awareness among health professionals of the correct method for measuring BP in line with national and international guidelines, none reported performing the full protocol in routine practice. Instead, professionals described adapting the protocol based on what was feasible in their setting. These modified approaches included partial adherence to key elements, such as using correct body position, while omitting others, such as observing a rest period, ensuring patient silence or repeating measurements. One GP remarked,

> *It's difficult isn't it ... we're talking for those 5 or 10 minutes. Yeah, definitely not*

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> (conducting the measurement to protocol, such as remaining quiet throughout). (GP 1).

Others described efforts to follow aspects of the protocol to approximate best practice within time and workflow constraints:

> *I don't wait 1 or 2 minutes between readings, but yeah, I try and do everything else* (according to the protocol). *They want to talk while you're doing it, so it's often hard.* (GP 2),

and

> *We do in terms of body positioning, but not in terms of the number of repeated measures.* (Health professional 1)

Community members reported never having experienced a BP measurement in line with the standardised protocol. Deviations described included measurements taken over clothing, absence of repeated readings and no rest period prior to measurement. One participant recounted,

> *… the doctor put the cuff on my elbow, I also had a coat on, and I queried him. Do you believe the GP or not?* (Community member 1)

Another stated,

> *I've never had my blood pressure taken on the bare arm by a doctor. Only a nurse.* (Community member 2),

while a third noted,

> *As soon as I walk in to see him, he does blood pressure straightaway. Not like here* (with rest time as per protocol). (Community member 3)

Adherence to clinic blood pressure protocol limited by lack of time

Limited time was the most frequently reported barrier to the implementation of the clinic BP protocol; however, this was described by health professionals and community in different contexts.

Time constraints and competing clinical priorities in clinical practice

Health professionals consistently described standard consultation lengths of 10–15 minutes as insufficient to include the full protocol alongside other clinical duties. As one GP explained,

> *10 minutes is unfortunately all we have with the patient.* (GP 3)

The same GP elaborated on the systemic constraints:

> *But remember, there's 14 of us. If all of us were to do that, the nurses would do nothing but take blood pressure.* (GP 3)

Clinicians also described struggling to align preventive tasks such as BP measurement with patients' presenting priorities. When other health issues took precedence – such as mental health or acute care needs – BP measurement was often deprioritised. One GP noted,

> *Too many other things as a priority.* (GP 4),

while another explained,

> *I find it really difficult if the blood pressure is my agenda, but that's not the patient's agenda. So, if they're coming in with mental health crisis or something else, I find it quite difficult to change tack to preventative.* (GP 5)

Limited time and access affected community experiences

Community members also perceived time pressures in general practice as a barrier to receiving standardised BP measurement. Some felt that BP was not routinely measured until specifically requested:

> *They don't have time to measure … You've got to actually ask.* (Community member 4)

> *Blood pressure is actually very rarely done at the GP anymore, like if you're just having a normal consultation.* (Community member 5),

and

> *GPs don't have that time anymore, it's straight in, put the old cuff on, yeah, write you out a prescription then off you go.* (Community member 6)

Several participants, particularly those from rural and regional areas, highlighted broader access issues such as delays in securing appointments and long waiting times. For example,

> *You can't even get into the doctor now.* (Community member 7),

and

> *… getting in* (to see a GP) *is difficult.* (Community member 8).

These structural challenges were seen to further diminish opportunities for quality BP care:

> *You can put all systems in, but unless you get the doctors to say 'hang on, you're important, I need to do this properly', but they don't because they don't have the time.* (Community member 6)

Incompatible environments and patient factors limit protocol practicality

Several health professionals described the protocol requirements, particularly the need for patients to remain silent and at rest, as incompatible with routine clinical interactions. Many noted the lack of access to quiet, private or dedicated spaces in which to conduct BP measurements without disruption. For example,

> *The quiet space would be difficult at our particular practice … it'd be good if we had a separate space or a room to do it … there's a lot going on, a noisy waiting room. It is difficult to get an accurate reading.* (Health professional 2)

Staff also reported that workforce capacity, particularly the availability of trained nurses, limited their ability to delegate BP measurement tasks. Reimbursement policies were described as inadequate, with some professionals noting that funding arrangements did not support the time required to perform standard BP measurement:

> *If you've got 20 minutes of a nurse's time, and you get an item number from Medicare that's worth very little.* (Health professional 3)

Patient-related factors further constrained protocol implementation and adherence. Some health professionals described patients with anxiety, restlessness or a sense of urgency (particularly among walk-in patients) as interfering with the rest period required for accurate BP measurement:

> *Usually they will just come in, they don't book an appointment beforehand, so when they are there all they want to do is just get out, so they won't be relaxed, they will always fidget some of the time and they voiced 'Is it okay, is it okay?'* (Health professional 4)

Community members also raised structural barriers that contributed to

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rushed or disrupted care. Transport limitations and difficulties accessing appointments (especially in rural areas) meant that opportunities for protocol-based measurement were limited:

> *A lot of people don't have transport.*
> (Community member 9),

and

> *We're an ageing population and a lot of them can't get out.*
> (Community member 2)

Even when access was possible, logistical challenges within clinics were seen as a barrier to implementing a structured protocol. As one participant remarked,

> *The hard thing is if you've only got one machine, how do you get the flow of people so there's someone there at 9 o'clock and someone else at quarter past … that could be problematic. The logistics need to be worked through for sure.*
> (Community member 10)

One GP reported that a patient highlighted cost as a significant barrier for many patients:

> *I find a lot of the working population, they don't go because they can't – 'I'm not paying 90 bucks to go to the doctor to get my blood pressure done.' It's the cost.*
> (GP 6)

In the priority setting activity, health professionals were asked to describe their implementation needs and key challenges for measuring BP in practice using a standardised protocol. These are summarised in Table 3, where the needs were highly reflective of the challenges and aligned with the developed themes.

Discussion

This study shows that the BP measurement protocol recommended in guidelines for clinicians to perform is not perceived as practical for use in routine primary care. This view was consistently expressed by primary care health professionals performing BP measurement, as well as community members having their BP measured. Although health professionals were aware of the recommended BP measurement protocol, time constraints and competing clinical priorities were the main barriers limiting uptake of the protocol. A further barrier was the impracticality of protocol requirements, such as not talking.

These findings have several major implications. Notably, standardised BP measurement must be performed for readings to be accurate, but the impracticality of the current protocol means that non-standardised, inaccurate BP assessment is routinely being performed. This is likely to result in highly variable BP readings that are not acted on. This also emphasises the value of clinicians making use of 24-hour ambulatory BP measurements and home BP measurements, which are better indicators of outcomes compared with clinic BP measurements.[14,15] Regardless, it is important to acknowledge unwieldy recommendations and develop workable solutions. For example, routinely incorporating BP measurement into the comprehensive cardiovascular disease risk assessment (Heart Health Check) or the chronic condition management plan, both of which provide more time compared with consultations for acute presentations, could be options for consideration. Alternatively, BP measurement performed by other health partners such as Pathology services (with inbuilt quality control and review processes)[16] could assist workflow and increase GP confidence in the measured BP.

This study supports other calls for improvement in the quality of clinic BP measurement.[17,18] The main effect of non-standardised clinic BP measurement is overestimation of the true underlying BP.[4,5] However, if only one BP is recorded, the true BP might be underestimated because subsequent BP readings can be higher up to 16.8% of the time.[19] A recent expert statement acknowledged that there were sparse contemporary data on clinic BP measurement but nonetheless concluded that BP measurement training, equipment and methods vary widely among clinics and 'nearly always deviate from methods recommended by guidelines.'[20] Thus, our study findings are not surprising, but provide confirmation of a longstanding issue that requires remediation. A potential solution to clinic BP measurement uncertainty might be achieved using automated (unobserved) office BP (AOBP) measurement, which is now the recommended clinic measurement standard in Australia.[21] However, policy changes would

Table 3. Key challenges and needs expressed by general practitioners and other health professionals for measuring blood pressure in practice using a standardised protocol

	Challenges	Needs
Staffing and time	Limited availability of staff and time to conduct BP measurements	Funding for staff time to conduct BP measurements
Location	Space and availability of a separate, quiet space to conduct BP measurements	An appropriate place and space to conduct BP measurements
Training	Appropriate training available for staff who would be conducting the standardised BP measurements	The right staff available and trained to conduct BP measurements
Equipment	Appropriate equipment, including automated BP monitors, to conduct BP measurements	Provision of required equipment
Reimbursement	Limited or unclear reimbursement options to cover staff time, training and equipment costs to conduct BP measurements	Policy changes to ensure cost of BP measurements are covered

BP, blood pressure.

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be needed to support the costs for sustained programs to implement AOBP measurement in general practice.

This study has several strengths, including undertaking consultation with a wide demographic of health professionals who measure BP in various primary care settings, as well as people in the community in whom this directly affects. To our knowledge this is the first time this has been done on the topic of clinic BP measurement. However, the study sample was opportunistically recruited in part and confined to regional centres of one Australian state. Thus, it cannot be assumed that the results are widely generalisable, despite the supportive evidence from previous research cited above. Furthermore, this study focused on clinic BP measurement according to guideline recommendations in the general practice clinic environment, but we also consulted other health professionals who measure BP outside this setting.

Conclusion

In summary, this study found that the guideline-recommended protocol for measuring BP in clinic is not practical for health professionals to perform as part of routine clinical practice. This was a consistent message reported by health professionals who measure BP in primary care, as well as community members who have had their BP measured. The findings highlight the urgent need for guideline review and updating recommendations to develop a protocol that is both accurate and practical for widespread clinical implementation.

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