Bulk purchasing can improve patient outcomes and save time and money

A system in which GPs prescribed wound dressings was wasteful, expensive and ineffective. This was overcome by nurses ordering dressings from local community pharmacies using a wound-care formulary as an order form

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What were the main factors that drove the review of wound product purchase, supply and management in your organisation?

- Technical fraud issue — named patient prescriptions were being used to obtain dressings for multiple patient usage.
- Large numbers of dressings were being returned to pharmacies for destruction, often from care homes.
- Isle of Wight spend on dressings was 40% higher than the national average for our more elderly population.
- Attempts to reduce waste often resulted in inappropriate dressings being applied. When faced with a prescription for small quantities of dressings, pharmacists preferred to issue full boxes of dressings rather than split them. This created a dilemma for nurses — should they continue to use a dressing for longer than was ideal, or switch to a more appropriate dressing and thus have to destroy any remaining dressings from the previous prescription?
- Nurses had difficulty gaining quick access to some dressings as pharmacists did not keep the required dressings in stock.
- Nurses were waiting for prescriptions to be signed by GPs. Meanwhile, the GPs wanted confirmation that the prescriptions they were signing were appropriate, formulary based and cost effective.
- GPs with little expertise in wound dressings had a gatekeeper role ie, they were signing the prescriptions.
- Patient inconvenience — patients had to wait for someone to obtain the dressing.
- The existing formulary was not adhered to.
- Earlier unpublished work by a medication review pharmacist identified that bulk prescriptions, as opposed to named patient prescriptions, would reduce waste and achieve significant cost savings plus other benefits. We sought to extend the principles established in care homes to the community. As bulk prescriptions cannot be used other than in schools or institutions, we developed the bulk purchasing idea.

Which stakeholders did you involve?

The medication reviews undertaken in care homes identified a number of the problems — including high levels of wastage, technical fraud and inappropriate dressing usage — as well as some solutions, such as bulk prescriptions and that dressings on repeat files needed to be reviewed regularly. A consultation exercise was undertaken with GPs, nurses, patients, carers, pharmacists, the Department of Health (DH), and Customs and Excise. The DH provided strategic advice, and Customs and Excise advice on VAT.

What were the main aims of the project?

To improve patient outcomes by avoiding delays in healing caused by the use of inappropriate dressings.

Also, to improve the service given to patients as wounds would be reassessed at every dressing change.

Other aims were to reduce nurse/GP inconvenience as nurses would no longer have to wait for a GP to sign prescriptions, while GPs were relieved of their gatekeeper role. We also wanted to reduce their workload by reducing the number of dressing prescriptions (they are now only 5% of previous levels) and by

avoiding the need for nurses to wait for prescriptions and dressings. Other objectives were to control costs, reduce waste and remove the technical fraud issue.

Were they achieved?
Yes. There was a £60–80k reduction in predicted dressing costs each year, as well as deflation for several years. Minimal quantities of dressings were returned to pharmacies for destruction. Also, there were no complaints about the system, which all clinicians said they preferred to the previous prescription-based system.

What was your role in the project?
To facilitate change. We (the prescribing team) developed the new system along with others, including GPs, nurses, pharmacists and managers, contributing to problem solving and discussion at every level. However, the success of the project was down to the nurses, GPs and others involved, who took it forward, used it and made it work.

What were the biggest challenges?
For me, it was persuading others that the idea could and should be taken forward. What kept spurring us on was our belief in the principles of the project, and sheer persistence. The other main challenge was getting everyone in the same room. This was overcome by inviting them to participate in training and discussion forums.

The biggest challenge for the group as a whole was getting used to a new way of working. Nurses use the local dressings formulary as an order form. Pharmacies supply against the order form, and are paid at the end of each month by the primary care trust (PCT). The order is photocopied onto yellow paper by the pharmacies and used as a delivery note. Nurses check deliveries against the delivery note and then send the latter to the PCT where it is married to the original order form, which the pharmacies use as invoices.

How long did it take from start to finish?
The project started in late 2000. It will continue to evolve but the original trials ended in 2003. The first trials concentrated on nursing homes only. They started in 2000, and involved all nursing homes by end of 2001/early 2002.

In late 2001 the trials were extended into the community. By 2003 all nursing teams were using the new system.

What existing documentation or examples of practice did you use?
Nothing at all as there was no similar system in any shape or form prior to our trials, which looked at the supply route and the effect on costs etc. Nurses continued, as before, to apply evidence to clinical choice. A team of nurses led by a tissue viability nurse controlled the formulary, and the new system supported the nurses' clinical choice of product.

What are the benefits of such an approach to wound product purchase, supply and management?
Cost savings and a significant reduction in waste. Cost savings, however, will only be seen if the levels of wastage that exist within the pre-existing system are fairly high (above 27%) as we have to pay VAT and no clawback or discount is taken from the pharmacists.

Also, the system is for nurses, run by nurses, and modified as necessary by nurses.

Were there any disadvantages?
Possible disadvantages are that the PCT has to pay VAT; the formulary restricts the use of newer dressings until they are included within it; some nurse prescribers may feel deskilled and storage may be a problem in small areas.

What would you do differently?
Involve industry for advice, support and expertise rather than working alone. This would have saved time.

How did you sell it to the trust board and clinicians?
We emphasised the potential to save money while improving clinical outcomes for patients. We also said it would reduce the workload of GPs and nurses. Their response was one of guarded welcome — hence, we proceeded with a series of trials and evaluations before taking the next step.

Are any future developments planned?
We have already moved the dressings budget out of the prescribing budget and into the nurse directorate control, and have increased cost savings by improving training.

As for the future, we hope to extend bulk prescribing into larger residential homes. If possible, we would like to take the principle of bulk purchase to other areas, such as sip feed and continence. ■