Making better use of prescribed wound-care products

As far back as 1986, the Cumberlege Report (Neighbourhood Nursing: A Focus for Care (DHSS, 1986) identified that very complicated arrangements for prescribing had arisen in the community. It was apparent that nurses were wasting considerable amounts of time requesting prescriptions from the GP for items such as wound dressings. The report suggested that allowing nurses to prescribe could rectify some of these problems. Today many community nurses are prescribing from a limited formulary. However, customs and practices that developed in the past, to circumvent the legislation on the prescription and supply of medicines, persist.

It has been common practice for many years for district nurses to use wound-care products that have been prescribed for one patient for another patient. It has many advantages: it saves waste, prevents a patient waiting for a product to be prescribed and saves the nurse time. The downside is that this practice is unlawful.

Stephen Lutener, head of professional conduct at the Royal Pharmaceutical Society, is clear that it is not good practice. ‘Every patient has a right to expect high-quality products. Once something has been stored in a patient’s house, you have lost that guarantee of quality and it should not be reused.

‘We are concerned about wastage, but we would encourage the prescribing of more reasonable quantities so there is no build up in the patient’s home of products which could end up being thrown away,’ he says.

Some primary care trusts are now finding ways around this dilemma. When a patient who was in the care of Mid-Sussex Primary Care Trust died, £600 of wound-care products was destroyed. The PCT has now set up an initiative that reduces the tendency for bulk prescribing and hoarding, and allows the nurse to carry prescribable dressings in his or her bag.

The system is called the ‘first dressing initiative’ under which all district nurses can pick daily from a stock box of the 10 most popular dressings. This includes products such as hydrocolloids, alginates, tape and bandages, which are carried in a clear plastic wallet and returned to the stock box at the end of the day.

If the nurse sees a patient who needs one of the dressings, he or she can use one from his or her stock and then generate a prescription on returning to the clinic. The trust takes responsibility for the prescription under a group protocol.

Sally Hyde is a clinical team leader for district nursing at the trust. She says: ‘The practice of district nurses using products previously prescribed for other patients goes back into history. In the past few years, there has been an awareness that it is not the right thing to be doing. Nurses like the first dressing initiative as they feel more in control. They are no longer at the mercy of the pharmacy, waiting for a product, so hoarding is discouraged.’

Another PCT has taken a more radical approach. On the Isle of Wight prescriptions for dressings are becoming a thing of the past. A pilot project launched at two GP surgeries at the beginning of 2002 proved so successful that from November of that year it was rolled out across the island.

A dressing formulary has been developed by the tissue viability nurses, which doubles as an order form. District and practice nurses simply fill in what they need on the form and take it into the chemist, who fills their order. The form is sent to the PCT that will pay for the ordered products.

Noel Staunton is prescribing adviser for the Isle of Wight PCT. He says that he does not know why they did not implement such a scheme before. He lists the advantages. ‘It saves nurses time, as they only have to fill in one form, not endless prescriptions for individual patients. When they have a box of dressings, they can use it for more than one patient because none of them is for a named patient.

‘The patients get the dressings they need when they need them and the nurse doesn’t have to worry about who the dressing belongs to.’

A group of nurses manages the formulary and meets twice a year to decide whether any items need to be added or removed. Since the scheme was introduced, the number of monthly prescriptions for dressings has fallen from 3,500 to fewer than 1,000. And the number is continuing to fall.

The cost of bulk-buying dressings is more expensive because without a prescription the PCT has to pay VAT. However, the reduction in wastage is more than cancelling out the VAT.

Mr Staunton says: ‘The idea of the scheme is not to save money but to save nurse and GP time, and let the patient get the right dressing at the right time. It is just simpler, easier, quicker and, as it turns out, cheaper.’

The Isle of Wight team is so happy with the results that it plans to extend it to continence products, food supplements and gluten-free foods.

The scheme is picking up a lot of interest within other PCTs and, if it spreads around the country, the nurse’s dilemma of what to do with named patient dressings and other non-prescription goods should disappear completely.