Bulk prescribing implementation guidance for: The Practice

Before implementing bulk prescribing there should be a discussion between the GP, community pharmacist, care home and the CCG medicines management team to agree the list of medicines and local processes.

Implementation of bulk prescribing

- Discuss list of medicines suitable for bulk prescription.
- Decide if service users fit the criteria for bulk prescribing.
- GP and care home manager discuss and agree on medicines that can be bulk prescribed in the care home and inform community pharmacy. Ideally the community pharmacist should be part of this discussion process. (Use Attachment 1 Agreed list of bulk prescribed medication form and Attachment 5 Community pharmacy letter if appropriate)
- Agree a system with the care home regarding requests for bulk prescriptions. (See Attachment 3 Bulk prescribing order form)
- On commencing treatment, the medication must be prescribed initially on a prescription bearing the service user's name. This will ensure the medicine and specific directions appear on that service user's subsequent MAR charts. An entry must be made on the repeat screen to ensure there is a record of bulk prescribing.
- Access the service users computer records and on selected medication include 'bulk prescription' to identify it is supplied as part of bulk prescription (e.g. Lactulose 10ml twice daily bulk prescription).
- Bulk prescriptions can either be handwritten or computer generated (they cannot be generated and transmitted as electronic prescriptions). The care home name is a requirement on the prescription. To allow computer generated bulk prescriptions to be issued, it is suggested that the practice 'registers' the 'care home name' as an inactive patient. Using this record to issue all bulk prescriptions for that care home ensures a chronological record of items issued for audit purposes.
- If the above process is not used, and bulk prescriptions are handwritten there must be an alternative method of recording. A record of the bulk prescription must be logged at the practice either via: Entry on the care home's 'inactive patient' record
 - > Entry on the care home's 'inactive patient' record
 - > Entering details onto each service users computer record.

NB. Handwritten scripts are not recommended as it is not possible to mitigate against risks of information not getting onto the patient record.

• Ensure the order form is retained by the practice for audit purposes e.g. the practice may choose to scan this order into the care home record.

• A new prescription must be generated for the individual service user if there is any change to the dose of the bulk prescribed medication. Subsequent prescriptions can be requested on bulk prescription.

• Ensure reception staff are aware of the bulk prescribing process.