Australian Nursing And Midwifery Federation Submission

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW TASKFORCE DRAFT REPORT FROM THE WOUND MANAGEMENT WORKING GROUP

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INTRODUCTION

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 280,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF welcomes the opportunity to provide feedback to the Medicare Benefits Schedule Review Taskforce *Draft Report from the Wound Management Working Group (2019)* and supports the Taskforce's commitment to providing wound management services that value affordable and universal access, are based on best practice principles, and offer benefit for the individual patient as well as the health system.

Registered and enrolled nurses

Registered and enrolled nurses are regulated health practitioners, who provide care in collaboration with other health professionals and individuals requiring care. Legislation and regulation guide nursing practice. Registered nurses, as qualified, registered health practitioners, are accountable and responsible for their own practice.

As autonomous, independent health practitioners, registered nurses work collaboratively with other nurses, medical and allied health practitioner colleagues when providing nursing care. In accordance with the Nursing and Midwifery Board of Australia's (NMBA) *Registered Nurse Standards for practice*,[1] registered nurses are responsible for delegation to, and supervision of, enrolled nurses. They are the only health practitioner that can do this.

Nurse Practitioners

Nurse practitioners are registered nurses whose registration has been endorsed by the NMBA under the *Health Practitioner Regulation National Law Act 2009*[2] (National Law). As is the case for registered and enrolled nurses, the title nurse practitioner is protected under the National Law making it an offence for use of the title by anyone other than those authorised to do so by the legislation. Endorsement to practise as a nurse practitioner is vested in the NMBA. To be eligible for endorsement, an applicant must meet the NMBA *Registration Standard: Endorsement as a nurse practitioner*.[3] The minimum educational preparation for a nurse practitioner is a Masters of Nurse Practitioner program accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA. Nurse practitioners practice in all clinical areas, across metropolitan, rural and remote Australia, in both the public and private sectors.

Nurse's role in wound management

Nurses manage acute and chronic wounds across multiple health care settings, including primary care, specialist community-based services, hospital in-patient and outpatient clinics and community and residential aged care facilities. They complete their undergraduate education with the skills and competence to perform wound assessment, care and management. Nurses build on these skills through experience and continuing professional development relevant to their context and scope of practice. Many nurses undertake postgraduate study to further develop their knowledge and expertise in the management of acute and chronic wounds.

The ANMF acknowledges the inclusion of the role of nurses in wound management frameworks outlined in the Draft Report. However, the report does not acknowledge the important role Wound Management nurse practitioners play in the care and treatment of complex acute and chronic wounds. These expert nurse practitioners spend more time with patients on wound care than medical practitioners, through more frequent visits and patient and family education.[4] Their specialised knowledge enables them to deliver individualised, targeted care to the patient, positively altering the healing trajectory of the wound.[5]

Access to the Medicare Benefits Schedule

Whilst nurse practitioners can access the Medicare Benefits Schedule (MBS) as providers in their own right, registered and enrolled nurses have been given access to some item numbers for "treatment provided on behalf of, and under the supervision of, a medical practitioner".[6] Nurses, whether working in general practice or another setting, do not provide care or treatment on behalf of, or supervised by, any other health practitioner. This MBS requirement is therefore contrary to the regulation of registered and enrolled nurses and should be wholly replaced by block funding. Although there needs to be a significant increase in the structure and amount of block funding, nursing services provided by registered and enrolled nurses in general practice should be entirely funded under the existing Workforce Incentive Program (WIP).

Using MBS item numbers for nurses in general practice narrows their scope of practice and prevents the provision of person-centred, holistic, comprehensive nursing care. Nurses are entitled to identify the care which they are educated, competent and authorised to provide. They are held accountable for their practice by the NMBA. The ANMF therefore does not support wound care funding through MBS item numbers for registered and enrolled nurses in general practice.

Credentialing

The ANMF does not support the proposal to introduce credentialing for nurses in wound care. A component of a nurse's obligations, as stipulated by the NMBA, is to undertake continuing professional development relevant to their context and scope of practice, and thereby maintain knowledge and competence to effectively fulfil their chosen role. There is no evidence to suggest that nurses require credentialing to provide wound care as it is an inherent part of all nurses' practice. Credentialing processes create additional barriers to care, have the potential to restrict consumer access, generally come at considerable cost to nurses, stand to profit private organisations and, most importantly, offer no assurance of safety and quality.

To fully utilise nurses' scope of practice, the ANMF proposes several of the recommendations be reviewed.

Response to the Recommendations

Role of nurses in wound assessment, management and professional relationships

Recommendation 1: GP initial wound assessment

Recommendation 2: GP wound assessment review

Recommendation 3: Practice Nurse wound treatments

Recommendation 4: Nursing care under team care arrangements

The Draft Report noted that: "*93% of practice nurses undertook wound management tasks either week or daily*".[7] Despite this, nurses are not identified as health professionals capable of performing initial wound assessments and wound assessment review in recommendations 1 and 2.

The role nurses have to play in the health care team is increasingly important as our health care system begins to shift from the traditional emphasis on acute and emergency health care, to health prevention and management of chronic health conditions through a primary health model. Nurses provide comprehensive, holistic, and person centred-care, not only in underserved communities (including remote areas, aged care, Aboriginal and Torres Strait Islander peoples, and for homeless populations), but also across metropolitan, rural and remote areas of clinical practice. They provide safe, affordable, expert clinical care within a variety of settings, values consistent with the principles outlined in the Draft Report.

As previously mentioned, registered nurses, like all qualified registered health practitioners, are accountable and responsible for their own actions. This means nurses must assess wounds prior to planning and performing wound care, regardless of whether or not another health professional has previously done so. Requiring GP review first therefore duplicates this process at the discomfort of the patient, for increased cost, with no clinical gain. A nurse is then required to evaluate the outcome/s of any intervention, and assess the need for referral to other health professionals for further management. Requiring patients to be assessed and reviewed by a GP, to then be assessed, managed and evaluated by a nurse is poor use of resources, and potentially creates a barrier to patients receiving timely cost-effective wound management services. This will have the greatest impact on underserved populations, including homeless persons and Aboriginal and Torres Strait Islander peoples.

Registered nurses perform initial wound assessment, provide wound treatment and subsequent wound reviews. This practice reduces fragmentation of care by facilitating consistent, comprehensive assessment, evaluation, and treatment. Dealing with one primary health provider, who in turn consults with, and refers to other health care providers reduces the risk of the consumer receiving conflicting advice or there being confusion with clinical decision making. This ensures the treating health provider has a complete clinical picture which facilitates a therapeutic relationship between the person receiving care and the health practitioner. It also offers increased opportunities to initiate health promotion discussions and disease prevention activities, thereby reducing the development and progress of burdensome preventable health conditions including those potentially contributing to continued risk for the development of chronic wounds.

Ongoing evaluation of wound management progress is documented and managed by the nurse. This occurs in all healthcare settings and does not require continuous medical review where a nursing intervention is in place, unless it is clinically indicated.

The ANMF proposes that an additional recommendation be added to the chronic wound management framework that identifies the role nurses can perform in initial wound assessment and review.

Utilising nurses to their full scope of practice will improve access to acute and chronic wound management primary care, particularly in rural and remote areas. This will reduce overall cost to the health care system, and facilitate integrated care that benefits the patient without doubling up on service provision, addressing the core objectives of the Review: to provide affordable and universal access, and value for the health system.

The ANMF does not support the wording of recommendations 3 and 4 pertaining to supervision and medical oversight of nursing practice by GPs.

Recommendation 3 states:

"*The criteria for accessing the proposed new items are as follows…the medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient*" p37.

Recommendation 4 states:

"*Although ultimately under the supervision of the GP, the proposal is that the nurse operate autonomously to a degree*" p40.

As outlined in the NMBA *Registered Nurse Standards for practice*, registered nurses are responsible for "autonomous practice within dynamic systems."[8] They do not work under the supervision of the GP (or other health professionals) and are required (by the NMBA) to make their own assessments, think critically, and determine, coordinate and provide safe, quality nursing care including evaluating outcomes. These core elements of nursing practice further support the inclusion of an additional recommendation identifying the role nurses can perform in initial wound assessment and review.

The nature of the nursing profession means nurses are accustomed to operating as part of a holistic care team, and work well in collaboration with other health care professionals. At all levels of practice, registered nurses are adept at recognising where the knowledge, expertise and skills of our multidisciplinary colleagues are needed, then referring to and liaising with team members across the health professions.

Nurses unequivocally form an integral part of the primary health framework. Their involvement in care planning teams for optimal management of chronic wounds is identified in the Draft Report. However, the ANMF requests the wording of these recommendations (3 and 4) and the accompanying rationales be revised to recognise the NMBA *Registered Nurse Standards for practice*[9] which govern the scope of practice for registered nurses and the significant role nurses play in their own right in the management of chronic wounds.

Role of Nurses in General Practice in Wound Management and MBS Items

Recommendation 3: Practice Nurse wound treatments

Nurses in general practice are not accountable to non-nurse practice managers for clinical decisions and outcomes.[10] Historically, the introduction of MBS item numbers for nursing services in general practice has resulted in prescriptive care, at times directed to meet funding criteria. This has both, narrowed the nursing scope of practice, preventing the provision of holistic and comprehensive nursing care, and limited the full benefits of these services being provided by nurses for the patient's overall wellbeing.

Whilst the ANMF supports the recommendation for nurses in general practice to be included as an essential element in the primary care model for addressing chronic wound management, there is potential for broader health promotion activities to be missed when their role is restricted to the wound. An inherent principle of nursing practice is to provide comprehensive, holistic, person-centred care that is not focussed on the presenting health concern alone. This supports the underlying ideologies of primary care models that assess and promote health and wellbeing opportunistically. Discrete funding to facilitate nurses to manage chronic wounds restricts opportunistic and holistic health care, thereby diminishing the overall health and cost benefits of utilising nurses in primary care models.

Prior to 2012, the MBS provided specific item numbers for the delivery of nursing services, such as cervical smears, immunisations and wound care, provided for and on behalf of a GP. For each occasion of nursing service, remuneration was provided to the general practice from Medicare. This funding model significantly impacted on the services that were delivered by nurses in general practice.[11] On 1 January 2012 the Practice Nurse Incentive Program (PNIP) was implemented.[12] This program, now replaced by the Workforce Incentive Payment (WIP), provides incentive payments to accredited general practices to offset the employment of a registered nurse and enrolled nurse.[13] The amount of incentive payment received by a Practice is based on its Standardised Whole Patient Equivalent (SWPE) value and the number of hours worked by nurses.[14] This incentive aims to support an "enhanced role for nurses working in General Practice" as it is not tied to the delivery of any specific services.[15]

From the introduction of the PNIP 2012, and at the commencement of the MBS Taskforce Review, the ANMF has argued for the abolition of the remaining MBS item numbers allowing for the claiming of services provided by a nurse in general practice 'for and on behalf' of the GP, or 'under the supervision' of the GP. These item numbers are for: health assessments (701, 703, 705, 707, 715, 10986 and 10987), chronic disease management (10997), antenatal care (16400), management plans (721, 732), team care arrangements (723), spirometry (11506), ECG (11700), and telehealth (10983, 10984).

The ANMF has also argued for the removal of the current restriction in the block funding for the numbers of nurses employed being tied to the number of GPs in a practice, in order to access payment. The WIP funding of nurses in general practice needs to be uncoupled from the GP (that is, deconstruct the GP: Nurse Ratio). This would enable more nurses to be employed within general practice and better meet community needs.

The retention of some MBS item numbers has linked funding to the provision of specific services only. This perpetuates a model whereby employers, usually GPs, or practice managers, direct nurses to focus care only on those activities that can be billed through Medicare. This has meant the original intent of the PNIP, now replaced by the WIP, to enhance the role of nurses working in general practice has not been fully achieved.

Consequently, the ANMF does not support the introduction of two new item numbers for wound management services provided by a nurse in general practice. As regulated health practitioners, registered nurses are not 'supervised' nor do they provide care 'for and on behalf of' any other health care practitioner. Nurses acknowledge that all health care is a collaborative endeavour focused on positive outcomes for individuals and groups.

Instead of continuing with these MBS item numbers and introducing more, the amount of funding for the WIP should be significantly increased to acknowledge the role that all nurses in general practice undertake in the provision of wound care – assessment, management and review, as well as opportunistic and holistic health assessment and promotion. This is necessary because wounds, particularly those that are slow to heal, are often related to other co-morbidities, like diabetes and venous insufficiency. Block funding would allow for concomitant management of both the wound and associated biopsychosocial issues, addressing the current lack of holistic, person-centred, integrated, cost effective care pathways across the health, aged, and disability care systems.

Funding and therefore billing should support integrated, multi-disciplinary person-centred care. This block funding would allow nurses to work to their full scope of practice, the original intent of the PNIP, and not be directed by others to undertake only the aspects of nursing care for which the general practice can bill Medicare.

Role of Nurse Practitioners in Wound Management and MBS Items

It is disappointing that the considerable expertise and contribution of nurse practitioners to wound management is not acknowledged in the Draft Report. Nurse practitioners work in a variety of contexts, across diverse practice settings to deliver high level, clinically focused nursing care. The scope of practice of the nurse practitioner builds upon registered nurse practice, enabling nurse practitioners to manage episodes of care, including wellness focussed care, as a primary provider of care in collaborative teams. Nurse practitioners use advanced, comprehensive assessment techniques in screening, diagnosis and treatment. They apply best available knowledge to evidenced-based practice. Nurse practitioners order and interpret diagnostic tests, prescribe therapeutic intervention including the prescription of medicines, and independently refer people to healthcare professionals for conditions that would benefit from integrated and collaborative care. They accomplish this by using skilful and empathetic communication with health care consumers and health care professionals. Nurse practitioners facilitate person-centred care through the holistic and encompassing nature of nursing. They evaluate care provision to enhance safety and quality within healthcare. Although clinically focused, nurse practitioners are also expected to actively participate in research, education and leadership as applied to clinical care.[16]

The introduction of the nurse practitioner role in Australia has improved primary health care access for marginalised, disenfranchised, and geographically isolated populations, while providing nursing expertise in such diverse areas as wound care, pain management, palliative care, cardiac health, alcohol and other drugs, mental health and renal replacement therapy.[17] Extending rebates for the services nurse practitioners can provide will reduce fragmentation of care by facilitating comprehensive assessment, evaluation, and treatment by nurse practitioners. It also offers increased opportunities to initiate health promotion discussions and disease prevention activities, thereby reducing the development and progress of burdensome preventable health conditions.

The Nurse Practitioner Reference Group (NPRG) review of nurse practitioner access to MBS items[18] has determined that changes to the Schedule (including additional items) will streamline the safe, timely provision of quality health care to Australians, reduce costs, duplication of work and documentation, and improve equity of access to those who face disadvantage. The present restrictions on some of these items increases inequity in already disadvantaged populations (particularly older Australians and those living in rural and remote areas), and impairs the viability of successful nurse practitioner practices, both independent and within health care clinics. In many cases, these restrictions on access to MBS items mean that GPs need to review and assess patients who have already been evaluated by nurse practitioners, not because of their clinical condition or complexity, and not because of concern on the part of the nurse practitioner, but only to allow for further testing and management.

Specifically, the following recommendations made by the NPRG, if adopted on completion of the MBS Review, will enable nurse practitioners to provide appropriate, timely, cost-effective wound care in accordance with their scope of practice:

Recommendation 4 - Increase the schedule fee assigned to current MBS nurse practitioner professional attendance items

Recommendation 5 - Longer nurse practitioner attendances to support the delivery of complex and comprehensive care

Recommendation 7 - Access MBS rebates for nurse practitioner care received outside of a clinic setting

Recommendation 8 – Remove requirement for nurse practitioners to form collaborative arrangements

Recommendation 9 - Remove current restrictions on diagnostic imaging investigations

Recommendation 10 - Access MBS rebates for procedures performed by a nurse practitioner

Recommendation 13 - New MBS items for direct nurse practitioner-to-patient telehealth consultations

The ANMF supports these recommendations made by the NPRG to the MBS Review Taskforce. In addition, the ANMF made a recommendation to the NPRG for an additional change to the MBS to improve patients' access to care: that allied health practitioners be able to claim for review of and interventions for patients referred by nurse practitioners. Making this change will reduce the current issues resulting from nurse practitioners needing to send patients to GPs for allied health referrals, which include duplication of assessment, health practitioner workload, unnecessary cost in both time and money to the patient and the health care system, and delay in accessing appropriate treatment. Involving allied health practitioners in the management and prevention of wounds, particularly chronic wounds, will improve access to best practice health services and be of value to both the individual patient and the health system.

Training and Credentialing

Recommendation 16: Nurse training and credentialing

Recommendation 18: Nurse Practitioner training and credentialing

Recommendation 22: Defining and credentialing of specialist wound practitioners

Whilst the ANMF supports the need for health practitioners to have the underpinning knowledge and skills to manage chronic wounds optimally, we strongly oppose any recommendation to introduce credentialing for nurses in general practice and nurse practitioners to provide wound care under the MBS.

Internationally, credentialing has been promoted as "a means of assuring quality and protecting the public by confirming that individuals, programmes, institutions or products meet agreed standards".[19] In the Australian context, this is achieved through statutory regulation in the form of profession specific registration. Professional organisation credentialing offered as an additional validation process is not required for a nurse to maintain their registration to practice and is unnecessary.

Quality health care and the safety of the Australian public is assured through the National Registration and Accreditation Scheme, under the *Health Practitioner Regulation National Law Act 2009* [20] (National Law). The statutory regulation of registered nurses, midwives and enrolled nurses begins with initial registration following successful completion of an accredited education program.[21] Entry to practice programs require graduates to meet minimum standards for practice as set down by the NMBA. On registering, nurses and midwives are listed on the Australian Health Practitioner Regulation Agency (AHPRA) Public Register for health practitioners. The public and employers are thereby able to validate and satisfy themselves of the individual health practitioner's registration status, and any associated conditions, notations or endorsements by accessing this Public Register.

From initial registration, registered nurses are required, as statutory regulation dictates, to undertake continuing professional development relevant to their scope of practice and maintain competence to practice within their context of practice as defined by the NMBA *Registered Nurse Standards for practice.*[22] Therefore, nurses working in general practice and nurse practitioners, as in any other area of nursing, bring a range of skills and knowledge specific to their context of practice.

There is no evidence to suggest that nurses require credentialing to provide wound care as it is an inherent part of all nurses' practice. Credentialing has the potential to lead to restrictive employment practices, reduce consumer access to an already skilled workforce, and has the potential to profit private organisations without any clinical or consumer gain. Wound assessment, care and management are core components of undergraduate nursing education and the nurse's role and scope of practice.

Credentialing arrangements offered by some professional organisations are not recognised under the national regulatory framework, and do not provide the public with the same safeguards afforded by national registration. That is, statutory regulation provides the public with the mechanism by which they can be assured of the registration status and thus the right of an individual health practitioner to practice.

Nurses are required to undertake continuous professional development annually as part of their registration requirements. Where there is an identified need for additional knowledge there are recognised education courses available for the practitioner to access without the additional financial and time-consuming burden of undertaking credentialing.

To avoid the potential pitfalls associated with mandatory training and credentialing as identified above, the ANMF proposes that recommendations 16, 18, and 22 be removed. Ideally, continuing professional development for nurses is self-selected based on their context and scope of practice and individual learning needs.

Addressing the Cost of Wound Care Consumables

Recommendation 23: Remove bulk-billing restriction

The ANMF is concerned that recommendation 23 is not consistent with the key goals of the Taskforce – affordable and universal access, best practice health services, value for the individual patient and value for the health system. Introducing an exemption to the restriction prohibiting practitioners from charging for the cost of a wound dressing applied during a bulk-billed consultation has the potential to significantly increase the costs of wound care for those least able to meet these costs. It is proposed in the Draft Report that the introduction of this exemption would mirror the current exemption for vaccinations. However, the exemption for wound care consumables would transfer considerably greater cost to the patient than that for a one time or short series of vaccinations, as some chronic wounds require frequent dressings over a period of months or even years. The likely consequence of removing the bulk-billing restriction is that patients may be unable to afford dressings or choose not to seek treatment, leading to poorer health outcomes and increased presentations to acute care services when wounds have deteriorated to the point where they cannot be ignored.

This recommendation is not supported.

Recommendation 24: Development of a wound consumables scheme

The ANMF supports the establishment of a Commonwealth-funded wound consumables scheme to ensure eligible patients can access appropriate wound care products. Patients who are unable to afford wound care consumables, or would be greatly impacted by the cost, should be able to access evidence-based wound care. The provision of a wound dressing formulary under this scheme would offer a systematic and transparent framework for best practice dressing selection, allowing nurses to make informed choices for optimal outcomes for patients requiring wound care.[23]

Wound Management in Residential Aged Care Facilities

Recommendation 12: Education and training of RACF staff

The ANMF recognises and acknowledges the importance of continuing professional development relevant to the context and scope of practice of all health professionals and therefore supports recommendation 12 to provide professionals working in the residential aged care sector with additional skills and knowledge in skin integrity management. However, we have identified some potential limitations in the effectiveness of such a strategy.

As submissions and statements to the Aged Care Royal Commission[24] have clearly demonstrated, systemic issues faced by the aged care sector need to be addressed for residents to receive the holistic, competent care they require. Identified issues of inadequate staffing and inappropriate skill mix will dilute any gains made via the implementation of education and training packages targeted to address one facet of health when the overall system is underserved across multiple domains.

Furthermore, skin integrity management is complex and not limited to prevention, assessment, and management of breaks in skin integrity at direct point of care. Therefore addressing wound management in residential aged care facilities requires a multidisciplinary approach with effective collaboration and systems in place.[25] It follows, then, that education and training should be collaborative in nature, and involve all health professionals. The health practitioner would have to first assess the aged care consumer's needs in relation to wound care and then determine if the assistant in nursing, personal care worker, or Aboriginal and Torres Strait Islander health practitioner or health worker has the ability to undertake any aspect of wound care.

Recommendation 13: Review funding for chronic wounds in RACF

Recommendation 14: Access to wound care experts in RACF

The AMA's 2017 Aged Care Survey Report [26] demonstrates that, despite rising demand in both number of residents and need for health practitioner attendance, fewer GPs are prepared to service this sector. In view of this, recommendations 13 and 14 offer the ideal opportunity for increased utilisation of nurse practitioners. Nurse practitioners are both willing and able to provide safe, efficient, quality primary care to the ageing community. Where nurse practitioners are utilised to their full scope of practice in chronic wound management, and as discussed above, the NPRG recommendations adopted, they present a cost effective solution to increasing access to wound care specialists in the residential aged care sector.

Utilisation of unregistered health care workers in chronic wound management

Recommendation 12: Education and training of RACF staff

Recommendation 17: Aboriginal and Torres Strait Islander Health Practitioner and appropriately training Aboriginal Health Worker wound management training and credentialing.

As identified in the report, comprehensive knowledge is required to manage chronic wounds. Despite this, unregistered health care workers are identified in the proposed frameworks in the management of wounds in the community and in residential aged care facilities. The ANMF views this as potentially problematic given a guiding principle of the review is to deliver best practice health services. Where unregistered health care workers are involved in the management of wounds, their role must be limited to observation of skin integrity and reporting of their findings (as per their education preparation) to the supervising registered nurse. Access and reporting pathways to qualified health professionals should be strengthened.

CONCLUSION

Thank you for this opportunity to provide feedback on the Draft Report. The ANMF commends and supports the Taskforce's commitment to providing wound management services that value affordable and universal access, are based on best practice principles, and offer benefit for the individual patient as well as the health system. Increased utilisation of nurses in wound care management is consistent with these aims. However, the proposed frameworks do not acknowledge the significant role of nurses in person-centred wound care management nor adequately support increased inclusion of holistic nursing care. To enable nurses to be fully utilised in wound management frameworks, the recommendations must be reviewed to remove restrictions compromising consumer access to care created by the proposed funding, credentialing, and medical oversight models in the Draft Report.

The ANMF looks forward to further participation in the next phase of consultation.

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