2008

Psychiatric Nurses' Association

[PUBLIC CONSULTATION DRAFT NATIONAL QUALITY STANDARDS RESIDENTIAL SERVICES FOR PEOPLE WITH DISABILITIES]

Table of Contents

Introduction

The Psychiatric Nurses' Association (PNA) welcome the opportunity to offer our views and comments on the **Draft National Quality Standards Residential Services for People with Disabilities**. As a National professional organisation representing nurses working in Intellectual Disability Services we are committed to progressing the quality agenda for those services providing care for people with a disability, indeed the strategic planning of nursing and quality assurance of all health services are of paramount importance to the work of the Psychiatric Nurses Association.

The PNA represents all disciplines of qualified nurse, including RNID, RPN, RGN and those dual qualified, for the purposes of this submission we will be referring to the term nurse which encompasses all disciplines of nursing in ID services.

It is the Psychiatric Nurse's Association (PNA's) understanding that patient safety and quality of care are considered to be central, drivers in the reform of our health services. The Psychiatric Nurses Association continues to identify the urgent need to address the health care needs of individuals, families, and groups to improve their access to, and attainment of, quality care in a variety of settings and environments. The essence of any service provision and care for vulnerable care groups must combine the concepts of rights and responsibilities with a systematic transparent roll out of the necessary resources and structures in an accountable climate.

Our members have been anticipating the publication of the Draft National Quality Standards Residential Services for people with Disabilities with enthusiasm indeed the Health Act 2007 is welcomed as a legislative framework to proceed with the registration and inspection of residential services for people with disabilities.

In order to consult and to ensure that such developments take place in an informed and responsive way, we held a consultative forum in an effort to outline pertinent and valuable contributions / views for discussion reflective of key stakeholders which have enabled us to inform our contribution to this submission. This submission takes an experiential approach pulling together a conglomeration of experiences related by our members who have direct contact with service users. This composite document is more

detailed and focused on ID nursing rather than the whole nursing workforce. It has drawn together the key interlinked themes arising from the forum

It is important to state from the outset as articulated to us by our members that there are some concerns with the consultation process itself. Whilst this organisation (PNA) acknowledges that every effort was made by the Health Information and Quality Authority (HIQA) to target every service with copies of the documentation, our members have stated that there have been problems with regard to its dispersal/ circulation to those care providers working at the coal face. This circulation problem may be for a variety of reasons least of which is the internal communications within organisations; none the less as a National organisation we re-circulated these documents in order to gain our members views. We would also have welcomed an invitation to one of the organised discussion groups provided.

1. It is important that the standards document contains clear language and is easy to follow. Please tell us your views on this.

Section 1 outlines clearly the context and background to the document however a broad outline of the inspection schedule and process would be useful at this point.

With regards to the following we note the exemptions to "designated centres "there in as defined by the Health Act 2007 that is, residential services for children, older people and people with disabilities[i].

"Designated centres do not include mental health facilities. In-patient mental health facilities are registered with the Mental Health Commission, in accordance with the Mental Health Act 2001, and are inspected against standards contained in the Quality Framework for Mental Health Services in Ireland. Similarly, designated centres do not include centres in which the majority of persons being cared for are being treated for 'acute' illnesses or provided with palliative care."

Whist recognising the scope of the standards as laid down above, we have some suggestions to make within this regards.

Residential services for people with disabilities are provided to a diverse wide range of client groups within different living accommodation types.

Services to the following groups appear to be included as part of this process by virtue of them being residential services: and a "designated centre".

People with an intellectual disability

People with a physical disability

Clients with severe challenging behaviour

People with an intellectual; disability and autism, /mental health problems

Those who are profoundly multi impaired and those who are medically fragile.

It is our belief that a separate set of standards should be drafted bearing in mind the different client groups and therefore the various services required to provide a comprehensive holistic person centred service.

Within this context we propose a separate set of standards be drafted for those residential services which provide care to persons with an intellectual disability.

Further we propose that these standards make the distinction for the purposes of providing an appropriate service, the difference in facilities and therefore standards based between residential care in a clustered residential setting, residential care in a community setting/ independent living and a residential service which provides care for those who are profoundly multi impaired and those who are medically fragile.

In section two we note the timeframe for review of the standards will be reviewed after three years, in keeping with the process undertaken by the Mental Health Commission for a review of its rules and codes of practice and timeframes to work within the standards we welcome this timeframe.

As a general comment it was felt that section 6 whilst outlining the standards and the relevant criteria therein, was ambiguous in its language at times.

E. g having a standard that pertains to an individual's routine and lays down criteria which states

"The routines of the centre promote a sense of homeliness and reflect prevailing social patterns"

Was interpreted as superfluous and almost derogatory in that if we are saying from the outset that one of the principles supporting the standards and therefore the service is based on

Key principle: *The services should be person-centred.*

Than language/ criteria pertaining to "routines" requires revision and needs to be contextualised, it was articulated to this organisation that some services found this section offensive and not typical of the terminology used within some services.

The glossary of terms needs some development, our contributors recommended the following:

With regard to the definition of key worker we recommend the following definition:

Key Worker: The key worker is a designated **qualified person competent to meet the needs of an individual.**

Person-in-Charge*: The person whose name is entered on the register as being in charge of or managing the residential service**. (At a grade no less than Director of Nursing/ Director of Services) whilst we accept these definitions are laid down in the legislation our contributors had much debate with regard to these definitions and felt it was crucial to elaborate further on the grades of these persons.**

Registered Provider*: The person whose name is entered on the register as the person carrying on the business of the residential care setting. **(At a grade no less than Chief Executive Officer (CEO in voluntary services) and Local Health Manager (LHO in Health Service Executive)**

2. Section 3 outlines principles informing the standards. What further principles, if any, do you think need to be included?

This section we found to be most confusing, in short if the document proceeds to describe the principles informing the document and the context of same (which it articulates) it should also outline those standards and list them. We regard this a major omission in the larger document and needs to be addressed. Secondly the language of the principles requires refinement suggestions as follows:

Firstly

> ***Key principle:*** *People who live in residential services for people with disabilities should have a good quality of life.*
>
> **We feel the following should be added to this principle "that meets their individual needs and potential".**

For people in residential services to enjoy a good quality of life there should be good staff who understand and support them.

As a professional group of people the nurses who contributed to the PNA consultative forum felt the term **good staff** was inappropriate and should be omitted

Secondly

With regard to the following principle:

> ***Key principle:*** *People with disabilities should be supported to live the lives they want to lead.*

This group recommended the principle of "reasonableness" should be added or incorporated to this principle .Also to omit the following phrase in the documentation

> ***instead of doing things for them.***

Reading instead

> ***The draft standards are aimed at putting people with disabilities in charge of their own lives. They require staff and providers of services to work with people who use services***

Thirdly

> ***Key principle:*** *The standards should encourage the development of community based services.*

The following should be added

Which are tailored to meet the individual's needs.

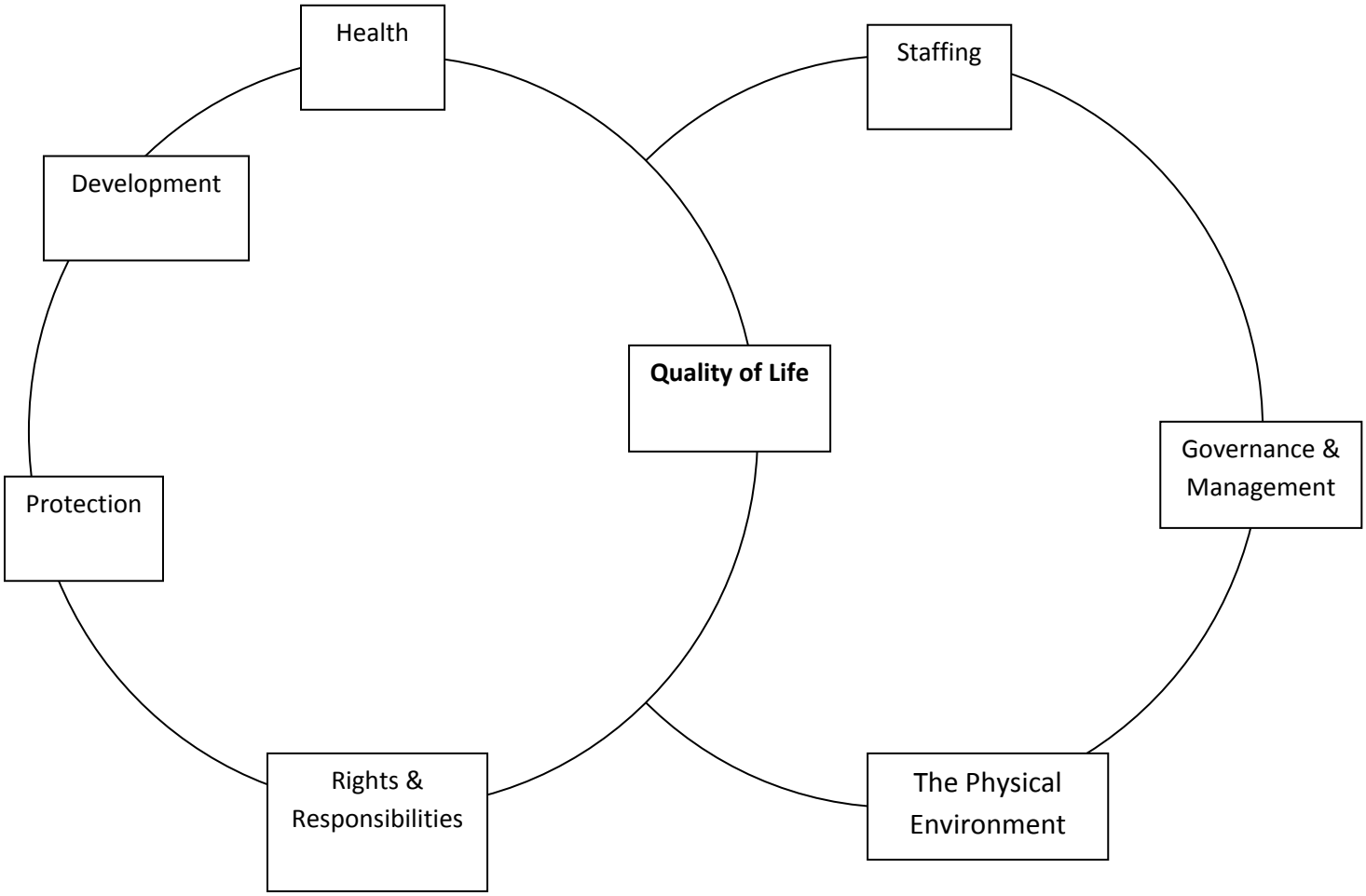
Fourthly

> ***Key principle:*** Residential services for people with disabilities should be well run.

This group felt this principle was badly articulated and should have incorporated the language of competencies with regard to staff and indeed their professional qualifications.ie **that every professional working within that service is qualified and sufficiently competent to deliver that service.**

3. What are your views on the order of the standards

Rather than ordering the standards In terms of weighting one over the other, this group felt they were interlinked with equal weighting attached to each standard but all centred around quality of life, similar to the diagram below: It was also agreed to separate health from development as we felt as stated in this document both sections were significant within their own right and should be treated as such.



4. In your views, what further issues, if any, should the standards include?

With regard to the Section on Rights, this group felt that there was a need to include responsibilities, in that all service users are citizens with rights but all persons with rights have responsibilities within those rights, and so the following standard was proposed to be added as follows:

Standard ??:Rights and Responsibilities

Each individual is made aware of their responsibilities and how they underpin and support their rights.

In addition this group also felt that the standards posed in this document are disability blanket standards, which do not take account of special groups within the disability sphere. Some of the groups are discussed below. The **Draft National Quality Standards Residential Services for people with Disabilities** discusses and refers to person centred care yet provides a document which doesn't take account/ make reference to special groups which require a specific type of service which also will need standards specific to that service, such as

- appropriate health specific placements for those who are medically fragile, and defined standards around these placements – for example there are areas within the ID sector (medical centre infirmary type) placements which should have specific standards to meet this client group's needs and should defined have admission criteria. Possibly, some of the standards from the **National Quality Standards for Residential Care Settings for Older People in Ireland**[ii] would be appropriate to apply to this type of service. E.g. some of **Section 3 Health and Social Care Needs pg 17**

- Autism appropriate or autism specific placements those with autism tend to be have many different needs to those individuals with an intellectual disability and these need to be addressed in an appropriate care setting .

- Persons with a Mental illness and Intellectual Disability. The National Mental Health Strategy Vision for Change (2006) iii set out plans for the development of a mental health service for people with intellectual disability; it included community teams, acute inpatient beds, and mental health rehabilitation beds.

These standards worryingly make no reference to the Vision for Change instead it's only reference to mental health is:

> *9.8 Where the individual requires a mental health service it is provided in the most appropriate setting for that person.*
>
> *9.9 Every effort is made to ensure continuity in the mental health treatment of individuals with communication difficulties.*

These standards need to take cognisance of the plans laid out in Vision for Change and recognise there is a requirement for a specialist Mental Health/ ID service and as such where an individual requires treatment in a residential specialist mental health ID facility that the standards and quality for that service are consistent also with the Mental Health Commissions Quality Framework 2006 [iv] and indeed at least refer to the Mental Health Act 2001 (Approved Centres)[v].

5. What do you think about the specific standards

As an overall statement this document makes the following recommendation that section 6.4 Development & Health should be treated separately as they are significant sections in their own right and require expansion.

With regard to Standard 9 Health - The health needs of each individual are assessed and met.

This representative group had some specific concerns:

This standard fails to take account of the well documented health need of people with an intellectual disability; the NIDD 2007 reported that there were 25,613 people registered on the National Intellectual Disability Database (NIDD) in April 2007, representing a prevalence rate of 6.04 per 1,000 population. It found 8,262 clients are in receipt of full-time residential services, which is an increase of 81 since 2006 and is the highest figure recorded on the NIDD since 2001. Of this population total population 19,799 people avail of one or more multidisciplinary support service. The most commonly availed of services by adults are medical services, social work and psychiatry.

This proves a major need for much more specialised and advanced provision of medical care. Whilst it is no one's wish to label the ID residential care population as a sick population it is evident that ill health and unmet health needs are a feature of a major group of these clients.

In short the National Quality Standards for Residential Care Settings for Older people in Ireland fit more convincingly with certain client groups; it should also be an aim of this process to reach these standards for the older population of persons with an Intellectual Disability. The NIDD (2007) provides evidence to suggest that the population of people with intellectual disability in Ireland is an ageing one. Increased longevity in this population is attributed in the research literature to improved health and well-being, the control of infectious diseases, the move to community living, improved nutrition, and the quality of health care services. It is with this in mind that standards 10 to 16 of the National Quality Standards for Residential Care Settings for Older People in Ireland should where relevant be incorporated in this document.

This submission also makes specific comments on **Standard 6 Safeguarding and Protection and Criteria 6.10 – 6.14**

These points appear to legally allow restrictive measures whereby clients within a service can be restrained, secluded, and medications administered to manage behaviour.

The 4 points which aim to control its use are poor in terms of the safety and protection of the client, criteria 6.14 states where there is an immediate risk to the safety of individuals or staff. When it states that staff are trained in its use, surely more specific criteria are necessary. With regard to restraint, there are agreed best practice models with regard to physical restraint and currently a working group examining those models which will need to be referred to as part of these standards. The Mental Health Commissions Rules on Seclusion and Bodily Restraint should also be referred to within this document and discussed. One particular comment within the group exemplified the ambiguous language put forward in this document. *"What is the training for deciding to administer Sodium Amytal 160mg for agitation or a laxative for constipation which presents as agitation?"*

This document also states *"it is carried out in strict accordance with national guidelines and centre policy",* on this point the group had several questions , should this document not name the national policy referred to, why make such an open statement, it then states adhere to centre policy, who reviews this policy, how is adherence to this policy assessed? Why is a national policy not been developed, on all there issues.

Points that need to be reviewed, within this standard should take cognisance of the Mental Health Act 2001 this is the only legislation, which allows for seclusion, restraint, and administering of medications. This standard in its current format is laden with difficulties. The National Disability Authority report commented that the vast majority of individuals with ID who reside in community accommodation and who also may be receiving medication or other psychiatric treatment to which they

have no capacity to consent are defecto detained and are not subject to any formal independent monitoring. (NDA 2003).

The Mental Health Act 2001 provides for seclusion and restraint in an approved centre which is subject to inspection, clients subject to seclusion and or restraint in ID services which are not approved centres will not be protected by the Mental Health Act 2001 or indeed the Mental Health Commissions Rules on Seclusion and Bodily Restraint the group posed the question "is a lesser standard set for those with an ID". Vision for Change (2006) stated that this is "highly unsatisfactory" yet the draft standards appear in an ad hoc way to allow for such restrictive and specialised interventions.

In addition the group found the whole section **Standard 3: Routines** ambiguous contradictory and unhelpful and has recommended the removal / and review of this whole section.

With regard to each specific standard the following table elaborates and indeed questions some of the wording and terminology and seeks clarification with regard to roles and responsibilities for the services to enforce some of the standards.

1.3	*participates in staff selection* *is consulted about new admissions*	While both of these are ideal there is no established mechanism and is not monitorable in any way.
1.9	*The particular needs, preferences and contributions of individuals with restricted mobility and communication are encouraged and valued.*	What mechanism is in place to monitor this? Who will inspect that their needs are being met
2.3	The individual's privacy, dignity, modesty and preferences are *respected at all times, and with particular regard to:*	There needs to be further criteria for this point

	receiving visitors	i.e. Each residential unit will have a visitors room. These rooms should be created instantly in services.
2.3	The individual's privacy, dignity, modesty and preferences are *respected at all times, and with particular regard to:* Expressions of intimacy and sexuality	This remains difficult to assess. Eg Two clients may have a relationship in which 1 of the clients views it as abusive
2.3	The individual's privacy, dignity, modesty and preferences are *respected at all times, and with particular regard to:* Intimate and personal care giving	This needs to have guidelines nationally set
2.3	The individual's privacy, dignity, modesty and preferences are *respected at all times, and with particular regard to:* Care received during illness and prior to and at the time of death	The standard should state a single palliative care room must be available where the client has not got a single bedroom. Refer also to standard 16 end of Life Care Health Information and Quality Authority National Quality Standards for Residential Care Settings for Older People in Ireland
2.4	There are clear expectations concerning privacy so that individuals *understand their own entitlements and do not inadvertently invade the privacy of others.*	This should state the number of bathrooms per number of clients ratio Unobstructed access to bathrooms. Toilets and separate bathrooms Tangible concrete numbers are needed as there are in the older person services.

2.6 2.7	The individual receives accurate and timely information and appropriate *support to deal with critical events in his/her life such as loss and bereavement.* *The individual receives enhanced support at times of acute distress in a manner that takes account of his/her particular needs and preferences.*	This needs to be advanced on as it is currently unclear Who will provide the appropriate support or the enhanced support Is this counselling?
2.9	The individual's wishes and choices regarding end of life care are *discussed, documented and implemented.*	This needs to be clarified if the statement of purpose is not that of palliative care should the client not be moved to a service with this purpose and function. Again refer to Health Information and Quality Authority National Quality Standards for Residential Care Settings for Older People in Ireland
3.1 –3.4 & 3.6 3.8	Routines	Where is this research from? This group[recommended the removal of this whole section !! Routine is important! This standard should be removed and adapted. It is unreasonable and un-person centred to expect any individual to adhere to an intuitions routine. Sometimes structure is clinically indicated i.e. Autistic Spectrum Disorder
4.2	The families, friends and partners of the individual are welcomed by *staff.*	If this does not occur what happens?

Standard 5	Each individual receives sensitive and personalised care and support in accordance with his/her wishes and aspirations from an adequate number of staff who are recruited in accordance with best safe care practice and who possess the appropriate personal qualities, qualifications and skills	How do we audit adequate numbers? Qualifications vary. What is the correct qualification?
5.4	All staff have written job descriptions and a copy of their terms and *conditions of employment prior to taking up post.*	Job descriptions differ from service to service • need for standard job descriptions
5.8	The numbers and skill mix of staff are determined by reference to the *assessed needs of the individuals and the size, layout and purpose of the residential service.*	Very ambiguous
5.9	At all times there is sufficient staff available to ensure the safety of *the individuals.*	If there is not what will happen
5.10 5.11	There are catering, cleaning, ancillary and administrative staff *appropriate to the size of the centre and its stated purpose and function.* *The numbers of staff on duty at any one time reflects the needs of the individuals and the level of support required to implement their personal plans.*	Set numbers per dependency of client Statement too open and unclear
5.12	All staff are supervised on a regular basis appropriate to their role.	By who?
5.14	All staff understand and adhere to key policies and procedures *including:* *safe care* *medication management* ***use of physical restraint and/or seclusion*** *provision of intimate and personal care* management of individuals' finances.	This needs to be further discussed The Mental Health Commission rules on physical restraint and seclusion and indeed refer to the report and recommendations which will be put forward with regard to restraint by the expert group reviewing

		this. Appropriate rooms etc And refer to the documents put forward y An Bord Altranis with regard to safe medication management.
6.13	Where the individual experiences repeated difficulty in managing *his/her own behaviour, an assessment is carried out by a suitably qualified professional in order to draw up a plan to provide additional support to him/her. The plan is reviewed regularly.*	Need for MDT
6.14	No exceptional measure, such as any form of restraint, seclusion or *medication to manage behaviour, is used unless:* *there is an immediate risk to the safety of individuals or staff* *staff are trained in its use* *it is carried out in strict accordance with national guidelines and centre policy* *it is subject to multidisciplinary review.*	The wording of this section is ambiguous and open for misinterpretation again reference needs to be made to the relevant documentation already in use in sections of the health services and their applicability in this regard also. The Mental Health Commission rules on physical restraint and seclusion and refer to the report and recommendations which will be put forward with regard to restraint by the expert group reviewing this.

6.15 to 6.18	Protection	This section is taken from the children first guidelines would a more appropriate guideline not be trust and care. It appears that subtle differences appear to be present. Could this standard not state to adhere to the national trust and care policy.
7.3	*Where the individual requires assistance to manage his/her financial affairs, he/she nominates the person (family member, friend, representative, member of staff or other) to be entrusted with this responsibility. Information (for example, a PIN number) given to a staff member, so nominated, is not shared with any other member of staff, apart from the person-in-charge.*	This is not safe guarding enough particularly in view of how budgets are managed within services Clients with severe or profound ID need much clearer guidance
8.2	*The personal plan addresses the individuals' assessed needs. Assessments are carried out in collaboration with the individual and his/her family, representative and professionals involved in his/her care and treatment in accordance with his/her informed wishes and interests. The outcome of the assessment is reviewed as required to amend and update the individual's personal plan.*	The wording provides for confusion, is this a life style plan which should not be based on care or treatment but on wishes goal and plans for the future.
8.6	*The individual retains possession of his/her personal plan. Its content is shared with support staff, other professionals, relatives and friends in accordance with the individual's interests, wishes and informed consent.*	This becomes problematic particularly in clients with intellectual disability, from point 8.3 bullet point 5 we read medication plans risk management plans are in one single plan, now this client has possession of potentially damaging information and potentially could share this information which may

		damage his / her reputation For example a client with ID who has a repeated history of sexual attacks, and this is stated in there single plan which they have procession of, and they share this with members of the community or non direct care providing staff. This must be revised as it can be extremely damaging to the client.
Standard 9	*Health*	
13.5	Unsuccessful applicants and those who refer them are given a *written explanation for the decision not to accept their application*	Here this document fails to inform the route for redress, should this not be forth coming
13.6	*Waiting lists are managed in an effective and transparent manner and, at a minimum; the needs of those on the waiting list are reassessed every six months.*	While this is a very good idea, who is this done by what is the procedure etc what redress occurs if this should not occur
14.5	Staff is trained to understand behaviour that indicates an issue of *concern or complaint that the individual cannot communicate by other means. Such messages receive the same positive response as issues of concern and complaints raised by other means*	What is this training
Standard 15	This standard fails to take account off 1. fire and safety regulations 2. infection control 3. heating temperature preventing clients suffering hyperthermia 4. water temperature preventing clients becoming burned 5. pipe work is covered preventing burns 6. screening is provided in rooms where there is more than 1 client. 7. ventilation 8. window height	

	9. that all areas are independently accessible ie toilets kitchens etc 10. that all areas where possible are wheelchair friendly 11. That where bedpans or urine receptacles are present that there is a sterilizer present. and suitable storage areas 12. clients laundry facilities in there home 13. that bedroom provide or aim to provide 9.3m^2 usable floor space (as seen as best standard in the national quality standards for residential care settings for older people. i.e. that standard 25.39 and 25.40 be observed 14. one toilet per 6 clients as outlined in national quality standards for residential care settings for older people 15. That there is at least 1 assisted toilet area, to allow for 2 staff and 1 client safely. 16. that there is an assisted bathroom area 17. That there is a second / separate toilet from the bathroom.	
Standard 16	Should be mirrored of the national quality standards for residential care settings for older people	
17.10	The person-in-charge ensures that the centre has systems in place to *effectively* *manage risk, including a designated person(s) to contact in an emergency*	Should a care centre with a certain number of clients or specific client groups not have a manager on site where congregated or on stand by where community based.
18.1	The statement of purpose and function includes: *the aims, objectives and ethos of the centre* *the number of places, and level of need that can be accommodated* *the services and facilities provided* *a list of key policies that inform practice*	This statement of purpose should be individual unit based, to prevent the idea of admitting clients to beds as appose to admitting clients to services.
19.1	*Any information about the individual is treated as confidential and held in accordance with legislative, regulatory and best practice*	This point is in direct contradiction to point 8.6 of

	requirements	this document

This document fails anywhere to take onboard the informing of the family/ significant others of the outcome to a prioritisation of need case, where a client receives particular recourses

6. We would like the section on Registration and Inspection of Residential Services to be clear and easy to understand. Please tell us what you think about the information in this section.

With regard to the "Fit Person Entry Programme" for registered providers and persons in charge this organisation is seeking further clarification and information on such an initiative. As a National Organisation representing nurses, this submission questions the relevance of such a programme for its members. The nursing qualification is a four year honours degree programme, which is considered one of the most comprehensive educational preparatory programmes in healthcare provision. Secondly all nurse are governed by the regulatory body An Board Altranais and the Nurses Act[vi]. Nurses fitness to practice is regulated within this regard, so this submission poses the question, Why is it necessary for nurses to embark on a Fit Person Entry Programme? And should there be aspects of this programme which may need to be addressed, can they not be incorporated into the nursing programme?

7 How do you think the standards will help to improve the quality of residential services provided for people with disabilities?

The National Quality Standards Residential Services for people with Disabilities should provide a reference point for the development and improvement of all services for people with disabilities. Ultimately their development and implementation should contribute to the social gain of persons with a disability and the quality of people's lives as a result of service interventions. Service quality must add to the quality of people's lives. One overriding aspect of every residential service is the quality of the interactions between the staff providing the service and the service users. How staff relate to clients is at the heart of every residential service for persons with a disability- and this is based not just on their own beliefs and attitudes but on the aims and standards of the service. Finally standards have to be attainable. It is easy for standards to be drafted by those when not confronted

by the reality of their own practice to lay down a standard which in theory looks reasonable but in practice may be as inaccessible as the Holy Grail. It is also vital to observe the distinction between standards as the outcome to be achieved and criteria as the level of attainment for that standard. Good structures increase the likelihood of good processes and good processes increase the likelihood of good outcomes for service users and their families – this must be the ultimate validator of effectiveness and a quality residential service.

As a recommendation from this organisation PNA and consultation group we would like to state having regard to the legislation *Health Act 2007* and the standards set thereafter this organisation PNA recommends a consultative process / educational training for staff operating under the Act and its relevant standards applied similar to the process provided for staff working under the *Mental Health Act 2001* [vii] and the process undertaken by the Mental Health Commission before the full roll out of that particular piece of legislation.

As a general comment with regard to the structure of the documentation i.e. the main document we found the numbering and flow of the document cumbersome, one suggestion might be rather than numbering the sections they should be alphabetically laid out as there is too much numbering between sections, standards, principles and criteria - on the whole it makes for confusing reading

References

[i] Health Act 2007, The Stationery Office, Dublin

ii Health Information and Quality Authority National Quality Standards for Residential Care Settings for Older People in Ireland

iii Department of Health and Children (2006). A Vision for Change Report of the Expert Group on Mental Health Policy. Dublin: Stationary Office.

[iv] Mental Health Commission (2006) Quality Framework Mental Health Services in Ireland

[v] Mental Health Act 2001 (Approved Centres Regulations) 2006

[vi] Government of Ireland (1985) Nurses Act

[vii] (2001) Mental Health Act. Stationery Office, Dublin.