Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Kilcoran and East Cork
Name of provider:	Health Service Executive
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	31 August 2023
Centre ID:	OSV-0005603
Fieldwork ID:	MON-0040428

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Kilcoran East Cork is a designated centre located in the East Cork region. Residential services are currently afforded to 21 adults with an intellectual disability, following reconfiguration of the centre. The centre is comprised of six bungalows each being decorated in line with the residents' individual preferences and taste. The service operates on a twenty four hour, seven day a week basis ensuring residents are supported by staff at all times. Staffing levels in each house are allocated according to residents' assessed needs, as reflected within individualised personal plans. Nursing support is in place as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 31 August 2023	09:00hrs to 17:00hrs	Laura O'Sullivan	Lead
Thursday 31 August 2023	09:00hrs to 17:00hrs	Lucia Power	Lead

What residents told us and what inspectors observed

This was an unannounced risk based inspection completed in Kilcoran and East Cork; a designated centre operated by the Health Service Executive. The inspection was completed following receipt of solicited information from the provider and focused on specific regulations. Throughout the inspection, both inspectors spent time in two houses under the remit of the provider. They had the opportunity to meet and interact with residents.

On arrival at the first house, the inspectors were greeted and welcomed by a resident and the appointed clinical manager. The resident showed one inspector around the centre and showed them some of their favourite areas such as the kitchen, the sunroom and their bedroom. This resident liked their own space and explained to the inspector they liked to lock their bedroom door to keep their possessions safe. Their favourite spot to sit was in the sunroom as they could see people coming and going. They also mentioned that it was quiet here as "the noise can go on forever and ever"

At the time the inspector was sitting and chatting with this resident, another resident was also present in the house. They were vocalising loudly and appeared unable to relax. Inspectors did not interact with this individual as they did not want to cause undue anxiety. Inspectors observed staff interacting with this resident to reduce their anxiety and to reduce the noise levels in the house. The resident was brought for a social outing when transport was available.

Another resident spoken with later in the day told the inspectors the noise levels in the house can be loud, even at night and they didn't like it. They said they don't say it to staff but they would like it if that resident moved out. They did not like the "screeching" and did not want to spend time in the same room. They would rather be out and about or spend time in their bedroom.

Throughout the inspection, several restrictive practices were observed and the provider did not demonstrate to have awareness of these restrictions. For example, one resident who smoked had to request a cigarette from staff as they were locked into the press in the office. It was also not recognised that at times residents could not use communal spaces in that house due to the noise levels or anxiety of a peer.

Residents in the house were observed to be out and about. One resident went for breakfast with staff while another told inspectors they were baking in the day service and brought back cake for them. One resident had a lie-in as they were tired. After speaking with the inspectors they went about their day.

This house did present as warm and homely with resident sharing their own bedroom space. As discussed previously, one resident did enjoy spending time in the sunroom. On the morning of the inspection, it was observed that several wheelchairs and a heater were blocking the fire exit of this room. Pressure relieving

cushions and sun lounger cushions were stored in a corner and wheelchair footrests were left on a couch.

In the afternoon, the inspectors visited another house operated under the remit of the designed centre. On arrival, residents were preparing to leave the centre. One resident was heading to the local library and another was going on their choice of social outing. It was observed that the residents did require assistance from two staff to walk down the steps of the house as there was no ramp present. An electrical ramp was visible but when this was questioned, inspectors were informed that it was broken and had not worked properly since installation.

One resident was sitting at the kitchen table when the inspectors arrived. This resident chatted with an inspector as they had moved to the centre since the previous inspection. They told the inspector they had good days and bad days. They were waiting to go for a cup of coffee if the staff could get transport. They wanted to try and meet their friends and required assistance to ring them on their mobile phone. They told the inspector they get annoyed when people take numbers off their phone. The inspector was informed that the resident could accidentally delete numbers from their phone. Despite this causing, the resident upset and anxiety there was no evidence of support being in place. The resident said goodbye to the inspectors and went into town for their favourite coffee shop.

A resident was relaxing in their bedroom listening to music. They said hello to the inspector and told them they were happy in the centre and liked living there. They enjoyed music and liked to relax. They also liked to go to mass and asked staff present if they could go to say their prayers in the morning. Staff reassured the resident that this would happen.

As stated previously this was a risk inspection in which one focus was residents' rights. It was observed in both houses that improvements were required to ensure residents' rights were promoted at all times. Records of residents were stored in an open press in the kitchen area and were not secure or private. While records were reviewed of residents raising concerns, evidence of effective follow-through was not observed. From a review of documentation, it was evident that the resident's assessed needs were not reviewed as required. Following alleged incidents measures were not implemented to support the holistic needs of residents. This will be discussed in more detail in the quality and safety section of the report.

The next two sections of the report present the findings of this inspection about the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered

Capacity and capability

This was an unannounced risk based inspection completed in Kilcoran and East Cork; a designated centre operated by the Health Service Executive. The inspection

was completed following receipt of solicited information from the provider and focused on specific regulations. Due to concerns evidenced during the inspection the registered provider was issued urgent actions under Regulation 23 Governance and management, Regulation 8 Protection and Regulation 9 Residents' rights.

Prior to this inspection, following a number of alleged incidents the person in charge had completed the required notifications to the Chief Inspector of Social Services. Given the number and context of notifications received pertaining to the care and welfare of the residents in the centre, the provider was requested to provide assurances.In response to this the provider submitted a letter of assurance/action plan to the Chief Inspector on 29 June 2023 and provided a further update on 2 August 2023. The primary focus of the inspection was to seek assurance on these matters.

The inspectors reviewed the actions that the provider committed to during the inspection and noted a number of areas that were not completed within the time frame given by the provider. For example, the provider was to review a robust system pertaining to medicines, however, there were findings on the day of the inspection of a number of medicine management errors. These included expired medicines and no clear rationale for changes in both long term and as required medicines. Time frames identified in formal safeguarding plans were not adhered to and reviewed in line with the provider's own time frames.

From the review of the documentation completed, there was evidence of a lack of oversight from the provider in relation to an overall action plan, and a safeguarding plan. While a six monthly unannounced visit had been completed this was not utilised to highlight areas of non-compliance and address these in a timely manner. The registered provider had implemented some measures following receipt of the allegations. This included the introduction of face-to-face staff training in safeguarding vulnerable adults from abuse, the completion of peer review of personal plans and an increase in the number of unannounced visits from on-call managers to the house. However, further action was required to ensure that the care and welfare of residents in the centre was paramount. Due to these concerns, an urgent action was issued to the provider on the day of the inspection under Regulation 23.

Regulation 23: Governance and management

The registered provider's management systems within the designated centre had not ensured the service to be provided to residents was safe, appropriate to the assessed needs of residents, consistent and effectively monitored.

From the findings of the risk inspection, there was limited evidence of provider oversight pertaining to the overall action plan that was submitted to Chief Inspector and also the follow up review by the provider did not demonstrate that the actions as identified were implemented, following the receipt of alleged incidents. It was also evident that the provider did not adhere to the actions and time frames as

identified in their safeguarding plan to support the care and welfare of residents.

Judgment: Not compliant

Quality and safety

Kikcoran and East Cork is a designated centre consisting of six houses and has a capacity of 21 residents. As stated previously, this was an unannounced risk inspection which focused on specific regulations. It was observed that residents were active in their community on the day of the inspection and their activities of choice were promoted. Interactions between staff and residents were observed to be jovial and respectful. However, improvements were required to ensure overall adherence to regulations.

Residents' rights required review in the centre in several areas. In one house, resident folders were stored in the kitchen next to the fridge and were not secure as the press was open. Following a series of alleged incidents residents were not afforded additional support and to exercise their rights. The provider had committed to follow-up meetings for each resident to enable them to raise concerns and referrals to an advocacy service if they so wished; there was no evidence during the inspection that this was implemented. The person in charge did note that they spoke with residents regarding this and the alleged incidents but there was no documented evidence to support the same.

There was no evidence on the day of the inspection that residents were supported to participate and consent to decisions about their care and support. Residents were checked by staff hourly at night, however, there was no clear rationale for this and no evidence that these were discussed with residents. The recording for some did not correlate with the legends. The staff validated these checks and did not consider the impact on the residents. This was also not recognised as a restrictive practice.

One resident was to be reviewed by an external organisation to review their support needs. This was due to be completed in June 2023. This had not been followed up on and no evidence that support efforts was made regarding the same. A resident was charted for medicine pertaining to cognitive decline but this resident did not have the rationale on file to demonstrate the use of this drug with staff unable to validate this. This resident was prone to vocalisation with no support plan in place to alleviate this and look at cause and effect. There was also no consideration given to the impact on others with two residents discussing with inspectors the impact of the same. One staff member also flagged the impact. Residents had flagged the impact of this resident's behaviour but this was not reviewed as potential allegation.

Following the reporting of a series of alleged incidents the provider had developed individualised safeguarding plans. These were reviewed by the inspectors. A number of areas of concern were identified including time frames identified in the plans that were not adhered to and reviewed in line with the provider's own time frames.

There was no consistent evidence of the development of a safeguarding plan for the person alleged to have caused concern and their specific needs being taken into consideration.

Given the nature of one resident and what was deemed to be inappropriate behaviour, there was no specific indented support for this person in relation to awareness and skills. There was no evidence of support being offered to residents after the allegations, taking into account the possible impact on the rights of the person and their emotional well-being. Due to such findings, urgent actions were issued to the provider on the day of inspection for Regulations 8 and 9.

Regulation 8: Protection

The registered provider had not ensured that each resident in the designated centre was assisted and supported to develop the knowledge and self-awareness, understanding and skills needed for self-care and protection. For example, One resident was noted as having inappropriate behaviour, however, there was evidence to support awareness or skills training carried out with the individual.

The registered provider had not ensured effective measures were in place to protect all residents from all forms of abuse. This included;

- There was no evidence of a safeguarding plan for the person alleged to have caused concern and that their specific needs were taken into consideration.
- Residents had flagged the impact of another resident and this was not reviewed as a potential allegation.
- A behaviour support plan was noted in the safeguarding plan for one resident but this plan was not in place,
- Time frames identified in safeguarding plans were not adhered to and reviewed in line with the provider's own time frames.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had not ensured that the designated centre was operated in a manner which was respectful to the residents' individuality and personal needs. For example, several restrictive practices had not been recognised as such including a resident's access to their cigarettes. There was no evidence that, given the allegations made, all residents were afforded additional support and to exercise their rights.

The registered provider had not ensured that each resident, in accordance with their assessed needs participated in and consented with supports to decisions about their

care and support. For example, a resident was to be seen by an external organisation to review their support needs in June 2023, this was yet to be completed.

Measures in place within the centre did not ensure that each resident's privacy and dignity were respected in, but not limited to, personal living space, personal information and professional consultations. This included;

- Resident folders were stored in the kitchen next to the fridge and were not secure as the press was open.
- Hourly night check with no clear rationale for same or evidence of consultation with residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kilcoran and East Cork OSV-0005603

Inspection ID: MON-0040428

Date of inspection: 31/08/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider will address the issues which resulted in some management systems in the designated centre not ensuring that all aspects of the service provided met the requirement of Regulation 23 (1)(c).

The PIC attended training in maintaining regulatory compliance on 03/10/2023. The requirement for further training will be analysed and appropriate training will be provided as required.

Management systems are undergoing a review to ascertain the reason why the systems in place did not identify the non-compliances with the regulations which were identified by the inspectors. This will include a review of the unannounced visits by the provider/person nominated by the provider and additional unannounced visits.

Measures taken to address the non-compliances identified on inspection and ensure ongoing compliance include:

Medicines Management:
- As a result of the immediate action required on the day of the inspection in respect of expired medicines the PIC carried out an audit in all houses. This was completed on 15/09/2023.
- Additional support on auditing provided to relevant staff completed on 29/09/2023.
- The medicine prescription sheet which had been rewritten the day prior to the inspection and had omitted PRN (as required) medicines was rectified on the day of the inspection.
The non-adherence to the procedure has been addressed and the CNM is overseeing the system to ensure there is no risk of re-occurrence.
- In order to address the identified non adherence to the medication management

procedures relevant staff will complete medication management training and clinical audit training. This will be completed by 31/12/2023.
- The medication audit tool and timelines are being reviewed to strengthen the procedure and the CNMs and PIC are carrying out regular audits to ensure adherence to the process. These will be in place by 31/12/2023 and in the interim the PIC is providing support and guidance in respect of medicines management in the centre.
- A new system for the prescribing and administration of medicines will be in place in the centre by 31/05/2024. This will further strengthen the system and measures in place to audit the practices in the centre.
- The protocols for the use of psychotropic medicines were reviewed by 15/09/2023 and clear guidance is in place for all staff.

Supports for residents:
- External companies are being procured to provide supports to residents in respect of Regulations 8 and 9.
- All support plans are being reviewed by the PIC to ensure they are fully reflective of the residents' needs.
- All restrictive practices are being reviewed and will be referred to the Rights Review Committee and addressed as appropriate.

Premises:
- The date of removal of the external lift and installation of the new external lift has been provided by the company as 13/10/2023
- Other outstanding items which require improvement have been re-escalated to HSE Estates.
- The system of daily checks of fire exits has been reviewed and added to the daily and nightly checks for staff handover to strengthen the system.
Documentation:
- Resident support plans which had not been updated with the detail of healthcare appointments have been updated and a system has been implemented to ensure there is no risk of re-occurrence.
- A system is being implemented to ensure all resident files are stored in locked cabinets. In the interim, staff are overseeing to ensure residents' documents are secure.
- A review of all resident support plans is taking place by the PIC to ensure that all support plans are reflective of each resident's assessed needs. This will be completed by 31/12/2023.
Auditing:
- The auditing systems are being reviewed to ensure there is effective monitoring of the service provided. The review will include an identification of amendments required to the system and training and/or support required for staff.

All actions will be completed no later than 31/05/2024

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The registered provider will address the issues which resulted in some systems in the designated centre not ensuring that all aspects of the service provided met the requirement of Regulation 8 (1) and (2).

The PIC attended training in maintaining regulatory compliance on 03/10/2023. The requirement for further training will be analysed and appropriate training will be provided as required.

Management systems are undergoing a review to ascertain the reason why the systems in place did not identify the non-compliances with the regulations which were identified by the inspectors. This will include a review of the unannounced visits by the provider/person nominated by the provider and additional unannounced visits.

Measures taken to address the non-compliances and ensure ongoing compliance include:
- All resident safeguarding plans have been reviewed 20/09/2023. A system has been implemented to strengthen the oversight of safeguarding plans to ensure all plans are in place and adherence to timelines.
- An external advocacy company has been procured to provide support for residents. The initial visit took place on 28/09/2023. One resident declined to engage with the service. Further support will be provided for the resident to engage if they so wish. All residents will receive the support identified as required from the external advocacy company by 31/12/2023.
- Residents' safeguarding plans have been reviewed and all required actions have been identified with a plan in place to address these. This will include support from the external advocacy company and other relevant external companies as appropriate.
- Support plans have been compiled for persons alleged to have caused concern and a system is in place to ensure these are reviewed on an ongoing basis.
- The HSE Patient & Service User Engagement Officer has been scheduled to meet with residents impacted by safeguarding concerns. All residents will have met with the Officer by 31/12/2023 and actions identified as required will be addressed.
- An external counselling service is being procured for residents. Work is ongoing to identify the most appropriate service to provide this support.
- Referral to an external service to support residents in respect of sexual wellbeing, awareness and training is being progressed. Initial meeting with potential provider is scheduled for 10/10/2023
- A referral to an external service with expertise to support a resident in respect of specific care need has been made.
- All residents are being reviewed to ensure that all restrictive practices are identified and appropriate referrals will be made to the Rights Review Committee.
- Action has been taken in respect of the restrictive practice identified by the inspectors. This includes relevant allied health professional input and updated agreements with the resident.

All actions will be completed no later than 31/05/2024

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The registered provider will address the issues which resulted in some systems in the designated centre not ensuring that all aspects of the service provided met the requirement of Regulation 9 (1), (2)(a), (2)(d), (3).

The PIC attended training in maintaining regulatory compliance on 03/10/2023. The requirement for further training will be analysed and appropriate training will be provided as required.

Management systems are undergoing a review to ascertain the reason why the systems in place did not identify the non-compliances with the regulations which were identified by the inspectors. This will include a review of the unannounced visits by the provider/person nominated by the provider and additional unannounced visits.

Measures have been implemented to ensure the urgent action required on the day of inspection is addressed on a long term basis and there is no risk of reoccurrence.

Measures taken to address the non-compliances and ensure ongoing compliance include:

- Resident documentation which was stored in the kitchen has been moved to a locked cabinet and a system is being implemented to ensure all resident files are stored in locked cabinets. In the interim, staff are overseeing to ensure residents' documents are secure. Complete 31/08/2023.
- A historical practice in respect of nightly checks on residents is being reviewed to ensure that checks are consistent with residents' assessed need. A plan to address this is under formulation and the implementation of same will be dependent on each resident's assessed needs.
- A resident's support plan has been reviewed to ensure that staff are aware of the measures to take when the resident has concerns regarding their mobile phone.
- All resident support plans are being reviewed by the PIC – to be completed 31/12/2023.
- As outlined under Regulation 8 an external independent advocacy company has been procured.
- Staff are supporting residents to ensure their individuality, privacy and dignity is respected. This will be supported by the external advocacy service.
- Local management are implementing systems to ensure residents are supported to make complaints, raise concerns and to address any concerns that residents express either verbally or by other means locally or via the appropriate mechanisms. The PIC is overseeing this.
- A review has been carried out to further support a resident in respect of a specific preference and ensure their rights are known and respected. The external advocacy company will support this further.
- The communication plan for a resident which had commenced with an assessment prior to the inspection will be completed by 09/10/2023.
- The remaining residents who required dementia screening have now received same and follow up is being actioned as appropriate.

All actions will be completed no later than 31/05/2024

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/05/2024
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	31/05/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	20/09/2023
Regulation 09(1)	The registered	Not Compliant		31/12/2023

	provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.		Orange	
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	31/05/2024
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Not Compliant	Orange	31/05/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is	Not Compliant	Orange	31/08/2023

	respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			