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:	SVC - SDN
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 7
Type of inspection:	Short Notice Announced
Date of inspection:	17 December 2020
Centre ID:	OSV-0004023
Fieldwork ID:	MON-0026762

About the designated centre

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

SVC - SDN is a designated centre located on a campus setting in North Dublin which provides residential care and supports to 11 residents with complex needs, mental health diagnoses and behaviours of concern. The centre is comprised of five separate spaces which include a range of apartment spaces, bedrooms, living rooms, bathrooms, kitchen areas and enclosed garden spaces. There are additional staff areas which include an office space, storage rooms, visiting room and staff bathrooms. The staff team employed in the centre are made up of a person in charge, a clinical nurse manager, social care workers, staff nurses, care staff and household staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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 - 2015 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 17 December 2020	09:40hrs to 17:15hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

The inspector met with five residents during the course of the inspection and spent time observing care and support being delivered by the staff team. Some residents found it difficult to communicate verbally so the inspector spoke with three family representatives by telephone and received five completed resident questionnaires which were circulated in advance of the inspection. Overall, the inspector observed that residents were supported in a sensitive and kind manner by staff members and responded to in a timely manner. Family members informed the inspector that residents were happy with the service they were in receipt of and were very complimentary of the staff and management teams. They reported that staff members regularly engaged with them and always placed a priority on the individual needs of residents. The questionnaires asked respondents a number of questions which focused on the living accommodation of the centre, food and mealtime experience, arrangements for receiving visitors, personal rights of residents, activities, the care and support received, staffing supports and complaints. The responses received were very positive and complimentary of the service being received by residents.

Capacity and capability

Overall, there were mixed findings from this inspection. There were some good examples of compliance with the regulations in areas such as staffing, the management of complaints and protection against infection. However, the inspector identified a number of concerns including the use of restrictive practices, the management of behaviours of concern, the manner in which residents were supported to exercise their personal rights and the management of risk.

The inspector reviewed the centre's staffing arrangements and found that there were sufficient numbers of staff with the right skills and qualifications to meet the needs of residents. There were planned and actual staff duty rosters maintained which demonstrated that there was continuity of care and support for residents. While there were relief and agency staff employed in the centre, the management team had taken appropriate infection control measures to ensure that there was no cross over of these staff members to other designated centres. Staff members met with spoke about residents in a very respectful and dignified manner.

Staff training records were reviewed by the inspector. There were a number of deficits in training courses which were described by the person in charge as being mandatory. The inspector found that there were appropriate arrangements in place for the supervision of staff members with formal one-to-one supervision meetings

taking place for all staff members on a regular basis.

The inspector completed a review of the centre's staffing arrangements and found that there were clear management structures in place. An annual review of the centre and six-monthly unannounced visits by the registered provider had been completed as required by the regulations. There was a quality improvement plan in place and a suite of audits had been completed. The inspector met with the person in charge during the course of the inspection and found that they were knowledgeable of the relevant legislation, regulations and national policy and their associated responsibilities. The inspector found, however, that there was a need for the further development of management systems in the centre to ensure increased oversight in some key areas including the management of risk, positive behaviour support, the use of restrictive practices and ensure that residents' rights are respected.

A review was completed of the arrangements in place in the centre for the management of complaints. It was found that two complaints had been made in the time since the last inspection and in both instances they were investigated and responded to in a prompt and appropriate manner. There was a complaints management policy in place (dated December 2018) and easy read procedures were available locally within the centre.

The inspector reviewed the centre's written policies and procedures and found that those required by Schedule 5 of the regulations were in place in the centre. The policies had been reviewed as required within the last three years and staff members had access to these documents.

Regulation 15: Staffing

There were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

There were deficits in staff training across a number of areas including fire safety, food safety and the management of behaviours of concern.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a need for the development of management systems to improve oversight in a number of key areas including the management of risk, positive behaviour support, the use of restrictive practices and ensuring that residents' rights are respected.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector found that effective systems for the management of complaints had been established and implemented in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

All Schedule 5 policies were in place in the centre and had been reviewed within the last three years as required by the regulations.

Judgment: Compliant

Quality and safety

A walk through of part of the centre was completed by the inspector in the company of the person in charge. Certain parts of the centre were deemed to be 'in crisis' during the inspection and as a result the inspector did not enter these areas. Some parts of the centre were found to be in reasonable condition, however, other parts were not maintained to an appropriate standard. There were broken tiles in bathrooms, stains to floors, walls marked and dirty on occasions and a broken toilet seat in one resident bathroom had not been replaced. Overall, the inspector found that the premises of the centre were not designed or laid out in line with the statement of purpose and did not meet the individual needs of residents. In some cases, the internal space available to individual residents was limited and sufficient outdoor space was not available for some residents.

The inspector reviewed the arrangements in the centre for the management of risk.

There was a risk management policy in place (dated September 2019) which was found to appropriately outline the information required by the regulations. There was a risk register maintained, however, the inspector found that this was not appropriately maintained by the management team. For example, there were seven red rated risks listed on the register and in some of those cases it was not clear what the risk or hazard was and what control measures were in place. In the case of one risk which was risk rated at 25/25 there was a lack of documentary evidence to demonstrate that it had been escalated to the executive management team. In addition, there was an absence of any response from that forum on how to continue managing that risk. The inspector found that overall, the systems employed to manage risk were underdeveloped and required significant improvement. As a result, there was limited oversight of risk in the centre by the management team.

A review of the measures taken by the registered provider to protect residents against infection was completed by the inspector. The registered provider had taken appropriate action to prevent or minimise the occurrence of healthcare-associated infections in the centre including COVID-19. Staff members had access to stocks of personal protective equipment in the centre and there were systems in place for stock control and ordering. There was a COVID-19 information folder available in the centre, which was updated with relevant policies, procedures, guidance and correspondence. These included a response plan in the event that an outbreak were to occur in the centre. There were hand sanitizing stations at a number of locations throughout the centre and signage in place to remind staff and residents to regularly wash their hands.

The inspector reviewed the fire precaution measures in place in the centre. There were individualised personal emergency evacuations plans completed for each resident which clearly outlined the supports required in the event of a fire or similar emergency. There was a fire alarm and detection system in place along with emergency lighting as required. There were records maintained which demonstrate that both the fire alarm and detection system and emergency lighting were serviced on a regular basis. Fire drills had been completed on a regular basis and demonstrated that residents and staff members could evacuate the centre in a reasonable time frame. While there were some fire containment measures in place, the inspector found that self-closing devices had not been fitted to all doors which required them. In the case of a significant number of doors which had self-closing devices fitted, the inspector observed that these had been wedged open and as a result would not be effective in containing the spread of fire in the centre.

A review was completed of the arrangements in place to support residents with their behavioural needs. Overall, it was noted that there were very complex behavioural supports needs in the centre. Despite this, comprehensive behavioural support plans or multi-elemental support plans were not in place for residents. While there were some more informal guidance documents in place, there was an absence of overarching comprehensive documents to inform staff on how to best manage the complex behavioural presentations.

There was significant use of restrictive practices in the centre which primarily included environmental restraints. Some of the restrictions included the use

of closed-circuit television cameras in resident apartments and in a resident's bedroom. The inspector found that the individual justifications for, or risks associated with, the use of some of these restrictions were unclear. The restrictions were not applied in line with national guidelines and in many cases the use of these restrictions was not recorded or logged. The restrictions were found to have a significant impact on the freedom of movement and civil liberties of residents and while there were processes and systems in place for the review and local approval of the use of restrictions, in some cases it was not clear who was contributing to these decisions. The inspector was not assured that appropriate consideration had been given to the individual rights of residents as outlined in Article 14 of the UN Convention on the Rights of Persons with Disabilities. For example, a number of trials on the reduction of restrictions were underway at the time of the inspection, however, when reviewed by the inspector some of these trials were ongoing for prolonged periods of time with no action taken as a result. In the case of one resident, a trial for allowing them have free access to running water had begun in August 2019 and there was clear evidence recorded that the resident did not experience any negative impacts as a result of the trial. Despite this, the restriction on that resident accessing running water from a tap remained in place at the time of the inspection. The inspector found as a result that the least restrictive measure was not used for the shortest duration possible.

The inspector found that residents were appropriately protected from experiencing abuse in the centre. The person in charge was knowledgeable of the different types of abuse and the actions that are required to be taken in response to witnessing or suspecting incidents of a safeguarding nature. A review of incident and accident data found that while a number of alleged incidents of a safeguarding nature had occurred in the time since the last inspection, these had been appropriately investigated and followed up on in line with local organisational and national policies.

The arrangements to support residents with their rights were reviewed by the inspector. The inspector found that despite the significant use of restrictive practices in the centre, only one of the 11 residents were referred to independent advocacy services for review. There was an absence of evidence to demonstrate that some residents were afforded the opportunity to exercise choice and control over their daily lives and to exercise their civil and legal rights. Particular behaviours which compromised dignity, were not appropriately managed to ensure the privacy and dignity of all residents. Other examples included the use of restrictive practices in response to the behaviours of one resident but these restrictions having a negative impact on other residents in that area.

Regulation 17: Premises

The centre was not kept in a good state of repair internally. The inspector found

that the design and layout of the premises of the centre was not in line with the statement of purpose and did not meet the needs of some residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

The systems in use for the management of risk in the centre were found to be underdeveloped and as a result there was limited oversight of risk in the centre.

Judgment: Not compliant

Regulation 27: Protection against infection

The registered provider had developed policies, procedures and guidelines for use during the COVID-19 pandemic to prevent or minimise the occurrence of the virus in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector found that some doors which required self-closing devices had not been fitted with them. In a significant number of cases where self-closing devices had been fitted, the inspector observed that these doors had been wedged open.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Despite the complex presentation of residents, there was an absence of clear behaviour support guidance for staff. The justification for the considerable use of restrictive and invasive practices in the centre was not clear to ensure that they were proportionate to the needs of residents. The oversight of the use of restrictive practices was limited and required improvement. The least restrictive measures were not used for the shortest duration possible.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that the registered provider and the person in charge demonstrated a high level of understanding of the need to ensure the safety of the residents availing of the services of the centre.

Judgment: Compliant

Regulation 9: Residents' rights

There was an absence of appropriate supports from independent advocates for a significant number of residents who experienced considerable restrictions in their lives. Some residents were not afforded the opportunity to exercise choice and control over their daily lives or to exercise their civil and legal rights. In addition, the inspector found that the registered provider had failed to ensure that the privacy and dignity of residents was respected.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for SVC - SDN OSV-0004023

Inspection ID: MON-0026762

Date of inspection: 17/12/2020

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has reviewed all staff training records and put a plan in place with the training department to address training requirements for staff in 2021: Fire Safety- Seven staff out of a team of 32 require refresher fire training. This has been escalated to the training department for immediate attention with a date scheduled for completion for end of February 2021 Food Safety- An online food safety programme is now available through the training department. All staff will be facilitated to complete this training by 30th March 2021. Managing Behaviours of Concern- four staff out of a team of 32 require refresher behaviours of concern training. The refresher input will be provided by 30th March 2021	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Register Provider has established a governance oversight group which is chaired by the ACEO. This governance oversight group are responsible for ensuring that all actions identified in the HIQA report are executed in line with agreed time frames	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The designated centre is scheduled to be painted as soon as Covid restrictions on external contractors permits access to premises.

One bathroom is scheduled to have tiling replaced with white rock as soon as Covid restrictions on external contractors permits access to premises.

The designated centre has had a deep clean carried out.

The PIC has requested OT to carry out an assessment to identify and source a toilet seat to support needs of one resident for whom a conventional toilet seat is not suitable
The governance oversight group will ensure a review of the existing premises is completed and make recommendations to the Registered Provider regarding any changes or alterations that need to be carried out so that the designated centre meets the needs of all residents.

Each resident will be supported to have a comprehensive individual needs and preference assessment (IPNA) carried out to determine their needs and preference in relation to their living environment. The residents needs and preferences will inform future planning of premises to ensure it meets the needs of all residents.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The register provider has requested the Service Manager, PIC and the Quality and Risk Officer to carry out a comprehensive review of risk management systems in the designated centre to ensure that all risks are assessed, managed and reviewed in line with the organisations risk management policy. The risks identified in the centre will be reviewed quarterly by a core team which will include the PIC, Quality & Risk Officer, PPIM and Service Manager.
The internal process which identifies how risks are escalated has been reviewed to ensure that there is a clear written communication process on how risks are escalated to the Executive Management Team and Board of Management and how feedback is provided to the designated centre.
The Quality and Risk Officer will provide enhanced training on risk management to the PIC and local staff team.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
An audit of all fire doors in the designated centre was carried out on the 27th January 2021 by the organisation's Fire Officer and Service Manager. Each fire door in the centre has been assigned an unique number for tracking purposes. Fire doors identified as requiring self closing electronic devices have been identified and closing devices have been ordered and will be installed by 30th April 2021.

The Health and Safety Officer issued a memo on 18th December 2020 to all staff reminding them that fire doors can not be wedged open. All staff in the designated centre read and signed the memo. Health and safety is a standing agenda item for all staff meetings.

The PIC has assigned a named person to ensure the weekly check of fire doors is carried out in the designated centre and is recorded in the fire folder

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The current practice is that the positive behaviour support plans for residents with complex behaviour/ mental health needs is integrated into relevant aspects of each persons care plan. Following feedback from the most recent inspection the PIC in consultation with MDT members has developed a revised document that provides a concise summary of the functional assessment, and proactive/reactive strategies required to support residents.

The Registered Provider has requested that all restrictive practices in use in the designated centre are reviewed by the regional restrictive practices steering group.

The PIC and MDT will review all documentation pertaining to use of restrictive practices to ensure it is recorded and logged in line with the organisations policy.

The Registered provider has put a process in place where MDT members will allocate dedicated time weekly to work in the designated centre. MDT members will work closely with the PIC providing direct support to residents and mentoring staff to ensure residents receive appropriate and timely intervention to manage their behaviour and to ensure their civil and legal rights are upheld. A log of all supports and interventions provided by the MDT will be maintained in residents personal plans.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Registered Provider has requested that all restrictive practices in use in the designated centre are reviewed by the organisation's Restrictive Practices and Ethics committees to ensure residents are supported to exercise their rights as outlined in the UN convention on the rights of people with Disabilities

The Registered Provider has ensured that the residents are supported to exercise choice and support over their daily lives by putting a process in place to review and update their personal plans with their needs, wishes and preferences clearly documented.

The Registered Provider has ensured that residents and their families have being provided with information on Advocacy Services and how to access same. The Social work department has engaged with the National Advocacy Service to seek support for residents living in the designated centre.

Pic will ensure privacy of residents is maintained by having curtains in place which can be used to protect the dignity of residents as necessary

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/03/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	01/12/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Not Compliant	Orange	01/08/2021

	state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	01/08/2021
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.	Substantially Compliant	Yellow	28/02/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/04/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Not Compliant	Orange	31/03/2021

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/08/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/04/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/06/2021

Regulation 09(1)	The registered 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.	Not Compliant	Orange	30/08/2021
Regulation 09(2)(b)	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 the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/08/2021
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Not Compliant	Orange	30/08/2021
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	Not Compliant	Orange	30/06/2021

	disability has access to advocacy services and information about his or her rights.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is 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.	Not Compliant	Orange	30/06/2021