Home from Home Care Limited

The Hawthorns

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 22 November 2016 and was announced.

The Hawthorns is registered to provide accommodation and personal care for up to nine people who have a learning disability or autistic spectrum disorder.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. All of the people living at the service had their freedom lawfully restricted under a DoLS authorisation.

Relatives told us that their loved ones were cared for by kind and caring staff. Staff undertook appropriate risk assessments for all aspects of a person's care to keep them safe from harm inside and outside of the service. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that were competent to do so. The registered provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were supported to have a nutritious and balanced diet and hot and cold drinks and snacks were available throughout the day. People had their healthcare needs identified and were able to access healthcare professionals such as their GP and dentist. Staff knew how to access specialist professional help when needed.

People were at the centre of the caring process and staff acknowledged them as unique individuals. Relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and advance skills to enable them to perform their roles and responsibilities.

People were supported to have an active life and were encouraged to take part in hobbies and interests of their choice. Relatives commented that their loved ones were well looked after and their wellbeing had improved since moving into the service.

People where able, were supported to make decisions about their care and treatment and maintain their independence. People had access to information in an easy read format about how to make a complaint. Relatives told us that they could approach staff with concerns and knew how to make a formal complaint to the provider.

The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the registered manager approachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had their risk of harm assessed to keep them safe.

Staff were aware of safeguarding issues and knew how to raise concerns.

Medicines were stored, administered and unwanted medicines were disposed of safely.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have a healthy lifestyle and received support from healthcare professionals when the need was identified.

Is the service caring?

Good

The service was caring.

People were supported by caring staff and treated with kindness.

Staff communicated with people in a way that helped them to understand their care.

People were treated with dignity and staff respected their choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People received personalised care, specific to their individual needs.

A complaints policy and procedure was in place in a format that was accessible to people. Relatives knew how to make a complaint and they received a response to complaints made.

Is the service well-led?

Good

The service was well-led.

There were systems and processes in place to check the quality of care to improve the service.

Staff felt able to raise concerns with the registered manager. Staff were aware of the whistleblowing policy and procedure.

The registered manager created an open culture and supported staff.

The Hawthorns

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22 November 2016 and was announced. The inspection team was made up of one inspector.

We gave 48 hours notice of our inspection because people who live at the service are often out of the service taking part in recreational activities. We needed to be sure that they would be in so as we could speak with them.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager, an assistant manager and three members of care staff. Following our inspection we spoke with four relatives by telephone. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included staff training information, staff recruitment safety checks and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for four people and medicine administration records for two people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who were unable talk with us.

Good

Is the service safe?

Our findings

Most people who lived in the service had communication difficulties and were unable to tell us if they felt safe living there. However, we watched people interact with staff and saw that they were at ease with them. We observed that people had put their trust in the staff to look after them safely.

We spoke with relatives of four people who lived at the service who told us that the provider had processes in place to ensure people were as safe as they could be. One relative told us, "[Name of person] is certainly safe and secure." Another relative said, "As a parent you have to trust them [staff] and we do."

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and how to recognise signs of harm and abuse and who to report any concerns to. One member of staff said, "We have all the information in the office. If a concern wasn't looked into by my line manager I would raise it myself with the [registered] manager or the local safeguarding team, we have the telephone number." Another staff member said, "We also have a company safeguarding officer that we can contact."

There were systems in place to support staff when the registered manager was not on duty, such as access to on-call senior staff out of hours for support and guidance. There was a business continuity plan to guide and support staff in an emergency situation such as a power failure. If the service needed to be evacuated in an emergency, procedures were in place to relocate people to a neighbouring service.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care, such as travelling in the mini bus. Detailed care plans were in place to enable staff to reduce risks and maintain a person's safety. For example, one person was provided with a snack when travelling in the mini bus to help them relax. A member of staff explained the process they went through to risk assess an activity and said, "Each risk assessment is individual. We risk assess every activity. [Name of person] wants to swim. We are at the planning stage. The risk assessment is done, but [name of person] has never swam before and has no experience of water. We have to consider that in our planning and risk assessment."

A senior member of staff undertook a daily walk-around of the service and the registered manager undertook a walk-around once a week. We found that the purpose of the walk-arounds was to do visual checks on the internal and external environment to ensure that there were no hazards that compromised people's safety. Any maintenance concerns were reported electronically to the provider's maintenance team.

There were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. All new staff undertook a four week induction where they followed a structured learning programme and shadowed experienced staff. New starters also completed the care certificate. This is a training scheme supported by the government to give staff the skills needed to care for people.

We found that the provider employed sufficient numbers of staff to keep people safe and each person had a support worker allocated to them to assist with assessing, planning and delivering their care and social needs. The registered manager explained that the service used a layering system of staffing to ensure people had the right support to undertake hobbies and interests and keep them safe inside and outside of the service. Having a layering system meant that staffing levels were increased to cover periods of high activity. The relatives we spoke with said that staffing levels and the previous high turnover of staff had recently improved. One relative spoke of the impact this had on their loved one and said, "When there are lots of changes to staff [name of loved one] health deteriorates and it knocks them back. They need people to trust. They have got a good key worker now." We noted that staff worked in a core team of four staff, this was to ensure that people were cared for by the same group of staff and continuity of care was maintained.

People received their medicine from staff that had received training in medicines management and had been assessed as competent to administer them. We observed medicines being administered at lunchtime by two members of staff to reduce the risk of errors. We looked at medicine administration records (MAR) for two people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a recent photograph of the person for identification purposes and any allergies and special instructions for the storage and how to administer the medicines were recorded. We saw that robust safety checks had been implemented by the provider. For example, in addition to signing the MAR chart when a medicine had been administered, staff also recorded this electronically. If a medicine was not given at the prescribed time this was picked up by the provider and the service received a phone call to ask why the medicine had not been given.

We found that one person had their medicines administered covertly; that is hidden in their food or drink to ensure that they took them. We saw that all the necessary checks had been implemented and the person's consultant psychiatrist and pharmacist had been involved in the decision making process. All staff were trained in administering "rescue" medicines that are given when a person has a seizure. This meant that people at risk of seizures were enabled to access the community with a member of staff without the fear of not having essential rescue medicines.

All medicines were stored in accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines, the medicines policy and a system that identified when medicines needed to be reordered. Furthermore, individual fact sheets were available for each medicine a person was prescribed. We noted that some of this information was in an easy read format with pictures for to support people to understand their medicines.

Good

Is the service effective?

Our findings

Relatives told us that staff has the knowledge and skills to provide appropriate care for their loved one. One relative said, "They have a fairly comprehensive induction scheme. The staff are people who genuinely care. They are trained and have the maturity to care." People were unable to tell us if staff had the knowledge and skills to look after them. Therefore we observed staff deliver care to people and saw that they understood people's individual needs and they acted in a responsible and confident manner. All staff undertook mandatory training in key areas such as safeguarding, deprivation of liberty safeguards and health and safety. In addition, staff were provided with training in areas relevant to the care needs of people who lived in the service. Such as the care of a person living with epilepsy and autistic spectrum disorder and safe hold and breakaway techniques. The provider had their own training facility that staff attended for most of their training needs. We saw a copy of the staff training matrix that identified when staff training was due for update in the next three years.

All of the staff we spoke with were positive and enthusiastic about the training they had received. For example, one member of staff said, "It is the most extensive training I have ever done. It is tailored to the needs of our residents. It is realistic." Staff received an annual appraisal and regular supervision sessions, called one to one sessions and were expected to attend 10 sessions a year. In addition, the registered manager received regular supervision and an annual appraisal from their line manager. The responsibility for undertaking staff appraisals was shared by the registered manager, assistant managers and team leaders. A member of staff shared with us the benefits of their one to one sessions and said, "I have them monthly. It's a two way street. It allows for maximum input from the member of staff. I have loads of scope to speak out and make training requests. I can make suggestions to benefit our roles, such as I suggested we introduce a staff library, an education resource." The registered manager later showed us a room that had been set aside for this purpose.

Most people who lived in the service were unable to give consent to their care and treatment and we saw that staff followed the guidance in the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. For example, we saw that people had their mental capacity assessed and best interest decision were made so as they could receive their medicines safely.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and nine applications had been submitted to the relevant local authority and all had been authorised The provider had properly trained and prepared their staff in understanding the requirements of the MCA and staff knew that people

who lived in the service were subject to a DoLS authorisation and how to support them. The local authority who had approved the DoLS authorisations for two people had appointed them with an independent mental capacity advocate (IMCA). An IMCA is someone who provides support and representation for a person who lacks capacity to make specific decisions where the person has no one else to support them. The IMCA service is different from the lay advocacy service.

The service did not employ cooks and all staff had been trained in the safe handling of food. People who lived at the service regularly met with staff to plan the menus for the following week. We saw that there was a range of photographs of meals to help people make their choices. A member of staff told us that they directed people towards healthy options including fresh fruit and vegetables and fish. We found that where able, people were supported to order the weekly food order on-line and access food shops in the local community. Mealtimes were flexible and were planned around the times that people were coming and going from their different activities and trips out.

Some people who lived at the service were unable to eat a "normal" diet for health reasons. Staff were aware of their special dietary needs and their care plans reflected this. One person was at risk of over eating and drinking too much and this could cause them to deplete the salts in their body and make them seriously ill. Therefore, they had their food and fluid intake monitored to prevent them from becoming unwell. We noted that as a safety measure food and drinks were stored in locked cupboards and fridges. However we observed that people could have a drink or snack at any time. For example, we saw that one person had a low calories snack box and when they stood at the fridge a member of staff offered them a snack from their box.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP and dentist. Members of staff told us that they had a good relationship with the local doctor's surgery and the GP would visit people who lived in the service who would otherwise become distressed and anxious if they had to visit the surgery. In addition, people had access to health screening and advice pertinent to their age and gender. On the day of our inspection one person had a hospital appointment to have diagnostic tests. Two staff from their core team went with them. A member of staff told us, "We have built a good working relationship with the hospital learning disability nurse who meets us on arrival and [name of person] is taken straight through for their appointment without waiting." They added that this helped the person to lessen their fears and anxieties.

Staff supported people to take regular exercise to maintain their physical fitness. We saw that a wide range of activities were enjoyed outside the service, such as countryside walks, swimming and football. People were also supported to exercise inside the service or grounds. For example, one person had a rowing machine in their bedroom and others accessed the trampoline or swing and climbing equipment in the garden. In addition, we saw that people were provided with different relaxation techniques to help them stay calm and reduce their anxieties. For example, we saw that there was a quiet room with a music and light system that helped people to relax.

Good

Is the service caring?

Our findings

We observed staff interacting with people who lived at the service. People and staff had a good relationship and there was evidence of mutual respect and trust. A member of staff explained that each person was cared for by a core team, which included their key worker and three support staff. They said this supported continuity of care and people and staff got to know each other well.

We spoke with relatives who were positive about the care their loved one received. One relative said, "The standard of care is exceptional. It's a wonderful environment. Very well looked after. I'd say it's homely and loving. I'm very impressed."

We found that a person centred approach was taken with people who had difficulty communicating their needs verbally. For example, some people used picture cards to inform staff of their needs. These picture cards were also used to provide the person with some structure to their day. We saw one person had pictures of everyday tasks in the order they undertook them when they first got up in the morning. This helped to ensure that their hygiene needs were met and that their bedroom was kept clean and tidy. People had a communication passport that they took with them on visits to their GP or to attend an outpatient appointment. We noted that one person's passport translated what different sounds meant to them. In addition, people had an "accident and emergency" grab sheet that went with them if they were admitted to hospital as an emergency. The grab sheet provided hospital staff with information that the person would be unable to share them.

People were enabled to maintain contact with family and friends and could receive visitors at any time. We saw that some people had regular visits to the family home. Relatives spoke about the contact they had with their loved ones. One person's relative told us, "We meet up in town about once a month. [Name of person] key worker comes with them." Another person's relatives told us, "We can visit anytime. Try to give them [members of staff] some notice, as [name of person] is so busy. It's better we visit him [at The Hawthorns] as he gets distressed if away from The Hawthorns for too long." Finally another relative commented that they liked to give the service notice of their visits to ensure that their loved one was at home and said, "I ring up before we set of if we are planning to take [Name of person] out. They like to go for walks and to the shops. We drive to see their grandma and go for walks in the country."

We observed how staff enabled people to develop and maintain their skills to be as independent as possible. As we mentioned earlier, the service did not employ ancillary staff such as a cook or housekeeper. People who lived at the service were supported to undertake a range of general housekeeping duties where physically able. One person's relative told us, "[Name of person] is well looked after, and encouraged to make their bed, clean their room and look after their personal care. They love the kitchen and encouraged to do things in the kitchen and make their own drink." We saw that this person was capable of making a hot drink with supervision and made the inspector a cup of coffee during the inspection.

We saw that people's right to their privacy and personal space was respected. For example, people with

their bedroom on the first floor of the service who looked out over the main road and residential properties had a screen on the lower half of their window. This meant that people did not have their privacy compromised by neighbours and passers-by. Another person did not want their peers to enter their bedroom uninvited, especially when they were out the service. When the person was out in the community on an activity, we noted that their bedroom door was locked and they had been assessed as able to look after their door key.

Members of staff made people and their relatives aware of the lay advocacy service. Lay advocacy services are independent of the service and local authority and can support people to make and communicate their wishes. One person's relative told us that they were no longer able to attend regular reviews and had approached the local lay advocacy service to provide someone to attend on their behalf. Another person had a lay advocate who attended their reviews in the absence of a family member.

Good

Is the service responsive?

Our findings

Each person had their own bedroom and en-suite bathroom or shower room. Most people were happy for us to see their rooms. We saw that their decoration, furniture and personal items were relevant to their needs, preferences and personality. We saw that areas of the service had been adapted to meet individual needs. One person's relative explained to us that the provider was responsive to their loved one's needs and said, "They are very responsive to his needs. The shower was not suitable for him, so they put in a bath. He is troubled with asthma in the hot weather, so they put air-conditioning in his room to help ease it."

One person had their bedroom sound proofed, with triple glazed windows and a double door entry to their bedroom. We were told by members of staff and observed that this person would often shout loudly when distressed and this had a negative impact on other people. We looked at their care pan and noted that a positive behaviour risk assessment and support plan were in place for a member of staff to support the person in their own room with diversional therapy, such as reading a story to the person until they relaxed.

The provider had a discussion group called "our voices" for people who lived in their services. One person who lived at the service represented their peers at the monthly meetings. We saw that the meeting minutes were accessible to all and were recorded in word and picture format. The vice chairperson of "our voices" discussion group had been involved in creating a "resident" satisfaction survey. The survey used pictures and words to help people understand the questions asked and people gave their response through "yes, no and don't know" smiling faces. In addition, the service held "our voices" meetings twice a month. The purpose of "our voices" was to empower people who lived in the provider's services to have a say in the running of their service and give their feedback on areas for improvement.

The registered manager told us that each day was different and structured around the people who lived in the service and was influenced by their planned activities and individual moods and behaviours. We observed and care records recorded that people lived busy and active lives and were encouraged to take part in hobbies and interests of their choice. Some people were supported in education, one person had recently taken up a voluntary work placement and others enjoyed sporting activities. We found that people's sporting, life skills and academic achievements were recognised. For example, we saw that one person had received an award for gardening.

Throughout our inspection we noted that people were supported to take part in activities and pastimes of their choice. For example, one person had walked to the local shop with their support worker to buy a newspaper and soft drink, and another person had gone for a drive in the car with a member of staff. We saw that several people were engaged with staff in one to one activities, such as one person took part in an arts and crafts activity and made and decorated a birthday card for a relative. Meanwhile others were listening to their favourite music, watching their favourite film or playing with musical instruments.

People where able were supported to make and maintain friendships. For example, one person went out to lunch with their friend from a neighbouring service. Both were supported by a member of staff. Other people enjoyed dancing to their favourite music and met up with friends from other services at a local club that was

aimed specifically for people with learning disabilities and autistic spectrum disorder to get together.

We found that staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of care throughout the day. The handover was face to face and also an electronic record was maintained and staff could consult this at any time during their shift. We looked at copies of the handover sheets for the previous 24 hours and saw that an update was provided on each person who lived in the service. In addition staff had access and maintained a "service user" daily diary that recorded all aspects of the person's day. For example, any accidents or incidents, any contact made with their family and in-depth details of any activities undertaken and their outcome.

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people where able and their relatives or lay advocate were involved in planning their care. One person's relative told us, "At the last review we found a very comprehensive set of care plans. They were indicative of staff who knew what they were doing." Another relative who lived some distance away told us that when they were unable to attend reviews that they spoke with their loved one's key worker through Skype and said, "If I can't attend we do Skype. The last review went very well." We looked at the care plans for four people. We saw that individual care plans focussed on supporting a person to live well, maintain their independence and develop new skills. A new care plan system had been introduced across the provider organisation following feedback from CQC inspections undertaken in the last year. We found that the new care plans were person centred, straightforward and we readily found the information we needed.

People and their relatives had access to information on how to make a complaint and we saw it clearly displayed in word and pictorial format. One person's relative told us that they could raise concerns with staff at any time and said, "I'm happy to feedback positively and raise concerns. In five years there will always be something not quite right. But they are very open to discussion and remedying concerns." Another person's relative shared with us that previously they had issues about their loved ones standard of hygiene and appearance and had complained to staff and the provider and said, "I know [name of person] has a certain amount of choice, but if [name of person] can get away with it, he will. He will follow a routine and structure. They are now keeping on top of his hygiene needs." We saw that one complaint made had been followed up and the provider had followed their own procedures.

Good

Is the service well-led?

Our findings

Staff told us that they found the registered manager approachable, supportive and knowledgeable and said they could go to them at any time. One staff member said, "Very easy person to get on with." We found that although the registered manager of The Hawthorns was also the registered manager for three other locations on the same site that strategies were in place to ensure that they were supported in their role and the assistant managers in the other locations were being developed to take on the registered manager's role.

Although relatives can speak with the register manager or any staff member at any time, the provider had recently introduced a system called "Parent call". Relatives have the option to receive a regular monthly phone call at a time convenient to them from a member of staff from the provider organisation. We saw that three relatives had signed up to this initiative. Relatives and members of staff told us that the annual events such as the summer fayre and annual barbeque were good opportunities to speak with each other. One staff member said, "When we have events the relatives attend. We sit down with them and learn from them [about their loved one]. We reassure parents that their loved one really matters to us." We saw a copy of the 2016 annual quality assurance questionnaire that is planned to be sent to relatives in November. The results of the last questionnaire were not made available to us.

We were informed that people who lived at the service and staff had a positive relationship with the local community. A member of staff explained how they had built mutual trust with local people and said, "We go to the festival in the village and other village events. At first local people didn't want to know the home. The vast majority [of local people] now feel safe talking to them [people who lived at the service]. Its fear of the unknown. We go into the shops and pubs and the locals talk to us. Our residents feel welcome."

Monthly staff team meetings were held with the registered manager and a member of the human resources department. Human resources attended so as any employment issues could be addressed straightaway. Staff were expected to attend a minimum of ten meetings a year. Topics discussed at team meetings included quality assurance, training and development and health and safety. A member of staff said, "We have regular team meetings with team leaders, the manager and HR, every month and we have a choice of two dates so as we can all attend."

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on safely managing violence and aggression. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager. We noted that staff had access to confidential helpline set up by the provider. In addition, several members of staff had key roles in topics such as cleanliness and infection control, tissue viability and safeguarding; to act as a resource to their colleagues.

We found evidence that the registered manager was committed to providing high quality care. The Hawthorns had achieved a bronze level award from Investors in People. The registered manager informed us that they would be leading the team in 2017 towards achieving a silver ward. We saw a copy of the award

was on display in the service.

A programme of regular audit was in place that covered key areas such as health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff at team meetings. In addition, some areas were subject to external audit such as the safe management of medicines by the dispensing pharmacist and local authority quality visits. Furthermore, the service had an unannounced quality audit once a month that was structured on the Health and Social Care Act 2008 regulations. We saw the results of the audit undertaken on 18 October 2016. All actions were identified with the name of the person responsible and the date to be achieved by.

The provider had an effective system were the registered manager reported their staffing levels and skill mix, and accident and incidents to their head office once a week. In addition, the provider had informed us of notifications as required by law. Notifications are events which have happened in the service that the provider is required to tell us about.
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