

Wealden Community Care Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Wealden Community Care provides personal care to people living in their own houses and flats. It provides a service to older adults, some of whom are living with dementia. At the time of the inspection there were approximately 100 people using this service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found

Most people described care calls as sometimes being late, some people had experienced missed calls and people told us there was not a robust system for being kept informed. Some people told us they were updated by care staff, other people said they did not receive any contact to explain late calls.

People told us they felt safe receiving care, however one person told us of an incident when a fall was not responded to safely or by following the correct procedure. This had not been recorded as an incident. Staff had not all received annual refresher training in knowledge and skills such as moving and handling, or safeguarding adults.

Some people we spoke with did not know if they had a care plan or what was in it. One person told us they had accurate care plans, another told us they had some care plans which were not relevant. We found care plan information to be lacking detail about how risks and needs, such as the application of prescription cream, should be supported.

People told us they were not asked for specific feedback about the quality of their care or if they were happy, some people had received a survey which they did not find meaningful. People who use the service knew how to contact the office if they had a question or concern. Some people had raised concerns with the manager and felt these had been dealt with appropriately.

People described care staff as being caring, respectful, polite and helpful. Some people told us they had regular care staff who understood their needs and respected their independence. One person told us, "Oh absolutely, they are caring! If I feel down, they'll listen to me. We do have our little chats, which I like."

People described care staff as responsive and respectful. People said they were asked how they wanted to be supported during care calls and their preferences were followed. One person told us the changes they requested to their care provision had been made.

Rating at last inspection and update

The last rating for this service was Requires Improvement (published 6 August 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the

provider was still in breach of regulations.

The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last three consecutive inspections.

Why we inspected

This was a planned inspection based on the previous rating. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wealden Community Care Ltd on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Wealden community Care Limited

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

Two inspectors visited the service and were supported by an assistant inspector who telephoned people using the service and their relatives.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 72 hours' notice of the inspection. This was because it is a domiciliary care service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 2 December 2020 and ended on 15 December 2020. We visited the office location on 2 December 2020.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service and we viewed the providers website. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection

We spoke with the registered manager. We reviewed a range of records. This included six people's care records and medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We looked at training data and quality assurance records the provider sent us. We spoke with six people who used the service about their experience of the care provided. We spoke with six members of staff and received feedback from the Local Authority.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection the provider had failed to manage risks and medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risk assessments were not always in place and people's specific and complex needs were not fully and effectively recorded. There was a lack of formal assessment tools in use and staff were unclear on the risks posed to people using the service. Some people had complex health needs including muscular dystrophy, brain injuries and diabetes. There was no guidance in place for staff to meet the specific needs of these individuals. This posed a risk as staff were not following clear support plans.
- Some people who were at risk of falls and pressure damage had little or no guidance in their care plans on how this risk should be managed. This meant these risks may not be managed safely.
- Records demonstrated that consent had been obtained from people who managed their own medicines. However, there was no evidence that this had been appropriately risk assessed.
- There was conflicting and confusing information regarding the application of prescribed topical creams. Care plans did not contain clear guidelines to staff about where cream should be applied. One person told us that their cream was applied to different parts of their body, which were different to what was written in their care plan. Staff told us, "There is a separate sheet for creams. It [the sheet] doesn't say exactly where the cream goes on the body, but I ask the person, they tend to know". In order to mitigate risk it is imperative that staff have up to date and accurate information about how to support people with their prescribed medication.
- Some staff told us they did not always feel their rota provided enough time for travel and care calls to be managed safely. One member of staff told us, "Sometimes it feels like the calls are back to back but actually we do get enough time for the tasks to be completed." Another staff member said, "Sometimes I run over the time. It depends on the person you go to."
- The lack of effective action to manage risks and medicines safely has put people at prolonged risk of harm. We discussed this with the registered manager who said that they, "Had worked really hard and made improvements." We saw that a medicines audit had been introduced, however this had not highlighted the

gap in information regarding application of prescribed topical creams.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure recruitment checks were completed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In our last report we had named this as a breach of regulation 18 in error.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

- Recruitment checks were not always completed to ensure staff were suitable. For example, three of the four staff files we saw did not contain evidence of satisfactory conduct from the staff members previous employers. There was no analysis in place to show that management had considered the risks of employing these members of staff.

We found no evidence that people had been harmed, however, recruitment checks were not robust. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure that there were enough staff to ensure that visits were on time and staff stayed for the correct length of time. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18(1).

- We saw that the provider had recently recruited four members of staff who were going through their induction process.
- The registered manager told us they had actively recruited to ensure they had enough staff to meet their commitments.
- People told us the reliability of the service had improved. One person said, "No calls have been missed".

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The service had not ensured that staff were trained and competent to safeguarding people from harm and abuse. Staff we spoke with had some understanding about how to identify and report abuse, but training records showed that not all staff had received safeguarding training. Lack of training about how to safeguard people meant they were at risk of neglect or abuse.
- One person told us about an incident when a care staff did not respond to a fall by following safe moving and handling procedures or calling an ambulance. There was no record of this incident or any actions taken by the service to improve staff knowledge or responses to falls.
- Two staff members we spoke with were unaware of the providers whistleblowing policy. We were told, "I don't know what whistleblowing is" and "I don't know if there is one for definite."

Preventing and controlling infection

- We were somewhat assured about the providers' response to the current Covid pandemic. Staff had not received any specific training in relation to Covid and the provider had not assessed the risks and needs of people and staff in relation to Covid. However, staff had received infection control training and the provider told us they sent regular bulletins to staff informing them of any government Covid updates and procedures for wearing personal protective equipment (PPE). There were policies in place for infection prevention and control (IPC) and use of PPE.
- Staff had access to enough appropriate PPE, including masks, gloves and aprons to use when visiting people. One staff member told us they visited the office every week to collect gloves.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience

- Staff did not always have the relevant skills and knowledge to care for people using the service. For example, some people had complex health needs including muscular dystrophy and brain injuries. Training had not been completed by staff who cared for people with these specific health conditions. This posed a risk to people using the service as specific knowledge and skills about health conditions had not been gained by care staff.
- Staff supervisions and spot checks had not been consistently carried out. This placed people at risk of harm due to inconsistent care.
- The registered manager told us that staff training in lifelong health conditions including, multiple sclerosis, muscular dystrophy and anaemia was mandatory. However, there was no evidence this training had taken place, it was not included in the staff training records the registered manager sent us after our visit to the agency's office.
- Training in safeguarding vulnerable adults had been completed by most staff. However, two of the staff we spoke with were unaware of the service's whistleblowing policy. Only one staff member we spoke to told us they would report any concerns to the local authority.
- Records and feedback from staff showed they had received training in other topics including, moving and handling, infection control, hand hygiene and health and safety. Training records showed some staff had not received refresher training about key aspects of care and support, including safeguarding adults, for over a year.
- Feedback from people was more positive in relation to staff training, one person told us, "I think staff have the skills to look after me." Another person told us, "I think staff have enough training. I mean, it's not rocket science how to put on a pair of socks. They seem skilled in how they do things."

We found no evidence that people had been harmed however, staff training was not in place to ensure that people's needs were appropriately met. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's care plans did not always record details about meals or dietary requirements. There was no mention of specific dietary requirements for people with health conditions, for example, people's dietary needs to manage diabetes was not recorded. There was very little information concerning people's preferences in relation to their food in the care plans.
- People had mixed experiences of support with their meals, one person told us, "Sometimes, on a Sunday if my daughter works, I will ask them [care staff] for mealtime support. I can ask some to help me prepare food but then there's some you'd rather not ask." Another person told us, "I choose what I want, and they cook it."
- Care plans identified when care staff should contact district nurses or GPs in relation to needs, such as skin care and diabetes. GP contact details were on care plans.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (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.

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- Decisions about mental capacity had been made for some people, however, there was no record to show how these decisions were assessed. This does not follow best practice in line with the act.
- People had signed a medication consent form, but there was no evidence that mental capacity assessment had been considered. Where people administered their own medicines, it was not clear if they had the mental capacity to do so.
- Staff had limited understanding of the MCA and told us they provided people with choices, for example they asked people what they wanted to eat.

We recommend training in MCA is improved to increase staff knowledge.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant people were not always supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- People were not always involved in creating their care plans. One person said, "There is a care plan here. The manager came around and went through loads of questions. We were interviewed." However, other people had no knowledge about their care plans, "I don't know what's in it", another person said, "I don't know if I have a care plan. There is a book here. They write what time they come and go, what they do to me and sign their name. I don't look in the book, I don't know if it says anything about me."
- Care was not always person centred, people often had their religion recorded but were not asked about their cultural preferences or characteristics during their initial assessment, we saw that people's ethnicity was not always recorded.

Respecting and promoting people's privacy, dignity and independence

- Care plans did not reflect people's preferences, how they wanted to be supported or how they wanted their independence supported. Care staff were given instructions for tasks such as to 'put the washing machine on' or 'ensure [the person] had dried themselves properly', however there were no details about how people liked these tasks carried out or things they did not like.
- People had mixed experiences of how their choices and independence were supported. One person told us they had experienced inconvenient call times to support them with meals and were "put to bed" in the early evening too soon. Another person told us, "Staff respect my requests. These carers let me take the lead and do what I can."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we recommended the provider ensures care is designed to meet people's personal preferences and wishes. Not enough improvement had been made at this inspection and the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Person-centred care

- People's care plans were brief and did not give staff sufficient detail to be able to ensure consistent care. For example, one person's care plan in relation to their foot care was generic. There was no guidance to tell staff what they should be checking for and the frequency of the checks was not specified.
- People's care plans contained contradictory information and were not updated to reflect their current needs. For example, one person's risk assessment stated they had a weakness on their right side however, the care plan said it was their left side. This was discussed with the registered manager who told us, "This was a typing error, which has been rectified."
- Care calls were not always reliable, people did not always experience timely care calls and were not always informed about late calls. People told us, "Sometimes they do miss calls" and, "They're not always on time, it depends if they get someone like me as it can take a while and then it makes them late," "Occasionally, now and again, they might be in a real hurry and say they can't do something but overall its good," and "No calls have been missed but sometimes they are late. I don't always get informed when they are running late. Sometimes I do and it comes via the office."

People were at risk of inconsistent and uncoordinated care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to respond to complaints. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

- People had confidence that action would be taken if they raised any concerns.
- One person told us, "If I had concerns I'd go back to the agency owner. Nope, never had to complain. I like

the manager, I felt she was very helpful this morning." Another person said "There was one person that I asked the office to please not send her again and they didn't."

- We saw the registered manager had followed up and investigated complaints received. The registered manager had informed people of the outcome following their complaints. This was inline with the providers complaints policy.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider was aware of their responsibilities under the AIS.
- People's initial assessment included information regarding their hearing and sight. However, this information was not always clear. One person's records stated that they, 'Communicate well' and have 'No hearing issues'. The same person's records also stated the person, 'Has hearing aids, but does not wear them.'

End of life care and support

- Care plans did not contain information regarding peoples end of life care. There was a reliance on individual staff knowledge to enable people to receive appropriate support at the end of their life. This meant there was a risk that people would not receive appropriate support as their wishes were not recorded within the care plan. However, at the time of our visit end of life care was not being provided.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The last rating for this service was Requires Improvement (published 6 August 2019) and there were multiple breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of multiple regulations.
- Following the last inspection, the provider was asked for assurances as to how they would improve systems of quality monitoring and governance. During our inspection, we found these systems had not been embedded within the service, which meant improvements had not been made. We found risk assessments had not always been completed, care plans lacked person-centred detail, staff supervisions and spot checks had not been consistently carried out and audits were not robust. This placed people at risk of harm due to inconsistent and uncoordinated care.
- A recent notifiable incident had not been reported to safeguarding. Therefore, we could not be assured that all incidents and accidents were reported to CQC or safeguarding appropriately.
 - We saw that staff completed accident forms, however, there was no evidence of any analysis to identify trends and themes within the service around accidents and incidents. For example, we saw no analysis of falls or specific incidents to prevent re-occurrence, or evidence of how improvements were made and lessons could be learnt. The provider was not fully recording or reporting all incidents, which meant there was a further lack of governance and monitoring to keep people safe. This exposed people to further harm.
 - When asked if they thought the service was well-run one person told us, "I don't know about it being run well." Another person said, "I don't have any problems with the manager at all, we get on very well. They haven't contacted me so far to ask if I'm happy with the service, but then the manager comes to me once or twice a week, so she knows what's going on. She does some caring, she's hands on."

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- People using the service told us there was a lack of communication. For example, when visits were late people were not always informed. One person told us, "They don't ring me if they're late, I ring them, or they just turn up and say they got held up. I want to know that they are running late. I think most times it's the traffic and it's not their fault. If they are late sometimes my calls are cut short." Another person told us, "One carer is very good at letting us know if she's going to be late. We don't hear from anyone else if they are going to be late." A further person added, "Carers have said to me that they can have 2-3 rotas sent a day because they keep changing things."
- People did not always feel their experience of care was regularly sought or used in a meaningful way. The registered manager told us they actively sought the views of the people using the service. However, people told us, "I don't know who the staff in the office are. I don't know what they are like. No one rings me from the office."
- One person told us, "The manager hasn't phone me to ask if I'm happy with the service. They did a questionnaire which I thought was odd. It didn't ask about which staff were nice or helpful, even McDonalds want to know names of staff that were helpful. Don't they want to credit individual carers?" Another person told us, "They haven't phoned or spoken to ask me if I'm happy about the service."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to assess and monitor the quality and safety of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- As part of our inspection we viewed the provider's website. The most recent rating by the Commission of the service provider's overall performance was not displayed on their website. Failure to display the ratings could mislead the public and prevent people making informed choices when arranging their care.

This is a breach of regulation 20A (Requirement as to the display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure that care was delivered in a person-centred way.
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider did not ensure that recruitment checks were robust.
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider had not ensured that the most recent rating by the Commission of the service provider's overall performance was displayed on the providers website
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not ensure that staff training was in place to ensure people's needs were appropriately met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that people were kept safe from risks or avoidable harm.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not ensure that systems were in place or robust enough to assess and monitor the quality and safety of the service.

The enforcement action we took:

Warning Notice