Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2015	2015_189120_0009	H-000759/763-14	Follow up

Licensee/Titulaire de permis

NIAGARA HEALTH SYSTEM
63 THIRD STREET WELLAND HOSPITAL SITE WELLAND ON L3B 4W6

Long-Term Care Home/Foyer de soins de longue durée

NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT
155 Ontario Street St. Catharines ON L2R 5K3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 20 & 21, 2015

An inspection (2014-191107-0009) was previously conducted April 8-24, 2014 at which time non compliance was issued with respect to bed safety and maintenance of tubs and tub lifts. For this follow-up visit, the order related to tubs and tub lifts has been rectified, however, non-compliance remains outstanding for the order related to bed safety. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Building Services Supervisor, Director of Care, non-registered staff and residents. The Inspector toured resident rooms, reviewed bed safety audits, resident health care records, tub and tub lift equipment inspection documentation and service reports.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 90. (2)	CO #001	2014_191107_0009	120

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not assess all residents who used bed rails in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices for bed rail assessments includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration.

Random residents were selected to determine if they were assessed for bed rail use after observing them sleeping in bed on January 20, 2015 with at least one full sized bed rail elevated. Electronic records titled "Welland Bed Rail Utilization Assessment" were reviewed with the Director of Care. The records were incomplete for 6 out of 6 residents reviewed and the assessments were not developed in accordance with prevailing practices. The 6 assessments for identified residents were partially completed but no conclusion was established by an interdisciplinary team as to whether a resident needed a bed rail, whether alternatives were trialled, how many rails were needed and the specific side, the size of the rail and why. Further review of the residents plan of care revealed that 2 out of the 6 residents had information listed indicating that they were to have their "right/left rail elevated for turning or repositioning". How the evaluator came to this conclusion was not made apparent in any of the records. In addition, numerous beds throughout the home where observed to have at least one bed rail elevated where the beds were unoccupied. This practice is an indicator that health care staff are applying bed rails out of habit as opposed to assessed need. Confirmation was made with the Director of Care that staff did not receive any formal education or training with respect to

bed rail use hazards or how to complete appropriate assessments. [s. 15(1)(a)]

2. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The licensee commissioned a company to complete an entrapment assessment of all resident bed systems on September 4, 2014. The results of the audit however could not be used to establish conclusive results as to whether the beds were measured accurately or fully in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. In addition, since September 2014, the beds in the home had been relocated, different beds introduced that were not on the original assessment and mattresses moved around. The home did not have their own measurement tool and did not complete any re-tests or measurements when changes were made over the last 4 months.

The entrapment assessment results from September 4, 2014 identified that 11 resident beds with a foam mattress failed zone 2 (under the rail and the side of the mattress) and/or zone 3 (between the bed rail and the side of the mattress). Approximately 12 additional beds with a therapeutic mattress on the frame were identified to be in the home on September 4, 2014, but were documented as having passed zones 2-4, which was not possible, as the mattresses were not equipped with a reinforced side wall and were compressible and very flexible. The evaluator concluded that "there was no way to accurately test these gaps as they will change with each cycle, however we test them to simply ensure the mattress, rail and bed frame work together". Unfortunately, the licensee was therefore not appropriately guided to ensure that risks associated with therapeutic surfaces were managed and mitigated.

For the failed beds with a foam mattress, the licensee responded by inserting a bed rail pad on 7 of the beds and had documented their actions on a form titled "Bed Safety and Entrapment Action Sheet - ECU and ILTC" dated October 14, 2014. On January 21, 2015, accompanied by the employee who completed the form and had inserted the pads, none of the 7 resident beds had any bed rail pads on the rails. The employee confirmed that since October 14, 2014, no monitoring to ensure that the beds remained safe was implemented. The beds were verified at the time of inspection to be the same bed by cross referencing a unique bed number that was listed on the document.

The following residents were observed on January 20 and 21, 2015:

Resident #001 in an identified bed was observed to be lying on a therapeutic mattress with both full rails elevated and no accessories to mitigate zone 2 and 3 risks.

Resident #002 was observed in a bed on a therapeutic air mattress with both full rails up without any accessory in place to mitigate zone 2 or 3 risks.

Resident #003 was interviewed about their bed as they were not in it at the time of inspection. A full right bed rail was elevated and a bolster along the length of the therapeutic mattress was provided. But no bolster was included on the left side of the mattress. The resident confirmed that when they are in bed, both full rails are elevated.

Resident #004 was observed in a bed with both full rails elevated without zone 3 accessories to reduce zone 3 entrapment gaps. The bed was identified to have failed zone 3 on September 4, 2014.

Resident #005 was observed in a bed with both full rails elevated without zone 2 and 3 accessories to reduce zone 2 and 3 entrapment gaps. The bed was identified to have failed zone 2 and 3 on September 4, 2014. [s. 15(1)(b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 17th day of February, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2015_189120_0009
Log No. / Registre no:	H-000759/763-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 9, 2015
Licensee / Titulaire de permis :	NIAGARA HEALTH SYSTEM 63 THIRD STREET, WELLAND HOSPITAL SITE, WELLAND, ON, L3B-4W6
LTC Home / Foyer de SLD :	NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT 155 Ontario Street, St. Catharines, ON, L2R-5K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HELEN FERLEY

To NIAGARA HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0009, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following;

1. Where bed rails are used, mitigate immediately all zone 2-4 entrapment zones for residents residing on a therapeutic air mattresses and those that reside on a foam mattress where the bed was previously identified as failing entrapment zone 2-4.
2. Have all beds re-measured/re-assessed for entrapment zones 2-4 using Health Canada's guidelines titled "Adult Hospital Bed: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008.
3. Label all mattresses with the same number used to number the bed frame when the bed is being measured/assessed.
3. Accurately document the results of the bed assessments and continuously maintain the document when changes to the bed system occurs (i.e. mattress changed, rail replaced).
4. Educate all health care staff with respect to entrapment zones, bed safety and rail use hazards using the following document as a guide "Adult Hospital Bed: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008.

Grounds / Motifs :

1. The licensee did not assess all residents who used bed rails in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices for bed rail assessments includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration.

Random residents were selected to determine if they were assessed for bed rail use after observing them sleeping in bed on January 20, 2015 with at least one full sized bed rail elevated. Electronic records titled "Welland Bed Rail Utilization Assessment" were reviewed with the Director of Care. The records were incomplete for 6 out of 6 residents reviewed and the assessments were not developed in accordance with prevailing practices. The 6 assessments for identified residents were partially completed but no conclusion was established by an interdisciplinary team as to whether a resident needed a bed rail, whether alternatives were trialled, how many rails were needed and the specific side, the size of the rail and why. Further review of the residents plan of care revealed that 2 out of the 6 residents had information listed indicating that they were to have their "right/left rail elevated for turning or repositioning". How the evaluator came to this conclusion was not made apparent in any of the records. In addition, numerous beds throughout the home where observed to have at least one bed rail elevated where the beds were unoccupied. This practice is an indicator that health care staff are applying bed rails out of habit as opposed to assessed need. Confirmation was made with the Director of Care that staff did not receive any formal education or training with respect to bed rail use hazards or how to complete appropriate assessments. [s. 15(1)(a)]

2. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The licensee commissioned a company to complete an entrapment assessment of all resident bed systems on September 4, 2014. The results of the audit however could not be used to establish conclusive results as to whether the beds were measured accurately or fully in accordance with Health Canada

Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. In addition, since September 2014, the beds in the home had been relocated, different beds introduced that were not on the original assessment and mattresses moved around. The home did not have their own measurement tool and did not complete any re-tests or measurements when changes were made over the last 4 months.

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For the failed beds with a foam mattress, the licensee responded by inserting a bed rail pad on 7 of the beds and had documented their actions on a form titled "Bed Safety and Entrapment Action Sheet - ECU and ILTC" dated October 14, 2014. On January 21, 2015, accompanied by the employee who completed the form and had inserted the pads, none of the 7 resident beds had any bed rail pads on the rails. The employee confirmed that since October 14, 2014, no monitoring to ensure that the beds remained safe was implemented. The beds were verified at the time of inspection to be the same bed by cross referencing a unique bed number that was listed on the document.

The following residents were observed on January 20 and 21, 2015:

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Resident #002 was observed in a bed on a therapeutic air mattress with both full rails up without any accessory in place to mitigate zone 2 or 3 risks.

Resident #003 was interviewed about their bed as they were not in it at the time of inspection. A full right bed rail was elevated and a bolster along the length of the therapeutic mattress was provided. But no bolster was included on the left side of the mattress. The resident confirmed that when they are in bed, both full rails are elevated.

Resident #004 was observed in a bed with both full rails elevated without zone 3 accessories to reduce zone 3 entrapment gaps. The bed was identified to have failed zone 3 on September 4, 2014.

Resident #005 was observed in a bed with both full rails elevated without zone 2 and 3 accessories to reduce zone 2 and 3 entrapment gaps. The bed was identified to have failed zone 2 and 3 on September 4, 2014. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop a comprehensive bed safety assessment tool using the US Federal Drug and Food Administration document as a guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
2. An interdisciplinary team shall assess all residents using the bed safety assessment tool and document the results and recommendations.
3. Update all resident health care records to include why bed rails are being used, how many and any accessories that are required to mitigate any identified entrapment risks.
4. Health care staff shall be provided with and follow directions related to each resident's bed rail use requirements.
5. Institute a monitoring program that will ensure that residents who require accessories to reduce entrapment zones will continue to be provided with those accessories.

Grounds / Motifs :

1. The licensee did not assess all residents who used bed rails in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices for bed rail assessments includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration.

Random residents were selected to determine if they were assessed for bed rail use after observing them sleeping in bed on January 20, 2015 with at least one full sized bed rail elevated. Electronic records titled "Welland Bed Rail Utilization Assessment" were reviewed with the Director of Care. The records were incomplete for 6 out of 6 residents reviewed and the assessments were not developed in accordance with prevailing practices. The 6 assessments for residents in identified beds were partially completed but no conclusion was established by an interdisciplinary team as to whether a resident needed a bed rail, whether alternatives were trialled, how many rails were needed and the specific side, the size of the rail and why. Further review of the residents plan of care revealed that 2 out of the 6 residents had information listed indicating that they were to have their "right/left rail elevated for turning or repositioning". How the evaluator came to this conclusion was not made apparent in any of the records. In addition, numerous beds throughout the home where observed to have at least one bed rail elevated where the beds were unoccupied. This practice is an indicator that health care staff are applying bed rails out of habit as opposed to assessed need. Confirmation was made with the Director of Care that staff did not receive any formal education or training with respect to bed rail use hazards or how to complete appropriate assessments. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

Service Area Office /
Bureau régional de services : Hamilton Service Area Office