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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2014	2014_189120_0003	H-000921-13	Complaint

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street, St. Catharines, ON, L2N-4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street, St. Catharines, ON, L2N-4J4

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

BERNADETTE SUSNIK (120), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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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 Complaint inspection.

This inspection was conducted on the following date(s): January 15+ 16 & ~~17~~ BJ, 2014

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, infection control designate, environmental services supervisor, registered staff, personal support workers, housekeepers and residents.

During the course of the inspection, the inspector(s) toured all three floors, reviewed resident health care records, infection control policies and procedures, observed rashes on several residents, observed restraint device use on residents and reviewed manufacturer's directions on restraint device use.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff did not apply the physical device in accordance with any manufacturer's instructions.

On January 15, 2014 resident #001, a cognitively impaired resident with high risk for falls, was observed sitting in a tilt wheel chair with a rear closing seat belt. The distance between the resident's abdomen and seat belt was approximately 8 inches thereby creating a large gap under which the resident could have slid and possibly become entangled. A review of the resident's clinical records revealed that the seat belt was being used as a physical restraining device. Interview with the RPN confirmed that the seat belt was a restraint and was to fit 'snug' across the abdomen to prevent the resident from slipping down. The RPN was observed to be unable to adjust the strap to tighten the belt as the buckle was applied in a manner that prevented the adjustment of the seat belt. Specifically, the manufacturer's instructions and "Guide for use" provided by the home identified that "the belt must be fitted tightly across the lower pelvis" and a loose belt can allow the resident to "slip down and create a risk for strangulation". The instructions further identified that "the adjustment strap at the buckle should be approximately three inches long". Interview with Administrator and DOC acknowledged that the physical restraint device was not applied in accordance with the manufacturer's directions and therefore created a risk to resident #001. The DOC immediately notified an external contractor to have the device adjusted which was completed within several hours of identifying the risk. [s. 110(1)1]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The infection prevention and control program, specifically related to the surveillance program has not been evaluated and updated at least annually in accordance with prevailing practices.

Current prevailing practices titled "Surveillance of health care-associated infections in patient and resident populations" October, 2011 by the Provincial Infectious Diseases Advisory Committee details how long term care homes are to systematically collect, collate and analyze resident health data on an ongoing basis in order to identify infections in a timely manner and to disseminate information to those who require it in order to take action. The surveillance program is also useful in monitoring the overall effectiveness of an infection prevention and control program.

The home's written policies and procedures available to staff during the inspection were dated April 2005 and did not adequately reflect the current best practices in the field of surveillance. Nursing staff were not able to provide any evidence that they were collecting, collating, analyzing or disseminating information to appropriate individuals for follow-up action with respect to residents who had rash-like symptoms between June 2013 and January 2014. [s. 229(2)d)]

2. The licensee did not have a written record that included the date that the infection prevention and control program was evaluated, the name of the person who

participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 229(2)e)]

3. Staff did not record symptoms of infection in residents on every shift and did not take immediate action as required.

The home's "infection control record" was established so that registered nurses on each of the home's three floors could record the names of the residents exhibiting any symptoms, whether related to their skin, eyes, gastrointestinal or respiratory systems. The record is also known as a line listing. The line listing is part of the home's surveillance and monitoring policy and procedure. It allows the infection control designate to review one source of documentation to determine if an outbreak is occurring and to track residents progress and treatments.

When these forms were requested for the months of June 2013 to January 2014, only one record for the month of October was provided by the designated infection control co-ordinator. On this record, no resident's with a skin symptom were documented, even though 2 residents (#001,#002) were identified to have a rash and their symptoms documented in other records. Failure of staff to record resident symptoms on the line listing led to cases that were not identified, assessed or treated.

Multiple residents were previously identified to have a rash with an unknown source on their body in June and July 2013. Registered staff did not document the information on the infection control record. Some registered staff recorded the residents' symptoms on a scrap of paper, some in their health record known as progress notes and others did not document anything at all. The rash was confirmed on July 22, 2013 to be related to Scabies, a mite that infests the skin and causes intense itching. Scabies is a communicable disease and can be spread from person to person very quickly. By July 22, 2013, over 20 residents were identified to have a rash and residents and staff received proper treatment for Scabies on July 23, 24 and 25, 2013. However, an unknown number of residents and specifically residents #001 and #002 were still positive with skin rash throughout the months of October, November and December 2013. Their symptoms were not recorded on an appropriate surveillance form (line listing) and for resident #001, no action was taken to address their rash.

According to the DOC, Infection Control Co-ordinator and the administrator on January 16, 2014, they were not aware of any residents who were still exhibiting any rash-like symptoms. However, when personal support workers were interviewed, they

reported that at least 5 residents either acquired a new rash or have re-occurring rashes since October 2013.

Resident #001's clinical record identified that the resident had "a raised pin-point marks scattered all over" a particular area of their body on a specified date in December 2013. The clinical record identified that the resident still had a rash on 2 specified dates in January 2014. Based on observation of the resident's skin by the inspector, the resident had a large area of their body covered in a rash. Based on the clinical record and interview with the DOC, immediate action had not been taken. The resident had not been assessed or followed up by the home's physician.

Resident #002 received Scabies treatment cream in July 2013 but continued to have rash-like symptoms into October 2013. The resident's clinical records did not indicate that a second treatment was given. A post treatment skin assessment was not completed and the progress notes did not identify whether the treatment was effective. No further action was taken to determine if symptoms had resolved.
[s. 229(5)(b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 13th day of February, 2014

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

B. Susnik, R. Mackie

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2014_189120_0003
Log No. / Registre no:	H-000921-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 13, 2014
Licensee / Titulaire de permis :	BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED 600 Lake Street, St. Catharines, ON, L2N-4J4
LTC Home / Foyer de SLD :	HEIDEHOF LONG TERM CARE HOME 600 Lake Street, St. Catharines, ON, L2N-4J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELENA CADDIS

To BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall apply a physical device on all residents requiring such a device in accordance with manufacturer's specifications.

Grounds / Motifs :

1. The licensee did not ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:. 1. Staff did not apply the physical device in accordance with any manufacturer's instructions.

On January 15, 2014 resident #001, a cognitively impaired resident with high risk for falls, was observed sitting in a tilt wheel chair with a rear closing seat belt. The distance between the resident's abdomen and seat belt was approximately 8 inches thereby creating a large gap under which the resident could have slid and possibly become entangled. A review of the resident's clinical records revealed that the seat belt was being used as a physical restraining device. Interview with the RPN confirmed that the seat belt was a restraint and was to fit 'snug' across the abdomen to prevent the resident from slipping down. The RPN was observed to be unable to adjust the strap to tighten the belt as the buckle was applied in a manner that prevented the adjustment of the seat belt. Specifically, the manufacturer's instructions and "Guide for use" provided by the home identified that "the belt must be fitted tightly across the lower pelvis" and a loose belt can allow the resident to "slip down and create a risk for strangulation". The instructions further identified that "the adjustment strap at the buckle should be approximately three inches long". Interview with Administrator and DOC acknowledged that the physical restraint device was not applied in accordance with the manufacturer's directions and therefore created a risk to resident #001. The DOC immediately notified an external contractor to have the device adjusted which was completed within several hours of identifying the risk. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2014

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. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee shall:

1. Assess all residents for any symptoms, specifically rash-like symptoms.
2. Record any symptoms identified on a line listing.
3. Institute appropriate best practice follow-up actions for residents with symptoms.
4. Record the follow-up actions taken for each resident on the line listing.
5. Continuously monitor each resident on a daily basis (shift to shift) for symptoms.
6. Continue to record resident's symptoms on the line listing on a daily basis (shift to shift)
7. Evaluate the data collected on the line listing once a month to detect trends for the purpose of reducing the incidence of infection and outbreaks.

Grounds / Motifs :

1. Staff did not record symptoms of infection in residents on every shift and did not take immediate action as required.

The home's "infection control record" was established so that registered nurses on each of the home's three floors could record the names of the residents exhibiting any symptoms, whether related to their skin, eyes, gastrointestinal or respiratory systems. The record is also known as a line listing. The line listing is part of the home's surveillance and monitoring policy and procedure. It allows the infection control designate to review one source of documentation to

determine if an outbreak is occurring and to track residents progress and treatments.

When these forms were requested for the months of June 2013 to January 2014, only one record for the month of October was provided by the designated infection control co-ordinator. On this record, no resident's with a skin symptom were documented, even though 2 residents (#001, #002) were identified to have a rash and their symptoms documented in other records. Failure of staff to record resident symptoms on the line listing led to cases that were not identified, assessed or treated.

Multiple residents were previously identified to have a rash with an unknown source on their body in June and July 2013. Registered staff did not document the information on the infection control record. Some registered staff recorded the residents' symptoms on a scrap of paper, some in their health record known as progress notes and others did not document anything at all. The rash was confirmed on July 22, 2013 to be related to Scabies, a mite that infests the skin and causes intense itching. Scabies is a communicable disease and can be spread from person to person very quickly. By July 22, 2013, over 20 residents were identified to have a rash and residents and staff received proper treatment for Scabies on July 23, 24 and 25, 2013. However, an unknown number of residents and specifically residents #001 and #002 were still positive with skin rash throughout the months of October, November and December 2013. Their symptoms were not recorded on an appropriate surveillance form (line listing) and for resident #001, no action was taken to address their rash.

According to the DOC, Infection Control Co-ordinator and the administrator on January 16, 2014, they were not aware of any residents who were still exhibiting any rash-like symptoms. However, when personal support workers were interviewed, they reported that at least 5 residents either acquired a new rash or have re-occurring rashes since October 2013.

Resident #001's clinical record identified that the resident had "a raised pin-point marks scattered all over" a particular area of their body on a specified date in December 2013. The clinical record identified that the resident still had a rash on 2 specified dates in January 2014. Based on observation of the resident's skin by the inspector, the resident had a large area of their body covered in a rash. Based on the clinical record and interview with the DOC, immediate action had not been taken. The resident had not been assessed or followed up by the

home's physician.

Resident #002 received Scabies treatment cream in July 2013 but continued to have rash-like symptoms into October 2013. The resident's clinical records did not indicate that a second treatment was given. A post treatment skin assessment was not completed and the progress notes did not identify whether the treatment was effective. No further action was taken to determine if symptoms had resolved. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that summarizes how, when and by whom the infection prevention and control program will be evaluated and updated in accordance with evidence-based practices identified as "Surveillance of health care-associated infections in patient and resident populations" October, 2011 by the Provincial Infectious Diseases Advisory Committee.

The plan shall be submitted to Bernadette.Susnik@ontario.ca or faxed to the Hamilton Service Area Office at 905-546-8255 by March 31, 2014. The plan shall be implemented by June 30, 2014.

Grounds / Motifs :

1. The infection prevention and control program, specifically related to the surveillance program has not been evaluated and updated at least annually in accordance with prevailing practices.

Current prevailing practices titled "Surveillance of health care-associated infections in patient and resident populations" October, 2011 by the Provincial Infectious Diseases Advisory Committee details how long term care homes are to systematically collect, collate and analyze resident health data on an ongoing basis in order to identify infections in a timely manner and to disseminate information to those who require it in order to take action. The surveillance program is also useful in monitoring the overall effectiveness of an infection prevention and control program.

The home's written policies and procedures available to staff during the inspection were dated April 2005 and did not adequately reflect the current best practices in the field of surveillance. Nursing staff were not able to provide any evidence that they were collecting, collating, analyzing or disseminating information to appropriate individuals for follow-up action with respect to residents who had rash-like symptoms between June 2013 and January 2014. (120)

2. The licensee did not have a written record that included the date that the infection prevention and control program was evaluated, the name of the person who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

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 13th day of February, 2014

Signature of Inspector / Signature de l'inspecteur : B. Susnik

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

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