Expected Length of Stay

Length of stay will vary by individual needs as determined by the health care team. Patients should expect to return to their previous care setting within 60 days of admission. A Take Back Agreement may be required for inter-facility transfers.

Application Process

Referral must be signed off by a physician or nurse practitioner.

The Centralized Access (Intake and Referral) Process to Senior Specialty Hospital Beds is a single entry point for providing access to geriatric mental health beds at Baycrest, CAMH and Toronto Rehabilitation Institute within the Toronto Central Local Integration Health Network (TC-LHIN).

Please fax completed application forms directly to the TC - LHIN Centralized Intake and Referral Office at 416-506-0439.

Each application is reviewed by the team prior to admission for eligibility and appropriateness. Applicants will also be considered for assessment by the Virtual Behavioural Medicine (VBM) team.

Contact Us

For more information, you may contact a social worker at 416-785-2500 ext. 2319.

Inpatient Behavioral Neurology Program: http://www.baycrest.org/care/care-programs/inpatient-care/behavioural-neurology-unit-2/

Update: January 2021

Baycrest

Inpatient Behavioral Neurology

Admission Criteria

Baycrest Health Sciences

Baycrest is proud of its continuum of healthcare, which encompasses specialized inpatient care for the older adult population, including:

- The Shirley and Philip Granovsky Palliative Care Unit
- Complex Continuing Care
- Inpatient Rehabilitation Program
- Inpatient Psychiatry Program
- Behavioural Neurology Unit

Inpatient Behavioral Neurology

The Behavioral Neurology program is a 20-bed short-term inpatient unit that focuses on assessment and treatment of adults with a diagnosis of neurocognitive disease, specifically dementia. The program offers a specialized interdisciplinary service that focuses on diagnosis and treatment of complex neurological diseases and associated behavioral symptoms.

Goals of the program

The goals of the program are to stabilize behavioral symptoms in order to enhance the well-being of the client and overall quality of life; improve the ability of families and caregivers to cope with challenges associated with the disease process; clarify diagnosis of dementia in order to provide optimal treatment; and facilitate smooth transition from hospital.

Inclusion

- Adults age 55 and older (younger clients will be considered on a case by case basis)
- Patient is medically stable (i.e. does not require acute care intervention) to participate in and benefit from treatment and management of responsive behaviours.
- Confirmed or suspected diagnosis of dementia with associated behavioral symptoms, including those with additional diagnosis of acquired brain injury/traumatic brain injury (ABI/TBI), Huntington's disease, developmental disability or other mental health illness
- Expectation that discharge planning and discharge destination are determined prior to admission.
- Patient or substitute decision maker (SDM) or Power of Attorney (POA) are expected to actively participate in discharge planning to return or transition to the appropriate destination.

Exclusion

- Dialysis
- Mechanical ventilation
- Bi-level Positive Airway Pressure (BiPAP)
- Cuffed Tracheostomy Tube
- Needs greater than 50% Oxygen
- Total parenteral nutrition (TPN)
- Bariatric equipment needs (300lbs +)
- Referrals for patients for whom placement is the main issue
- Patients requiring crisis admissions
- Patients with significant behavioral disturbances related to primary diagnosis of recent acquired brain injury/ traumatic brain injury (ABI/TBI), Huntington's disease, developmental disability or other mental health illness
- Patients with complex medical needs that cannot be managed on a non-medical unit
    - Ongoing IV therapy
    - Patients with tracheostomy
    - Patient with complex wounds
    - Enteral feeding
    - Oxygen needs greater than 50%
    - Acute medical problems
- Need for extensive rehabilitation or physiotherapy