Bruyère Continuing Care is the champion of well-being for aging Canadians and those requiring Continuing Care, helping them to become and remain as healthy and independent as possible through innovative and compassionate care, research, education and advocacy.

**Bruyère Continuing Care provides:**
Complex Continuing Care  
Palliative Care  
Rehabilitation Care  
Care of the Elderly  
Long-Term Care  
Family Medicine Care  
Research for Care

**Bruyère Continuing Care is:**
Élisabeth Bruyère Hospital  
Saint-Vincent Hospital  
Élisabeth Bruyère Research Institute  
Saint-Louis Residence  
Élisabeth Bruyère Residence  
Bruyère Family Medicine Centre  
Primrose Family Medicine Centre  
Bruyère Foundation

www.bruyere.org
WHAT IS REHABILITATION?
Rehabilitation is a progressive, dynamic, goal-oriented and time-limited process, which enables an individual with impairment to identify and reach their optimal mental, physical, cognitive and social functional level.

REHABILITATION AT BRUYÈRE CONTINUING CARE
Rehabilitation services at Bruyere Continuing Care cover a spectrum of inpatient and outpatient services in two areas: Care of the Elderly and Physical Medicine & Rehabilitation.
Assessment and rehabilitation services serve patients who have had a recent decline in their ability to manage everyday activities. The programs’ main goal is to improve the patient’s daily functional abilities through assessment and treatment of physical, cognitive, medical and social issues. Services are available in both official languages.

INTERPROFESSIONAL HEALTH CARE TEAM

Working closely with the patient and their family, rehabilitation teams establish a therapeutic treatment plan that aims to rehabilitate the patient so that he or she can achieve or maintain their maximum potential.

Our interprofessional health care teams consist of the following team members:

- physician
- nurse
- physiotherapist
- occupational therapist
- rehabilitation assistant
- social worker
- social service worker
- speech language pathologist
- neuropsychologist
- spiritual advisor
- pharmacist
- clinical dietician
- recreation therapist
Referral process
We welcome referrals from our community partners. All referrals should be initiated by a physician. Referrals from sources outside our usual catchment area will be considered. Please refer to the program descriptions for referral information on individual programs.

REHABILITATION PROGRAMS

Care of the Elderly
Our emphasis is on providing seniors with assessment and treatment of common geriatric issues, such as falls, cognitive decline, depression and incontinence, while also providing rehabilitation to improve their level of functioning.

Geriatric Rehabilitation
This inpatient unit provides rehabilitation to patients over 65 years of age who are experiencing a loss of ability to care for themselves as a result of a recent onset illness or accident. Patients receive a comprehensive geriatric assessment with the overriding goal of maximizing their level of independence. Typical referring diagnoses include: hip fracture, other orthopaedic fractures, post-operative deconditioning, due to new onset medical conditions, and neurological conditions such as Parkinson’s Disease or Spinal Stenosis. Length of stay is individualized according to the patient’s functional status and goal, and is determined by the team within the first week. The majority of our patients are discharged home or to retirement home settings. Detailed information about the program is outlined in the patient information brochure.
Geriatric Day Hospital
The John and Jennifer Ruddy Geriatric Day Hospital is an outpatient program that provides assessment and treatment to seniors with complex medical issues. The program aims to enhance elderly peoples’ ability to live independently in the community by working closely with an interprofessional team. Clients visit once or twice weekly for up to 10 weeks to complete a personalized program. Detailed information about the program is outlined in the patient information brochure.

Direct inquiries to
613-562-6262 extension 4010
Referrals can be faxed to:
613-562-4265.

Physical Medicine & Rehabilitation
We provide comprehensive assessment and treatment to adults presenting with new as well as chronic rehabilitation needs. We are a centre of expertise in post stroke rehabilitation offering a range of programs including specialized inpatient

Direct inquiries to
Admissions co-ordinator:
613-562-6262 ext. 1488
Referrals can be faxed to:
613-562-6095
rehabilitation services and an ambulatory stroke rehabilitation service. The continuum is designed to allow patients to move to the most appropriate service as their recovery progresses.

Physical Medicine & Rehabilitation (PM&R) Clinic
This clinic is a specialist consultation service. Patients are seen for post stroke follow-up, as well as chronic pain, spasticity and weakness problems related to neurological, or neuro-musculoskeletal conditions. Following a comprehensive initial assessment, patients are actively linked with follow-up services and resources offered by partner agencies and programs. The clinic also acts as the point of entry for all patients seeking rehabilitation services in the Ambulatory Stroke Service.

Direct inquiries to the Coordinator:
613-562-6262 ext. 1007
Referrals may be faxed to:
613 562-6312

Ambulatory Stroke Service
We provide rehabilitation services designed to help patients continue to work on their rehabilitation goals following their discharge from the inpatient stroke rehabilitation programs. The service also works with patients from the community referred by the Physical Medicine and Rehabilitation Clinic and who identify new rehabilitation goals as they continue their recovery.

Direct inquiries to the Coordinator:
613-562-6262 ext. 1007
Referrals may be faxed to:
613 562-6312
Post-stroke Rehabilitation

The inpatient unit provides specialized rehabilitation to patients in the early stages of recovery following a stroke. Patients receive comprehensive assessments and intensive, daily therapies in an environment that is designed to reinforce and consolidate new skills.
Families are encouraged to participate in the rehabilitation process and in planning for discharge.

Patients who are unable to participate fully in intensive rehabilitation may be directed to the Low Intensity, Long Duration Stroke program at St. Vincent Hospital. This option is designed to meet the needs of patients with more significant functional impairments who are not yet able to tolerate daily, intensive therapies. The goal is to prevent the risk of post stroke complications, to maintain optimal function and to support families in planning for discharge. Note that this program is a Complex Continuing Care program and is subject to co-payment requirements.

Referrals to both post-stroke rehabilitation options are centralized and patients are triaged to the most appropriate program based on a comprehensive intake assessment.

Inquiries may be directed to the Clinical Admissions Coordinator at 613 562-6262 ext 1488. Referrals may be faxed to: 613-562-6095