Spirituality and service design: Supporting spiritual care in Ontario long-term care homes

by

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Abstract

Spiritual care is crucial to the holistic care and health of a person, especially throughout the journey of aging. This study explores the role of spiritual care services in Ontario long-term care homes through a service design lens.

The research involved a multi-method approach to understand the landscape of spiritual care services across Ontario, as well as the experiences of long-term care service providers. This study involved secondary analysis of an existing spiritual care questionnaire, an environmental scan of long-term care home websites, a service design questionnaire, as well as a series of multi-stakeholder co-design sessions.

The results of this study reveal the diversity of spiritual care services provided across the province and share insight into the uniqueness of this service. Applying service design within this complex healthcare context demonstrated both the strengths as well as the limitations of the approach.
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List of Acronyms

CA – Census Agglomerate

CMA – Census Metropolitan Agglomerate

ROO – Rest of Ontario
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Chapter 1: Introduction

As a determinant of health (Zimmer et al., 2016), spirituality is an important factor in our lives that can greatly influence a person’s sense of wellbeing. Spiritual care is a facet of healthcare that tends to our spiritual needs (Kuepfer, 2018) and supports healthy aging (Zimmer et al., 2016). This study uses a multi-method approach to better understand how spiritual care services are provided across Ontario long-term care homes.

1.1 Rationale

Within this study, I explore spirituality; a deeply personal experience that continues to change and shift across Canada as fewer and fewer Canadians identify with a religion over time (Cornelissen, 2021). Through this research I have had the opportunity to consider how services can be designed to support this complex and meaningful part of ourselves. I have also had the privilege of expanding my knowledge in this field through gaining insight from a multitude of service providers’ perspectives in long-term care homes. These partners in research played a crucial role by sharing their lived experience and revealing the complexities of providing spiritual care.

While spirituality is often closely tied to religion, these concepts are different (Pargament, 1999). Kenneth Pargament, a leading researcher in psychology, health, and spirituality, states that there are diverse understandings of both spirituality and religion, and these understandings change and shift with time (1999). Similarly, understanding the differences between the two is equally varied (Koenig, 2018). According to Pargament (1999), common views on spirituality are associated with “a search for meaning, for
unity, for connectedness, for transcendence” (p.6), while religion is often seen as an “institution and formalized belief” (p.6). Schneiders (2003) views spirituality as encompassing both religious and secular spiritualities. Spirituality and religion are interrelated concepts, yet they are often pitted against each other in discussion of their differences (Pargament, 1999; Schneiders, 2003). While I cannot dig into this rich and complex discussion within the scope of this thesis, the study addresses the concept of spirituality. Religion, however, still holds significance in this study as illustrated by the study results.

Spirituality is a core component of understanding spiritual care, yet it is difficult to define (Kuepfer, 2018; Edwards et al., 2010). Pargament (1999) defines spirituality as “a search for the sacred” (p.12). Within the context of healthcare, spirituality and spiritual care are most often associated with the delivery of palliative and end-of-life care. A Consensus Conference on the role and quality of spiritual care as a dimension of palliative care proposed the following definition: “Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred” (Puchalski et al., 2009, p.887). Spirituality will be considered within the domains of health and wellbeing of older adults in this research, and as such these definitions hold significance in the development of this study.

Spirituality plays a significant role in shaping our perceptions of reality, our beliefs, and our sense of self (Witt Sherman, 2006). It is a core aspect of holistic health care and palliative care (Doehring, 2019; Southard, 2020; Puchalski, 2012). As a result, a patient’s decision-making process and care pathways can be shaped by spirituality. For
example, spiritual beliefs can greatly influence how patients cope with pain (Puchalski, 2001), and religious rituals may be requested by patients and their families based on their faith, particularly at the end of life (Witt Sherman, 2006). Despite its significance to our health and wellbeing, spiritual care is a commonly overlooked area within our healthcare system (Puchalski, 2012). Part of the difficulty in incorporating spiritual care within formal health service delivery is that it falls outside of most clinicians’ understanding of health and the medical model of disease. While healthcare systems often seek cure-based approaches, spiritual care embraces a holistic approach that emphasizes compassionate care (Puchalski, 2001). Spiritual care is mandated by the Long-Term Care Homes Act (2007), an enacted legislation governing the operations of long-term care homes in Ontario, and all long-term care providers are required to ensure residents have the opportunity to "pursue social, cultural, religious, spiritual and other interests" (paragraph 23, section 3). While mandatory, the Act provides minimal detail on how to provide and support spiritual care in long-term care homes, and there is little information on how spiritual care across long-term care homes in Ontario is provided.

Service design offers a human-centered approach to support seamless service delivery and innovation (Stickdorn et al., 2018). Service design has been applied to the public sector and healthcare contexts to streamline and improve the overall service experience. Through this research, service design will be applied to the context of spiritual care services in Ontario long-term care homes.
1.2 Research Questions

The study aims to better understand how spiritual care is provided across long-term care homes in Ontario and the potential value of service design as a tool applied to the context of spiritual care. By situating service design within the unique context of spiritual care, this research also provides new insights on the service design approach.

This thesis addresses the following research questions:

RQ1. *How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?*

RQ2. *What are the experiences of service providers, such as spiritual care providers and long-term care home administrators, in providing spiritual care?*

RQ3: *How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?*

By working with spiritual care providers and long-term care home administrators, I focused on understanding the service providers’ perspective. While this narrowed scope allowed for a more in-depth investigation of service design from the providers’ point of view, further research should involve discussions with long-term care residents and family.

This study contributes to the existing literature by capturing the current landscape of spiritual care in Ontario long-term care homes. Through a mixed-methods approach, the findings offer a broad overview of how spiritual care is provided across long-term care homes, as well as a rich understanding of the context through service provider perspectives. Furthermore, this study provides insight into the opportunities as well as the
shortcomings of a service design approach when applied to this unique field of healthcare and wellness.

1.3 Thesis Structure

The journey of this research is shared over 6 chapters:

Chapter 1 - Introduction: This chapter covers the purpose and goal of the research, provides a brief background on this field of research, and outlines the scope of the study and its contributions.

Chapter 2 - Literature review: The literature review provides a background on the topic by introducing the current spiritual and religious demographics in Canada. This chapter then describes spiritual care for the elderly, and how this is currently supported within the Ontario long-term care system. Finally, the literature review covers a background on service design and its applications in public and healthcare contexts. This chapter provides an understanding of the current context and introduces the opportunity for applying service design.

Chapter 3 - Methods: This chapter provides a summary of the methods used to answer the thesis research questions. This multi-method study involved a secondary analysis of an existing questionnaire from a study conducted by Kuepfer et al. (2022), an environmental scan of long-term care websites, a service design questionnaire, as well as a series of co-design sessions with long-term care service providers.

Chapter 4 - Findings: Results from the different phases of research are shared in this chapter.
Chapter 5 - Discussion: The findings of the research are revisited to answer the study research questions. This chapter returns to the literature and connects the findings to existing research. Study contributions and opportunities for further research conclude this chapter.

Chapter 6 - Conclusion: The thesis is wrapped up with a brief conclusion that summarizes the contributions of this research.
Chapter 2: Literature Review

2.1 Introduction

This literature review covers the fields of spiritual care for the elderly, long-term care, and service design, which informed the design of the research study. The review begins with context that led to the development of RQ1: *How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?* and RQ2: *What are the experiences of service providers, such as spiritual care providers and long-term care home administrators, in providing spiritual care?* Here, shifts in aging and spirituality demographics in Canada are introduced to better understand the current and future Canadian context for spiritual care in long-term care. The chapter then outlines factors and policies governing spiritual care service delivery in Ontario long-term care homes. A review of best practices and existing gaps in spiritual care is introduced, as well as research on staff perspectives in providing spiritual care in Ontario long-term care homes. The final section of the literature review explores opportunities for service design in this area of research, as proposed in RQ3: *How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?* As service design is a relatively new area of design research and practice with roots in industry, this section covers the possible values and shortcomings of service design, as well as its potential for application in more unconventional public service domains such as spiritual care.
2.2 Background

2.2.1 An aging population

According to the Canadian Institute for Health Information (2017), the population of seniors aged 65 and over has tripled since 1977. Between 2016 and 2021, the population of Canadians aged 85 and up grew by 12%. This was more than double the growth of the overall population, which increased by 5.2% (Statistics Canada, 2022). Statistics Canada (2022) anticipates that the population growth of older adults will continue to increase, peaking in 2031. This growing senior population may increase the need for more long-term care beds, as older individuals are likely to have multiple chronic conditions and functional impairments that require 24-hour nursing and personal support provided in residential care settings. It is estimated that over the next 20 years the number of beds available in Ontario’s long-term care system will need to double to meet the demand (Ontario’s Long-Term Care COVID-19 Commission, 2021).

2.2.2 The shift in spirituality and religion in Canada

In Canada, the landscape of religion and spirituality is shifting. In a study exploring changes in religious affiliation and diversity in Canada from 1985 to 2019, Cornelissen (2021) found that the percentage of people who reported having a religious affiliation steadily declined from 90% in 1985 to 68% in 2019. In addition to the decreasing number of people who have a religious affiliation, Canadians also reported less frequent participation in religious group activities and individual practices (Cornelissen, 2021). This is a result of a growing number of people from younger generations with no religious affiliation, creating a noticeable generational gap. There is a significant difference in the importance of religion to younger adults in Canada (Pew Research Center, 2018), and cultural shifts from prior decades have led to a different outlook on religion for the Baby Boomer generation from those generations that preceded them.
(Bibby, 2017). Much of the data on spirituality in Canada reveals that different generations and ethnic groups hold different belief systems and spiritual backgrounds.

Canada has been identified as a rapidly changing religious landscape, as the influx of immigrants over previous decades has introduced a diversity of religious backgrounds within the population (Bibby, 2017). While the number of people reporting spiritual affiliation has decreased, the number of people reporting a non-Christian affiliation has increased. A study looking at religious affiliation of Canadians between 1961-2001 reported increasing religious diversity within Canada (Gaye & Kunz, 2009). Between 2011-2016, the population of “visible minority” seniors in Ontario increased by 44% (Ministry for Seniors and Accessibility, 2017). This is nearly triple the rest of the senior population, which increased by 16% (Ministry for Seniors and Accessibility, 2017). Cornelissen (2021) found a larger percentage of immigrants reported having a spiritual affiliation that is an important part of their lifestyle.

It is likely that this ongoing demographic change will continue to shape the future of spirituality and religion in Canada (Statistics Canada, 2021). As cultural demographics in Canada shift and younger generations age, those receiving significant healthcare services such as palliative and end-of-life care, as well as individuals entering long-term care will have very different outlooks on spirituality than the generations that preceded them.

2.2.3 What is spiritual care?

As a deeply meaningful and personal service, spiritual care can be difficult to define (Raffay et al., 2016). Kuepfer et al. (2022) define spiritual care as “care that recognizes and responds to the needs of the human spirit (including the need for connection, emotional support, respect for values and beliefs, and the search for meaning in life/suffering)” (p.2). Landau et al.
describe spiritual care as "compassionate client-centered care, a mastery of divinity perspectives, and cultural sensitivity with psychotherapeutic insight to meet a client’s therapeutically assessed need for counseling, discernment, sacred expression (prayer, ritual), religious and emotional support” (p. 217). Spiritual care can involve meeting religious needs, but extends beyond solely religious care (Kuepfer et al., 2022; Raffay et al., 2016), which is important to consider as the percentage of the population with a faith affiliation dwindles (Cornelissen, 2021; Nolan 2021).

Spirituality has long been explored as a determinant of health and is an important aspect of healthy aging (Zimmer et al., 2016). The spirituality and religion of a patient has been identified to support positive practices, such as receiving social support, encouraging healthy habits and psychosocial responses, and managing stress (Zimmer et al., 2016). Spiritual care is recognized as an important aspect of providing holistic care to a patient (Doehring, 2019); however, it is commonly overlooked in healthcare (Puchalski, 2009, Hvidt et al., 2020). The spirituality of a patient has been shown to influence their health outcomes and quality of life, emphasizing the necessity for considering spiritual needs in healthcare settings (Doehring, 2019; Abu-Raiya et al., 2015; Hvidt et al., 2020; Edwards et al., 2010). For example, Pargament et al. (2004) documented the spiritual coping methods of older adults facing illness over the span of 2 years. The researchers found that patients who engaged in positive spiritual coping, such as connecting with others spiritually or seeking out spiritual support, were more likely to be healthier physically and mentally than those engaging in negative spiritual coping methods. Further, patients who engaged in negative spiritual coping methods, such as questioning their faith or feelings of spiritual
unfulfillment, were more likely to face worsening health and higher chances of death (Pargament et al. 2004).

Spiritual care plays a very significant role in palliative and end-of-life care. According to the World Health Organization (WHO), palliative care: “integrates the psychological and spiritual aspects of patient care” (Klinger, 2013). The Canadian Hospice Palliative Care Association (2014) identifies the spiritual domain as a key aspect of palliative care. Spirituality plays a role in defining one’s sense of self and providing hope and meaning-making when faced with illness. This is especially true towards the end-of-life, as people often experience a need to find closure and work through opportunities for reconciliation and forgiveness (Edwards et al., 2010).

As many individuals now enter long-term care homes at an older age and may require palliative care, spiritual care plays an important role throughout this journey. The next section will provide further insight into Ontario’s long-term care system and the significance of spiritual care practice.

2.3 Introduction to Ontario’s long-term care system

Long-term care homes are licensed residential care facilities that are available to those who require around-the-clock support with daily activities and access to regular care, including nursing and personal care (Ontario Ministry of Health and Long-Term Care, 2021). In other jurisdictions, these may be known as nursing homes, personal care homes, or residential care facilities. In Ontario, there are 627 homes (Canadian Institute for Health Information, 2021) providing care to over 115,000 people annually. The long-term care home system is funded by the provincial government and regulated under the Long-Term Care Homes Act (OLTCA, n.d.).
In terms of owner-operator model, there are three main types of long-term care homes in Ontario: publicly-owned and -operated municipal homes, private for-profit homes, and private not-for-profit homes. The type of home can influence the way that they operate, such as how their funds are disbursed and the support they receive. Of the 627 long-term care homes in Ontario, the majority (362) of the homes are owned and operated by private for-profit organizations (Canadian Institute for Health Information, 2017), as illustrated in Figure 1.

Despite the differences in their operation, all long-term care homes in Ontario are funded by the provincial government, at a per diem rate of $191.02 per resident. This funding is allocated to different aspects of care, including nursing and personal care, raw food, programs and support services, and other accommodations. Most of these funds are assigned to nursing and personal care, totaling $102.34, whereas programs and support services, including spiritual care, are allotted $12.06 per day (Ontario Ministry of Health and Long-Term Care, 2019).

Many not-for-profit homes hold socially driven values and objectives that can define the way they allocate funds towards caring for their residents. As a not-for-profit home, they are also
not required to pay income tax. Establishing a long-term care home within or adjacent to every municipality is required under the *Long-Term Care Homes Act* (2007). Thus, public homes are supported and sustained by municipal governments and do not need to pay municipal taxes (Ontario's Long-Term Care COVID-19 Commission, 2021).

Home size also makes a long-term care home eligible for additional funds. As every home receives most of their funding based on the number of beds (Financial Accountability Office of Ontario, 2019), larger homes receive larger funds. Having a larger home confers the advantage of economies of scale; resources and specialized care can be accessed and allocated across a larger home. To further support small homes consisting of 64 beds or fewer, the government provides an additional $180,000 as an annual staffing supplement to add to their Nursing and Personal Care (NPC) funding, whereas large homes, consisting of 65 beds or more, receive $106,000 per year (Ontario Ministry of Health and Long-term Care, 2019).

Alongside this, some long-term care homes in Ontario are culturally specific and provide care directed at long-term care residents from specific ethnic or cultural backgrounds. As of 2016, there were 56 cultural long-term care homes across Ontario (Dziedzic, 2016). These homes tend to be not-for-profit (Meiklejohn, 2021), and the goals and values of their home drive the cultural services and care they offer. Due to the small number of these homes however, there are longer waitlists to enter these homes, averaging 6 months longer than average wait times for any other type of home (Meiklejohn, 2021).

These factors account for differences in how much funding these different home types allocate to the care of their residents. This is important to consider when examining the care given to residents in different homes (Ontario's Long-Term Care COVID-19 Commission, 2021).
2.4 Understanding spiritual care in Ontario long-term care homes

The topic of spiritual care will be discussed primarily within the context of care for elderly residents in long-term care, recognizing that spiritual care is also provided to patients in other healthcare settings, such as in hospices or inpatient palliative care units. The focus of this topic reflects the scope of this research and presents the current context.

2.4.1 Spiritual care in long-term care homes

The Long-Term Care Homes Act (2007) for Ontario provides some guidance around delivery of spiritual care, however it is vaguely defined. The Resident Bill of Rights states: “Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential” (paragraph 23, section 3). All long-term care homes must meet all aspects of care, listing the delivery of religious and spiritual care as a requirement (Section 6, Paragraph 14). The Act, however, does not provide definitions of ‘religious and spiritual care’.

Religious and Spiritual Practices is listed under Care and Services (Section 14), stating that: “Every licensee of a long-term care home shall ensure that there is an organized program for the home to ensure that residents are given reasonable opportunity to practice their religious and spiritual beliefs, and to observe the requirements of those beliefs” (Section 14). The newly proposed long-term care homes act, Fixing Long-Term Care (2021), proposes steps to increase the quality of care, such as increasing the number of hours of staff-to-resident interaction and improvements to infection prevention and control. While there is also greater emphasis on providing palliative care, the sections on religious and spiritual practices have not been updated, despite the changing spiritual needs of those in long-term care.
In general, there is very little information about the way that spiritual care is provided across Ontario long-term care homes. In a recent study investigating spiritual care in long-term care homes in Southwest Ontario, Kuepfer et al. (2022) conducted a survey with spiritual care providers and recreational coordinators to better understand the care provided across these homes. Results of the study offered insight into the programming that was provided, based on the event calendar in a long-term care home. These programs varied widely, spanning weekly (e.g., services, prayer, music, and arts engagement) to monthly events (e.g., holiday observances and cultural engagements). Off-calendar events were also studied, which included one-on-one visits, family care, crisis intervention, and volunteer coordination (Kuepfer et al., 2022).

2.4.2 Who provides spiritual care?

According to the Long-term Care Homes Act (2007), all homes must have “...a designated lead for the program who has sufficient knowledge and experience to co-ordinate religious services and spiritual care in a multi-faith setting” (Section 85, paragraph 4). Stang et al. (2021) define a spiritual care provider as professionals who “work in a variety of settings and respond to varied requests for emotional support, spiritual and/or religious care” (p.4). Kuepfer et al.'s (2022) study on spiritual care providers in long-term care homes in Southern Ontario revealed that out of 177 homes, 49% employed a designated spiritual care provider, while 51% of homes have other staff members that organize and provide the care. The availability of an on-site spiritual care provider within the home varied. For example, not-for-profit homes and urban homes were more likely to hire a chaplain, and while 59.2% of homes with over 100 beds or more employed a spiritual care provider, only 34.2% of homes with fewer than 100 beds employed a spiritual care provider. This study concluded that while it is necessary for all team members in long-term care to
be aware of and provide spiritual support within the home, having a designated spiritual care provider is crucial to catering to the individual needs of the residents, instead of relying solely on what is offered by the community (Kuepfer et al., 2022).

2.4.3 Competencies of spiritual care providers

While spiritual care is not outlined in detail in the *Long-term Care Homes Act* (2007), there are other organizations that have developed standards and competencies for spiritual care providers and the delivery of spiritual care services. The Canadian Association of Spiritual Care (CASC) provides training and certification for spiritual care providers in Canada, specifically Spiritual Care Practitioners, and Psycho-Spiritual Therapists. The organization identifies key competencies of certified professionals in the following areas: “Professional Identity, Knowledge, Professional Ethical Conduct and Professional Skills” (CASC, 2019). Specific knowledge requirements outlined within these competencies include self-awareness of one’s own connection to spirituality and/or religion, cultural humility and competence, understanding of relevant psychological theories, as well as research capabilities. Professional skillsets of a CASC-certified professional include fostering therapeutic relationships, assessing clients’ spiritual needs, providing interventions based on needs (such as prayers, services, and rites), documenting spiritual care services and referrals, and advocating for the importance of spiritual care within their organization (CASC, 2019). The *Long-Term Care Home Act* (2007) does not specify any requirements or certification to provide spiritual care in long-term care, so the spiritual care providers in long-term care homes do not need to be certified by CASC or any other organization. While an increasing number of spiritual care providers in long-term care do have CASC certifications, others may come with prior religious or spiritual leadership experiences, such as
retired clergy (Kuepfer et al., 2022). As a result, spiritual care providers entering long-term care homes can come from diverse backgrounds, with varied training and knowledge.

In their survey of spiritual care in long-term care homes across Southern Ontario, Kuepfer et al. (2022) found that spiritual care providers listed key skills in their role as: “compassion, listening, presence, trust, comfort, acceptance/love, hope, peace, faith-finding, meaning, time to understand, encouragement, focus, resources and help/support” (p. 5). These skillsets are valued by spiritual care providers in long-term care and contribute towards providing good spiritual care.

2.5 Spiritual care practices

While spiritual care is broadly defined and tasks can vary for each care provider, certain recommendations have been put forth to support quality spiritual care.

2.5.1 Centered approaches to care

Thompson et al. (2018) discuss ‘Centeredness’, a term that encompasses person-centered, resident-centered, patient-centered, family-centered, and relationship-centered care. The term is across various healthcare settings, as different care contexts invoke a different centered concept (Thompson et al., 2018). For example, spiritual care providers within acute care settings focus on providing ‘client-centered care’ (Cooper et al., 2013), or ‘patient-centered care’ (Raffay et al., 2016; Puchalski et al., 2009; Edwards et al., 2010) to meet the individual and unique needs of each person. The biopsychosocial spiritual model of care (Puchalski et al., 2009) focuses on the needs of those receiving care and supports all dimensions of their wellness. Through supporting the biological, psychological, social, and spiritual elements of the patient (Reese, 2013), the care provided considers each individual holistically and caters to their needs accordingly.
2.5.2 Relational care

Spiritual care is deeply rooted in interacting with others and building relationships. Consequently, the care team is crucial to the delivery of quality spiritual care (Edwards et al., 2010), and the examination of spiritual care must also consider the characteristics of the spiritual care provider as well as the quality of their relationship with the patient or resident in long-term care. In a discussion with spiritual care providers to define spiritual care, Hvidt et al. (2020) found that: “...the delivery of [spiritual care] can never be considered a task external to the person providing [spiritual care]” (p.7). Related to this is the notion of continuity of care, which emphasizes the significance of strong interpersonal relationships between the spiritual care provider and the resident/patient, or staff member (Doehring, 2006; Cooper et al., 2013; Holyoke & Stephenson, 2017). Landau et al. (2013) described the importance of the spiritual care provider's role in creating a relationship that does not impose beliefs or prescribe solutions, but instead involves being present and ready to listen. According to Gijsberts et al. (2019), “[b]eing there’ implied that the spiritual caregiver recognized the shared humanity of each person” (p.11). This recommendation highlights the importance of connection and interaction that contributes towards a centered approach to care.

2.5.3 Intercultural care

Providing spiritual care to serve diverse spiritual needs requires further research (Selman et al., 2014). The intercultural approach to spiritual care supports spiritual caregiving that acknowledges the uniqueness of a person’s spiritual needs and individualizes care for each person and context (Doehring, 2019). This approach does not force the religion of the care provider onto the care recipient, but rather encourages the spiritual caregiver to support a person within their own religions and/or spiritualities, and their corresponding value systems. Ultimately, this invites
the care provider to practice “cultural humility in honoring the complexity of cultural identities” (Doehring, 2019, p. 71). Building on relational and centered approaches, intercultural care facilitates gaining a deeper understanding of the patient and forming strong interpersonal relationships.

### 2.5.4 Interdisciplinary care

Holyoke & Stephenson (2017) describe the need for spiritual care to be seen as “an emergent property of the system of care, not a distinct piece or part of care” (p.5). Results from a study investigating barriers faced by spiritual care providers in palliative care revealed the need for “shifting from multidisciplinary to interdisciplinary care” (Koper et al., 2019, p.7) by including and integrating spiritual care providers earlier in the patient/resident care journey. Greater integration of spiritual care documentation in a patient/resident’s care plan is recommended as an important part of integrating spiritual care into the health service delivery, as well as increasing communication among the team (Koper et al., 2019; Puchalski et al., 2009).

It is important that all members of interdisciplinary healthcare teams are trained in spiritual care and have an awareness of the importance of supporting the spiritual needs of patients/residents (Puchalski et al., 2009; Kuepfer, 2022; Koper et al., 2019; Gijsberts et al., 2019). This care team extends beyond the healthcare staff. Family members also hold significance as a member of the support team, in particular when the patient/resident is at the end-of-life and may struggle with communication (Vohra et al., 2006). However, having a specialist who focuses solely on supporting spiritual needs, such as a chaplain or spiritual care provider, is critical to prioritizing and delivering care that meets individual needs (Kuepfer, 2022).
Relational care, centered care, intercultural care, and interdisciplinary care are all important practices to support spiritual care (Figure 2). However, there are also numerous gaps that may create barriers in delivering quality spiritual care.

**Figure 2 - Important Practices in Spiritual Care**

### 2.6 Gaps in spiritual care delivery

Various gaps in spiritual care delivery have been identified within spiritual care research in both long-term care and palliative care settings.

#### 2.6.1 Lack of research

While spiritual care is a requirement in Ontario long-term care homes, there is a lack of documentation on how this care is provided across homes. The sparse detail pertaining to the delivery and scope of spiritual care in the *Long-Term Care Home Act* (2007) has led to vastly different spiritual care services being offered across Ontario long-term care homes (Kuepfer et al., 2022). Likewise, Landau et al. (2013) have drawn attention to the lack of research that currently exists around the role of spiritual care within an interdisciplinary care team in Ontario long-term care homes. In conducting this literature review, few articles were found on spiritual care in Ontario long-term care homes, further supporting this claim.

In an international survey of palliative care researchers and clinicians, spiritual care was almost unanimously recognized by respondents as a field that continues to need more research to
develop (Selman et al., 2014). The study revealed a number of research priorities which stemmed from questions like “1) How do we help staff talk about spiritual issues? 2) How do we identify patients and family members with spiritual needs? 3) How should we respond to spiritual distress or needs for support, that is, what works well?” (Selman et al., 2014, p. 523). Other priorities included “understanding of spiritual care, staff education regarding spiritual care, understanding of spiritual needs and distress, spiritual care for nonreligious people and people of different faiths, conceptualizations and definitions of spirituality/the spiritual” (Selman et al., 2014, p. 522). These factors highlight the importance of definition and clarity around spiritual care, as well as improving the education and awareness of staff to provide spiritual care and support spiritual needs.

2.6.2 Lack of resources

Spiritual care providers are often limited by time constraints, making it difficult to build strong relationships with each individual (Kuepfer, 2022; Edward et al., 2010). As relationships are crucial to the delivery of spiritual care (Doehring, 2006; Cooper et al., 2013; Holyoke & Stephenson, 2017), providers require time to nurture connections with those who require spiritual support. According to the study by Kuepfer et al. (2022), spiritual care providers in hospitals served an average of 160 persons, whereas one spiritual care provider was responsible to serve an average of 308 persons in long-term care homes (Schidt, 2013, as cited by Kuepfer et al., 2022). In a case study of spiritual care in a Southern Ontario long-term care home, Landau et al. (2013) reported an overdependence on volunteers to provide spiritual care, as well as burnout among volunteers due to poorly resourced care. When spiritual care providers are overburdened with the responsibility of care for many residents, they are restricted from building relationships. This
becomes increasingly difficult in homes without a designated spiritual care provider, when the person responsible is also running other recreational programs or the home relies on external community support.

Beyond spiritual care, staffing shortage and health human resources challenges have been a persistent issue for Ontario long-term care homes (OLTCA, 2019). In a 2018 study, 90% of long-term care homes struggled with hiring new staff (OLTCA, 2018). Due to staff shortages in long-term care homes, caregivers often take on tasks unrelated to direct care, resulting in less time to care for the resident (OLTCA, 2019).

2.6.3 Lack of awareness

Currently there is no unified understanding of the importance of spiritual care (Selman et al., 2014; Koper et al, 2019) and the spiritual caregiver (Puchalski, 2012; Cooper et al, 2013) in healthcare. Kuepfer et al.’s (2022) study on long-term care in Southern Ontario found that higher level staff such as management were often unaware of the significance of spiritual care. According to the authors (2022), “[d]espite evidence that spiritual care is central to well-being in later life, and policy that requires its provision, spiritual care seems to be seen as an optional extra, rather than an essential investment"(p.5). When the organization and leadership within a long-term care home fails to recognize the significance of spiritual care, this can impact how spiritual care is supported and implemented within the home. Gijsberts et al. (2019) describe the ‘invisibility’ of spiritual care providers and spiritual care services within health organizations. The authors called for greater ‘visibility’ in order to establish a greater awareness of spiritual care within an organization (Gijsberts et al., 2019).
There is an identified need for spiritual care training for all staff on a care team to support interdisciplinary spiritual care and holistic care (Edwards et al., 2010; Koper et al., 2019; Gijsberts et al., 2019). Healthcare providers often lack training or experience to recognize spiritual distress and refer patients to a spiritual care provider (Koper et al., 2019; Gijsberts et al., 2019). Kuepfer et al. (2022) identified a need to develop training specific to long-term care homes, as the increasingly complex needs of long-term care residents (Landau et al., 2013) create a unique situation for spiritual care delivery in Ontario. The identification of an appropriate spiritual care provider could also be supported by a centralized organization that encourages skill building and appropriate training for spiritual care providers entering the long-term care workforce and helps connect homes to qualified spiritual care providers (Kuepfer, 2022). Alongside training and education, Edwards et al. (2010) recommend care staff take time to reflect on their personal beliefs and spiritualities as a way of supporting spiritual care.

2.6.4 Impact of COVID-19 on spiritual care

The COVID-19 pandemic greatly impacted the way that spiritual care was delivered. Due to the lockdowns that occurred in Ontario, many patients and their families were unable to connect with their cultural and spiritual communities, which was particularly distressing during the end-of-life and palliative stages of care (Stilos et al., 2021; Schwellnus et al., 2021). In April 2021, Ontario’s Long-Term Care COVID-19 Commission released their final report detailing the issues in long-term care that led to devastating outcomes during the COVID-19 pandemic and proposed steps to improve the long-term care system. This report described how the long-term care system did not support quality of life for residents, noting that palliative care and end-of-life care were often overlooked. The report discusses the inadequate support for diversity, including spirituality,
in long-term care, highlighting the shortage of culturally-specific homes (Ontario's Long-Term Care COVID-19 Commission, 2021).

Spiritual care delivery changed during the pandemic, resulting in lower quality of care or the loss of care entirely (Ferrell et al., 2020). In an international survey exploring changes to spiritual care during the pandemic, spiritual care providers stated they experienced loss of physical and emotional connection with a patient and their loved ones, loss of value of their job within the team dynamic, as well as a loss of the ability to create community through facilitating rituals and important services (Vandenhoeck et al., 2021). Families and patients struggled to receive appropriate spiritual care during the pandemic and spiritual care teams were limited by lack of community support due to isolation protocols. However, the pandemic also invited new ways of delivering and providing care.

Findings from a study by Vandenhoeck et al. (2021) indicated that, during the pandemic, most spiritual care services and communications with loved ones became virtual. The virtual format made some spiritual care services more accessible for all, and communications with family and patients became more frequent as a result. Furthermore, spiritual care providers took on new tasks of facilitating remote communication between family and patient/resident, as well as creating awareness of spiritual care by supporting the wellbeing of staff working through the pandemic. While the study highlighted issues around distancing and pandemic protocols that hindered delivery of quality spiritual care, it also revealed opportunities for improved communication with remote family members as well as greater support for health staff and partners (Vandenhoeck et al., 2021).
Spiritual care services are a requirement under the *Long-Term Care Homes Act* (2007), yet there are many gaps in the provision of these services. The next section introduces service design and explores potential opportunities for its application in the context of spiritual care.

### 2.7 The unlikely role of service design

This thesis explores the possibilities of service design applied in the context of spiritual care. Through gaining an understanding of spiritual care services, the literature review provided an opportunity to consider how principles and practices of service design may relate to the values of spiritual care.

#### 2.7.1 What is service design?

Service design is driven by applying a design thinking approach in order to improve service experiences or design new services (Stickdorn et al., 2018). It offers a human-centered approach to gain a holistic perspective of a full service experience, through the perspectives of the client and the organization. Stickdorn et al. (2018) outline key principles and values of service design (Figure 3). The six main principles that encompass the service design approach (Stickdorn et al., 2018) are described in Table 1.
Six principles of service design (Stickdorn et al., 2018)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service design involves recognizing the experiences of all people who are involved and affected by the service.</td>
</tr>
<tr>
<td>Service design involves working with people who are involved and affected by a service throughout the design process.</td>
</tr>
<tr>
<td>Service design is an iterative process that involves frequent prototyping to further develop ideas, before arriving at a solution.</td>
</tr>
<tr>
<td>Service design considers the service in detail by considering the various interactions and how they connect to provide a service.</td>
</tr>
<tr>
<td>Service design relies on research, prototyping, and testing within real contexts and stakeholders in order to develop solutions that serve real needs.</td>
</tr>
<tr>
<td>Service design works to meet the needs of every stakeholder involved and affected by the service.</td>
</tr>
</tbody>
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TABLE 1 - SIX PRINCIPLES OF SERVICE DESIGN (STICKDORN ET AL., 2018)

According to Stickdorn et al. (2018), service design serves organizations and bring value in different ways, as listed in Table 2.

<table>
<thead>
<tr>
<th>Views on service design (Stickdorn et al., 2018)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service design as a mindset</td>
<td>Service design fosters a human-centered and co-creative mindset when considering design problems.</td>
</tr>
<tr>
<td>Service design as a process</td>
<td>Service design encourages an iterative process that supports quick and messy prototyping throughout a design project.</td>
</tr>
<tr>
<td>Service design as a toolset</td>
<td>Service design offers various tools that visualize the human-centered, co-creative approach, and support the design process.</td>
</tr>
<tr>
<td>Service design as a cross-disciplinary language</td>
<td>Service design invites collaboration across disciplines, using visualizations and design approaches that invite discussion between stakeholders and facilitate silo-breaking.</td>
</tr>
<tr>
<td>Service design as a management approach</td>
<td>Service design also facilitates innovation within an organization, through supporting an iterative management approach.</td>
</tr>
</tbody>
</table>

TABLE 2 - VIEWS ON SERVICE DESIGN (STICKDORN ET AL., 2018)
Service design is valued as an approach to innovation and organizational advancement, which contributes towards establishing a more sustainable knowledge-based economy (Meroni & Sangiorgi, 2011). The development of service design marks a shift away from product or technology-centric mindsets to consider “soft dimensions” (Meroni & Sangiorgi, 2011, p.14) that consider users, experiences, and interactions, and their unseen connections within systems (Meroni & Sangiorgi, 2011).

Service design is recognized as an approach that can foster transformative social change and promote wellbeing (Fisk et al., 2018; Vink & Koskela-Huotari, 2021). Service research related to wellbeing is referred to as Transformative Service Research (Anderson et al., 2013), which refers to the creation of social value and societal wellbeing through services (Fisk et al., 2018). While these potentials exist, there are common practices in service design today that are highlighted as preventing the growth of the field and realization of social change. As service design is a newly developing field and most publications reflect real-world practices and learnings, there is a gap in theoretical and systemic academic articles that support theory-building
around service design (Sun, 2019). According to Akama (2009), most service design case studies are written with the intention of showing and promoting the value and benefits of service design. While this was initially necessary for the growth of the field, these articles often simplify the process, failing to share all of the complexities, conflicts, and real-world struggles that emerge through the project. Similarly, service design toolkits and methods are important in introducing approaches in service design; however, an over-reliance on the use of standardized methods reinforces the idea that these methods can be uniformly applied to any context (Akama, 2009). This establishes a flattened and idealized vision of service design (Akama, 2009). Service design toolkits are often perceived as a one-size-fits-all solution that can be easily duplicated and applied to any context by any designer (Akama, 2009; Akama & Prendiville, 2013). Despite the intangible focus of service design, this simplified approach focuses on physical outputs and results, with little consideration of the value of interactions or learning by the stakeholders involved in co-designing (Akama & Prendiville, 2013; Vink & Koskela-Huotari, 2021). Akama (2009) emphasizes that context and the lived experiences of stakeholders are crucial elements that are not taken into account through these materials.

Service design has the potential to recognize hidden institutionalized structures and develop more inclusive systems. Within the context of government institutions, design has been viewed as an enabler of change and innovation of public service. However, common design methods often fail to consider and reflect on the complexities of an underlying system and organizational culture (Kimbell & Bailey, 2017). Vink & Koskela-Huotari (2021) discuss the role of service design in facilitating reflexivity of designers and stakeholders, recognizing the role institutions play in shaping services and systems, and identifying opportunities to change and
improve these invisible systems. Reflexivity through service design is fostered through: “revealing hidden structures, noticing structural conflict, and appreciating structural malleability” (Vink & Koskela-Huotari, 2021, p.2). In response to the complexity of systems and their effect on service users, Patricio et al. (2011) proposed the Multilevel Service Design (MSD) framework. This approach acknowledges the various levels of systems that form to provide services, within and across organizations: “Service systems can be modeled and designed at different levels. The network of service offerings provided by different firms can be viewed as a system of systems. The firm’s configuration of people, technologies, and other resources can be viewed as the service system at the organizational level” (Patricio et al., 2011, p.181). This perspective on service design provides a holistic view of systems and how the high-level values of organizations may translate into services for a user. For these reasons, the MSD framework is seen as an ideal approach to fostering service inclusion and designing services that support and accommodate the diverse needs of all users (Fisk et al., 2018). According to Fisk et al. (2018), many service design projects focus on the services provided by a single organization, whereas the development of inclusive services requires consideration of the larger systemic forces and pressures established by the nation-state, or government authority.

In considering “systems of systems” (Patricio et al., 2011, p.181), such as long-term care homes operating under the Ontario government and legislation, this framework provides a useful perspective on the potential of service design in extending beyond singular organizations and considering systems more broadly.
2.7.2 Service design for healthcare

While initially used in commercial and corporate contexts, service design has been identified as a unique approach to apply to complex systems such as healthcare. It is recognized as a method to innovate within the public sector by applying an interdisciplinary and holistic approach to tackling complex societal challenges (Thoelen et al, 2015).

According to Freire & Sangiorgi (2010), the economy has shifted through trends of mass production, to mass customization, to mass collaboration. Over time, more organizations are embracing a human-centered approach through collaborating with key stakeholders. Within healthcare, this same transition to mass collaboration illustrates a need for greater implementation of participatory (Freire & Sangiorgi, 2010) and person-centered (Patricio et al., 2019, Patricio et al., 2020) approaches to improve healthcare.

Healthcare is becoming increasingly complex, as there are more care providers, specialists, and numerous points of interaction that complicate the journey of a patient. This large network of stakeholders providing and receiving care is often fragmented and lacks communication channels, making it a difficult experience to navigate (Patricio et al., 2020). Service design offers an approach to leverage connections and facilitate more seamless experiences through working with stakeholders to identify these opportunities. By engaging all stakeholders in the process of designing solutions, this collaboration may support more human-centered outcomes and invite participants to define what value creation means (Freire & Sangiorgi, 2010; Wetter-Edman & Moritz, 2015).

The Experience Based Design (EBD) framework is a healthcare-oriented design framework that encourages greater collaboration and co-creation with stakeholders (NHS, 2009).
This approach centers on the experiences of those involved in healthcare to gain insight and implement improvements and innovation. To further emphasize the importance of working with stakeholders in healthcare throughout the design process, the title of the approach was later changed to Experience Based Co-Design (EBCD). Donetto et al. (2015) describe the EBCD process as bringing together “...participatory design and user experience design to bring about quality improvements in healthcare organizations” (p.238). The EBCD process invites stakeholders to engage in co-design approaches and share their insights and ideas to ultimately inform future improvements or changes. According to Donetto et al. (2015), this approach holds value beyond the generated outcomes of the co-design process. Stakeholders involved in EBCD are learning about human-centered approaches to healthcare, providing them with new skillsets that they can then apply to their work. In a study reviewing the role of co-design in healthcare research, Slattery et al. (2020) determined that co-design research in healthcare typically involved participants in interviews or focus groups. Participants were often acting in an advisory role to support research proposals as well as co-producers of research outcomes. Ultimately, a significant amount of health research is not informed by stakeholder priorities and applying a co-design approach may encourage greater mobilization of research outcomes (Slattery et al., 2020).

There are challenges that arise with the implementation of service design in healthcare. Healthcare systems and public health institutions are generally risk-averse, which is an important consideration in the development and implementation of innovative approaches such as service design within these contexts (Aguirre & Vink, 2013). Furthermore, established hierarchies and roles within healthcare make it difficult to facilitate co-design between different stakeholders (Donetto et al., 2015). For example, in an EBCD project involving multiple healthcare
stakeholders, Donetto et al. (2015) found that: “most healthcare staff can find it very challenging to move between their familiar ‘expert’ and ‘decision-maker’ role and that of partner and colleague required by co-design work” (p.239). Best practices that encourage greater adoption of design within the space of healthcare include supporting existing practices that are already effective, initiating incremental changes, and working with key stakeholders to understand their ideas (Aguirre & Vink, 2013). Service design is a useful approach within the context of healthcare that drives innovation. The following section will explore the opportunity for its application in the unique healthcare field of spiritual care.

2.7.3 Opportunities for service design in spiritual care

Service design has been applied to various projects to support the elderly. According to Project Design Led Innovations for Active Learning (Project DAA) (2014), various service design projects for seniors are taking place across Europe that encourage engagement with stakeholders. Service design projects address opportunities to support active aging, shift attitudes around assistive devices, and develop services systems for persons with Alzheimer’s Disease. For example, in response to a fragmented care system with disconnected care providers, the Barcelona Design Center developed a simple and cohesive care process for patients with Alzheimer’s Disease. Through the process of improving public services for older adults in Buckinghamshire, service design provided methods to engage the community to co-design solutions (Service Design Toolkit, n.d.). Ho (2019) has identified the application of Transformative Service Research to facilitate the well-being of an ageing population in Japan. The author (2019) promotes community-driven services that engage local residents to support the elderly, creating both
individual and collective value. These new service design projects support a design process that fosters greater stakeholder involvement and community-based solutions.

There is limited research on the potential of service design within the context of long-term care. Service design has been applied to the hospice context to promote community connection (Fuelfor, 2013), as well as exploring the service gaps that arise in long-term care when communicating with family members living at a distance (Oikonen, 2015).

Service design for spirituality and religion at end-of-life is also limited. Existing design research on spirituality and religion at end-of-life is rarely considered on its own, but rather as an element within a broader discussion of mental health (Schwellnus et al., 2021). Through the literature review, no research has been found related to service design for spiritual care. It has been identified, however, that there is a need to gain greater clarity of spiritual care as a service within healthcare, and better understand its importance from a service design perspective (Raffay et al., 2016).

This literature review highlights spiritual care service gaps and opportunities within the context of Ontario’s long-term care system. These gaps include a need for greater research, resources, and awareness, which ultimately hinder the delivery of spiritual care as a service. Service design is an emerging field of study that can support complex contexts such as healthcare, design for the elderly, and multi-level systems. For that reason, service design may offer value as an approach to explore service gaps outlined in spiritual care practices in long-term care. This thesis explores the role service design plays in the context of spiritual care by considering how it may act as a tool to support the design and delivery of spiritual care services in long-term care. As discussed above, spiritual care involves relational, centered, interdisciplinary, and intercultural
care. These practices align with some of the principles and approaches of service design (Figure 4). The practices of relational, centered, and intercultural spiritual care all connect to the need for the delivery of human-centered services to meet spiritual needs, a key principle and mindset of service design. Furthermore, the need for interdisciplinary teams to support spiritual care within long-term care homes aligns with the collaborative and holistic nature of service design, which considers the values of all stakeholders, and acts as a cross-disciplinary language between the collaborators. Through conducting research in a real-world context and applying design methods that investigate the service context, this thesis will also embody the iterative, sequential, and real principles of service design.

**Figure 4 - Connections between Spiritual Care and Service Design Practices**

There has been investigation of frameworks and models for spiritual care delivery that systematizes the process of providing spiritual care and referring spiritual care providers. Puchalski et al. (2009) developed two frameworks for providing spiritual care to patients in both in-patient and outpatient contexts. These frameworks show explorations of systems of care and
diagram processes that align with the service design approach. For example, Figure 5 shows a diagram of how spiritual care is provided to patients and family members, starting from admission into care services. Similar to service design mapping, this diagram provides a sequential visualization of the spiritual care process, but also provides a holistic perspective by illustrating the actions that must be taken by all stakeholders including service providers. This visualization of spiritual care embraces service design principles, suggesting there is an opportunity to explore spiritual care through a service design lens and create value through the approach.

**Figure 5 - Example of Spiritual Care Frameworks, taken from Puchalski et al. (2009)**

2.8 Summary of the literature review

The objective of this literature review was to establish an overview of long-term care, spiritual care, and service design, to explore their connections and better understand the opportunity for this research.
First, I examined the current context of spirituality and religion in Canada. This investigation revealed a steadily declining population of religious Canadians, particularly among younger Canadians (Cornellisen, 2021). Concurrently, the rise in immigration within Canada introduced cultural and religious diversity (Bibby, 2017). These trends indicate that the spiritual needs of new residents entering long-term care is changing and will continue to evolve over time as the role of spirituality in Canada shifts. In an overview of the long-term care system, I outlined how home type, home size, and location influence funding allocated to spiritual care. This chapter also presents the significance of spiritual care in Ontario long-term care home settings. The *Long-Term Care Home Act* (2007) provides little information about spiritual care and, as a result, the provision of spiritual care services varies vastly across long-term care homes in Ontario. There must be a designated spiritual care provider within long-term care homes; however, Kuepfer et al.’s (2022) study of long-term care homes in Southern Ontario revealed that more than half of long-term care homes did not have a chaplain and relied on community volunteers to provide this care. Currently, spiritual care in long-term care homes is undermined by insufficient staffing, a lack of support and awareness of the importance of spiritual care within the organization, as well as a need for more research in the field.

Finally, the concept of service design was introduced as an approach with the potential to be applied across systems and within healthcare contexts. Service design in healthcare supports a person-centered perspective (Patricio et al., 2019) and co-produced care outcomes (Freire & Sangiorgi, 2010), and can facilitate more seamless experiences within a complex system. In this review, no research connecting spiritual care and service design was identified, however the review revealed shared principles and values between spiritual care and service design
approaches, suggesting there may be an opportunity to apply and evaluate the use of service
design in this field.

Overall, this literature review builds a picture of the existing context, challenges for the
long-term care sector and, more specifically, spiritual care providers, while proposing
opportunities for design within this space. The literature review also provided key information that
led to the development of the study methodology. The methods for the research will be outlined in
the following chapter.
Chapter 3: Methodology

A multi-method approach is used in this study to provide a holistic perspective of spiritual care services, with greater focus around the perspectives of the service provider. Driven by the holistic principle of service design (Stickdorn et al., 2018), each method was developed to provide insight on the landscape of spiritual care services in long-term care homes in Ontario. To do this, a secondary analysis of existing data from an Ontario long-term care spiritual care questionnaire was conducted. This was followed by an environmental scan of long-term care home websites in Ontario to examine the ways that spiritual care was advertised and promoted. Next, a questionnaire was released to Ontario long-term care home administrators to further build on the insights of the secondary analysis. Finally, a series of co-design workshops were held with administrators and spiritual care providers to discuss the opportunities and barriers within spiritual care in long-term care homes, as well as brainstorm design opportunities to support spiritual care services. As the research unfolded, these methods built off each other and supported establishing a holistic understanding of the service. Examples of the developed materials are presented throughout this chapter, refer to the Appendix C to view a larger set of the graphics developed.

The research scope was established to focus primarily on the service provider. Given the limited research of spiritual care in Ontario long-term care homes, it was necessary for this study to focus first on spiritual care service providers to better understand the design of the current system, their perspectives and establish an understanding of province-wide strategies for service delivery in spiritual care in long-term care homes. Limiting this scope also allowed for greater
richness and depth in the research, recognizing that future studies should widen stakeholder involvement.

3.1 Considerations around ethics, recruitment, and participation

This research was reviewed and approved by the Carleton University Research Ethics Board. The long-term care system has been under pressure during the COVID-19 pandemic, and many homes have faced severe staff shortages, particularly during the Omicron outbreaks in Ontario. Being mindful of this, I aimed to avoid overburdening staff members through a short questionnaire, as well as trying to avoid hosting co-design sessions during the peaks of pandemic waves.

Participants that were involved in this research included Ontario long-term care home administrators and spiritual care providers. These participants were recruited through various channels, including social media; blog promotion conducted by the Centres for Learning, Research, and Innovation in Long-Term Care (CLRI-LTC); the Ontario Long Term Care Association (OLTCA); as well as direct emails to administrators at long-term care homes.

For the initial phases of research with participants, long-term care administrators were invited to participate in completing a 10–15-minute questionnaire to share information about their long-term care home. This questionnaire was hosted on Qualtrics, and all responses provided were anonymous. Completion of the questionnaire linked the participant to a second questionnaire where they were invited to share their contact information if they were interested in participating in further phases of this research, ensuring that the data from the initial questionnaire remained anonymous. There was no compensation for their participation in this activity.
For the final phase of research with participants, both long-term care administrators and spiritual care providers were invited to participate as members in a co-design working group. Participants were involved in 3 co-design sessions where they participated in discussion and design exercises to explore the topics of spiritual care through a service design approach. Prior to each session, a booklet was provided, outlining the discussion topics for the session, so that participants knew what to expect, and were able to prepare if they desired. There was flexibility in co-design participation to account for different technology ability levels, as well as accommodating the schedules of on-call staff. Participants were able to engage with the content using Miro, a whiteboard platform, to share ideas. If they were not comfortable with this, they could also share their insights verbally during the sessions. If participants were unable to join due to conflicts in their schedule but still wanted to participate, they were invited to respond to the questions and activities individually using the booklet as a guide.

To thank co-design participants, they were each given a $25 gift card. To ensure participants were not put at risk, they were asked not to criticize their employer during the sessions and keep all discussions that took place within the working group confidential. They were also informed that they would have up to 2 weeks following each session to withdraw their participation and have their information removed.

3.2 Secondary analysis of an existing Ontario spiritual care questionnaire

Research began with a secondary analysis of an existing questionnaire on spiritual care in long-term care homes in the South West, Waterloo-Wellington, and Toronto areas. This survey
was conducted by Kuepfer et al. (2022). Researcher Dr. Jane Kuepfer provided the raw de-identified data from this research for a secondary analysis from a service design lens.

3.2.1 Participants

Participants were spiritual care providers and recreational coordinators. Spiritual care providers held a dedicated role providing or coordinating spiritual care as the primary part of their work. Homes without a spiritual care coordinator have recreational coordinators organizing spiritual care alongside additional recreational activity responsibilities within the home. A total of 46 spiritual care providers and 13 recreational coordinators participated in the questionnaire, for an overall total of 59 participants.

3.2.2 Procedure

The questionnaire asked participants to share details of their personal role, such as the name of their position, the number of hours they work, the colleagues they work with, as well as their values around spiritual care. The questionnaire also included questions about the spiritual care services, such as the types of spiritual care programs provided in the long-term care home, the volunteers and community members involved, and budgets allocated to spiritual care in the long-term care home. Overall, this work provided an overview of the role of spiritual care from the perspective of spiritual care providers and recreational coordinators in southwest Ontario, as well as insight into the responsibilities of those providing and coordinating spiritual care.

Secondary analysis of this data involved reviewing and organizing the information using service design tools. Design mapping offers value to healthcare innovation through the visualization of complex systems and services, supporting greater understanding of a healthcare system, as well as catalyzing discussion between stakeholders (Patricio et al., 2020). The data was used to formulate service design maps, including stakeholder maps, spiritual care provider
personas, and initial service blueprints. The stakeholder map is a human-centered design method that visually represents systems of people and/or groups involved in an identified context (Martin & Hanington, 2012). Personas is another design tool that is used to create an archetype of a group of stakeholders that is informed by research (Stickdorn et al., 2018). Laubheimer (2020) from the Nielsen Norman group outlines 3 ways of making personas, as outlined in Table 3.

<table>
<thead>
<tr>
<th>Three ways of making personas (Laubheimer, 2020)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proto personas</td>
<td>Quick personas created based on a team’s current knowledge and assumptions; no additional research is done to create this persona.</td>
</tr>
<tr>
<td>Qualitative Personas</td>
<td>Informed by research conducted through 5-30 interviews with people who represent the target group. While these personas are informed by the perspectives of the user, the limited quantity of participants may affect the accuracy of the findings.</td>
</tr>
<tr>
<td>Statistical Personas</td>
<td>Informed by larger scale research, often conducted via surveys. While this is a large undertaking to develop, it results in a more accurate representation of the different stakeholder groups as personas.</td>
</tr>
</tbody>
</table>

Table 3 - Three ways of making personas (Laubheimer, 2020)

Statistical personas were developed based on the data from the questionnaire, however recognizing they are drawn from a relatively small quantity of participants (N=59). Recently, there has been discussion in the design field about common approaches to personas. Personas have been criticized as creating stereotypes that are uninformed by data and focus on irrelevant details about a hypothetical user (Brummer, 2021; Common Problems with User Personas, 2016; Frazier, 2020; Roman, 2019). The developed personas in this study do not focus on creating a hypothetical character based on limited or anecdotal information, but rather on presenting aggregated data to synthesize and conceptualize a person’s role.

Through this secondary analysis, exploratory service blueprints were also developed to illustrate the flow of the service based on the data. A service blueprint is a visualization showing how the operations within an organization support the service delivery and experience of a client.
(Stickdorn et al., 2018). Service blueprints are designed to show the frontstage and backstage experiences of a service. Frontstage aspects of a service include anything that the client sees and experiences, including processes and people involved in providing the services. Backstage aspects of a service take place within the organization and are not seen by the client (Stickdorn et al., 2018). This tool is effective in providing a full view of a service and illustrating processes that must take place within a service organization for services to be delivered.

This initial set of maps provided a foundational set of tools that visually synthesized a current understanding of spiritual care services within the context of Ontario and served as a communication tool to discuss with participants during future phases of the research. The data was initially organized and analyzed manually using Miro. Colour coding and grouping strategies were used to structure and visualize the features of the data, such as the type of home the respondent worked in, and the size of the town or city where the home is located. Initial rough maps were refined and redrawn to be used as a probe for discussion in future research phases. The data was also placed in Tableau, a data visualization software, to map out patterns that emerged within the survey results.
In analyzing Kuepfer et al.’s (2022) data, the goal was to gain a greater understanding of the people involved in providing spiritual care in Ontario and reinterpret these findings through design tools and visualizations to help facilitate the next phases of this study. People are a key element of the service provision (Gibbons, 2017) and their roles and responsibilities are important considerations when designing a service. Analysis of this data provided insight into the perspective of spiritual care providers, their responsibilities, as well as the larger networks that support spiritual care within Ontario long-term care homes.
3.3 Environmental scan of spiritual care services in Ontario

This phase of research involved a scan of 210 long-term care homes websites across Ontario. The goal of this scan was to identify how homes were discussing and advertising spiritual care for prospective residents (i.e., understanding an element of the frontstage of the service blueprint), as well as to gain an understanding of the landscape of spiritual care services offered across Ontario long-term care homes.

3.3.1 Participants

Homes that were chosen for this data collection were selected through a process of stratified random sampling. Stratified random sampling involves grouping participants within the sample based on a certain characteristic and ensuring that the size of each group included in the sample are proportional to the actual population. This allows for greater accuracy of representation than simple random sampling approaches, which do not consider grouping (Robson & McCartan, 2016). To do this, a list of the 630 long-term care homes in Ontario was organized in Microsoft Excel based on the size of the city, the size of the home, and the type of long-term care home. Through stratified random sampling, a third, or 210 of the homes were selected to be reviewed, with city size, home size, and long-term care type as factors shaping the stratified sample.

The size of city was categorized based on the Canadian census subdivisions, identifying the city sizes as Census Metropolitan Areas (CMA), Census Agglomerates (CA), and Rest of Ontario (ROO) (Table 4).
The size of the long-term care home was determined based on the Ministry of Long-Term Care (2019) definition of small home size, which identified a home of 64 beds or less to be a small long-term care home. Nearly a quarter, or 23% of Ontario long-term care homes are considered small homes (Ministry of Health and Long-Term Care, 2019). Type of long-term care home was categorized based on its status as a not-for-profit, private, or municipal long-term care facility (Table 5).

<table>
<thead>
<tr>
<th>Type of Home</th>
<th>Percentage (%) of Ontario Long-term care homes of this type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not-for-profit</td>
<td>27</td>
</tr>
<tr>
<td>Private</td>
<td>57</td>
</tr>
<tr>
<td>Municipal</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 5 - Distribution of Long-term Care Home Types in Ontario (CIHI, 2018)

Location, home size, and home type were all considered in the process of stratified sampling because they have been identified as having influence over the resources that long-term care homes can access, including funding and staffing (Ontario’s Long-Term Care COVID-19 Commission, 2021).

These distributions were then applied to a target sample of 210 homes to determine the number of homes that must fall into each category based on census subdivision, home size, and home type, as seen in Table 6, Table 7, and Table 8. From this, the 630 long-term care homes were sorted by location, size, and type, and then randomized using Excel in order to determine the final selection of 210 homes for the environmental scan.
<table>
<thead>
<tr>
<th>Census Subdivision</th>
<th>Percentage (% of Ontario Census Population)</th>
<th>Number of homes (in sample of 210)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census Metropolitan Area</td>
<td>81.5</td>
<td>171 (81.5%)</td>
</tr>
<tr>
<td>Census Agglomerate</td>
<td>8.2</td>
<td>17 (8.2%)</td>
</tr>
<tr>
<td>Rest of Ontario</td>
<td>10.3</td>
<td>22 (10.3%)</td>
</tr>
</tbody>
</table>

**TABLE 6 - NUMBER OF HOMES IN SAMPLE BASED ON LOCATION**

<table>
<thead>
<tr>
<th>Home size</th>
<th>Percentage (% of Ontario Census Population)</th>
<th>Number of homes (in sample of 210)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (64 beds or less)</td>
<td>23</td>
<td>48 (23%)</td>
</tr>
<tr>
<td>Other (65 beds or more)</td>
<td>77</td>
<td>162 (77%)</td>
</tr>
</tbody>
</table>

**TABLE 7 - NUMBER OF HOMES IN SAMPLE BASED ON HOME SIZE**

<table>
<thead>
<tr>
<th>Type of Home</th>
<th>Percentage (% of Ontario Long-term care homes of this type)</th>
<th>Number of homes (in sample of 210)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not-for-profit</td>
<td>27</td>
<td>57 (27%)</td>
</tr>
<tr>
<td>Private</td>
<td>57</td>
<td>120 (57%)</td>
</tr>
<tr>
<td>Municipal</td>
<td>16</td>
<td>33 (16%)</td>
</tr>
</tbody>
</table>

**TABLE 8 - NUMBER OF HOMES IN SAMPLE BASED ON HOME TYPE**

### 3.3.2 Procedure

The websites of the homes selected were analysed to determine if spiritual care was advertised online. If spiritual care was mentioned, the location, title of their spiritual care services, and the services listed were collected. This scan also examined if there was any mention of serving specific faiths or spiritual needs, any information on spiritual care providers, and any objects or locations that were mentioned. This approach helped identify physical spaces and objects involved in service delivery, as well as the language used to label and discuss spiritual care. This provided a sample of ‘physical evidences’ of the spiritual care service provided by long-term care homes. In service design, ‘physical evidences’ are any physical or digital products that are part of the front stage interactions with the service (Stickdorn et al., 2018). In this study, any spaces or objects mentioned on the website, as well as the website itself, all represented ‘physical evidence’ of the service. As a long-term care home’s website is one of the ‘touchpoints’
for learning more about the spiritual care service, this scan provided insight on how spiritual care is promoted, and values communicated to website visitors.

After this data was collected, it was synthesised using Tableau to visualize key findings of the scan. All data was initially visualized based on the entire sample, and later groupings of different characteristics such as home size, home type, and location were analyzed to draw out further insights.

3.4 Service design questionnaire on spiritual care services in Ontario

A questionnaire was sent to long-term care home administrators across Ontario to collect information about spiritual care delivery within their long-term care home and to understand the administrator perspective on the design and delivery of spiritual care services. This questionnaire built off the secondary analysis conducted on Kuypfer et al.’s (2022) data which focused on spiritual care providers, with greater focus on other service factors beyond the spiritual care provider that may influence spiritual care delivery.

3.4.1 Participants

Administrators of Ontario long-term care homes were the primary participants in the completion of this questionnaire. Administrators were reached directly by email to increase uptake. Public-facing emails shared on the long-term care home website, or on resources such as Healthline were acquired and used to contact administrators at long-term care homes. A total of 479 long-term care homes were contacted through this approach. An invitation to complete the questionnaire was also sent out through the CLRI-LTC e-newsletter and social media, as well as the OLTCA newsletter. There was a total of 55 responses received.
3.4.2 Procedure

Administrators at long-term care homes were invited to complete a short questionnaire regarding the spiritual care services provided at their long-term care home. As the study aimed to reach long-term care administrators across over 600 homes in Ontario, a questionnaire format was chosen as it supports efficient data collection from a large number of participants (Robson & McCartan, 2016). This questionnaire was created using Qualtrics, an online platform used to create online surveys.

Following analysis of Kuepfer et al.’s (2022) data, this questionnaire sought to learn more about the operational perspectives of administrators in delivering spiritual care. This survey also sought to gain more detail on ‘physical evidences’ (Stickdorn et al., 2018) that are important to service delivery, such as the key locations and objects within long-term care homes.

The questions covered the following areas:

- The home type and location: Like the environmental scan, these factors were important to understand the funding and support provided to the home.
- Basic information about the respondent and their understanding of spiritual care in long-term care: This was useful information in learning the role of the respondent and their relationship to the spiritual care programs provided within their home.
- Information about the spiritual care provider, the other staff who are supporting the delivery, as well as the programs, services, and teams where spiritual care is important: These questions build off Kuepfer et al.’s (2022) questionnaire to determine the connections spiritual care providers have with the rest of the team, as
well as the spiritual care support provided by the entire long-term care team to facilitate interdisciplinary care delivery.

- The spiritualities and religions they serve: Based on the literature review, the aging population has shifting spiritual and religious needs (Cornelissen, 2021). These questions address the respondents’ understanding of the current spiritual and religious diversity within their home, as well as the resources they have available to support these needs.

- Coordination of related spaces and objects for the delivery of spiritual care: These questions probe at the value of ‘touchpoints’ other than the care provider in delivering the service.

- Promotion and communication of spiritual care services: Similar to the environmental scan, these questions address the front-stage ‘touchpoints’ that promote spiritual care and determine their communications about the service.

Information from the questionnaire helped supplement the existing design mapping developed using Kuepfer et al.’s (2022) data to provide a richer understanding of the service. The quantitative data was also visualized using Tableau to provide a synthesis of the findings and communicate the outcomes of the data collection for presentation in this thesis, as well as to share with co-design participants. Qualitative data was coded using descriptive coding (Saldana, 2016). Descriptive coding is a process used to quickly identify the topics that are being discussed by the participant (Saldana, 2016). This coded data provided further information about service processes, as well as gaps and challenges that could be compared to the data collected during the co-design sessions, which is discussed below.
3.5 Co-design sessions with Ontario long-term care spiritual care workers

The data collection and analysis concluded with a series of 3 co-design working group sessions with Ontario long-term care staff, specifically spiritual care providers, administrators, and recreational coordinators. The goal of these sessions was to explore the experiences, values, and priorities of those working in long-term care, and discuss opportunities to apply service design to improve the design and delivery of spiritual care.

3.5.1 Participants

These sessions included a total of 10 long-term care workers across Ontario with varied roles in providing spiritual care. Participants involved in the co-design sessions consisted of 5 spiritual care providers, 3 administrators, and 2 recreational coordinators. The administrator and recreational coordinator participants were recruited using the questionnaire. Administrators who expressed interest in co-design sessions were encouraged to share this information with their spiritual care provider, creating a snowball sample of participants (Robson & McCartan, 2016). This combination of spiritual care providers, recreational providers, and administrators brought together perspectives that were initially collected separately in both Kuepfer et al.’s (2022) study as well as this study’s service design questionnaire, inviting cross-disciplinary collaboration (Stickdorn et al., 2018).

3.5.2 Procedure

Participants were invited to join 3 co-design sessions to discuss spiritual care and brainstorm opportunities. The 3 sessions were hosted multiple times, consisting of smaller groups of 2-3 participants. These sessions lasted 1 hour and were hosted over Zoom. These sessions were conducted in smaller groups in order to keep the sessions brief, while also allowing all participants
ample time to participate and contribute. Content was presented using Miro. Participants were invited to try using Miro but could still engage without Miro based on their comfort level and preferences. Through these sessions, outcomes developed from the secondary analysis and the service design questionnaire were shared with participants and acted as probes for discussion.

These co-design sessions were inspired by the EBCD approach, which encourages working with healthcare stakeholders to understand their experiences and emphasizes the importance of co-designing with participants (Donetto et al., 2015). The first 2 sessions were an opportunity for participants to discuss experiences they had in providing spiritual care in long-term care homes. These initial sessions invited sharing ideas and perspectives, identifying existing barriers and strengths, and becoming acquainted with each other and their practices. In the final session, a series of design probes were presented to support discussion around design opportunities for spiritual care in long-term care homes. While these sessions were initially planned based on the findings of prior research, the participants’ goals and interests were taken into consideration in the initial sessions and shaped the topics covered in the following sessions.

**Session 1**: The first session was an opportunity to introduce the research as well as understand the motivations and goals for the participants in attending these sessions. Prior to the first session, 3 questions were sent to participants through Qualtrics:

- *What is important to you in providing spiritual care in long-term care homes?*
- *What supports you in providing good spiritual care, and what barriers do you face?*
- *Please share if there is anything you are hoping to explore or gain from these sessions, and I will do my best to incorporate it into the sessions.*

During the first session, responses were added to the Miro board and participants were invited to add additional thoughts or discuss certain ideas that resonated with them.
During the second phase of the session, participants were shown a stakeholder map from the secondary analysis of Kuepfer et al.’s (2022) spiritual care questionnaire. The map outlined the different staff in long-term care who were involved in the spiritual care of the resident, according to respondents. Using this map as a reference, participants were asked to create and describe their team and how they support spiritual care.
Session 2: Based on the results of the first session, the second session was tailored to encourage greater interaction and sharing between the participants. The beginning of the second co-design session started with 2 questions for discussion:

- *Share any spiritual care initiatives, practices, approaches, or moments that you are proud of. What successes have you had?*
- *Do you have any questions that you would like to ask other participants in this session?*

![Figure 9 - Co-design Session 2 – Ideas Exchange](image)

For the second activity, participants were shown results from this study’s service design questionnaire. The graphic illustrated a list of Places, Props, and People, which were listed by respondents as important to the delivery of spiritual care. This language of Props and People is taken from Gibbon’s (2017) discussion on key elements of service design, and alternative language (Places and Objects for Props, Teams for People) was also provided to make this diagram more understandable for participants. ‘Processes’, which refers to actions and steps throughout the service (Gibbons, 2017), emerged through discussion of these elements of the service. From this list, participants were asked to identify ‘Stars’ and ‘Wishes’. ‘Stars’ represented
something on the list that supported spiritual care in the long-term care home, and ‘Wishes’ represented something that the participant wished they had or wished was improved to better support spiritual care.

**Figure 10 - Co-design session 2 – Stars and Wishes**

**Session 3:** The final round of sessions concluded the research by bringing together the outcomes of the sessions and research and presenting design probes for feedback and further ideation. Initially, participants were shown a series of ‘How Might We’ questions. ‘How Might We’ questions are a design approach used to reframe problems as design opportunities (Stickdorn et al., 2018). These questions were framed based on discussions from prior sessions and presented to participants for feedback. After reviewing the questions, participants were asked the following:

- *Are any of these statements of interest to you, or relevant to your work?*
- Do you disagree with any of these? If so, why, and how would you change it?
- Is this board missing any opportunities that we have discussed?
- What ideas or possible solutions do you have in response to any of these questions?

**Figure 11 - Co-design sessions 3: How Might We**

During the session, participants were shown a series of design probes that proposed ideas to enhance and support spiritual care (See Appendix C). These concepts were developed based on the insights and ideas shared by participants during previous sessions. Each probe listed ‘How Might We’ questions that are addressed. The probe also indicates how the project would be implemented: as a grassroots initiative developed by care providers or long-term care organizations, or as a government-led initiative that would be implemented through government policy. As the co-design session discussions touched on working in low-resource environments and real-world contexts, the logistics of implementation was added as an important consideration for the concept. After sharing these ideas, participants were asked to provide feedback.

Following the end of these sessions, participants were invited to complete a brief feedback form to share their feedback on the experiences of the co-design sessions. This ensured that there
was an opportunity for these stakeholders to provide feedback on the design process, while limiting the amount of time required to dedicate to the study.

These sessions were recorded and transcribed. Any notes written on the Miro board were also collected and coded. The transcriptions were coded using In Vivo coding (Saldana, 2016). In Vivo coding is an approach to analysis that focuses on using direct quotations from the data to shape the themes. This approach is valuable in maintaining the integrity of the participant’s voice, as well as highlighting choice of language that may also hold meaning (Saldana, 2016). As the participants in the co-design sessions each came with unique outlooks on spiritual care, In Vivo coding was used to honour the participants’ perspectives, as well as draw attention to important language that reflected their knowledge and understanding of spiritual care.

3.6 The value of a multi-method service design approach

This multi-method approach enriched the research in numerous ways. Puchalski et al. (2009) recommends multi-method approaches that consists of both quantitative and qualitative research methods to research spiritual care, given the complexity of the field. Through larger scale quantitative research methods such as the environmental scan and questionnaire, broader understandings of the landscape of spiritual care across Ontario long-term care homes can be more clearly understood. However, smaller scale qualitative research such as the co-design working groups allowed for greater richness in the data, to better understand the experiences of stakeholders and spiritual care in detail.

Furthermore, from a service design lens, each method provided a different perspective that supported a more holistic understanding of the service (Stickdorn et al., 2018), and provided insight on both front stage and backstage service delivery processes. The secondary analysis of
Kuepfer et al.’s (2022) spiritual care questionnaire, the environmental scan, and the service design questionnaire all contributed to mapping and visualization of spiritual care services in Ontario long-term care homes. The co-design workshops embraced the human-centered approach of service design by inquiring and designing with professionals in the field to gain more insight into their experiences and encouraging cross-collaboration between spiritual care providers and administrators. Ultimately, these methods were driven by the study research questions (Figure 12) and support the potential of a service design approach in researching spiritual care services in Ontario long-term care (Figure 13).
RQ 1  
How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?

RQ 2  
What are the experiences of service providers such as spiritual care providers and long-term care home administrators in providing spiritual care?

RQ 3  
How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?
Chapter 4: Findings

4.1 Introduction

This chapter presents the results of a secondary analysis of questionnaire data collected by Kuepfer et al. (2022), an environmental scan of long-term care websites, a service design questionnaire, and a series of co-design sessions. Outcomes from the initial phases of research supported the development of materials for the spiritual care co-design sessions. Collectively, these findings reveal insights into various aspects of Ontario long-term care spiritual services, including stakeholders involved, use of space, and programming efforts.

4.2 Secondary analysis of Kuepfer et al.’s (2022) questionnaire

I completed a secondary analysis of a spiritual care questionnaire conducted by Kuepfer et al. (2022). This questionnaire received a total of 59 responses from spiritual care providers and recreational staff responsible for providing spiritual care in Southwestern Ontario. This phase informed all 3 research questions: RQ1: *How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?*, RQ2: *What are the experiences of service providers, such as spiritual care providers and long-term care home administrators, in providing spiritual care?,* and RQ3: *How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?*

The data was visualized using Tableau and secondary analysis allowed me to produce design maps using Adobe Illustrator. Not all data collected in Kuepfer et al.’s (2022) study was analyzed for this research. The findings of this analysis provide insight on: the demographics of...
the respondents and their home; the roles and responsibilities of the respondents; the programs and services organized and offered by the respondents; and the other staff and volunteers involved in spiritual care.

4.2.1 Participant demographics

The respondents held a variety of role titles. For dedicated spiritual care providers, ‘chaplain’ was the most common title (Figure 14) whereas every recreational care respondent held a different title (Figure 15). While spiritual care respondents were both contract and salaried employees, most contract spiritual care providers worked in for-profit homes, while salaried spiritual care providers were employed by not-for-profit homes. Most recreational care respondents were salaried employees (Figure 16). Spiritual care providers worked in homes with an average of 165.6 residents, whereas recreational care providers worked in homes with an average of 127.7 residents. Spiritual care providers primarily worked in urban areas (n=40, 86%), while 69% (n=9) of recreational care providers worked in rural areas.

![Spiritual Care Job Title](image)

**Figure 14 - Word cloud of spiritual care respondents’ role title**
Recreational Care Job Title

Director of Recreation
Life Enrichment Coordinator
Recreation and Leisure Manager
Program and Support Services Manager
Director of Activities and Volunteer Services
Activation Manager
Manager of Programs & Volunteer Services
Volunteer/Pastoral Coordinator
Activation Supervisor
Recreation Director
Activity Director

**Figure 15 - Word Cloud of Recreational Care Respondents’ Role Title**

**Figure 16 - Graph of Respondents’ Job Type**

Spiritual care providers and recreational care providers reported spending different amounts of time on their tasks and responsibilities. Spiritual care providers spent the majority of their time directly working with their clients through preparing programs, leading programs, and one-on-one care. By contrast, recreational care providers’ role was stretched across various tasks including administration, preparing and running programs, and recruiting volunteers (Refer to Appendix D). The questionnaire asked about what degree of autonomy respondents felt they had over the design and delivery of the spiritual care programs within their long-term care homes, as
well as how mandated and regulated the spiritual program is by the long-term care home. On a scale of 0-100, with 0-20 referring to ‘I’m free to provide what I choose’, and 80-100 referring to ‘expectations are set’, spiritual care responses averaged 43.65, while recreational care responses averaged 64.60. Many spiritual care providers reported that while the roles and expectations of their position were established, there was room for growth and adjustment to the programs based on their expertise.

A range of services and programs were offered within respondents’ long-term care homes. The most common services were hymn sings, memorial services, Remembrance Day, and Bible studies (Figure 17). The data also reveals a wider variety of services offered by long-term care homes with a dedicated spiritual care provider (Figure 18).

**Spiritual Care Services Offered**

![Image: Word Cloud of Spiritual Care Services]

**Figure 17 - Word Cloud of Spiritual Care Services**
Many staff and volunteers were also involved in the provision of spiritual care services. Recreational care providers were considered key staff involved in supporting and providing spiritual care, according to 40 (68%) of respondents. Nurses and personal support workers (PSWs) were also considered key staff according to 35 (59%) respondents. While most respondents did collaborate with other staff in providing spiritual care, 9 (20%) spiritual care providers reported that they held a very independent role. The majority of respondents relied on volunteers, with 52 (88%) respondents working with clergy and other community members to provide spiritual care.

See Appendix C for more visualizations created during this secondary analysis.

The results from this data informed the development of service design tools that were used as topics of discussion in the co-design sessions. Through the process of synthesizing these findings, design maps were created to unify the data and visualize the information. These included
two personas for dedicated and non-dedicated spiritual care providers, as well as a stakeholder map illustrating the different actors involved in providing spiritual care (Refer to Appendix C). This stakeholder map was used as a probe during the co-design sessions. By visualizing this data, research findings could be presented to spiritual care service providers in order to gain their perspectives. This approach offered qualitative insights from the co-design sessions that built on the findings from the questionnaires and environmental scan.

4.3 Environmental scan of spiritual care services in Ontario

For this phase of the research, 210 long-term care home websites were reviewed in an environmental scan to explore how spiritual care in long-term care was described, advertised or promoted across Ontario. This phase informed RQ1: *How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?* and RQ3: *How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?*

The data was visualized using Tableau. Long answers were coded using descriptive coding. The findings from this scan illustrate different features of spiritual care advertised by long-term care homes across Ontario, including: spiritual care services; spiritual care providers; and spiritual care spaces. Home type, size of home, and location of the homes were also documented and considered in the visualized findings in order to determine if these factors influenced the way that spiritual care was advertised.

4.3.1 Spiritual care services

Out of 210 home websites searched, 140 (66%) of long-term care homes discussed and promoted spiritual care on their website. A total of 50 (24%) long-term care homes did not
mention spiritual care on their website, and 20 (9.5%) long-term care homes did not have an operating website at the time of the search. There were 38 names for spiritual care services identified throughout the scan (Figure 19). The most frequently mentioned title was religious services and spiritual programs, which was mentioned 15 times. This name was used across all Revera homes, and this consistency in naming conventions resulted in a high frequency of this title in the scan. In comparison, smaller homes or independent organizations provided a unique name for their spiritual care services, resulting in an array of titles. The second most frequent name was spiritual care, which was mentioned 13 times (Refer to Appendix D).

**Figure 19 - Word cloud illustrating names of spiritual care services**

Out of the 140 homes that advertised spiritual care, 72 (51%) of homes listed the spiritual care services and programs they provide. A total of 136 different services were listed in the scan. Commonly listed services included hymn sing, bible studies, and memorial services, while the titles of most services and programs listed were completely unique to each home (Figure 20).
Most services were listed by long-term care homes based in CMA areas (Figure 21). The diversity of urban areas may be a factor in the greater range of the services listed. By contrast, a small number of homes in CA areas listed spiritual care services. Larger homes also listed a greater variety of spiritual care programs and services than small homes (Figure 22). In terms of home type, municipal long-term care homes listed fewer services than not-for-profit and for-profit homes (Figure 23).

**Figure 20 - Word cloud illustrating spiritual care services and programs offered**

**Figure 21 - Spiritual care services offered based on location**
4.3.2 Spiritual care providers

Of the 140 homes that advertised spiritual care, 33 (24%) of homes listed spiritual care providers who would offer spiritual care. The websites revealed 17 roles that were listed as supporting spiritual care in long-term care homes (Figure 24). The most common role was a
chaplain, which was listed by 14 (10%) homes. Chaplains were typically described as on-site, or in-house. Few other staff were listed as providing spiritual care, however other spiritual care provider titles such as pastoral care coordinator and spiritual advisor were listed. A total of 16 (11%) homes mentioned community roles that support spiritual care, and 12 (9%) of these homes only listed community members and volunteers as providers of spiritual care with no mention of staff roles.

Municipal long-term care home websites did not frequently mention spiritual care providers, while not-for-profit and for-profit long-term care homes listed various roles both on-staff and volunteer-based. Municipal websites were often formatted with a template that was used across the municipality, which may have resulted in a format that did not include space to advertise spiritual care roles. While CMA and ROO-based home websites listed numerous staff and volunteer roles involved in providing spiritual care, few CA-based home websites had roles listed (Refer to Appendix D).

![Internal and external long-term care spiritual care providers](image-url)

**Figure 24 - Internal and external long-term care spiritual care providers**
4.3.3 Spiritual care spaces

The scan also reviewed spiritual care spaces that were mentioned on long-term care home websites. No mentions of objects or artifacts for spiritual care were found in the scan. A total of 35 (25%) homes listed spiritual spaces, and 5 (4%) of these homes listed more than 1 space where they provided spiritual care. Chapel was the most commonly listed spiritual space (Figure 25). Homes in CMA areas reported the most variety of space types, whereas homes in ROO and CA regions only listed chapels. Spiritual care spaces were also listed more commonly by homes with 64 or more residents.

![Figure 25 - SPIRITUAL CARE SPACES](image)

4.4 Service design questionnaire on spiritual care services in Ontario

The service design questionnaire was sent to Ontario long-term care administrators to ask them about the spiritual care services their home provides. The questionnaire received a total of 55 responses. This phase informed all 3 research questions: RQ1: How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?, RQ2: What are
The experiences of service providers, such as spiritual care providers and long-term care home administrators, in providing spiritual care?, and RQ3: How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?

The data was visualized using Tableau as well as Adobe Illustrator. The findings provide insight on spiritual care services from an administrative perspective, complimenting the perspective of the questionnaire results from the study conducted by Kuepfer et al. (2022). The service design questionnaire results provide information on: demographics of the respondents and their home, as well as their level of knowledge of spiritual care in the home; the staff and teams involved in providing spiritual care; the places and objects involved in supporting spiritual care; how spiritual care is promoted and accessed; and the challenges that are faced in providing spiritual care.

4.4.1 Participant demographics

Most respondents were located in Southern Ontario (Figure 26). Over half of the respondents were based in CMAs. Most respondents were from not-for-profit or for-profit long-term care homes; there were only 8 municipal homes that participated in the survey. Questionnaire respondents held various positions in their long-term care homes. The most frequently listed roles included administrator and executive director (Figure 27). Other respondents were staff involved in programming and recreation. The majority (n=40, 73%) of respondents felt very knowledgeable (within a range of 6-7 on a scale of 1-7) about the spiritual care services provided in their home. A total of 24 (43%) respondents considered themselves to be extremely knowledgeable, or 7 on a scale of 1 to 7 (Figure 28). The mean average response was 5.98.
FIGURE 26 - LOCATION OF PARTICIPATING LONG-TERM CARE HOMES

Role of respondents

Client Programs Supervisor
Manager of Resident Services
Director of Care
Recreation Manager
Director of Resident and Family Services
Associate Administrator and Director of Quality and Resident Experience
Program Manager
Executive Director
Activity Director
Spiritual Care Coordinator
Resident and Family Experience Coordinator
Coordinator of Spiritual and Religious Care
Program and Social Service Supervisor
CEO
Life Enrichment Supervisor
Assistant General Manager
Manager of Recreation and Environmental Services
Director of Recreation
Director of Programs & Support Services

FIGURE 27 - WORD CLOUD OF PARTICIPANT ROLES
How knowledgeable are you about the spiritual care services, initiatives, and programming provided in your home?

**Figure 28 - How knowledgeable are you about the spiritual care services, initiatives, and programming provided in your home?**

4.4.2 Key roles, teams, and departments supporting spiritual care

Most respondents listed their recreational coordinator as their primary person involved in coordinating and running spiritual care programming. Recreation coordinator was selected by 29 (53%) participants as the primary spiritual care provider, whereas 17 (31%) respondents have spiritual care providers as primary care providers. Respondents who selected ‘other’ also mentioned the program manager as a primary care provider (Figure 29). When looking at the staff who support spiritual care, other than the physician and director of care, all roles were selected at least once, with particular emphasis on the recreation team as well as volunteers (Figure 30).

Other care providers that respondents mentioned included specific members of the community such as priests, pastors, or church groups, as well as staff such as program managers, the director for program support & volunteer services, and virtual programming. Other than finance, all departments within long-term care were involved in participants’ long-term care homes to support
spiritual care. The majority (n=47, 85%) of respondents listed that spiritual care was involved within the recreation department (Figure 31). Those who selected ‘other’ also mentioned the spiritual care department, palliative care, and music therapy.

About half (n=28, 51%) of the respondents stated that they felt their staff involved in spiritual care were properly trained to provide this care. Results showed that 20 (36%) of respondents felt some, but not all their staff, are equipped with appropriate training, and 8 (14%) felt those providing spiritual care were not equipped.

**Figure 29 - Who is the primary person responsible for coordinating spiritual care and running spiritual care programming within the long-term care home?**

<table>
<thead>
<tr>
<th>Role</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational Coordinator</td>
<td>28</td>
</tr>
<tr>
<td>Spiritual Care Provider</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>Volunteer Coordinator</td>
<td>3</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
</tr>
<tr>
<td>Personal Support Worker</td>
<td>1</td>
</tr>
<tr>
<td>Volunteers and/or Community Members</td>
<td>1</td>
</tr>
</tbody>
</table>

(Figure 29 - Who is the primary person responsible for coordinating spiritual care and running spiritual care programming within the long-term care home?)
Who else is involved in providing spiritual care and spiritual programming within the long-term care home?

Figure 30 - Who else is involved in providing spiritual care and spiritual programming within the long-term care home?

Is spiritual care and spirituality of a resident involved in or part of any of the following programs, services, and/or teams?

Figure 31 - Is spiritual care and spirituality of a resident involved in or part of any of the following programs, services, and/or teams?
4.4.3 Meeting religious and spiritual needs

Overall, respondents reported a wide range of religious and spiritual diversity in their long-term care homes. The responses averaged 3.77, nearly center on the Likert scale. The majority of respondents who reported higher diversity within their long-term care homes were based in CMAs (population of at least 100,000), while less diverse spiritual needs were reported by CAs (population of at least 10,000, no greater than 100,000), and ROOs (population less than 10,000) (Figure 32). To accommodate the level of diversity in their home, many respondents reported relying on the community to find volunteers and community members of certain spiritual affiliations to support specific needs. Some respondents also mentioned the need for individualized care plans that consider the needs of each resident. Other practices mentioned included embracing a multi-faith approach, providing a variety of services and programs, educating themselves and the home staff about different faiths, and accessing different media and virtual programming when in-person services are unavailable.

All respondents reported that they supported persons with Christian affiliations in their long-term care home. Less than half of the respondents listed other faiths, however all faiths listed in the questionnaire were supported by at least some of the respondents (Figure 33). Other religions mentioned by respondents included: Catholic, Jehovah’s Witness, Wiccan, Anglican, Presbyterian, Protestant, Salvation Army, and general spirituality and meditation.

To access spiritual care services, most respondents stated that residents should let the staff know directly of their needs. Residents could also discuss their needs through certain staff such as the chaplain, recreation staff, or social worker. Community members and family members were also mentioned as individuals that facilitate access to spiritual care. Other ways of accessing
spiritual care included informing and reviewing spiritual needs of a resident at admission and during care conferences, as well as using technology to provide virtual programming and access to community services.

Most team members on long-term care staff and in the surrounding community were selected at least once as being aware of the residents’ spiritual needs on a daily basis. Respondents commonly selected the recreational coordinator (n=28, 51%) and team members (n=35, 64%), friends and family members (n=21, 38%), and the spiritual care provider (n=18, 33%) (Figure 34).

**How diverse are the spiritual and religious needs of residents, family members and staff at the long-term care home (based on location)?**

![Figure 32 - Results based on location - How diverse are the spiritual and religious needs of residents, family members and staff at the long-term care home?](image)

77
What religious or spiritual groups/affiliations do spiritual care services currently support in your LTC home?

**Figure 33** - What religious or spiritual groups/affiliations do spiritual care services currently support in your LTC home?

Who is likely to be most aware of the spiritual needs of a resident on a daily basis?

**Figure 34** - Who is likely to be most aware of the spiritual needs of a resident on a daily basis?
4.4.4 Promotion of spiritual care services

The majority of respondents (n=42, 76%) of respondents stated that all or some of their services were advertised. Only 4 (7%) respondents reported that none of their spiritual care services were advertised. Those that selected ‘other’ (n=8, 15%) stated that spiritual care could not be advertised during the pandemic, or they were unsure if services were advertised. Posters in the home (n=29), newsletters (n=27), and brochures (n=20) were the primary mediums listed as ways to promote their spiritual care services (Figure 35). Other ways of promoting spiritual care included through the home website, social media, video conferencing, the home’s activity or recreation calendar, the resident handbook, and over conversation.

How do you promote spiritual care services for residents, family members, staff, as well as future residents in the long-term care home?

![Bar chart showing various methods of promoting spiritual care services.]

Figure 35 - How do you promote spiritual care services for residents, family members, staff, as well as future residents in the long-term care home?
4.4.5 Spiritual care spaces and objects

Out of 54 responses, 40 (74%) homes stated that they had a dedicated spiritual care space. Of these 40 homes, 24 (60%) homes had 1 space, 4 (10%) homes had 2 dedicated spaces, and 6 (15%) homes listed 3 or more spaces dedicated to providing spiritual care. All spaces in the home were seen as supporting spiritual care, however the multi-purpose rooms and resident rooms were the most commonly selected spaces (Figure 36). Respondents who selected ‘other’ also mentioned the following spaces: activity room, library, living room, lounges, reflection rooms, and private board rooms.

In the design of both dedicated spiritual and non-spiritual care spaces, respondents discussed the importance of a quiet and private space. Respondents often noted that the long-term care home buildings were small and lacked space. Overall, due to the pandemic, respondents reported that these spaces were not being used as frequently as a result of restrictions. Respondents also mentioned that spiritual care spaces were being repurposed as other spaces due to space shortages. When asked to describe how the design of the spiritual care spaces supported the provision of spiritual care, some respondents discussed a multi-faith approach to the design of the space, while other respondents described spaces specifically designed for a certain faith, such as Catholicism or Orthodox Judaism. Respondents indicated that some spaces were still used for religious services. Larger environments that allowed for people to gather for a program was an important consideration, depending on pandemic restrictions. The respondents discussed the importance of residents being able to display their spiritual images and symbols, and aesthetic and visual appeal was also mentioned as important factors in creating a space that invited people to engage in spiritual care.
A variety of objects were listed as important in providing spiritual care in long-term care homes (Figure 37). Respondents frequently listed books, including hymn books and religious books, as well as ritual objects, such as rosary beads, cross, and communion supplies, and other religious objects. Different technologies and digital services were also listed, such as tablets, TVs, sound systems, Spotify, and online programs.

**Figure 36 - What other places in the home support spiritual needs and delivery of spiritual care?**
4.4.6 The challenges of providing spiritual care

The COVID-19 pandemic was most frequently mentioned as a major challenge in providing spiritual care. Respondents described the issues of cohorting, distancing, and other pandemic restrictions that prevented in-person programming, as well as the loss of community partners who provided spiritual care before the pandemic. Even prior to the pandemic, respondents expressed a shortage of clergy members and community partners available to provide services to residents. Some respondents struggled with meeting diversity of spiritual needs as it was difficult to find community members who could provide specific services. Shortages of resources such as space and staff were listed, and many respondents expressed a need for a full-time dedicated spiritual care provider.

4.5 Co-design sessions with Ontario long-term care spiritual care workers

Finally, a series of co-design sessions was hosted with spiritual care providers and long-term care home administrators to discuss issues and strengths of spiritual care in their work, as
well as brainstorm opportunities for service design to support spiritual care in Ontario long-term care homes. There was a total of 10 participants in the co-design sessions (Table 9). This final phase informed RQ2: *What are the experiences of service providers, such as spiritual care providers and long-term care home administrators, in providing spiritual care?*, as well as RQ3: *How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?* This section will describe how the 3 sessions unfolded, offering insight into the co-design process and how participant engaged in the sessions. This is followed by the results of a thematic analysis developed based on discussions in all 3 sessions.

<table>
<thead>
<tr>
<th>Participant code</th>
<th>Participant Job Role</th>
<th>Participation in co-design sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD1</td>
<td>Director of Programs and Support Services</td>
<td>Session 1, Session 2, Session 3</td>
</tr>
<tr>
<td>AD2</td>
<td>Chief Executive Officer</td>
<td>Session 1, Session 2</td>
</tr>
<tr>
<td>AD3</td>
<td>Recreation Therapist and Program Manager</td>
<td>Session 1, Session 2, Session 3</td>
</tr>
<tr>
<td>AD4</td>
<td>Administrator</td>
<td>Session 2</td>
</tr>
<tr>
<td>AD5</td>
<td>Director of Operations</td>
<td>Session 2</td>
</tr>
<tr>
<td>SC1</td>
<td>Chaplain</td>
<td>Session 1, Session 2, Session 3</td>
</tr>
<tr>
<td>SC2</td>
<td>Rabbi and Director of Pastoral Care</td>
<td>Session 1, Session 2, Session 3</td>
</tr>
<tr>
<td>SC3</td>
<td>Spiritual Care Provider</td>
<td>Session 1, Session 3</td>
</tr>
<tr>
<td>SC4</td>
<td>Chaplain and Counsellor</td>
<td>Session 1, Session 2</td>
</tr>
<tr>
<td>SC5</td>
<td>Spiritual Care Provider</td>
<td>Session 1, Session 2, Session 3</td>
</tr>
</tbody>
</table>

**TABLE 9 - LIST OF CO-DESIGN PARTICIPANTS**

### 4.5.1 How the sessions went

I begin this section of the findings by describing how the sessions went to provide some insight on the application of service design approach within the context of spiritual care, followed by a cumulative analysis of what I found through a thematic analysis of all 3 sessions.

**Session 1- Discussing Values and Motivations:** During the first session, participants discussed their outlooks on spiritual care. The questions guided the participants to identify their values around spiritual care practice, as well as identify challenges they faced in their work.
Participants discussed spiritual care serving more than religious needs, reliance on community support, as well as issues of a lack of understanding around spiritual care. Participants were also invited to share their reasons for attending these sessions. Participants expressed an interest in finding others with similar interests in this area, as well as discussing existing and new ways to support spiritual care in long-term care settings. This input helped inform the development of the following sessions.

**Session 2 - Exchanging experiences:** Based on the participants’ interest in meeting and connecting with others interested in this topic during Session 1, this session invited greater interaction and exchange among participants. In the first activity, many participants shared that they were proud of their fellow staff and their home’s resiliency during the pandemic. When provided an opportunity to ask each other questions, participants asked for advice on topics they were struggling with, such as accessing certain religious communities. Participants enjoyed the opportunity to collaborate and speak with others, and even began to exchange contact information in order to continue to collaborate outside of these sessions. During the second activity, the importance of physical and tangible aspects of spiritual care became apparent. Throughout the sessions, participants discussed the challenges of spiritual care spaces that were too small, unsuitable, or were lost during the pandemic. One participant described the devastation of losing access to personal and religious objects due to infection prevention and control protocols. During these sessions participants also expressed their skepticism towards government support for spiritual care.

**Session 3 – Brainstorming ideas:** The final session was set up to discuss and brainstorm potential approaches to improve delivery of spiritual care, based on participants’ interest in
exploring innovative solutions. The final session also helped consolidate previous discussions by working together to identify opportunities. In the ‘How Might We’ activity, participants gravitated towards questions about collaboration and connection with others in the spiritual care field, greater education and awareness around spiritual care, as well as spiritual care spaces. In this first activity, participants also began to propose ideas to address these questions. These ideas included partnership and collaboration among organizations, designing more flexible and modular multi-purpose spaces that can be transformed to serve spiritual needs, spiritual care kits containing activities and objects to facilitate this type of care, as well as creating awareness around spiritual care through social media promotion (Figure 38).

**Figure 38 - Notes from Co-design Session 3 – ‘How Might We’ Activity**
In the second activity, participants were presented with a set of 5 design probes inspired by the conversations from previous sessions (Table 10). See Appendix C for further detail on these presented concepts.

<table>
<thead>
<tr>
<th>Name of probe</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary Community of Practice</td>
<td>A community that welcomes anyone who is interested in long-term care to connect, discuss, and promote spiritual care.</td>
</tr>
<tr>
<td>Community Representative</td>
<td>A dedicated staff member responsible for nurturing relationships with the community and fostering greater connections between long-term care homes and the community.</td>
</tr>
<tr>
<td>Spiritual Care Toolkit</td>
<td>For homes who currently do not have a spiritual care coordinator, the spiritual care toolkit acts as a guide for the design and delivery of spiritual care programs.</td>
</tr>
<tr>
<td>Collaborative Hybrid Program Delivery</td>
<td>With greater infrastructure provided, spiritual care and other programming could be provided across homes when a local provider is not available.</td>
</tr>
<tr>
<td>Co-creating Spiritual Space</td>
<td>Creating more spaces throughout the home that invite engagement and reflection.</td>
</tr>
</tbody>
</table>

**Table 10 - Probes presented in session 3**

Participants were invited to share their feedback about the different probes presented. Probe 1, ‘The Community of Practice’, was a popular concept. Participants emphasized a sense of isolation from other spiritual care providers and expressed an interest in a group to facilitate greater collaboration and connection. In discussing this concept further, participants saw value in facilitating learning and inspiration through this community. While this was a popular concept amongst all sessions, one participant noted that most people would not be able to attend regularly due to the demands of their workplace. In discussion of Probe 2, ‘Introducing a Community Representative’, participants expressed their lack of trust in government in supporting this role, due to lack of understanding of the field of spiritual care, as well as the lack of resources. Probe 3, ‘The Spiritual Care Toolkit’, was favoured by the recreational care providers. Both recreational care participants involved in this final session described their needs for more resources and guidance. Spiritual care providers had mixed opinions about the concept. Some spiritual care providers disapproved of the concept as it allowed long-term care homes to rely on written
resources and avoid hiring spiritual care specialists. These spiritual care providers emphasized that the person providing the care could not be replaced by materials and resources. Another spiritual care provider saw the toolkit as a useful resource; however only if it was designed in a way to share the values, mission, and overall philosophy of the spiritual care approach in order to help people understand how to provide spiritual care. This participant emphasized that this kind of resource could not be used as a standard kit with simple and modular tools, but must cover the more complex and broad concepts of spiritual care practice. For Probe 4, ‘Collaborative Hybrid Program Delivery’, many participants shared that virtual programming has already been used within their homes, so the further development of this service approach would be easy to facilitate. Participants also mentioned that technology was often ineffective, however, especially for residents facing cognitive decline. Finally, in the discussion of Probe 5, ‘Co-creating Spiritual Spaces, participants were interested in bringing spiritual care into more spaces throughout the home, however issues of infection prevention and control were discussed as major barriers to this. Overall, this final session revealed an emphasis on the importance of human connection in spiritual care, as well as a need for more resources for connection and collaboration.

**The role of Miro and graphics:** The activities set up on the Miro board provided a visual that invited participation and presented a different mode of communicating views on spiritual care. For example, in discussing the stakeholder map in the first session, participants described how their views on groupings differed from the 3 separate circles that were developed based on Kuepfer et al.’s (2022) questionnaire results. In discussing the different care providers involved in spiritual care, an administrator noted that he felt there were no boundaries between the personal and community networks, as drawn in the diagram. In addition, a spiritual care provider proposed
replacing the separated circles with one larger bubble that encompassed all the separate groups as one unified group that worked together to provide spiritual care. Throughout the sessions, participants expressed interest in the visual appeal of the diagrams. While participants were shown how to use the Miro board during the first session, participants mostly chose to discuss their ideas instead of engaging in the board. Through observing the sessions, I found that the Miro board acted as a supportive visual, however participants were able to more freely discuss their ideas without directly interacting with the board.

4.5.2 Thematic Analysis

The transcribed recordings of each session, as well as any notes taken by participants and facilitators on Miro were coded using in vivo coding. Using this coding approach, the language used by the participants shaped the codes that emerged. Similar in vivo codes were grouped together into categories and a total of 25 categories were identified (Figure 39). Through this coding process, 5 main themes around participant experiences in providing spiritual care emerged. These themes provide insight into the nature of spiritual care, best practices for spiritual care, as well as gaps that have caused challenges and issues in spiritual care delivery.
Theme 1: Spiritual care in long-term care homes is a changing field that supports holistic and inclusive care

Spiritual care is a changing practice that supports caring for the whole person. Participants noticed that the populations they are serving are changing. They are supporting a greater diversity of spiritualities and faiths, as well as a growing population of residents who do not identify with any religion. Spiritual care is often used synonymously with religious care, or “clothed as religious care”, however participants shared their efforts to support spiritual needs of all, including the “nones”, or those who had no religious affiliation. Participants discussed the importance of “connecting spiritually rather than religiously” and integrating spiritual care into everything. Furthermore, spiritual care is part of the resident’s journey in long-term care, from admission to end-of-life. Participants described the importance of spiritual care supporting residents throughout palliative and end-of-life care. According to a participating administrator, when non-religious individuals are facing end-of-life and grief, they will then seek out “the spirit piece”.
<table>
<thead>
<tr>
<th>Excerpts from Participants</th>
<th>In Vivo Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD2: ...I think as much of a person–centered approach where we look at each individual’s needs and try to match them to some type of spiritual program that is meaningful to them.</td>
<td>Person–centered approach Each individual’s needs</td>
<td>Caring for each individual Caring for each individual</td>
</tr>
<tr>
<td>AD5: ...and that’s one of the reasons why a number of years ago, we actually changed, you know, the chaplaincy role, title, the pastoral care, because people sort of think it’s about formal religion. And our role for our [spiritual care] coordinator is, of course, you know, he will support people that do identify as Anglicans or Catholics or, you know, Protestant, whatever. But it’s deeper than that, because many of our residents don’t. And so we changed the title to spiritual care to be more inclusive of everybody. And it’s interesting, too, because often, what we have found is people that you know, don’t want to participate in spiritual care. But [sic] as they have a significant health issue, or they are at end–of–life, or something happens in their lives. They don’t want the religious piece, but they do want to talk about the spirit piece.</td>
<td>It’s not about formal religion Many residents don’t identify with religion Be more inclusive Talking about spirituality at end–of–life</td>
<td>Serving spirituality beyond religion Serving spirituality beyond religion Caring for each individual Spiritual care supporting palliative and end–of–life care</td>
</tr>
<tr>
<td>SC2: So yes, we can bring spirituality into, into so much of what we do...</td>
<td>Bring spirituality into so much of what we do</td>
<td>Spiritual care in everything</td>
</tr>
<tr>
<td>SC3: So hopefully, a spiritual care provider could also provide support to those who are grieving, and grief is everywhere in long–term care.</td>
<td>Support those grieving</td>
<td>Spiritual care supporting palliative and end–of–life care</td>
</tr>
<tr>
<td>SC4: There’s, there’s so much we can do to connect with people, spiritually, rather than religiously.</td>
<td>Connecting spiritually rather than religiously</td>
<td>Serving spirituality beyond religion</td>
</tr>
<tr>
<td>SC5: [Spiritual care is] how do we support the spirituality of every individual in the home? And whose responsibility is it? Right. And for me, it’s every staff member down to the dieticians, the housekeepers, the PSWs, the nurses, all of them need to have an element of understanding of spirituality, in order to properly and appropriately serve a client’s overall health in all the other domains. Physical, mental, emotional, and social and environmental. Spirituality has to be in all of those, a little vein of it. And only a tiny piece of it is about religious practices. So that’s it. But it’s the other piece of this is that we lean on religion to bring the spiritual care. So what’s the other 50% look like? If someone says, ‘No, I don’t want Christianity?’ I don’t want any of it. I’m none. I’m a nothing. I’m an unknown, I’m no affiliation. What does their spiritual care look like?</td>
<td>Every staff member Spirituality in all domains Spiritual care for a ‘none’</td>
<td>Spiritual care in everything Spiritual care in everything Serving spirituality beyond religion</td>
</tr>
</tbody>
</table>

**Table 11 - Examples of coding analysis for theme 1**
Theme 2: Spiritual care is informal and ambiguous in nature, making it difficult to grasp in a medical environment.

Spiritual care is viewed as a naturally ambiguous practice, consisting of informal processes and practices. Participants described it as “fuzzy-boundaried” and “challenging to nail down”, which clashed with the task-oriented focus of other care provided in the home. This ambiguity is also seen in the legislation, leading to challenges of understanding and grasping spiritual care. Participants described “a lack of clarity” around descriptions of spiritual care. In the Long-Term Care Homes Act (2007), the government provides little definition around how spiritual care should be provided across Ontario. Many participants expressed their lack of trust in the government to support spiritual care services. Participants discussed the need for greater education around spiritual care from different perspectives. Administrators discussed their efforts to evaluate and improve the spiritual care services within their homes. Recreational care providers who were responsible for providing spiritual care felt they didn’t “have [the] knowledge base” and discussed their desire to learn more about how to support the spiritual needs of all residents. Spiritual care providers advocated for greater awareness around the work they do. Participants from spiritual care, recreation, and administrative perspectives were all supportive of spiritual care training and education in order to better grasp the significance of spiritual care.
<table>
<thead>
<tr>
<th>Excerpts from Participants</th>
<th>In Vivo Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC3: But a large barrier, in my opinion, is that the Ontario government is not clear about what they expect of spiritual care. So that’s a huge barrier, a lack of clarity, and even a lack of clarity about what requirements are needed for you to be called a chaplain.</td>
<td>Not clear</td>
<td>Poorly defined by government</td>
</tr>
<tr>
<td>AD2: ...we do benefit from the community, Jewish community, that wraps its arms around us and many of the rabbis within the community play different roles, not necessarily a formal role in the home, but either looking after their people who were once part of their congregation or still may be part of their congregation, or just a leadership role where, in an informal way, where they’ll come in and be part of an activity.</td>
<td>Not a formal role</td>
<td>Exists in an informal way</td>
</tr>
<tr>
<td>SC5: But there is no Master of spiritual care, for lack of a better term, or there’s no undergrad. Because spiritual care is a bit of a fuzzy-boundaried, sort of, it’s unsure. For the government to mandate it through the Long-Term Care Act, they have to get their head on straight as to what they’re mandating because what she just read is adequate, like I’ve pulled this apart and put it into a whole discussion about what does this mean, what does ‘adequately equipped’ mean and, you know, give us some background here because the long-term care homes are [sic] trying to manage that... So education to me on a systems board, you need consistent education, where people learn what it means to be, what is spiritual care? What does it mean, who delivers it? How does it get delivered? And for people like ADI, who’s trying to find her way and navigate through this ambiguous language world of spiritual care...</td>
<td>No official education</td>
<td>Exists in an informal way</td>
</tr>
<tr>
<td>AD3: I mean I don’t want to say something out of turn, I’m kind of nervous about that, but my observing is they’re more focused on getting the knee fixed. You know, there are a lot of jobs in long-term care that are very task-oriented. I’m not saying, people are emotionally numb, I’m not saying that [sic], I’m just trying to be realistic. When I say community groups, I’m thinking churches because I don’t really know who’s spiritual versus who’s formal religion. So that’s a grey area I’m not exactly sure [sic] where to go.</td>
<td>Getting the knee fixed</td>
<td>Task-oriented focus of other care</td>
</tr>
<tr>
<td></td>
<td>Very task-oriented</td>
<td>Task-oriented focus of other care</td>
</tr>
<tr>
<td></td>
<td>A grey area</td>
<td>Lack of clarity</td>
</tr>
</tbody>
</table>

Table 12 - Examples of Coding Analysis for Theme 2
**Theme 3: Human connection and relationship-building are central to spiritual care.**

Spiritual care greatly relies on connection-making and relationship-building on personal, community, and professional levels. Participants emphasized the importance of connection between people as part of the service. In discussing spiritual care, participants talked about providing “person-centered care” that is catered to “each individual’s needs”. An important aspect of providing this care was through "building rapport” and developing strong relationships with the resident. Spiritual care providers discussed their unique skillsets and experiences working in long-term care, highlighting the need for their expertise as a core part of the service. Relationships with the community were an important element of providing spiritual care. Many volunteers, local clergy, and other community organizations worked with participants to provide spiritual care and support unique needs. Participants also supported an interdisciplinary approach to spiritual care. Spiritual care providers were grateful for “a broad team approach” and the support they received from the rest of the staff on the team. While some spiritual care providers discussed the necessity of their unique role, participants also advocated for recognition of spiritual care as part of everyone’s role in long-term care. These co-design sessions also revealed a gap in connection between spiritual care providers across long-term care homes. Many participants expressed feeling alone with limited ways to connect with other professionals. Some participants mentioned that the type of long-term care home they worked at influenced their connections to community and other professionals. During the sessions, participants shared their excitement to learn from each other and expressed interest in future opportunities to connect with others who were struggling with the same issues.
Excerpts from Participants | In Vivo Code | Category
--- | --- | ---
AD1: I wish that there were a way for us to be able to continue connecting with each other. | Connecting with each other | Spiritual care providers supporting each other
AD3: Maybe we can continue to meet. I'll even drive to (city). I'm from (city), I'll drive to (city), we can chat about this. It's great. And, you know, be able to, I guess support one another when there just isn't the support. | Continue to meet | Spiritual care providers supporting each other
SC2: And we're fortunate that there's, there's a strong religious community right around our long-term care facility where they would come in and read stories. | Community comes in | Relationships with the community
SC3: And so a broad team approach is critical to good spiritual care, because otherwise you won't find out it's needed in a particular situation or a particular way. But it's, it's kind of loose and it's just such a unique skill set needed that isn't the same as hospital chaplaincy, it's not the same as hospice chaplaincy, your skill set that includes programming and the other stuff. | Broad team approach | Relationships with the staff
SC5: You have to build rapport, when we have spirituality we build rapport. I find I have some clergy that will come in and they wear the black shirt with the collar. And that breaks rapport with a lot of people, because if they're not thinking, if that's not a familiar icon to them if that's not something that's warm and fuzzy or brings them peace, then it breaks rapport. | Build rapport | Building relationships with residents

Table 13 - Examples of coding analysis for theme 3

**Theme 4: Space is a valued yet under-resourced asset that supports the delivery of quality spiritual care.**

Throughout the co-design sessions, space was discussed as an important part of providing spiritual care. Participants saw spiritual care spaces as "a quiet place” which can be accessed “for some solace”. Long-term care homes were described as the resident’s space, a space that should be treated like a home environment. However, spatial restrictions in long-term care homes were highlighted as well, leading to no designated spiritual care space, or loss of designated space. Spiritual care spaces were being used as lunchrooms, testing centers, or storage spaces during the
COVID-19 pandemic. Some care providers discussed how they used multi-purpose rooms or movable religious elements to create temporary spiritual spaces.

<table>
<thead>
<tr>
<th>Excerpts from Participants</th>
<th>In Vivo Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD1: We do have a chapel that we were using prior to COVID, but even before that we were bursting out of the space that is a very small room. It used to have pews that we ended up removing because of the amounts of wheelchairs.</td>
<td>Busting out of the space</td>
<td>Space restrictions</td>
</tr>
<tr>
<td>AD3: [Our spiritual care space is] called multipurpose everything room. Storage in COVID. Sorry, I'm not trying to be flippant, but it's yeah, it's a challenge. We are getting into building but it's still years away.</td>
<td>Storage in COVID</td>
<td>Losing designated spiritual care space</td>
</tr>
<tr>
<td>AD5: So, not any sort of religious affiliation, but just a quiet place and we don't really have that, and we don't have room for that because, again, our physical building is bursting at the seams as well.</td>
<td>A quiet place</td>
<td>Design of ideal space</td>
</tr>
<tr>
<td>SC2: ...but I think if we again, just keep that thought in mind, you're actually in someone's home, they actually live here 24 hours a day, not like me a couple of hours a day. Places... are actually extremely important when dealing with people, especially when their cognitive abilities are declining.</td>
<td>You're in someone's home</td>
<td>Treating space like home</td>
</tr>
<tr>
<td>SC3: We've lost our chapel to a testing center...So all our worship services are now in the dining room, so what can one do to enhance that space so that it will support the spiritual journey of people coming...</td>
<td>Lost our chapel</td>
<td>Losing designated spiritual care space</td>
</tr>
<tr>
<td>...we've all had to sort of struggle with that. Finding space that can become used for religious functions, but also then for people to have their own kind of quiet, you know, and that's hard to do. So, [sic] in our dementia care floor, I have created two little boxes that are quiet moment boxes...</td>
<td>Worship services in dining room</td>
<td>Creating space for spiritual care</td>
</tr>
<tr>
<td>SC5: In one of the homes I work in, the spiritual care room has on the door 'spiritual care room,' right? When you open the door, the cat litter's in there, there's a bunch of boxes in there. The staff uses it as a lunchroom. Literally, I was kicked out by staff because, I was with clients in there, and they came in and told me it was their lunchroom. And so I just want to note that [sic] conversation around multipurpose space being sort of designated and not having a spiritual care space is important for long-term care.</td>
<td>Kicked out by staff</td>
<td>Losing designated spiritual care space</td>
</tr>
<tr>
<td>SC1: We found, as time went on, and we were actually allowed to do a little bit more, the hallways were helpful because people could roll you know, if they're in a wheelchair, come to their doorway. And you could meet with more than one person, as long as they remained away within that space.</td>
<td>Hallways were helpful</td>
<td>Creating space for spiritual care</td>
</tr>
</tbody>
</table>

### Table 14 - Examples of coding analysis for theme 4

<table>
<thead>
<tr>
<th>In Vivo Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Busting out of the space</td>
<td>Space restrictions</td>
</tr>
<tr>
<td>Storage in COVID</td>
<td>Losing designated spiritual care space</td>
</tr>
<tr>
<td>A quiet place</td>
<td>Design of ideal space</td>
</tr>
<tr>
<td>You're in someone's home</td>
<td>Treating space like home</td>
</tr>
<tr>
<td>Lost our chapel</td>
<td>Losing designated spiritual care space</td>
</tr>
<tr>
<td>Worship services in dining room</td>
<td>Creating space for spiritual care</td>
</tr>
<tr>
<td>Kicked out by staff</td>
<td>Losing designated spiritual care space</td>
</tr>
<tr>
<td>Hallways were helpful</td>
<td>Creating space for spiritual care</td>
</tr>
</tbody>
</table>
Theme 5: The COVID-19 pandemic greatly impacted the delivery of spiritual care

The COVID-19 pandemic was mentioned in every co-design session as a barrier to providing spiritual care. Participants highlighted the difficulties experienced by staff and residents, as well as the loss of community and interaction that resulted from pandemic restrictions. Participants described the frustrations of “losing so many volunteers” that many relied on heavily, and the inability to get together and create community. When discussing services, participants often described the way things were “before COVID”, sharing that spiritual care services currently are “pretty non-existent”. Due to infection prevention and control protocols, program boards, sacred objects, and personal belongings were packed away, resulting in loss of physical touch and connection with meaningful objects. Despite imposed pandemic restrictions, participants shared their efforts to adapt and their “resiliency” in supporting “unique and wonderful ways” to continue to provide care. Technology was used to provide online services for residents and allow spiritual care providers to continue to connect with them. While technology was seen as a tool to facilitate spiritual care during the pandemic, it was also seen as something that could never replace in-person care. Spiritual care providers saw online services as useful, but often isolating, and emphasized the need for coming together and creating community. Overall, this final theme underlies all of the themes, and plays a role in many of the barriers and issues addressed in prior themes.
**Excerpts from Participants**

<table>
<thead>
<tr>
<th>AD1: I do head up the spiritual care department here, which is very lacking right now, especially because of the two years of COVID. We've lost a lot of our volunteers and churches that were coming in on a regular basis. And so basically, we're having to start from scratch again, to build our spiritual program up.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD2: So I'd say resiliency is something that we're proud of and creativity in making sure that we continue with things that are important in the lives of our residents during this difficult period.</td>
</tr>
<tr>
<td>AD3: Just two weeks ago, we got COVID... we've been in this state of hyper anxiety just kind of on edge for two years. Can't, can't, can't. No, no, no, like, you know, so everyone's [sic] in quarantine right now. So had to cancel church service and visits are minimal. I mean, it's just the essential caregivers who can come in. So I can't say anything's any better. It's worse than it was two years ago. Because of COVID, we got all of our boards taken down. So I had... was like a memorial board... but it's not infection control proof.</td>
</tr>
<tr>
<td>AD4: It feels so lonely online because you're by yourself, with a computer or a device, there's nobody around you, when there's people around you so united you feel come together and you're alone in front of a computer, like praying, you're saying, watching a mass or something but you don't feel a community, you don't feel togetherness.</td>
</tr>
<tr>
<td>AD5: I think it's interesting, I often talk about before pandemic, and after pandemic, because things look very different.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SC1: I've had to find unique and wonderful ways to meet the needs, not just individually, but also group wise... You know, we talk about moral injury, but we don't talk too much about spiritual injury, although that might be included in the moral injury. But I think spiritually, there was a lot of injury done. If somebody had COVID, they were packed up out of the room and moved to a different, totally different house... everything was removed, wiped down, removed, so that there was less stuff to have to clean. And less things to come in contact with. So a lot a lot of items, sacred items were packed up and put away. And people had no access to it because you couldn't even touch because we didn't understand what, where, or how this virus was being transmitted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC2: But I want to speak about technology. So at the beginning of COVID, we, we struggled a lot, because in the beginning I wasn’t even allowed in the building. And it was very difficult. So what I did was...I made videos on my phone of what we did for different neighborhoods, we did different lengths of time, so that they can see me because they're familiar with the face. And it could be on the projector, they got projectors in the dining rooms. And they were able to sit and listen.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In Vivo Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very lacking</td>
<td>Impact of COVID</td>
</tr>
<tr>
<td>Lost volunteers</td>
<td>Disconnection from community</td>
</tr>
<tr>
<td>Start from scratch</td>
<td>Impact of COVID</td>
</tr>
<tr>
<td>Resiliency and creativity</td>
<td>Adapting and seizing opportunities</td>
</tr>
<tr>
<td>State of hyper anxiety</td>
<td>Impact of COVID</td>
</tr>
<tr>
<td>Cancel church service</td>
<td>Disconnection from community</td>
</tr>
<tr>
<td>Taken down</td>
<td>Loss of interaction</td>
</tr>
<tr>
<td>So lonely online</td>
<td>Use of technology</td>
</tr>
<tr>
<td>Before COVID</td>
<td>Loss of interaction</td>
</tr>
<tr>
<td>Unique and wonderful ways</td>
<td>Adapting and seizing opportunities</td>
</tr>
<tr>
<td>Spiritual injury</td>
<td>Impact of COVID</td>
</tr>
<tr>
<td>Less things to touch</td>
<td>Loss of interaction</td>
</tr>
<tr>
<td>Sacred items packed up</td>
<td>Loss of interaction</td>
</tr>
<tr>
<td>Not allowed in building</td>
<td>Loss of interaction</td>
</tr>
<tr>
<td>Made videos</td>
<td>Use of technology</td>
</tr>
</tbody>
</table>

**Table 15 - Examples of coding analysis for theme 5**
4.6 Summary

The findings from this study reveal diverse approaches and experiences of spiritual care from long-term care homes across Ontario. The multi-method approach of this study shared a breadth and depth of results. The environmental scan, secondary analysis of Kuepfer et al.’s (2022) questionnaire, and the service design questionnaire provided insight into how services are promoted, organized, and provided across Ontario. The co-design sessions provided a richer understanding of spiritual care through the personal experiences of spiritual care providers, administrators, and recreational program coordinators in long-term care. Analysis of these sessions revealed 5 major themes. Implications of these findings are discussed further in the Discussion.
Chapter 5: Discussion

This study provides insight into the spiritual care services provided across long-term care homes, as well as opportunities for service design applications within this context. In this chapter, I discuss how the findings of the study address the research questions. I also explore how the study findings relate to existing literature. Finally, the chapter concludes with a discussion of the study’s contributions, its limitations, and opportunities for future research.

5.1 Spiritual care services across Ontario long-term care homes

This section describes how the study findings address RQ1: *How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?* This question was explored through an environmental scan of spiritual care services advertised on Ontario long-term care home websites, secondary analysis of Kuepfer et al.’s (2022) questionnaire focused on the roles and responsibilities of spiritual care providers, as well as a service design questionnaire exploring spiritual care services from an administrative and service perspective. What was found through these methods shows the breadth of practices, approaches, and delivery of spiritual care services across long-term care homes in Ontario. Homes of different types, geographic locations, and sizes all had a different degree of spiritual diversity within their homes. Spiritual care went by many names across homes, with a range of different and unique services.

According to participants, spiritual care was provided across departments and teams in long-term care by a variety of people, including staff, family, and community members. Spiritual care services in many long-term care homes rely heavily on the support of the community,
including local spiritual leaders and volunteers. Spiritual care programming often involved close collaboration with the recreational department and spiritual care services were often integrated into this department.

This study also revealed certain gaps in the service. The diversity of spiritual care service delivery demonstrates inconsistency and differences in spiritual care approaches across Ontario within the context of the *Long-Term Care Homes Act* (2007), which provides minimal guidance on requirements for ‘Spiritual and Religious care’. While the *Act* (2007) requires that programming is provided to ensure the spiritual needs of all are met (Section 14), findings from this study demonstrate that this guidance can be interpreted in innumerable ways. This guidance creates flexibility that allows homes to provide personalized care that meets the unique needs of their residents, however the lack of detail within the policy also illustrates minimal understanding around spiritual care and the resources that are required. This lack of support and guidance leaves each home to determine how this service should be provided, when in some cases, they do not hold adequate spiritual care knowledge.

Furthermore, reliance on the support of local community members is an unsustainable approach to providing quality spiritual care. Findings illustrated that spiritual leaders and community members were becoming increasingly difficult to find as more clergy retired. The COVID-19 pandemic further reduced access to community members as long-term care homes established visitor restrictions.

Space was also identified as a crucial gap in spiritual care services for long-term care homes. Due to the space limitations, participants reported having difficulty finding usable spiritual
spaces. Some homes reported the design of the space being inadequate. Homes also converted their spiritual spaces for other uses during the pandemic.

Spiritual care is centered care that can be tailored to each individual’s needs, and the diversity of the services across Ontario illustrates creative and unique approaches to spiritual care. However, the lack of structure and awareness around the practice, reliance on community members, and loss of spiritual spaces are service gaps identified in this research that can undermine this approach.

5.2 Spiritual care service provider experiences

This section addresses RQ2: *What are the experiences of service providers, such as spiritual care providers and long-term care home administrators, in providing spiritual care?* This question was explored through both questionnaires noted above, as well as the co-design sessions. The findings of this study provide insight on the perspectives from service providers of spiritual care and home administrators.

Findings from Kuepfer et al.’s (2022) research illustrates a wide range of expectations of the spiritual care provider role. Spiritual care providers had a wide range of working hours and a myriad of tasks and responsibilities, such as preparing and leading programs, providing one-on-one care, family support, palliative support, and administrative responsibilities. Many spiritual care providers were collaborative in their work, as illustrated in all phases of research. They often worked closely with the recreational team in long-term care homes and coordinated volunteers and community members to support spiritual care services in the home. In the co-design sessions, dedicated spiritual care providers shared their knowledge, experiences, and struggles they faced when promoting their practice. Spiritual care providers viewed spiritual care as a person-centered
practice. They expressed the importance of the relationships, and shared stories of impactful and meaningful exchanges they had with their residents. Many participants viewed their skillsets as unique to supporting spiritual care in the long-term care context, and some participants were reluctant of resources, such as a spiritual care toolkit, as it could not replace their abilities. These participants shared the importance of having a dedicated role for spiritual care in long-term care and all stages of care planning. Spiritual care providers felt that there was a lack of understanding around their profession and advocated for more education and awareness around the importance of spiritual care.

Recreation staff responsible for providing spiritual care shared the difficulties they faced in trying to support spiritual needs. The results of the study by Kuepfer et al. (2022) demonstrated that recreational staff were burdened by many other responsibilities alongside their spiritual care role, such as administrative responsibilities. In the co-design sessions, the recreational care providers expressed that they did not feel they had the knowledge base to provide spiritual care. These participants in the co-design sessions expressed an interest in solutions that could support their spiritual care awareness and program delivery, such as the spiritual care toolkit, despite the aversion towards this approach by many spiritual care provider participants.

Administrators who participated in the study were interested and invested in the spiritual care services in their long-term care homes. The service design questionnaire revealed that most administrator respondents were knowledgeable about the spiritual care services offered in their homes. This phase of research also revealed that there were many spiritual care spaces and objects that supported spiritual care services; however, administrators expressed a specific need for improvements in the design of spiritual care spaces. This was further emphasized in discussions
during the co-design sessions. During these sessions, administrators expressed the pride they felt for the efforts they made to continue to provide as much spiritual care as they could during the pandemic.

There were many similarities in experiences across all participants. All stakeholders shared their struggles in providing spiritual care for diverse needs. Participants expressed a need to promote spiritual care as more than religious support in their long-term care homes, such as providing relational care and companionship, as well as palliative and end-of-life support. Both the service design questionnaire and co-design sessions made it clear that all stakeholders struggled to provide quality spiritual care during the COVID-19 pandemic. Through the sessions it was also revealed that participants were interested in opportunities to connect and collaborate with other stakeholders. Finally, the co-design sessions revealed the lack of trust in government and legislation in supporting spiritual care. Participants of co-design sessions felt the government did not understand, nor properly define spiritual care. As a result, most participants were more reluctant to embrace the design probes that explored top-down, government-run initiatives, believing they would never be supported.

Alongside understanding stakeholder experiences, this research also revealed insights into how spiritual care should be provided from the perspective of stakeholders. Throughout the co-design session discussions, participants emphasized the importance of person-centered approaches to spiritual care that focus on meeting the needs of the residents. Participants discussed an informal and ambiguous approach to spiritual care, emphasizing the importance of human connection as a key part of providing this care. Spiritual care providers shared their appreciation for having a team that supported them in providing spiritual care. While some spiritual care
providers also discussed the uniqueness of their role and skillsets within these teams, many participants expressed the need for all long-term care staff to be involved in and responsible for spiritual care as well.

5.3 A service design approach: Insights gained

Through exploring the role of service design in this unique context, the study addresses RQ3: *How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?* All phases of research informed this final research question. Findings from this research also reveal certain limitations in applying a service design approach to this context.

Service design provided a unique lens to gain an understanding of spiritual care in long-term care homes. Service design tools were used to organize and visualize the results of the research, and the findings from each phase were used to synthesize and design materials that could be used in the next phase. The findings of the secondary analysis of Kuepfer et al.’s (2022) questionnaire data as well as the service design questionnaire were visualized and used as activities in the co-design sessions. Participants expressed an interest in the visual approach to the activities, and this often influenced the way that they engaged or communicated their ideas. This can be seen in their discussion of the stakeholder maps in Session 1, when participants commented on the visual groupings created in the diagrams.

As service design approaches focus on the tangible and intangible aspects of experiencing services, the application of this framework provided a perspective on ‘physical evidences’ and ‘touchpoints’ that may be important to the delivery of spiritual care. To complement Kuepfer et al.’s (2022) questionnaire, the service design questionnaire provided greater insight into the objects and spaces that are being used to provide spiritual care. The environmental scan also
provided insight on the potential role of long-term care websites as a tangible ‘touchpoint’ for advertising spiritual care. This approach supported exploring spiritual care beyond professional practices, considering other resources and aspects of systems that promote or support spiritual care. By examining this service holistically, I gained a better understanding of the larger context.

Finally, the service design approach promoted a collaborative process that invited stakeholders to work together to discuss their practice and resources and develop ideas for improvement. This approach inherently crosses silos by encouraging stakeholders from different levels of the system (spiritual care providers, recreational care staff and administrators) and across organizations (different homes in Ontario) to come together and provide different perspectives. These sessions revealed that participants appreciated opportunities for collaboration and meeting others who are also passionate about spiritual care. This finding illustrates that the service design principle of ‘collaboration’ is currently a key gap in supporting and designing spiritual care services in Ontario, presenting an opportunity for future applications of collaborative service design methods to support spiritual care stakeholders in their endeavours.

Limitations of the service design approach were also revealed within the context of spiritual care across Ontario long-term care homes. The findings illustrated the ambiguity of spiritual care, both in practice and overall understanding. This ambiguity involves a lack of awareness and clarity around the field; however ambiguity was also discussed as a natural and core part of spiritual care. This uncertainty is difficult to comprehend when put within the often precise and regimented nature of the healthcare setting. According to Raffay et al. (2016), "Spiritual and Pastoral Care (SPC) services...have traditionally stayed away from standard outcome measures as they do not fit with the ethos of the service” (p.1). However, there is a push for
spiritual care to be quantifiable to recognize its contributions to patient health. The ambiguous nature of this service approach is contrary to the often ‘compartmentalized’ or ‘categorized’, detailed and precise nature of developing service design maps, processes, etc., which is driven by a sequential understanding of a service.

In the co-design sessions, the importance of human connections and relationships was another key theme of the discussion. Relational care, as mentioned above, is a crucial part of spiritual care. The service design approach also recognizes the significance of relationships through encouraging collaborative approaches, as well as using tools such as stakeholder maps to understand the different perspectives involved in the context and how they connect. Service design processes can effectively map these relationships; however, the approach often portrays people in neatly linked categories (e.g., connected bubbles) and fails to consider the depth and nuances of each relationship, a core factor in spiritual care. Spiritual care relies on a large network of staff and community as support, an important system of relationships from a service design perspective. While spending time developing meaningful and personal relationships is just as crucial to spiritual care, this cannot be conceptualized fully within the service design approach. These findings are illustrated in Figure 40, and a full summary of the findings based on these three research questions is shown in Figure 41.
Common approaches to service design are not well equipped to capture the depth and nuances of relationships built through relational care.

The sequential and precise nature of service design clashes with spiritual care practices.

When applied to spiritual care, the service design approach promotes a collaborative approach that breaks silos between different long-term care staff within and across homes.

**Figure 40 – Revisiting the Connections Between Service Design and Spiritual Care Based on Research Findings**
# RQ 1: How are spiritual care services provided across long-term care homes in Ontario, and what service gaps exist?

<table>
<thead>
<tr>
<th>Spiritual care services...</th>
<th>Service gaps includes...</th>
</tr>
</thead>
<tbody>
<tr>
<td>- includes a breadth of practices, approaches, and delivery of spiritual care services across long-term care homes in Ontario</td>
<td></td>
</tr>
<tr>
<td>- relies on the support of the community</td>
<td></td>
</tr>
<tr>
<td>- is provided by many people, including team members, and family and friends</td>
<td></td>
</tr>
<tr>
<td>- often involves close collaboration with the recreational department</td>
<td></td>
</tr>
<tr>
<td>- a lack of guidance on how spiritual care should be provided</td>
<td></td>
</tr>
<tr>
<td>- a shortage of community support due to the pandemic, as well as retiring religious leaders</td>
<td></td>
</tr>
<tr>
<td>- a need for improved and dedicated spiritual care spaces</td>
<td></td>
</tr>
</tbody>
</table>

# RQ 2: What are the experiences of service providers such as spiritual care providers and long-term care home administrators in providing spiritual care?

<table>
<thead>
<tr>
<th>All providers...</th>
<th>Spiritual care providers...</th>
<th>Recreational care providers...</th>
<th>Long-term care home administrators...</th>
</tr>
</thead>
<tbody>
<tr>
<td>- believe in a person-centered approach to spiritual care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- struggle to support diversity of spiritual needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- advocate for spiritual care beyond religious care</td>
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<tr>
<td>- feel spiritual care is not well supported by government and legislation</td>
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<tr>
<td>- are looking for opportunities to connect with others providing spiritual care</td>
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<tr>
<td>- hold a variety of tasks and responsibilities</td>
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<tr>
<td>- work closely with recreational care providers</td>
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<tr>
<td>- appreciate a full-team approach, however they also hold unique and specialized skillsets to provide spiritual care</td>
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<tr>
<td>- advocate for greater awareness around their profession</td>
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<tr>
<td>- are burdened by many responsibilities alongside spiritual care</td>
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<tr>
<td>- feel they lack the knowledge base to provide spiritual care</td>
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<tr>
<td>- are interested and invested in the spiritual care services in their long-term care homes</td>
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<tr>
<td>- are proud of the resilience of their home in facing the COVID-19 pandemic</td>
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# RQ 3: How might we apply a service design approach to spiritual care services in long-term care homes in Ontario?

<table>
<thead>
<tr>
<th>Benefits of the service design approach</th>
<th>Gaps in the service design approach</th>
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</thead>
<tbody>
<tr>
<td>- visualizations of research findings invites a new way to engage with information</td>
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<tr>
<td>- considers important touchpoints (i.e., spaces, objects, and websites)</td>
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<td>- promotes a collaborative approach that breaks silos</td>
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<tr>
<td>- encourages connection across long-term care homes</td>
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<tr>
<td>- the ambiguous and organic nature of spiritual care clashes with the sequential and precise nature of service design</td>
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<tr>
<td>- common approaches to service design are not well equipped to conceptualize the depth of a relationship, a crucial aspect of spiritual care</td>
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5.4 Revisiting the literature

The initial phases of research provided a broad overview of the spiritual care services in Ontario, while the co-design sessions revealed a richer understanding of spiritual care service delivery through the perspectives of care providers. These findings demonstrate values around spiritual care that align with the literature on spiritual care practices.

The findings support the concepts of patient-centered (hospital context) and intercultural care approaches to spiritual care discussed by Doehring (2019). Participants discussed person-centered approaches to spiritual care, sharing the importance of always considering and supporting the person's individual needs. Participants also discussed the changing landscape of spirituality in long-term care as more residents entering long-term care do not have a religious affiliation. Participants found that there is a need to cater to the diversity of spiritual and religious needs, encompassing the concept of intercultural care (Doehring, 2019).

Responses also revealed the significance of interdisciplinary care (Koper et al., 2019) as an integral part of spiritual care delivery in homes. Interdisciplinary care practices encourage greater integration of spiritual care into the healthcare team and broad team approaches to support spiritual care needs (Koper et al., 2019; Puchalski et al., 2009). While most questionnaire respondents indicated the importance of the recreation care team as a key support involved in providing spiritual care, many participants also selected a variety of other teams and departments involved in providing spiritual care. Co-design participants discussed the importance of their team in supporting the delivery of spiritual care and highlighted the need for all staff to be involved in providing spiritual care.
Relational care (Hvidt et al., 2020) was also a significant practice, which was identified as a key theme from the co-design sessions. The study findings illustrate that deep interpersonal relationships developed between care provider and client were central to the quality of spiritual care, as stated in the literature (Doehring, 2006; Cooper et al., 2013; Holyoke & Stephenson, 2017). However, the findings suggest that the importance of relationships extended beyond the relationships between care providers and residents. While co-design participants emphasized the importance of fostering relationships with their clients, they also expressed a need for strong relationships within the wider network of care. The questionnaire and scan revealed that spiritual care was supported by not only staff, but family and community members. Many co-design participants relied on the community to support in providing care and serving diverse spiritual needs. The co-design sessions also revealed a gap in relationships held between long-term care homes. Co-design participants highlighted the lack of spiritual care communities of practice in long-term care and expressed a desire for more opportunities to meet others interested in spiritual care. Ultimately, relationships were seen as a valuable aspect of not only providing spiritual care, but also supporting those who provide care.

While centered care is among the key practices in providing spiritual care, findings from this research reveal emphasis on relationship-centered care. Relationship-centered care is viewed as a humanizing approach to healthcare that supports better quality of care (Soklaridis et al., 2016). According to Tresolini & the Pew-Fetzer Task Force (1994), “Practitioners’ relationships with their patients, their patients’ communities, and other practitioners are central to health care and are the vehicle for putting into action a paradigm of health that integrates caring, healing, and community...” (p.24). This approach to care recognizes the complexities of each person involved
and how this influences the development of relationships (Tresolini & the Pew-Fetzer Task Force, 1994). Nolan et al. (2004) argue that the person-centered approach to care for the elderly focuses too closely on the individual and proposes a shift to relationship-centered care that recognizes the many interdependencies and relationships that exist within the healthcare context. Tresolini et al. (1994) propose 3 key dimensions of relationship-centered care: Patient-Practitioner Relationship; Community-Practitioner Relationship; and Practitioner-Practitioner Relationship.

The findings of the study illustrate that stakeholders currently recognize and embrace the importance of the first 2 dimensions in their work, however, the co-design sessions revealed there are few opportunities to build strong practitioner-practitioner relationships in spiritual care across long-term care homes. While the participants’ perspectives do emphasize the importance of person-centered care, the research also illustrates the value of a relationship-centered approach to spiritual care in long-term care. Recognizing the breadth and diversity of relationships that exist across spiritual care illustrates the complexity of the service and provides a more holistic understanding of spiritual care, an objective that aligns with a service design approach.

The service design approach to this study provided a unique lens to understand spiritual care services. In exploring service design tools within this context, the findings reveal ways in which spiritual care may be enhanced by a service design approach, as well as the limitations of the approach within this context. As discussed in the literature review, this study illustrates the synergies between spiritual care and service design approaches. While human-centered approaches aligned with existing spiritual care practices, the service design approach also offered value by introducing collaborative and cross-disciplinary approaches to support spiritual care providers. By bringing different stakeholders together in the co-design sessions, all participants
expressed interest in the opportunity for collaborative and cross-disciplinary discussions that are encompassed in service design principles and practices (Stickdorn et al., 2018).

This study illustrates the layers of complexity that emerge when considering the larger system that spiritual care is situated in, as well as the other care systems involved. This complexity of care systems within healthcare is discussed by Patricio et al. (2020), who recommends a person-centered approach to developing solutions. The findings from this study illustrate the many long-term care, family, and community networks that support spiritual care. However, these organic systems and networks of stakeholders remain undocumented. While these networks of care are not institutionalized, and findings indicate the informal nature of their relationships with long-term care homes, there is still a high degree of complexity within each of these systems that must be investigated further. In applying a service design approach to this study, the findings revealed the various people and systems that support spiritual care which calls for greater reflection (Kimbell & Bailey, 2017; Vink & Koskela-Huotari, 2021). The research findings also illustrate the larger context of government systems and regulations, and how the gaps in awareness and support from the government have influenced spiritual care in long-term care homes. This insight into organic systems that interact with and govern spiritual care highlights the need to reflect on approaches in this sector that focus on larger, more complex systems, such as Multilevel Service Design (MSD) introduced by Patricio at al. in 2011.

Despite these potential benefits of applying service design within this context, the findings also demonstrate the limitations of this approach, limitations which have also been discussed in the literature. Akama (2009) discusses the tendency in service design to rely on toolkits as packaged and prepared approaches that can be applied to any context. This approach fails to
consider the nuances of context, stakeholders, and other situational factors that can greatly influence the effectiveness of a service approach (Akama, 2009; Akama & Prendiville, 2013). Similarly, within the co-design groups it became clear that some stakeholders were averse to these one-size-fits-all toolkit approaches applied to spiritual care service, emphasizing the importance of the people who provide the care. While service design offered a new perspective within the context of spiritual care, exploring this context also led to discoveries around where service design needs further investigation.

5.5 Research contributions

The findings of this research provide an understanding of the diversity of spiritual care services provided across Ontario long-term care homes. In analyzing existing websites, questionnaire data from previous research and this study, while also building on this analysis through design-driven research methods, this study offers new insights into an under-researched field that serves people at a seminal point in their lives. This research was also conducted during the COVID-19 pandemic. While this led to certain research limitations, it also provided unique and important insights about how spiritual care is provided during times of crises, including consideration of IPAC and COVID-19 restrictions. Furthermore, the research offered a unique context to explore the potentials of service design within long-term care. Results from the research highlight a need for greater collaboration and connection across long-term care homes, while illustrating the benefits of considering the many ‘touchpoints’ that support spiritual care. The study also reveals limitations of the service design approach in this context, such as the dissonance between the precision and detail typically expected in service design compared to the ‘fuzziness’
and ambiguity of spiritual care practice. Ultimately, applying the service design approach to an entirely new context revealed new insights about both spiritual care and service design.

5.6 Implications for the long-term care sector

The results of this research present considerations for policy and practice within long-term care. First, this study invites reflection on spatial and planning considerations. Study findings illustrate not only the shortage of space in long-term care to support spiritual needs, but also the inattention to values and beliefs held by many around the design of spaces to support spiritual needs, such as the importance of creating a sense of privacy or peace. This illustrates the need for larger spatial requirements in the design of long-term care homes in the future and presents an opportunity to explore how the spatial and architectural design across all long-term care homes could be designed to evoke these values. This study also demonstrates the importance of communities in supporting long-term care homes. From an urban planning perspective, the results illustrate that there is value in building homes within communities, to ensure they are well connected with local organizations and volunteers. Alongside considering options to facilitate greater connectivity between long-term care homes and communities, this study has revealed a clear need for greater connection between care providers working within long-term care. There is an opportunity to establish networks for staff working in spiritual care to support each other and create a community across long-term care homes.

Following the outbreaks and home shutdowns during the COVID-19 pandemic, there have been many new learnings about the significance of proper Infection Prevention and Control (IPAC) protocols to ensure the safety of all staff, residents, and caregivers within the homes. However, this led to an elevation of a medical model of care at the expense of supporting health
and well-being more holistically. This study has shown the impact of the isolating pandemic restrictions on the quality of life in long-term care, such as the loss of spiritual programming and social connection. Moving forward, health protocol and pandemic restrictions should aim to protect not only the physical health of those in long-term care, but also more broadly tend to their holistic health, considering psychological, emotional, and spiritual needs. This is an important consideration throughout the journey in long-term care, including in palliative care and end-of-life care contexts. Overall, the long-term care sector should strive to implement practices that facilitate meaningful engagement and consider the holistic health and wellbeing of everyone in long-term care.

5.7 Limitations

While this study attempted to extensively investigate spiritual care across Ontario long-term care homes using a multi-method approach, this study faced certain limitations. While attempting to expand current research by gaining multiple stakeholder perspectives, including administrators alongside spiritual care providers, this study does not include the experiences or insight of residents, family, community volunteers, and other stakeholders. As a result of focusing on service providers to gain a better understanding of the current service, as well as maintaining a realistic scope for this research, client perspectives did not inform the outcomes. This presents an opportunity for future research with greater integration of numerous stakeholder perspectives. The study also faced limitations due to the COVID-19 pandemic. The pandemic was extremely difficult for long-term care homes. As a result of short-staffing, efforts were made to avoid overburdening staff with study invitations during waves. There were likely fewer participants in the service design questionnaire and co-design sessions due to these pressures faced by long-term
care homes. Furthermore, additional methods involving on-site visits could not be considered due to COVID-19 restrictions. Finally, the results of the service design questionnaire revealed that most participants were knowledgeable of their long-term care home spiritual care programs. It is likely that the invitation to participate in a questionnaire related to spiritual care would primarily attract those who are interested in this area. As a result of this recruitment approach, this questionnaire may not represent the perspectives of homes with long-term care administrators who may be less knowledgeable or involved in their spiritual care programs.

5.8 Future research

Future research on this topic should involve other stakeholders, including residents, family and friends, and community members. These perspectives are crucial to gaining a full understanding of the experiences of spiritual care in long-term care. Through this research, there should be investigation of these additional networks of family and community in order to gain a fuller understanding of the informal networks of care that support spiritual care in Ontario long-term care homes.

The role of service design in supporting spiritual care in long-term care homes should be explored further. This study illustrated service providers' interest in opportunities for collaboration among care providers. Further research should consider the implementation of collaborative and cross-disciplinary spiritual care working groups and the development of strategies and solutions in consultation with key stakeholders. While this research considers spiritual care services across long-term care homes, future research should consider spiritual care services across provinces as well as internationally. This will further investigation on opportunities for collaboration within spiritual care, as well as provide new insights on Multilevel Service Design (Patricio et al., 2011).
through exploration of service design from a higher systems level. This study also offers unique insight into the role of relationships within service design. While relationships are important to service design, the quality and value of relationships are not commonly explored. In applying service design to unique services like spiritual care, which hinges on meaningful relationships, the context of this study challenges the service design approach. Future research should push the current understanding of relationships within service design and challenge this field of research by further exploring the value of service design in supporting deep and meaningful relationships.

Finally, the COVID-19 pandemic has had a devastating impact on Ontario long-term care homes; however, it has been a catalyst for enacting improvements to the long-term care system. The newly proposed long-term care homes act, *Fixing Long-Term Care* (2021), is part of the current initiatives to improve the quality of care and support within long-term care homes. The pandemic has highlighted the need for a more robust support system for palliative care (Stilos et al., 2021; Ontario's Long-Term Care COVID-19 Commission, 2021). As these changes are put into place, further research should investigate how the landscape of spiritual care in Ontario long-term care homes has shifted. This continual process of building on existing research on spiritual care services in long-term care homes will contribute towards shaping a deeper understanding of spiritual care and creating greater awareness around the importance of the practice.
Chapter 6: Conclusion

In this study, I investigated spiritual care services across Ontario long-term care homes from a service design perspective. The aim of the research was to explore how spiritual care services are provided across long-term care homes as well as understand the experiences of various service providers across Ontario. By applying a service design lens to the project, the research uncovers insights about both spiritual care services, as well as the potential of the service design approach. Through the literature review, I introduce the context of spiritual care in long-term care homes, highlight the synergies between service design and spiritual care, and present the opportunity for applying service design to the context of spiritual care services in long-term care homes. This study used a multi-method approach through a secondary analysis of Kuepfer et al.’s (2022) questionnaire results, an environmental scan of long-term care home websites, a service design questionnaire for long-term care home administrators, as well as a series of co-design sessions with spiritual care service providers. The research reveals a diversity of approaches to spiritual care service delivery across Ontario long-term care homes. Key insights from the research illustrate that spiritual care is a unique service that supports centered and relational care. Spiritual care also faces barriers, including a lack of awareness around the practice, a lack of spiritual spaces, as well as restrictions to spiritual care caused by the COVID-19 pandemic. Stakeholders highlighted the value of developing strong relationships with residents and communities as an important aspect of quality spiritual care, and the research revealed a need for more opportunities to develop relationships between service providers. Service design offered a holistic perspective of spiritual care services within long-term care homes, and study findings
demonstrated the importance of cross-disciplinary collaboration, as well as the role of physical artifacts and spaces in providing care. Service design shared new insights on spiritual care, however the sequential and detail-oriented nature of the approach clashed with the ambiguity and ‘fuzziness’ of spiritual care, which centers on building deep and meaningful relationships. Future research should consider resident and family perspectives, and opportunities for collaboration at organizational, provincial, and international levels.
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Appendices

Appendix A: Carleton University Research Ethics Board – Ethics Approval

Office of Research Ethics
4500 ARISE Building | 1125 Colonel By Drive Ottawa, Ontario K1S 5B6
613-520-2600 Ext: 4085
ethics@carleton.ca

CERTIFICATION OF INSTITUTIONAL ETHICS CLEARANCE

The following research has been granted clearance by the Carleton University Research Ethics Board-B (CUREB-B). CUREB-B is constituted and operates in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2).

Ethics Clearance ID: Project # 116644

Project Team Members:
Sophie Nakashima (Primary Investigator)
Chantal Trudel (Research Supervisor)
Amy Hsu (Research Supervisor)

Study Title: Spirituality and Service Design: Supporting spiritual care in Ontario long-term care homes

Funding Source: (If applicable):

Effective: December 23, 2021 Expires: December 31, 2022

This certification is subject to the following conditions:

Clearance is granted only for the research and purposes described in the application.
Any modification to the approved research must be submitted to CUREB-B via a Change to Protocol Form. All changes must be cleared prior to the continuance of the research.
An Annual Status Report for the renewal or closure of ethics clearance must be submitted and cleared by the renewal date listed above. Failure to submit the Annual Status Report will result in the closure of the file. If funding is associated, funds will be frozen.

During the course of the study, if you encounter an adverse event, material incidental finding, protocol deviation or other unanticipated problem, you must complete and submit a Report of Adverse Events and Unanticipated Problems Form.

It is the responsibility of the student to notify their supervisor of any adverse events, changes to their application, or requests to renew/close the protocol.

Failure to conduct the research in accordance with the principles of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2nd edition and the Carleton University Policies and Procedures for the Ethical Conduct of Research may result in the suspension or termination of the research project.

**IMPORTANT: Special requirements for COVID-19:**

If this study involves in-person research interactions with human participants, whether on- or off-campus, the following rules apply:

Upon receiving clearance from CUREB, please seek the approval of the relevant Dean for your research. Provide a copy of your CUREB clearance to the Dean for their records. See Principles and Procedures for On-campus Research at Carleton University and note that this document applies both to on- and off-campus research that involves human participants. Please contact your Dean's Office for more information about obtaining their approval.

Provide a copy of the Dean’s approval to the Office of Research Ethics prior to starting any in-person research activities.

If the Dean’s approval requires any significant change(s) to any element of the study, you must notify the Office of Research Ethics of such change(s).

Upon reasonable request, it is the policy of CUREB, for cleared protocols, to release the name of the PI, the title of the project, and the date of clearance and any renewal(s).

Please email the Research Compliance Coordinators at ethics@carleton.ca if you have any questions.

**CLEARED BY:** Date: December 23, 2021

Bernadette Campbell, PhD, Chair, CUREB-B

Kathryne Dupre, PhD, Co-Chair, CUREB-B
Appendix B: Service design questionnaire questions

Q1 Please enter the town/city of your long-term care home workplace.

________________________________________________________________

Q2 Please provide the first 3 digits of the postal code of your long-term care home workplace.

________________________________________________________________

Q3 What type of long-term care home do you work at?
• Not-for-profit (1)
• Privately owned (2)
• Municipal (3)

Q4 What is your job title?

________________________________________________________________

Q5 How knowledgeable are you about the spiritual care services, initiatives, and programming provided in your home?

<table>
<thead>
<tr>
<th>Knowledgeable at all</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
<th>Extremely knowledgeable</th>
<th>(7)</th>
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</table>

How knowledgeable are you about the spiritual care services, initiatives, and programming provided in your home? (1)
Q6 Who is the primary person responsible for coordinating spiritual care and running spiritual care programming within the long-term care home?

- Spiritual Care Provider (provide the title of their role) (1) ________________________________
- Recreational Coordinator (2)
- A recreation team member (3)
- Volunteer coordinator (4)
- Social worker (5)
- Music therapist, art therapist, horticultural therapist (6)
- Administrator (7)
- Support Staff (Housekeeping, Maintenance, Services, Culinary) (8)
- Personal Support Worker (9)
- Registered Nurse (10)
- Registered Practical Nurse (11)
- Physician (12)
- Director of Care (13)
- Other Allied Health Professional (Physical Therapist, Respiratory Therapist, Dietitian, etc.) (provide the title of their role) (14) ________________________________
- Volunteers and/or community members (15)
- Family Members or friends (16)
- Other (please specify) (17) ________________________________

Q7 Who else is involved in providing spiritual care and spiritual programming within the long-term care home? Select all that apply.

- Spiritual Care Provider (provide the title of their role) (1) ________________________________
- Recreational Coordinator (2)
- Recreation Team members (3)
- Volunteer coordinator (4)
- Social worker (5)
- Music therapist, art therapist, horticultural therapist (6)
- Administrator (7)
- Support Staff (Housekeeping, Maintenance, Services, Culinary) (8)
- Personal Support Worker (9)
- Registered Nurse (10)
- Registered Practical Nurse (11)
- Physician (12)
- Director of Care (13)
- Other Allied Health Professional (Physical Therapist, Respiratory Therapist, Dietitian, etc.) (provide the title of their role) (14) ________________________________
- Volunteers and/or community members (15)
- Family Members or friends (16)
- Other (please specify) (17) ________________________________

Q8 Is information on spirituality and spiritual needs of a resident shared with the home when a resident first enters long-term care?

- Yes (1)
- No (2)
- Sometimes (3)
- I don't know (4)
Display This Question:

If Is information on spirituality and spiritual needs of a resident shared with the home when a resi... = Yes
And Is information on spirituality and spiritual needs of a resident shared with the home when a resi... = Sometimes

Q9 Who collects this information and where is it recorded?

________________________________________________________________

Q11 Who is likely to be most aware of the spiritual needs of a resident on a daily basis? Select all that apply.
- Spiritual Care Provider (provide the title of their role) (1) __________________________
- Recreational Coordinator (2)
- A recreation team member (3)
- Volunteer coordinator (4)
- Social worker (5)
- Music therapist, art therapist, horticultural therapist (6)
- Administrator (7)
- Support Staff (Housekeeping, Maintenance, Services, Culinary) (8)
- Personal Support Worker (9)
- Registered Nurse (10)
- Registered Practical Nurse (11)
- Physician (12)
- Director of Care (13)
- Other Allied Health Professional (Physical Therapist, Respiratory Therapist, Dietitian, etc.) (provide the title of their role) (14) __________________________
- Volunteers and/or community members (15)
- Family Members or friends (16)
- Other (please specify) (17) __________________________

Q12 In your opinion, are those who are involved in providing spiritual care equipped with training or appropriate experience to give spiritual care?
- Yes (1)
- No (2)
- Some, but not all are equipped (3)

Q13 Is spiritual care and spirituality of a resident involved in or part of any of the following programs, services, and/or teams? (Select all that apply)
- Medical Services (1)
- Personal Care (2)
- Recreation (3)
- Food Services (4)
- Social Work (5)
- Therapeutic Services (6)
- Finance and Administration (7)
- Other (Please Specify) (8) __________________________

Q14 What religious or spiritual groups/affiliations do spiritual care services currently support in your LTC home? Select all that apply.
• Agnostic (1)
• Atheist (2)
• Buddhist (3)
• Christian (4)
• Hindu (5)
• Humanist (6)
• Jewish (7)
• Muslim (8)
• Sikh (9)
• Indigenous Spirituality (10)
• Another religion(s) or spirituality(ies) (Please specify) (11)

Further specify the above selected religious or spiritual affiliation: (12)

• I don't know (13)

Q15 Are there any residents with religious or spiritual groups/affiliations that currently need more support in your LTC home? Select all that apply.

• Agnostic (1)
• Atheist (2)
• Buddhist (3)
• Christian (4)
• Hindu (5)
• Humanist (6)
• Jewish (7)
• Muslim (8)
• Sikh (9)
• Indigenous Spirituality (10)
• Another religion(s) or spirituality(ies) (Please specify) (11)

Further specify the above selected religious or spiritual affiliation: (12)

• I don't know (13)

Q16 How diverse are the spiritual and religious needs of residents, family members and staff at the long-term care home?

<table>
<thead>
<tr>
<th>Diverse at all (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
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Q17 How do you serve this range of needs?

Q18 If a resident, family member, or staff member needs spiritual care services, how do they access these services in the home?
Q19 Does the long-term care home have a space dedicated for meditation, reflection and ritual?
- Yes (1)
- No (2)
- I don't know (3)

Display This Question:
If Does the long-term care home have a space dedicated for meditation, reflection and ritual? = Yes

Q20 What religious or spiritual groups/affiliations does the space(s) support? Select all that apply:
- Agnostic (1)
- Atheist (2)
- Buddhist (3)
- Christian (4)
- Hindu (5)
- Humanist (6)
- Jewish (7)
- Muslim (8)
- Sikh (9)
- Indigenous Spirituality (10)
- Another religion(s) or spirituality(ies) (Please specify) (11)

- Further specify the above selected religious or spiritual affiliation: (12)
- I don't know (13)

Display This Question:
If Does the long-term care home have a space dedicated for meditation, reflection and ritual? = Yes

Q21 How many spaces do you have dedicated to meditation, reflection and ritual?
- 1 space (1)
- 2 spaces (2)
- 3+ spaces (3)
- No dedicated space, but a multipurpose space (4)
- No space (5)

Display This Question:
If Does the long-term care home have a space dedicated for meditation, reflection and ritual? = Yes

Q22 What are your thoughts on the design of this space(s) relative to supporting the needs of residents, family members, and/or staff? Please describe any aspects about the design of the space that work well and/or not so well to support spiritual care.

__________________________________________________________________________________

Q23 What other places in the home support spiritual needs and delivery of spiritual care? Select all that apply.
- Resident Room (1)
- Dining space (2)
- Staff space (3)
- Multi-purpose room (4)
- Washrooms and Shower rooms (5)
- Outdoor space (6)
- Other (Please Specify) (7) ________________________________
- None (8)
Q24 How does the design of these spaces support the spiritual needs of residents, family members, and/or staff? Please describe any aspects about the design of these spaces that work well and/or not so well to support spiritual care.

________________________________________________________________

Q25 What objects or materials do you use to provide spiritual care and/or support spiritual needs (for example, religious texts, photos, ritual objects, etc.)?

________________________________________________________________

Q26 Are your spiritual care services advertised?
- None of our services are advertised (1)
- Some of our services are advertised (2)
- All of our services are advertised (3)
- Other: (4) ________________________________________________

Display This Question:
If Are your spiritual care services advertised? = None of our services are advertised
And Are your spiritual care services advertised? = Some of our services are advertised
And Are your spiritual care services advertised? = All of our services are advertised
And Are your spiritual care services advertised? = Other:

Q27 What spiritual care services, programming, and initiatives does the long-term care home advertise and promote? (for example, one-on-one visitations, support groups, death cafés, religious ceremonies and services, etc.)

________________________________________________________________

Display This Question:
If Are your spiritual care services advertised? = None of our services are advertised

Q28 Why are spiritual care services not advertised?

________________________________________________________________

Q29 How do you promote spiritual care services for residents, family members, staff, as well as future residents in the long-term care home? Select all that apply.
- Brochures (1)
- Newsletters (2)
- Posters in the home (3)
- Through the LTC home website (4)
- Through social media (e.g., Facebook, Twitter, Instagram, TikTok) (5)
- Through video conferencing (e.g., Zoom, Facetime, Skype) (6)
- We do not promote our spiritual care services (7)
- Other (Please specify) (8) ________________________________________________

Q30 How does your long-term care home measure or evaluate progress or success of your spiritual care services?

________________________________________________________________
Q31 Describe any challenges or gaps your long-term care home faces in coordinating, overseeing, organizing, or providing spiritual care.

__________________________________________________________________

Q32 Thank you very much for taking the time to complete this survey. Before you complete the questionnaire, is there anything else you’d like to add?

__________________________________________________________________
Appendix C: Sketches and Probes

Initial mapping

Developed based on Kuepfer et al’s (2022) findings
Personas
Developed based on Kuepfer et al’s (2022) findings
Design probes

Presented in Session 3 of co-design sessions

Probe 1

Interdisciplinary Community of Practice
A community that welcomes anyone who is interested in long-term care to connect, discuss, and promote spiritual care.

Grassroots
How might we...
- create opportunities for spiritual care collaboration and sharing across long-term care homes?
- facilitate greater awareness and education around spiritual care?

Anyone who is interested in spiritual care in LTC meet to discuss issues, share ideas, and offer support.

Social networks are set up to allow people to connect and share resources.

The community supports and advocates for more action and awareness around the importance of spiritual care.
Community Representative
A dedicated staff member responsible for nurturing relationships with the community and fostering greater connections between long-term care homes and the community.

Community rep recruits and coordinates volunteers.
The rep builds connections with the various community groups, providing resources to support various departments in long-term care.
Community initiatives are organized within LTC, bringing the community together.

Government-led
How might we...
create opportunities for spiritual care collaboration and sharing across long-term care homes?
facilitate greater awareness and education around spiritual care?
Spiritual Care Toolbox

For homes who currently do not have a spiritual care coordinator, the spiritual care toolkit acts as a guide for the design and delivery of spiritual care programs.

A series of program how-tos are provided, with basic instructions and tips on running certain events. A set of program templates are shared to help with planning events that support spiritual care. A list of contacts, resources, and communities are compiled for further information.
Collaborative Hybrid Program Delivery
With greater infrastructure provided, spiritual care and other programming could be provided across homes when a local provider is not available.

Resources to provide multiple formats of program delivery is invested in so that homes have the technology required.

Homes can stream their programs so that other homes can attend these programs remotely.

Residents who are in isolation can still participate in programming.
Co-creating Spiritual Spaces

Creating more spaces throughout the home that invite engagement and reflection.

The Reflection Room

 Explore opportunities for other spaces to be used to engage people in meaningful moments.

Working with residents, families, and friends, to consider what is needed in the space.

How might we...

Grassroots

How might we create spaces that support spiritual care when faced with spatial restrictions?
Appendix D: Findings - Additional graphs and visualizations

Kuepfer et al. (2022) questionnaire results

Percentage (%) of time spent on job responsibilities by spiritual care providers

- Leading programs: 25.81%
- Preparation for programs: 12.56%
- Palliative support: 9.92%
- Family support: 7.44%
- Administration/documentation: 10.06%
- Recruiting/organizing volunteers: 4.42%
- Staff support: 5.31%
- Other (please specify below): 3.08%
- One on one/relational spiritual care (other than palliative): 21.47%
Percentage (%) of time spent on job responsibilities by recreational care providers

- Administration/documentation: 21.00%
- Staff support: 9.00%
- Leading spiritual programs: 11.86%
- Recruiting/organizing volunteers: 12.33%
- Preparation for spiritual programs: 16.71%
- Palliative support: 8.67%
- Other (please specify below): 1.43%
- One on one spiritual care (other than palliative): 8.00%

Staff involved in providing spiritual care

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual care provider</td>
<td>Art therapist</td>
</tr>
<tr>
<td>Recreation &amp; Other</td>
<td>0</td>
</tr>
</tbody>
</table>
Volunteers involved in providing spiritual care

Environmental scan results

Name of spiritual care services
**Spiritual care providers based on home type, home size, and location**

<table>
<thead>
<tr>
<th>Location</th>
<th>Info on SCP</th>
<th>Home Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Small</td>
</tr>
<tr>
<td>CMA</td>
<td>Chaplain</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Clergy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community membe...</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Minist...</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coordinator of Spir...</td>
<td></td>
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<tr>
<td></td>
<td>Lay persons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ministers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pastor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pastoral Care Coor..</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Programs Director</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychotherapist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spiritual Advisor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spiritual Care Coor..</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Volunteers</td>
<td></td>
</tr>
<tr>
<td>CA</td>
<td>Chaplain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Local churches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pastor</td>
<td></td>
</tr>
<tr>
<td>ROO</td>
<td>Chaplain</td>
<td></td>
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<tr>
<td></td>
<td>Clergy</td>
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<tr>
<td></td>
<td>Community membe...</td>
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<td></td>
<td>Local churches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ministers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Volunteers</td>
<td></td>
</tr>
</tbody>
</table>

![Graph showing the number of spiritual care providers by location, home type, and home size](image-url)
Appendix E: Co-design results - Miro notes
Session 1 notes (Written by facilitators and participants)

What is important to you in providing spiritual care in long-term care homes?

- people centered
- having the expertise to serve all of the needs, and unique needs
- listen to the uniqueness of the needs with also the very specialized nature of the home they serve, which is majority Jewish and Orthodox
- important for people to be able to express their spiritual beliefs
- To teach spiritual care is more than religion
- To be at the table with the client and family for wholistic care
- spiritual focus, not just religious
- Proper knowledge in order to be sensitive to diversity, having the resources available to meet their needs.
- Always trying to head in the direction of peace, peace making, peace building
- To create awareness around a “good death” and help people accept death as a part of life
- build rapport
- Communication
- love of people
- treat as want to be treated
What supports you in providing good spiritual care, and what barriers do you face?

- Lack of support
- Spiritual care
- Number of participants
- Limited space
- Financial constraints
- Lack of resources
- Lack of training for staff
- Understanding of spiritual needs
- Team coordination
- Participation of the population
- Only one person
- Need for space
- Need for contact with people
- Need for spiritual care
- Need for coordination with other spiritual care providers
- Need for music, worship, and prayer
- Need for contemplation
- Need for communication
- Need for government support
- Need for family support
- Need for church support
- Need for spiritual leaders
- Need for a broad approach
- Need for a pastoral approach
- Need for training for staff
- Need for funding for spiritual care
- Need for a team approach
- Need for a spiritual care coordinator
- Need for a spiritual care provider
- Need for support from churches
- Need for support from spiritual care providers
- Need for support from the government
- Need for support from family
- Need for support from the spiritual care coordinator
- Need for support from the team
- Need for support from the rest of the team
Please share if there is anything you are hoping to explore or gain from these sessions, and I will do my best to incorporate it into the sessions.

I am hoping to gain some knowledge about how to provide exceptional spiritual care with limited resources and new and innovative ways to implement spiritual programs.

To answer/resource/put into practice my questions as noted above.

Open to life long learning

Spiritual care provider could be able to provide support for those who are grieving.

Communicating the needs of the people - special training for specific needs is essential.

Examples: dementia

Challenging for the interactions, example: memorial service

COVID also causes some anxiety on what can be done or not.
Session 3 notes (Written by facilitator)
Appendix F: Co-design pre-session materials

Spirituality and Service Design: Supporting spiritual care in Ontario long-term care homes

Spiritual Care Co-design Working Group Session #1

Thank you very much for your interest in participating! Through these sessions I look forward to hearing about your experiences in long-term care and exploring new opportunities for spiritual care together. This document will share an overview of what to expect for our first co-design session.

Before our first session, you are invited to:
1. Briefly review the material so you know what to expect (optional)
2. Reflect and respond to Activity 1 (5 mins) before we meet! (required, see below).

What you'll need:

If possible, please sign and return the consent form before the session! You can find it provided in the invitation email. Let me know if you need assistance.

Having access to a computer or laptop for these sessions is strongly recommended. We will be using Miro, a collaborative online workspace, which is easier to use with a computer. No background necessary, we will learn together!

These sessions will be run on Zoom. The link to the meeting can be found in the invitation email.
Workshop Overview

Schedule (1 hour):

1. Welcome & Introduction (15 mins)
2. Icebreaker: Values and Goals (20 mins)
3. Building our Team: Stakeholder map activity (20 mins)
4. Wrap up, comments (5 mins)

Activity 1: Icebreaker - Values and Goals
Complete before we meet! (See link below)

Before our first meeting, you are invited to reflect and respond to the following questions. We will look at these responses together in the session.

1. What is important to you in providing spiritual care in long-term care homes?
2. What supports you in providing good spiritual care, and barriers do you face?
3. Please share if there is anything you are hoping to explore or gain from these sessions, and I will do my best to incorporate it into the sessions.

Provide your responses here:
https://carletonu.az1.qualtrics.com/jfe/form/SV_82I7nI6wS3j1sC

Activity 2: Building Our Team - Stakeholder Map Activity
No prep needed, we will do this together

Below are diagrams of the different stakeholders involved in providing spiritual care in long-term care homes (Kuepfer, 2019). Review the diagrams on the next page and consider the following questions:

1. How does this compare with your team? How do these different individuals work together to provide spiritual care?
2. How do you work with administrators/ and or spiritual care providers in planning and executing spiritual care within the long-term care home?
3. What strengths are there within this network, what weaknesses or gaps exist?
And this will conclude our session! Please do not hesitate to reach out to me if you have any questions or concerns that I can address in advance of the session.

I can be contacted at sophienakashima@cmail.carleton.ca

data accessed from the ‘Spiritual Care in Ontario Long-term Care Study’, Jane Kuepfer, University of Waterloo, 2019.
Spirituality and Service Design: Supporting spiritual care in Ontario long-term care homes

Spiritual Care Co-design Working Group Session #2

Thank you very much for your interest in participating! Through these sessions I look forward to hearing about your experiences in long-term care and exploring new opportunities for spiritual care together. This document will share an overview of what to expect for our second co-design session.

This booklet will give you information about what to expect for this upcoming session. It is optional to review.

There will also be a small update on some of my findings in my thesis research thus far, which you are invited to review if it interests you.

What you'll need:

A computer or laptop
Having access to a computer or laptop for these sessions is strongly recommended. We will be using Miro, a collaborative online workspace, which is easier to use with a computer. No background necessary, we will learn together!

Access to Zoom
These sessions will be run on Zoom. The link to the meeting can be found in the invitation email.
Workshop Overview

Schedule (1 hour):

Welcome & Introduction (10 mins)
Ideas Exchange (20 mins)
Stars and Wishes (25 mins)
Wrap up, comments (5 mins)

Activity 1: Ideas Exchange
No prep needed, we will do this together

During this first part of the session, I wanted to create space for you to share and exchange ideas, as professionals who are supporting spiritual care in long-term care in various capacities.

1. Share any spiritual care initiatives, practices, approaches, or moments that you are proud of. What successes have you had?
2. Do you have any questions that you would like to ask other participants in this session?

Activity 2: Stars and Wishes
No prep needed, we will do this together

On the following page is a list of different spaces, objects, and teams that were reported by administrators as being part of spiritual care delivery. Using these as a reference, identify the following:

1. Superstars: What spaces, objects, and teams support you in the spiritual care work you do?
2. Wishes: What spaces, objects, and teams do you wish were improved, or you wish you had?
And this will conclude our session! Please do not hesitate to reach out to me if you have any questions or concerns that I can address in advance of the session.

I can be contacted at sophienakashima@cmail.carleton.ca
Research Updates

Spirituality and Service Design: Supporting spiritual care in Ontario long-term care homes

As partners in this research, I wanted to share some of the other investigation and analysis I am doing in my thesis research with you. I welcome any feedback, questions, or thoughts!

Environmental Scan of long-term care websites

As part of my research, I conducted an environmental scan of long-term care home websites to determine the way that spiritual care is promoted. 210 websites (1/3 sample of Ontario long-term care homes) were searched to determine if spiritual care was promoted, and if so, what services, spaces, and people were mentioned.

Was Spiritual Care mentioned?

[Diagram showing the results of the environmental scan]

- Yes: 140
- No: 50
- Do not have a website: 20
Further analysis of this data will include investigating how home's location (urban/rural), type (not-for-profit, private, municipal), and size may influence the service delivery.