

Training and Sustaining: A Model for Volunteer Spiritual Care Visitors in Long-Term Care

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Volunteer provision of spiritual care in an Ontario, Canada, long-term care home was the focus of a case study regarding resident spiritual care needs in a municipal environment that does not fund professional chaplains. Scope of practice issues, spiritual care skills in long-term care, and diversity sensitivity were identified as key areas for volunteer education. Volunteer training modules were designed using Theological Reflection as the theoretical framework for spiritual care provision. An innovative model for sustainable spiritual care provision in long-term care is proposed, which relies upon leadership from a professional chaplain (staff or volunteer).

KEYWORDS spiritual care, chaplain, volunteer training, Theological Reflection, long-term care

BACKGROUND

The delivery of spiritual care in long-term care is an important aspect of overall care and many institutions are still struggling with how to meet resident needs. This research explores issues of concern to professional chaplains, what happens when volunteers are the default spiritual care providers and how best to provide the kind of sustainable spiritual care that long-term care residents are seeking. In this context, it is understood that the practice

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of professional spiritual care brings together 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.

A gap between the theory and practice of spiritual care was identified in a Southern Ontario municipally funded long-term care home during the initial environmental scan of the Quality Palliative Care in Long Term Care research alliance. Stakeholder interviews revealed concerns over the municipality's reliance upon volunteer spiritual care, provision, scope of practice issues for volunteers, volunteer perception of gaps in spiritual care and concern regarding proselytizing with residents. Also, the home is located in an area that has experienced rapid population growth, with a marked increase in visible minority demographics.

Quality Palliative Care in Long Term Care is a five-year comparative case study research involving four long-term care homes in Ontario, Canada, funded by the Canadian Social Sciences and Humanities Research Council through the Community University Research Alliance Program. The central aim is to improve the quality of life of residents in long-term care homes, through the development of resources and palliative care programs. The Southern Ontario study site home, while well respected for care provided, is situated in a municipality that will not fund a professional chaplain. Community support is strong and spiritual care is delivered through volunteers and area clergy.

Aging Population in Long-Term Care and Need for Spiritual Care

Current research reveals that residents of long-term care facilities are presenting with an increasing complexity of care and an average life expectancy of three to five years (Moser et al., 2003). Residents are generally considered "older, sicker and with more complex care needs" than before (OANHSS Report, 2010, p. 11). Many homes do not adequately meet the needs of dying residents and their families (Wetle, Teno, Shield, Welch, & Miller, 2004) and little is known about spiritual care as part of interdisciplinary care in long-term care (Hamilton, Daaleman, Williams, & Zimmerman, 2009). Interdisciplinary care in long-term care has demonstrated better outcomes for residents, but chaplains are generally missing from the list of professionals working in the field (OANHSS Report, 2010). If, as reported by Shield et al. (2004), one in four Americans are dying in nursing homes, then there is a gap in care regarding the spiritual needs of residents (Edwards, Pang, Shiu, & Chan, 2010).

Nonetheless, a link between spirituality, aging, and palliative care is affirmed in the research (Mowat et al., 2010; Marsten, 2010; Edwards et al., 2010; Bushfield, 2010; Netting, 2010; Goodall, 2009; Stranahan, 2008). The

provision of spiritual care is especially important for older adults living in long-term care as they deal with end of life issues (Luff, Ferreira, & Meyer, 2011; Sinclair, 2011; Edwards et al., 2010; Jolley et al., 2010; Marsten, 2010; Hamilton et al., 2009). The hospice model of palliative care reveals the effectiveness of chaplains in creating meaning for the dying and finding hope in the face of death (Nolan, 2011; Coates, 2010).

Spirituality and meaning-making are considered integral to the major developmental tasks common in older adults. In a United Kingdom research study on spiritual care with dementia residents, Margaret Goodall (2009) found that by designing person-centered interventions that highlighted reflection, relationship, and restoration, they were also meeting the spiritual needs of residents. Studies on the effect of religion on health and coping with life changes acknowledge that religious practice is an important factor that must be taken into account for assessment and treatment and may enhance response to psychotherapy (Koenig, 2009; Wink & Scott, 2005; Pargament, Koenig, & Perez, 2002). Spiritual well-being is now readily acknowledged as an important component of palliative and end-of-life care, with growing attention to issues of cultural diversity (Green, 2009; Puchalski et al., 2009; Bosma, Apland, & Kazanjian, 2008; Heidrich, 2007; Kemp, 2007; Brietbart, 2002). Spiritual care provision, as a distinct professional practice, can address client need to explore religious, spiritual, and existential issues in multiple settings, most notably in long-term care.

Professional Chaplaincy and Delivery of Spiritual Care

Recognition of spiritual care as an element of whole person care has increased alongside a societal shift in understanding how spirituality differs from religion (Puchalski et al., 2009). The interdisciplinary health care field is much attracted to the provision of spiritual care and professional disciplines are examining ways in which spiritual care can be incorporated within their practice competencies. Social workers, nurses, and physicians are increasingly publishing on this topic (Saguil, Fitzpatrick, & Clark, 2011; Burkhart, Schmidt, & Hogan, 2011; Hodge & Horvath, 2011; Baldacchino, 2011; Bursell & Mayers, 2010; Puchalski et al., 2009; Weaver, Koenig, & Flannelly, 2008). The focus is often on creating tools for spiritual care assessments and finding good role models for spiritual care delivery.

However, there are important theoretical, educational, regulatory and scope of practice considerations regarding the provision of spiritual care in a professional context (Nolan, 2011; Mowat et al., 2010; Pesut, Reimer-Kirkham, Sawatzky, Woodland, & Peverall, 2012; Brown, 2010; Kelly, 2010; Carey & Devoren, 2008; Atchley, 2008; Austin, 2006; VandeCreek & Burton, 2001). In most jurisdictions, chaplains or professional spiritual care providers have earned a Master of Divinity or its equivalent before registering for chaplaincy training. While many clergy may receive basic chaplaincy training,

professional chaplaincy requires extensive clinical instruction. The professional chaplain is educated to meet both spiritual and religious needs as part of a relationship-based, whole person care model (Emanuel & Handzo, 2012). Contemporary chaplains also have instruction regarding cultural diversity, multi-faith and secular perspectives. There is a role for chaplains to lead provision of spiritual care for the interdisciplinary team and in volunteer education and management.

Spiritual care is practiced in distinct settings including prison ministry, military chaplaincy, and in clinical locations such as acute care hospitals, hospice, and long-term care homes. The professional training for prison, military, or “clinical” chaplains is the same and relies upon clinical pastoral education. Members of the Canadian Association for Spiritual Care (Canadian Association for Spiritual Care, 2012b) receive training in psychotherapeutic interventions. In some Canadian provinces, regulatory bodies recognize chaplains/spiritual care providers as psychotherapists. Being a professional chaplain or spiritual care provider creates a different relationship as opposed to other health care providers simply because the framework of professional spiritual care competencies incorporates the prophetic, the practice of reverence, the education and skill to discuss theological issues alongside psychotherapeutic modalities.

At the core of spiritual care provision is the creation of genuine trust relationships that help clients face life-changing events by discerning their practical and internal resources. The dynamic of spiritual care provision is in a dialogical process rooted in Theological Reflection as a theoretical framework.

Naturally occurring psychological processes such as end-of-life review is enriched by the meaning-making process integral to spiritual care (Butler, 1963, 1980 in Le Favi & Wessels, 2003). Peter VanKatwyk’s (2003) integrative perspective on “reconstructive communication” suggests that by joining others in a meaning-making process of understanding, new ways of interpreting our experience can emerge; this may include elements of prophetic ministry. Spiritual care has its roots in hermeneutics, the study of biblical texts. In spiritual care, we are all considered as “living human documents” (Boisen, 1936 in O’Connor, 1998, p. 2), full of elements of grace and flaws, open to interpretation. Using a hermeneutical method of theological inquiry in relation to person-centered care generates the potential for individual transformation.

The role of the professional chaplain is not to represent any one particular set of beliefs, but to be present in relationship, to allow the client to explore their concerns and to assess and provide therapeutic spiritual care interventions as needed (Coates, 2010; Bodde, 2008). This perspective is a unique aid for communities where demographic change has added a level of complexity in providing whole person care for minority groups. Being professionally conversant with multiple divinity perspectives, that is,

religious and spiritual outlooks, but not religious and secular outlooks is integral to a chaplain's practice because a client's belief systems, personal narrative, and culture will inform the spiritual care assessment and therapeutic interventions. Allied health professionals rarely have this level of expertise and professional chaplains should be consulted when making assessments within the spiritual care domain. Long-term care homes without a professional chaplain are missing an important element in one-on-one care and supportive community life that effective spiritual care can create.

In general, the theoretical framework for spiritual care is not well understood among health care professionals and administrators of health care facilities immersed in the clinical enterprise of evidence-based care (Berlinger, 2008; deVries, Berlinger, & Cadge, 2008; Jacobs, 2008; Mohrmann, 2008; Smith, 2008). At issue is a genuine understanding of the syncretic aspect of professional spiritual care practice that brings together elements of sacred expression with theoretically grounded therapeutic interventions. Chaplaincy is increasingly claiming the psychotherapeutic role as integral to our professional competencies; this may be a change for administrators used to seeing spiritual care providers as limited to religious support for patients and clients. As such, a comprehensive description of the evolution of Theological Reflection in spiritual care provision is included in the methodology of this research.

THEORETICAL FRAMEWORK: THEOLOGICAL REFLECTION IN PROFESSIONAL SPIRITUAL CARE

Spiritual Care/Chaplaincy as a professional discipline is rooted in the seminal work of theologian Anton Boisen (1876–1965). In the 1920s, his work of challenging seminarians to explore their study of the human experience by thinking theologically represents the beginning of Supervised Pastoral Education (Leas, 2012). Supervised Pastoral Education is the widely adapted model for didactic instruction and clinical training of professional chaplains and pastoral counselors (Canadian Association for Spiritual Care, 2012a; The Association for Clinical Pastoral Education, 2012; Association of Professional Chaplains, 2012; National Association of Catholic Chaplains, 2012; National Association of Jewish Chaplains, 2012).

As a theologian, Boisen was concerned that theology must correlate with lived experience. He drew upon the ideas of Friedrich Schleiermacher, a late eighteenth-century theologian regarded as the founder of Practical Theology and modern hermeneutics (Osmer, 2008). By using theology in the listening to and telling of the client's story, Boisen saw therapeutic benefit. Both client and chaplain are seen, in Boisen's language, as texts or "living human documents" (Boisen, 1936 in O'Connor, 1998, p. 2), akin to the Bible and open to interpretation. He envisioned the provision of spiritual care as

a therapeutic process, amalgamating the care of both acute mental health and spiritual difficulties into a theological methodology by conceptualizing the person as text, equally imbued with sin and grace. Boisen believed that the care of the soul can begin in a traumatic event and he pioneered “narrative therapy” as a kind of therapeutic “God-talk” (Leas, 2012). An early proponent of what evolved into case study methodology, Boisen educated clergy for pastoral ministry through the analysis of case records of psychiatric patients to understand the religious meanings of mental illness (VanKatwyk, 2003).

This framework helped to shape the Supervised Pastoral Education streams of Clinical Pastoral Education and Pastoral Counseling Education as an experiential adult-learning model for professional practice. Although initially founded on Christian theology, Supervised Pastoral Education is actively inclusive of diverse religious, spiritual, cultural, and gender identities. Professional chaplains and pastoral counselors must have their own formalized faith affiliation but they may or may not be ordained. They maintain unconditional positive regard for the personal views of their clients, including individuals who hold religious, spiritual, or secular perspectives.

Supervised Pastoral Education is a syncretic melding of didactic and supervised clinical work covering the span of theological, psychotherapeutic, social sciences, ethical, and interdisciplinary models. In short, Supervised Pastoral Education is a formalized application of practical theology (O’Connor, 1998). Contrasting with academic or fundamental theology and church-rooted systematic theology, practical theology deals with the praxis of ministry. The emphasis is on transformation as the result of critical reflection upon the intersections between theory and ministry practice.

Theological Reflection is a distinct element of professional self-reflection in the ethical practice of spiritual care. The narrative thread of inquiry within theological reflection aspires to articulate an alternate vision of reality within the story told by the “other.” Both the client and care provider can be enriched through the therapeutic relationship as self-reflection on the ministry encounter is open to transformative new insights (Aten & Leach, 2009; Williams, Teasdale, Segal, & Kabat-Zim, 2007; Pargament, 2007).

The incarnational theology of chaplain and Clinical Pastoral Education instructor Charles Gerkin (1989) incorporates Hans-Georg Gadamer’s philosophical hermeneutics (1975) as a central dynamic in the praxis of spiritual care (O’Connor, 1998). Praxis incorporates the idea that spiritual care is imbued with meaning, not just applied theory. Taking Gadamer’s metaphor of “horizon of meaning,” Gerkin’s understanding of practical theology integrated the dialogical interchange between client and caregiver as a fusion of horizons that yields new meanings. He sculpted deeper significance

from Boisen's understanding of the living human document to extrapolate that the spiritual care conversation is imbued with theological meaning and open to interpretation. Gerkin evolves Paul Ricoeur's hermeneutic of understanding/explaining/understanding as an instrument to fathom ministry practice into praxis/theory/praxis (O'Connor, 1998). The goal is to transform the encounter into a new praxis.

Using transformative Theological Reflection as a theoretical framework for qualitative investigation is becoming established in spiritual care research. A recent study by Harriet Mowat et al. (2010) used this same methodology to explore a group approach for chaplains working to provide effective spiritual care for older people. By integrating Gadamer's fusion of horizons with Gerkin's work on reflective tasks (1989), Mowat determined that a major task for chaplaincy is to help older individuals in their adaptive processes through focus on the underlying meaning of their life journey.

This informs a growing consensus that for the aging population, for those suffering from dementia and for those living in long-term care, the provision of spiritual care is relationship based (Mowat et al., 2010; Edwards et al., 2010; Goodall, 2009). The hermeneutics of ministry praxis and transformative Theological Reflection addresses the relational stance of spiritual care provision with older individuals and professional chaplains are best trained to provide that care.

METHODOLOGY

Design

This research incorporated case study methodology that is considered appropriate for investigations in long-term care (Luff et al., 2011; Moriarty, 2011). L. Brown (2010) affirms the common usage of case study in chaplaincy research as a means to strengthen professional practice, to connect theory with theology and facilitate the development of models that show the efficacy of spiritual care. Several authors advocate case study research in chaplaincy to demonstrate how spiritual care can make a difference in health-care settings and as a means to connect with other health-care professionals (Fitchett, 2011; O'Connor, 2006; O'Connor & Meakes, 1998).

This study involved three distinct phases of investigation in one facility; the long-term care home was considered as the unit of analysis. Undergirded by the theological framework for spiritual care, the capacity development process involved sequential steps, which focused on the following:

- Stakeholder focus group and thematic analysis of central concerns;
- Scope of practice and regulatory concerns for spiritual care volunteers; and
- Training of long-term care volunteers in spiritual caregiving skills and diversity sensitivity.

Setting

The study site for this research was an accredited long-term care home with 200 beds, providing permanent working teams with around-the-clock nursing and medical services, and social, therapeutic, and nutritional care to residents in a town with a population of less than 100,000. The home is funded by the municipality and spiritual care is provided by volunteers and area clergy.

The town has recently undergone substantial demographic changes; there was a 71% increase in population between 2001 and 2006 and growth of another 64% in 2011. A noteworthy 80% of new residents since the 2006 census have been from visible minorities (Statistics Canada, 2011). To date, few diversity or culturally-related issues have arisen in the home; however, a shift in their resident demographics is considered inevitable (Jovanovic, 2012).

In 2008, the volunteer chaplain resigned after receiving a parish appointment. Considerable tension arose for the home's administration between stakeholder groups when the home's application to fund a professional chaplain was refused by the municipality. Spiritual care provision has been covered by volunteers since that time. Three identified spiritual care volunteers with backgrounds in lay ministry visit on a one-on-one basis with residents and also lead worship-related activities. A lead volunteer supports 18 palliative care volunteers, many of whom attend monthly "Comfort Rounds" debriefing meetings with frontline staff.

Resident religious demographics are primarily Protestant, Catholic, Evangelical Christian, or no expressed faith allegiance. Area clergy support weekly worship and visit congregants living in the home.

Gaps in Spiritual Care at the Study Site

Issues regarding the provision of spiritual care emerged in the project's 2009 environmental scan. There was a general consensus that the provision of spiritual care was inadequate since the volunteer chaplain departed. In 2011, the project's professional chaplain researcher identified further gaps in the provision of spiritual care:

- Lack of oversight, training, and support for spiritual care volunteers
- Concern expressed by family members regarding proselytizing by volunteers
- Oversubscription of limited spiritual care volunteers resulting in burnout
- Internal communications issues, volunteers acting independently, no documentation of visits, and uninformed about resident deaths
- Portering wait times and length of worship services overextended fragile residents
- Lack of training regarding emergent diversity issues for staff and volunteers

Phase 1: Think Tank

In Phase 1, the sample group was a collaborative think tank that included the home's administrator, a spiritual care and a palliative care volunteer, members of the Ontario Multifaith Council (2012), and the project's chaplain researcher and knowledge broker. The Ontario Multifaith Council was identified early in the project as a community partner as it is legislated to provide support in long-term care. Additional concerns emerged through the Phase 1 consultation, as follows:

- Recent resident satisfaction survey top concerns: access to privacy and access to one-on-one spiritual care;
- Resident end-of-life issues and life review/spirituality issues that go unaddressed;
- Need for specialized volunteer training and support to provide spiritual care for residents with advanced dementia and for the dying; and
- Forthcoming provincial regulation to govern spiritual care therapeutic interventions and volunteer scope of practice limitations.

Phase 1 Results

The think tank group decided that a focus group with the home's spiritual care and palliative care volunteers was needed to further elucidate volunteer understanding of their roles, resources, and need for education.

Co-investigators emphasized the need to structure a formalized research process that included rigorous documentation, ethical approval, and evaluation so results could be transferrable to other long-term care homes. A literature search was undertaken and a working group included the home's administrator, chaplain researcher, knowledge broker, and an Ontario Multifaith Council chaplaincy consultant/trainer. Their tasks were to oversee Phases 2 and 3 of the study, in consultation with the co-investigators.

Phase 2: Focus Group

A full needs assessment was conducted with spiritual care and palliative care volunteers in a focus group luncheon at the home. The sample group for Phase 2 included:

- Four palliative care volunteers;
- Two spiritual care volunteers; and
- Two volunteers for worship services.

The eight participants were asked about their understanding of their volunteer role, to share stories of providing spiritual and palliative care in the home, to identify the resources they needed, their coping strategies, and

the kind of support of assistance they require. They were also asked about the kinds of education they thought they needed and how it could best be delivered to them.

Themes From Focus Group Transcript

The transcript from the focus group was assessed using a spiritual care theoretical perspective. Volunteers demonstrated clear role definition as supportive of residents and their families, especially as death approaches:

I see our role in comforting the resident and family and/or family in their journey towards death. Just being there, our presence is invaluable.

They considered their coping skills as quite good: “We’re okay with what we do or we wouldn’t do it” and they had questions about providing spiritual care that was respectful and informed regarding other faith traditions:

Maybe a more generalized kind of spiritual training where it would encompass all faiths [yeah] would be more beneficial in this day and age is more of a multicultural place than it used to be.

A need for specific spiritual care education was repeated:

More spiritual than religious [yes, that’s it] . . . you are right that kind of nuts and bolts would be helpful; this will be spiritual care in addition to the palliative care; Kind of a general social theology [yes, yes] that would be helpful . . . that’s a systems piece that we can um, you know, put forward, that would be helpful; Another resource is courses, I mean we have all taken courses but after 10 or 15 years it’s time for a refresher . . . offering a spiritual care course . . . because it’s been about 20 years since I’ve had mine.

They also expressed concern for recognizing and helping with staff grief:

. . . the staff here has become friends with the residents . . . and the whole experience for them is traumatic as well; and I think the staff is amazing here, welcoming volunteers no matter what role we are going for.

Repeated concern arose over how death is communicated internally in the home:

That communication piece of who is actively dying or you know, approaching the end, communication around that hasn’t typically been happening here; That’s part of our problem too, um, we’ll come in on

a Sunday morning and that person will pass and we won't know, and it might have been that very morning, so then it catches us unaware. [yeah] It's hard, it's hard, yeah. So you feel like you have been left out.

Phase 2 Results

Analysis of quotes from the transcript demonstrated volunteer requests for support from a full-time chaplain, for “nuts and bolts” spiritual care education, for training in all faiths and cultural diversity, and having more volunteers and concern over internal communication issues regarding resident death. Two training modules were designed to meet the expressed need of participants in the focus group and items that were previously identified as gaps in spiritual care provision.

Phase 3 Training Modules and Evaluation

The training sessions were held one week apart at the home, attended by three spiritual care and four palliative care volunteers. Of the seven who attended, 70% also participated in the Phase 2 Focus Group as well.

The first week's presentation covered “Enhancing Cultural and Religious Sensitivity, Diversity Issues.” Canadian and local demographic changes, education regarding diversity, power, and privilege were covered alongside non-discrimination policy. Openness to others was stressed within a context of non-proselytization and creating a non-anxious caregiver presence.

The second week presented on “Volunteer Spiritual Support Skills in Long-Term Care.” The history, meaning and theology of spiritual care in long-term care were introduced in the context of long-term care regulatory requirements. Understanding the difference between volunteer spiritual support and professional spiritual care was emphasized in the training.

Resident-centered helping skills were taught from the perspective of client-centered care (Rogers in Kirschenbaum & Henderson, 1989) and family systems theory (Friedman, 1985). Self-reflection on ministry practice was introduced as a key component of self-care and prevention of compassion fatigue. Volunteer identity in the caregiving team, prayer, and responses to grief and loss were also covered. The proposal for Spiritual Care Circles was also presented at this session, in order to ascertain volunteer feedback on how this may assist them in providing spiritual support for residents.

Phase 3 Results

Expectations of the training were met or exceeded in session two for all participants and for half of the participants in session one. One volunteer did not submit an evaluation for the first session. The information presented in

session two was considered organized, meaningful, relevant and well understood by all participants. For the first session on diversity issues, participants commented that they needed more practical information that they could apply in their volunteering.

Volunteer written responses from the first session regarding impact for their future caregiving included:

I think that the training affirmed my practice of the past 20 years.
I was trained to be open to all but would like to learn more about other faiths.
Probably will include more consideration to resident's spiritual needs.

For the second session, volunteers responded:

More thoughtful before going into a room.
More listening and less passing judgment about residents or trying to problem solve residents issues.
Yes, I will approach them more confidently with the information I received in both sessions.

Overall, 80% of the participants were satisfied with the presentations and comments regarding the Spiritual Care Circle were all positive; some wanted to know how soon it would be implemented for the home.

MODEL FOR SUSTAINABLE SPIRITUAL CARE IN LONG-TERM CARE

Developed out of the phased investigations at the study site, a model is suggested for sustainable delivery of spiritual care in long-term care homes.

The model, as illustrated in Figure 1, relies on three interconnecting elements to provide comprehensive spiritual care for long-term care communities. The model encapsulates the different processes involved: volunteer training plus regular oversight and support from an internal Spiritual Care Circle, complimented by a community-based Pastoral Support Committee.

Spiritual Care Circle

The design suggested for Spiritual Care Circles (see Figure 2) brings spiritual care theory and practice together through consultation. Led by a professional chaplain (volunteer or staff), the regular monthly meetings will be an opportunity for trained spiritual support volunteers and staff to examine their pastoral encounters with residents. Meetings are held in a "rounds" format to discuss the active caregiving issues that arise for the spiritual support volunteers. By instituting regular dialogical explorations of care provided,



FIGURE 1 Training and sustaining model for spiritual care in long-term care.

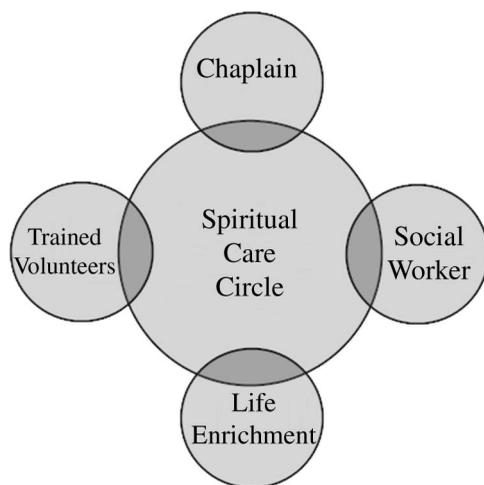


FIGURE 2 Spiritual Care Circle.

volunteers will deepen their relationships with the long-term care population, support spiritual and religious needs of residents and their families, and possibly assist as palliation draws near. Having a consistent consultative group that meets regularly and is focused on provision of spiritual care should meet the need for appropriate volunteer oversight.

Spiritual Care Circles can also support the volunteers with leadership from a professional chaplain and include a measure of self-care for volunteers, an aid to volunteer retention (Scott & Howlett, 2009). Ongoing education regarding enhanced spiritual care skills could also be offered at these sessions. This group would be bound by scope of practice,

ethical and confidentiality requirements regarding the residents they provide care for.

The need to assess appropriate boundaries for volunteers is an important consideration and central to any training provided. Legislation regarding therapeutic spiritual care interventions in Ontario, Canada, is forthcoming as part of a Registered College of Psychotherapists (Transitional Council of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario, 2012). Under the Ontario Psychotherapy Act (2007), the practice of psychotherapy (psychologists, chaplains, pastoral counselors, family and marital counselors, etc.) will adhere to a competency model for registration. This means all who engage in providing spiritual care psychotherapy, whether working in a volunteer capacity or as a paid professional, must hold membership in the Registered College.

Consequently, the model requires a lead professional chaplain who is trained in the kinds of spiritual issues that arise for residents living in long-term care homes; someone who can respond to volunteers through practical knowledge of spiritual care therapeutic interventions and professional competency requirements.

Volunteers may still provide spiritual support in a pastoral helping context and not require membership in a regulatory body; however, appropriate oversight and support for volunteers is essential. Certified spiritual care professionals possess the knowledge, skills, judgment, and experience to facilitate a spiritual care program, program quality assurance, spiritual care provision, and ongoing professional development (Canadian Association for Spiritual Care, 2012b).

Bringing both social workers and chaplains together at the table could be very workable for municipally funded homes that do not employ chaplains. In particular, any resident need for counseling could be identified by the volunteers and brought forward to the social work coordinator for psychotherapeutic referral.

The chaplain position on the Spiritual Care Circle is one that could be advertised for as a volunteer position, so the home would be assured of finding someone who would be well-trained, experienced, and dedicated to participation with this group. The home's administrator would require a line function oversight of the chaplain volunteer with a periodic performance review.

Of course, in homes where chaplaincy is fully funded and part of the interdisciplinary care team, this model is also a useful means to retain and support volunteers active in spiritual and religious care. As issues of religious and cultural diversity arise within long-term care settings, Spiritual Care Circles could actively identify resources for volunteers and staff so optimal care is provided within the home, care that is respectful of different cultural backgrounds and faith perspectives.

Volunteer Training

As part of full protection for the public and especially for elderly and vulnerable residents living in long-term care, volunteers require specific training for visiting. The training included in the Quality Palliative Care in Long Term Care toolkit includes three sessions for volunteers which address:

1. History, Meaning and Theology of Spiritual Care in Long-Term Care
 - Protection of the public and regulatory issues
 - Model for spiritual care in long-term care
 - Volunteer identity in the caregiving team
2. Building Spiritual Caregiving Skills for Volunteers
 - Family systems theory and client-centred care
 - Visiting ministry skills (active listening, empathy, prayer)
 - End-of-life issues for long-term care residents
 - Compassion fatigue and self-reflection on ministry practice
3. Culturally Sensitive Care and Communications
 - Power differentials
 - Faith/cultural fact sheets

Pastoral Support Committee

In most long-term care homes, area clergy are active in leading worship services and visiting their congregants who live in the home. Community support for the religious and spiritual care needs of long-term care residents must also be coordinated for the overall delivery of effective spiritual care.

The Pastoral Support Committee is a community-based group that promotes inclusive spiritual and religious care for the home's residents and family members. It is comprised of a resident from the home and the Life Enrichment Supervisor, spiritual care volunteers who lead regular worship services as well as representatives from the local faith communities, including clergy and pastoral care providers. The volunteer professional chaplain may or may not participate, depending upon his or her level of involvement, and the staff chaplain certainly would participate. The Pastoral Support Committee is accountable to the home's administrator.

In the study site home, a special effort was made to include visible minorities and diverse faith expressions, in recognition of local demographic changes. Also, the designated Ontario Multifaith Council regional manager participates to further guide diversity awareness in the home. This group meets quarterly and is chaired by a member of the local ministerial group.

The Pastoral Support Committee could be an effective source for recruiting new spiritual support volunteers from the community. These volunteers, once trained, would increase the number of one-on-one spiritual support

visits with residents and also receive support and oversight through the Spiritual Care Circle. Pastoral visiting in faith communities would also benefit from members trained in spiritual care. It is hoped that these three different components—volunteer training, the Spiritual Care Circle, and the Pastoral Support Committee—will provide long-term care homes with comprehensive spiritual care for their residents.

DISCUSSION

The phased investigative process of this research was in itself a kind of self-reflection on spiritual care practice in the study site long-term care home. By engaging stakeholder voices in interviews, think tank consultation, focus group and evaluation of formalized training, a praxis/theory/praxis hermeneutic was invoked.

The data gleaned from this process yielded a clearer understanding of the gaps in spiritual care provision at the long-term care home. It was important that volunteers themselves were engaged through a formalized research process to identify what they saw as needed for spiritual care in the home. Feedback from the focus group and thematic analysis of the transcript helped to create training that was undergirded by the spiritual care theological framework. Participants in the Spiritual Care Skills and Diversity training appreciated the practical skills and education about the history, theory, and theology of spiritual care. They requested more information regarding specific faith and cultural issues for long-term care. The Spiritual Care Circle was readily understood by participants.

Spiritual Care Circles as Best Fit for Long-Term Care

The “rounds” approach is a familiar and effective model in care-providing institutions such as hospice and acute care hospitals. The study site already has good experience integrating its palliative care volunteers in their monthly Comfort Care Rounds.

As many volunteers are attracted to pastoral work because of their own faith values, ongoing education with a professional chaplain will eliminate any hint of religious proselytization. Better understanding of the care they are providing will also aid in referrals for counseling and support expressed resident need for one-on-one spiritual care more effectively. The Spiritual Care Circle will also minimize risk to residents and ensure full protection for their privacy. They are a vulnerable population and may share personal information while discussing their end-of-life issues.

Volunteers may gain appropriate oversight and support, which encourages volunteer retention and better understanding of their role. They will also be encouraged to practice self-care. Training can protect volunteers from

going beyond regulatory and scope of practice boundaries regarding spiritual care therapeutic interventions. Professional staff involvement in the Spiritual Care Circles will also help identify referrals for residents who may need psychotherapeutic counseling. This paradigm may also be implemented in municipalities that are experiencing rapid demographic changes; being able to meet the spiritual care needs of visible minorities may pose a challenge for some communities.

Having a close link to local faith communities through the Pastoral Support Committee can keep the long-term care home current with fresh volunteers who can also make use of the long-term care training to work in their own parish visiting programs. The inclusion of diversity awareness will help overall integration in the community for visible minorities and hopefully minimize cultural misunderstandings in the long-term care home.

Limitations

In Ontario, Canada, privately funded and faith-based long-term care homes generally make provision for chaplaincy. The Quality Palliative Care in Long Term Care research (Palliative Alliance, 2013a) has demonstrated that funding models for long-term care homes in Ontario has left some municipalities in a position of having to choose between having a social worker or a professional chaplain. The northern study site homes are faith-based and have chaplains on staff; however, they struggle with aspects of providing social work, while the opposite was found in the two southern study site homes.

The Spiritual Care Circle requires a professional chaplain as volunteer oversight and support needs to reflect the ideology and ethical practice of spiritual care in long-term care, something professional spiritual care providers are trained to do. It is hoped that through the volunteer contribution of a professional chaplain's time, municipally managed long-term care homes may be able to provide for the spiritual care needs of their residents, although this is not the ideal.

The model is exclusive of staff needs for spiritual care and support, something which the staff of this study site were accustomed to with their former volunteer chaplain. Also, there is no chaplaincy presence on the interdisciplinary care team; in acute care institutions, spiritual care involvement in interdisciplinary care is a proven commodity (Burkhart et al., 2011; Nolan, 2011; Bursell & Mayers, 2010; Mowat et al., 2010; Pesut et al., 2012; Carey & Davoren, 2008; Atchley, 2008; Austin, 2006; VandeCreek & Burton, 2001).

CONCLUSION

A practical toolkit for use in long-term care homes was created using a Spiritual Care Circle, volunteer training and a Pastoral Support Committee as

an inter-functioning model to assist long-term care homes (especially those with no funding for a professional chaplain) to provide spiritual and religious care for their residents (Palliative Alliance, 2013b). This spiritual care sub-study was looking for a “direct practice intervention” (Netting, 2010) that would be responsive to the identified gaps in spiritual care for the group to whom this mattered the most—the long-term care residents. In attending to the beliefs, values, and observations of current spiritual care and palliative care volunteers in the home, a capacity development initiative based upon spiritual care ideology, ethical, and regulatory considerations endeavored to meet their expressed needs. The training provided for volunteers as part of this research made clear delineation between what a spiritual support volunteer offers for residents and what a professional chaplain can provide.

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