# NURTURING EASE:
## A HOLISTIC DESIGN APPROACH FOR HOSPICES IN ONTARIO

by
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presented to the University of Waterloo
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thesis requirement for the degree of
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# AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

# ABSTRACT

We all encounter death in life. For those facing terminal illness, having agency to prepare for the end-of-life or the loss of a loved one is a deeply personal and profound experience. Hospice aims to provide a comforting and peaceful environment for individuals and their loved ones during this final phase of life, an alternative to the home or hospital. This thesis focuses on establishing a holistic approach to hospice design, building upon existing compassionate architecture and evidence-based practices to prioritize human experience and create opportunities for meaningful moments of connection - with oneself, loved ones, and community.

This thesis integrates literature reviews, case studies, and fieldwork conducted in the Region of Waterloo to inform the architectural brief and kit of parts that shape the design proposal. Literature reviews on biophilic design and evidence-based design considerations for care environments, and case studies of hospice and adjacent residential-healthcare typologies in an international context serve as a basis for approaching hospice design. This is further contextualized to Ontario through an architectural catalogue of hospices across the province and fieldwork insights from care providers and staff of hospices in the Region of Waterloo, offering perspectives beyond what is prescribed in the current design standards informing hospice design in the province.

Ultimately, this thesis seeks to define a holistic design approach for hospice residences in Ontario, one that prioritizes human experience and contributes to the growing body of international research on hospice architecture. Through this, it establishes a practical design guide that enriches the spatial requirements for future hospices in the province, fostering environments where the final moments of life are supported with sensitivity and compassion.

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# TABLE OF CONTENTS

III AUTHOR'S DECLARATION
V ABSTRACT
VII ACKNOWLEDGEMENTS
XI LIST OF FIGURES
XXI PREFACE

1 1. INTRODUCTION
1 1.1 HOSPICE IN CANADA: AN OVERVIEW
14 1.2 THESIS OVERVIEW

17 2. HUMAN EXPERIENCE AT THE END-OF-LIFE
21 2.1 LANGUAGE, METAPHORS, AND RITUALS OF DEATH AND DYING
24 2.2 THE ETHICS OF CARE AND ARCHITECTURE
28 2.3 KEY OCCUPANTS IN HOSPICE
35 2.4 EMBODIED EXPERIENCE OF SPACE
36 2.5 HOSPICE AS HOME
39 2.6 CONCLUSION

41 3. EVIDENCE-BASED DESIGN CONSIDERATIONS
43 3.1 A STRONG CONNECTION TO NATURE
45 3.2 BALANCING PRIVACY AND COMMUNAL SPACES
47 3.3 ADAPTABILITY, PERSONALIZATION, AND MULTI-FUNCTIONALITY OF SPACE
48 3.4 THE IMPORTANCE OF ACCESSIBILITY AND EASE OF MOVEMENT IN SPACE
51 3.5 FOSTERING A SENSE OF HOME/EASE/DOMESTICITY THROUGH DESIGN
54 3.6 CONCLUSION

57 4. PRECEDENTS FOR A HOLISTIC DESIGN APPROACH
57 4.1 THE SPATIALIZATION OF HOSPICE:
62 4.2 ADJACENT ARCHITECTURAL TYPOLOGIES/CASE STUDIES
68 4.3 SELECTED HOSPICE DESIGN GUIDELINES
71 4.4 CONCLUSION

**73 5. SITE CONSIDERATIONS FOR HOSPICE**
73 5.1 SITE SELECTION
76 5.2 SITE PLANNING
81 5.3 CONCLUSION

**83 6. CATALOGUE OF RESIDENCES**
85 6.1 PROVINCIAL OVERVIEW
87 6.2 METHOD OF CATEGORIZATION - SITE TYPES
89 6.3 TYPES OF HOSPICE RESIDENCES
91 6.4 CATALOGUE OF RESIDENCES
94 6.5 REGIONS WITH MULTIPLE HOSPICES
119 6.6 FIELDWORK-BASED CASE STUDY: WATERLOO REGION
127 6.7 CONCLUSION

**129 7. ARCHITECTURAL BRIEF**
129 7.1 VALUE OF THE BRIEF
131 7.2 SPATIAL REQUIREMENTS FOR HOSPICE
142 7.3 THE BRIEF: A HOLISTIC DESIGN APPROACH TO HOSPICE

**145 8. SITE & CONTEXT**
149 8.1 SITE ANALYSIS

**153 9. DESIGN PROPOSAL**

**199 10. CONCLUSION**

**203 BIBLIOGRAPHY**
**214 APPENDIX**

# LIST OF FIGURES

## 1. INTRODUCTION

1 **Figure 1.1 St. Christopher's Hospice**
*By Stephen Craven. Retrieved from https://commons.wikimedia.org/wiki/File:St._Christopher%27s_Hospice.jpg*

2 **Figure 1.2 Connecticut Hospice**
*Screenshot by author, from Google Maps.*

2 **Figure 1.3 Royal Victoria Hospital**
*By D. Benjamin Miller. Retrieved from https://commons.wikimedia.org/wiki/File:Old_Royal_Victoria_Hospital_Entrance,_August_31,_2022.jpg*

5 **Figure 1.4 Timeline of key events**
*By Author, November 2024.*

8 **Figure 1.5 Patients identified as palliative, by care setting, 2020-2022**
*By Author, November 2024. Redrawn Figure 1 from Access to Palliative Care in Canada, 2023.*

10 **Figure 1.6 Leading causes of death, 2022**
*By Author, November 2024. Retrieved from https://www150.statcan.gc.ca/n1/daily-quotidien/231127/t001b-eng.htm*

11 **Figure 1.7 Population projections by age demographics**
*By Author, November 2024. Retrieved from https://www150.statcan.gc.ca/n1/pub/71-607-x/71-607-x2022015-eng.htm*

## 2. HUMAN EXPERIENCE AT THE END OF LIFE

19 **Figure 2.1 5 stages of grief: denial, anger, bargaining, depression, acceptance**
*By Author, November 2024. Redrawn from On Death & Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, & Their Own Families by Elisabeth Kubler-Ross, p.251.*

28 **Figure 2.2 Collaborative circle of care**
*By Author, November 2024.*

## 3. EVIDENCE BASED DESIGN CONSIDERATIONS

41 **Figure 3.1 Paimio Sanatorium**
*By Leon Liao. Retrieved from https://commons.wikimedia.org/wiki/Category:Paimio_Sanatorium#/media/File:Paimio_Sanatorium3.jpg*

41 **Figure 3.2 Colour scheme plan of the sanatorium by Eino Kauria**
*By Author, November 2024. Retrieved from https://www.alvaraalto.fi/en/architecture/paimio-sanatorium/*

43 **Figure 3.3 Direct and indirect encounters with nature**
*By Author, November 2024.*

## 4. PRECEDENTS FOR A HOLISTIC DESIGN APPROACH

58 **Figure 4.1 Maggie's, Nottingham**
*By Russ Hamer. Retrieved from https://commons.wikimedia.org/wiki/File:Maggies_Cancer_Care_Center_at_Nottingham_City_Hospital.JPG*

58 **Figure 4.2 Maggie's, Hong Kong**
*R.L. Phongkong. Retrieved from https://commons.wikimedia.org/wiki/File:Rlp_maggies_cancer_caring_centre.jpg*

58 **Figure 4.3 Maggie's, Cardiff**
*No Swan So Fine. Retrieved from https://commons.wikimedia.org/wiki/File:Maggie%E2%80%99s_Centre,_Cardiff,_April_2020_01.jpg*

60 **Figure 4.4 Hospital room**
*Retrieved from https://pikwizard.com/photo/empty-hospital-ward-with-beds-and-medical-equipment/eabb2f365631393cd3c1e22f86fc1c3f/*

60 **Figure 4.5 Hospice room**
*By Author, May 2024.*

63 **Figure 4.6 Princess Margaret Cancer Centre, by Hariri Pontarini Architects**
*By Author, November 2024.*

64 **Figure 4.7 Ronald McDonald House BC & Yukon, by MGA**
*By Author, November 2024.*

65 **Figure 4.8 Cabot Cliffs, by Fowler Bauld & Mitchell Ltd.**
*By Author, November 2024.*

66 **Figure 4.9 The Panorama, by ACDF Architecture**
*By Author, November 2024.*

67 **Figure 4.10 Village Langley, by NSDA Architects**
*By Author, November 2024.*

70 **Figure 4.11 Design with dignity vignette, p11**
*Screenshot by author, from https://hospicefoundation.ie/wp-content/uploads/2022/05/Design-Dignity-Guidelines-for-Physical-Environments-of-Hospitals-Supporting-End-of-Life-Care.pdf*

70 **Figure 4.12 Design with dignity vignette, p13**
*Screenshot by author, from https://hospicefoundation.ie/wp-content/uploads/2022/05/Design-Dignity-Guidelines-for-Physical-Environments-of-Hospitals-Supporting-End-of-Life-Care.pdf*

## 5. SITE CONSIDERATIONS FOR HOSPICE

79 **Figure 5.1 Outdoor seating near parking lot, HWR**
*By Author, May 2024.*

80 **Figure 5.2 Gosling Pollinator Garden, Hospice Wellington**
*Screenshot by author, from Google Maps.*

## 6. CATALOGUE OF RESIDENCES

84 **Figure 6.1 Ontario Health atHome regional map**
*By Author, November 2024. Redrawn from https://ontariohealthathome.ca/find-my-hccss/*

86 **Figure 6.2 Population density map of Ontario, 2022**
*By Author, November 2024. Redrawn from https://commons.wikimedia.org/wiki/File:Ontario_Population_Density_2021.svg*

86 **Figure 6.3 Network of hospice residences in Ontario, 2024**
*By Author, February 2024.*

91 **Figure 6.4 Network of hospice residences in Ontario, 2024**
*By Author, February 2024.*

92 **Figure 6.5 Distribution of hospices by building type**
*By Author, February 2024.*

92 **Figure 6.6 Existing vs new buildings**
*By Author, February 2024.*

92 **Figure 6.7 Emergence of hospice residences in Ontario**
*By Author, February 2024.*

93 **Figure 6.8 Distribution of hospices by adjacency**
*By Author, February 2024.*

93 **Figure 6.9 Rural vs urban hospices**
*By Author, February 2024.*

93 **Figure 6.10 # of beds per hospice**
*By Author, February 2024.*

94 **Figure 6.11 Regions with multiple hospices**
*By Author, February 2024.*

96 **Figure 6.12 Hospice Georgian Triangle - Campbell House**
*By Author, November 2024.*

96 **Figure 6.13 240 Erie St, Collingwood, ON L9Y 0X8**
*Screenshot by author, from Google Maps.*

96 **Figure 6.14 Hospice Simcoe**
*By Author, November 2024.*

96 **Figure 6.15 336 Penetanguishene Rd, Barrie, ON L4M 7C2**
*Screenshot by author, from Google Maps.*

96 **Figure 6.16 Matthews House Hospice**
*By Author, November 2024.*

96 **Figure 6.17 131 Wellington St E, Alliston, ON L9R 1G7**
*Screenshot by author, from Google Maps.*

98 **Figure 6.18 Mariposa House Hospice**
*By Author, November 2024.*

98 **Figure 6.19 1140 Brodie Dr, Severn, ON L3V 0V2**
*Screenshot by author, from Google Maps.*

98 **Figure 6.20 Hospice Huronia - Tomkins House**
*By Author, November 2024.*

98 **Figure 6.21 948 Fuller Ave, Penetanguishene, ON L9M 1G7**
*Screenshot by author, from Google Maps.*

100 **Figure 6.22 Casey House Hospice**
*By Author, November 2024.*

100 **Figure 6.23 119 Isabella St, Toronto, ON M4Y 1P2**
*Screenshot by author, from Google Maps.*

100 **Figure 6.24 Kensington Hospice**
*By Author, November 2024.*

100 **Figure 6.25 38 Major St, Toronto, ON M5S 2L1**
*Screenshot by author, from Google Maps.*

100 **Figure 6.26 Emily's House**
*By Author, November 2024.*

100 **Figure 6.27 45 Jack Layton Way, Toronto, ON M4M 0B7**
*Screenshot by author, from Google Maps.*

101 **Figure 6.28 Journey Home Hospice**
*By Author, November 2024.*

101 **Figure 6.29 90 Shuter St, Toronto, ON M5B 2K6**
*Screenshot by author, from Google Maps.*

102 **Figure 6.30 John Gordon Home**
*By Author, November 2024.*

102 **Figure 6.31 596 Pall Mall St, London, ON N5Y 2Z8**
*Screenshot by author, from Google Maps.*

102 **Figure 6.32 St. Joseph's Hospice of London**
*By Author, November 2024.*

102 **Figure 6.33 485 Windermere Rd, London, ON N5X 2T1**
*Screenshot by author, from Google Maps.*

104 **Figure 6.34 Ian Anderson House**
*By Author, November 2024.*

104 **Figure 6.35 430 Winston Churchill Blvd, Oakville, ON L6J 7X2**
*Screenshot by author, from Google Maps.*

104 **Figure 6.36 Carpenter Hospice**
*By Author, November 2024.*

104 **Figure 6.37 2250 Parkway Dr, Burlington, ON L7P 1T1**
*Screenshot by author, from Google Maps.*

104 **Figure 6.38 The Darling Home for Kids**
*By Author, November 2024.*

104 **Figure 6.39 5657 15 Side Rd, Milton, ON L9T 2X7**
*Screenshot by author, from Google Maps.*

106 **Figure 6.40 Emmanuel House Hospice**
*By Author, November 2024.*

106 **Figure 6.41 90 Stinson St, Hamilton, ON L8N 1S2**
*Screenshot by author, from Google Maps.*

106 **Figure 6.42 Dr. Bob Kemp House**
*By Author, November 2024.*

106 **Figure 6.43 277 Stone Church Rd E, Hamilton, ON L9B 1B1**
*Screenshot by author, from Google Maps.*

106 **Figure 6.44 Margaret's Place Hospice**
*By Author, November 2024.*

106 **Figure 6.45 170 Ogilvie St, Hamilton, ON L9H 3M4**
*Screenshot by author, from Google Maps.*

108 **Figure 6.46 Lisaard House**
*By Author, November 2024.*

108 **Figure 6.47 990 Speedsville Rd, Cambridge, ON N3H 4R6**
*Screenshot by author, from Google Maps.*

108 **Figure 6.48 Innisfree House**
*By Author, November 2024.*

108 **Figure 6.49 2375 Homer Watson Blvd, Kitchener, ON N2P 0E9**
*Screenshot by author, from Google Maps.*

108 **Figure 6.50 Hospice Waterloo Region**
*By Author, November 2024.*

108 **Figure 6.51 100 Solstice Way, Waterloo, ON N2K 0G3**
*Screenshot by author, from Google Maps.*

110 **Figure 6.52 The Ottawa Mission - Diane Morrison Hospice**
*By Author, November 2024.*

110 **Figure 6.53 35 Waller St, Ottawa, ON K1N 7G4**
*Screenshot by author, from Google Maps.*

110 **Figure 6.54 May Court Hospice**
*By Author, November 2024.*

110 **Figure 6.55 114 Cameron Ave, Ottawa, ON K1S 0X1**
*Screenshot by author, from Google Maps.*

110 **Figure 6.56 Roger Neilson House**
*By Author, November 2024.*

110 **Figure 6.57 399 Smyth Rd, Ottawa, ON K1H 8L2**
*Screenshot by author, from Google Maps.*

111 **Figure 6.58 Hein House - Ruddy-Shenkman Hospice**
*By Author, November 2024.*

111 **Figure 6.59 110 McCurdy Dr, Kanata, ON K2L 2Z6**
*Screenshot by author, from Google Maps.*

112 **Figure 6.60 Hospice Niagara - St. Catharines Hospice**
*By Author, November 2024.*

112 **Figure 6.61 403 Ontario St #2, St. Catharines, ON L2N 1L5**
*Screenshot by author, from Google Maps.*

112 **Figure 6.62 McNally House Hospice**
*By Author, November 2024.*

112 **Figure 6.63 148 Central Ave, Grimsby, ON L3M 4Z3**
*Screenshot by author, from Google Maps.*

114 **Figure 6.64 The Hospice of Windsor & Essex County - Windsor Campus**
*By Author, November 2024.*

114 **Figure 6.65 6038 Empress St, Windsor, ON N8T 1B5**
*Screenshot by author, from Google Maps.*

114 **Figure 6.66 Journey Home Hospice Windsor**
*By Author, November 2024.*

114 **Figure 6.67 1100 University Ave W, Windsor, ON N9A 5S7**
*Screenshot by author, from Google Maps.*

116 **Figure 6.68 Hill House Hospice**
*By Author, November 2024.*

116 **Figure 6.69 36 Wright St, Richmond Hill, ON L4C 4A1**
*Screenshot by author, from Google Maps.*

116 **Figure 6.70 Margaret Bahen Hospice**
*By Author, November 2024.*

116 **Figure 6.71 653 Queen St, Newmarket, ON L3Y 2J1**
*Screenshot by author, from Google Maps.*

116 **Figure 6.72 Hospice Vaughan**
*By Author, November 2024.*

116 **Figure 6.73 9383 Islington Ave, Vaughan, ON L4H 3G7**
*Screenshot by author, from Google Maps.*

120 **Figure 6.74 Reception area, Lisaard**
*By Author, May 2024.*

120 **Figure 6.75 Kitchen/dining, Lisaard**
*By Author, May 2024.*

121 **Figure 6.76 Resident suite, Lisaard**
*By Author, May 2024.*

121 **Figure 6.77 Resident washroom, Lisaard**
*By Author, May 2024.*

121 **Figure 6.78 Sunroom, Lisaard**
*By Author, May 2024.*

122 **Figure 6.79 Dayroom, Innisfree**
*By Author, May 2024.*

122 **Figure 6.80 Kitchen and family pantry, Innisfree**
*By Author, May 2024.*

123 **Figure 6.81 Workspace, Innisfree**
*By Author, May 2024.*

123 **Figure 6.82 Residence hallway, Innisfree**
*By Author, May 2024.*

123 **Figure 6.83 Courtyard, Innisfree**
*By Author, May 2024.*

124 **Figure 6.84 Sitting area, HWR**
*By Author, May 2024.*

124 **Figure 6.85 Residence hallway, HWR**
*By Author, May 2024.*

125 **Figure 6.86 Resident pergolas, HWR**
*By Author, May 2024.*

125 **Figure 6.87 Resident suite, HWR**
*By Author, May 2024.*

125 **Figure 6.88 Spiritual space, HWR**
*By Author, May 2024.*

## 7. ARCHITECTURAL BRIEF

134 **Figure 7.1 Symbol of Access**
*By Author, November 2024.*

134 **Figure 7.2 Accessible door hardware**
*By Author, November 2024.*

136 **Figure 7.3 Hospice room size requirements**
*By Author, September 2024.*

137 **Figure 7.4 Hospice room size requirements, by program**
*By Author, September 2024.*

138 **Figure 7.5 Waterloo Region Plan Analysis, Circulation**
*By Author, November 2024.*

139 **Figure 7.6 Waterloo Region Plan Analysis, Program**
*By Author, November 2024.*

141 **Figure 7.7 Program adjacency matrix**
*By Author, September 2024.*

## 8. SITE&CONTEXT

146 **Figure 8.1 Waterloo region population density, 2021**
*By Author, November 2024. Retrieved from https://www12.statcan.gc.ca/census-recensement/2021/geo/maps-cartes/thematicmaps-cartesthematiques/pd-pl/files-fichiers/2021-92173-001-541-013-02-00-eng.pdf*

147 **Figure 8.2 Waterloo region population demographics, ethnicity**
*By Author, November 2024. Retrieved from https://wr-community-profile-rmw.hub.arcgis.com/pages/ethnic-racial-identity*

147 **Figure 8.3 Waterloo region population demographics, religion**
*By Author, November 2024. Retrieved from https://wr-community-profile-rmw.hub.arcgis.com/pages/religion*

148 **Figure 8.4 1:5000 site plan**
*By Author, September 2024.*

150 **Figure 8.5 Zoning map**
*By Author, September 2024.*

151 **Figure 8.6 Site solar study**
*By Author, September 2024.*

## 9. DESIGN PROPOSAL

155 **Figure 9.1 Site plan (1:2000)**
*By Author, September 2024.*

156 **Figure 9.2 Elevation 1 - view of main entrance (1:200)**
*By Author, September 2024.*

156 **Figure 9.3 Elevation 3 - view of resident entrances (1:200)**
*By Author, September 2024.*

158 **Figure 9.4 Elevation 2 - view of site access from staff/volunteer rooms (1:200)**
*By Author, September 2024.*

158 **Figure 9.5 Elevation 4 (half) - view of front outdoor gathering space (1:200)**
*By Author, September 2024.*

159 **Figure 9.6 Exploded axonometric**
*By Author, September 2024.*

161 **Figure 9.7 Floor plan - phase 1 (1:200)**
*By Author, September 2024.*

162 **Figure 9.8 Floor plan - phase 2 (1:200)**
*By Author, September 2024.*

163 **Figure 9.9 Floor plan - phase 3 (1:200)**
*By Author, September 2024.*

164 **Figure 9.10 Overall floor plan (1:500)**
*By Author, September 2024.*

166 **Figure 9.11 Section a (1:200)**
*By Author, September 2024.*

168 **Figure 9.12 Section B (1:200)**
*By Author, September 2024.*

171 **Figure 9.13 Diagram - circulation**
*By Author, September 2024.*

172 **Figure 9.14 Material palettes**
*By Author, September 2024.*

173 **Figure 9.15 Diagram - program types**
*By Author, September 2024.*

174 **Figure 9.16 Diagram - connections to nature**
*By Author, September 2024.*

175 **Figure 9.17 Diagram - public vs private space**
*By Author, September 2024.*

176 **Figure 9.18 Perspective plan**
*By Author, September 2024.*

178 **Figure 9.19 Main entrance**
*By Author, September 2024.*

179 **Figure 9.20 Waiting spaces**
*By Author, September 2024.*

180 **Figure 9.21 Therapy rooms**
*By Author, September 2024.*

182 **Figure 9.22 Family gathering spaces**
*By Author, September 2024.*

184 **Figure 9.23 Care center alcoves**
*By Author, September 2024.*

185 **Figure 9.24 Washrooms**
*By Author, September 2024.*

186 **Figure 9.25 Staff rooms**
*By Author, September 2024.*

187 **Figure 9.26 Nurse's station (& med room)**
*By Author, September 2024.*

188 **Figure 9.27 Nooks**
*By Author, September 2024.*

189 **Figure 9.28 Sensory garden**
*By Author, September 2024.*

190 **Figure 9.29 Resident suite**
*By Author, September 2024.*

191 **Figure 9.30 Sunroom**
*By Author, September 2024.*

192 **Figure 9.31 Quiet room**
*By Author, September 2024.*

193 **Figure 9.32 Spiritual space**
*By Author, September 2024.*

194 **Figure 9.33 Outdoor gathering spaces**
*By Author, September 2024.*

196 **Figure 9.34 Perspective plan**
*By Author, September 2024.*

## 10. CONCLUSION

198 **Figure 10.1 Exterior view of design proposal**
*By Author, November 2024.*

# PREFACE

Throughout the course of this thesis, a common question I have been asked is, "how did you choose this topic?".

Before returning to the School of Architecture to begin graduate studies, my motivation for this thesis was to engage in work that was meaningful (in its impact, implications, context, and intended user). This motivation has driven me to pursue an area of design that not only had I never previously encountered, but also had not previously considered within my scope of interest relating to architecture. Hospice design, as I would soon discover upon starting my graduate degree, is not a heavily researched topic and my journey into this field of study was an unexpected one. My thesis focus was inspired by a conversation with a family friend, who envisioned a community- and nature-oriented hospice space.

As an architectural designer, I am guided by core design values - a focus on user (or "human" as I would eventually prefer) experience in space, incorporating evidence-based and biophilic design considerations, and an understanding of the responsibilities of architects for the spaces they design. I believe good design is not only functional and efficient, but also seeks to connect to the embodied experience (mental, physical, spiritual) of the occupants. This research on hospice design is rooted in these values, aiming to create environments that offer comfort and agency at the end-of-life.

My personal experience relating to death/end-of-life/palliative care for a loved one is mainly in the context of hospital or at-home care. I like to imagine that this thesis work is also in honour of those experiences, imagining possibilities for a setting for the end-of-life that exudes warmth and celebrates life, providing comfort and ease to anyone seeking an alternative environment for the end-of-life.

We will all encounter death at some point in life. We deserve agency and support, regardless of financial capability or support network, at the end of life. Experiencing the death of a loved one is also something unavoidable in life and knowing that a loved one is experiencing this phase of life in the most comfortable environment available for them makes a huge difference in the way we experience and process grief. Not all of us have support networks that can bridge the gap between healthcare services and specific needs for comfort, and hospice is meant to be the safety net for those who need it.

With the grassroots origins of hospice in mind, the intention is that this thesis work is accessible to anyone interested in learning more about compassionate hospice design and can serve to inspire new ways of thinking about environments for the end-of-life phase.

# 1. INTRODUCTION

## 1.1 HOSPICE IN CANADA: AN OVERVIEW

Hospice is a holistic, palliative care approach that supports individuals facing terminal illness, accepting dying as a natural part of the cycle of life. It recognizes the whole being (mind, body, spirit), offering space to focus on life and living out the rest of one's days with agency. For an individual, agency at the end of life encompasses the ability to decide where, with whom, and how they want to live out the rest of their lives. Some prefer to be alone in a natural environment, others prefer to be surrounded by family or friends. This compassionate care philosophy considers the importance of the environment in providing comfort and ease during the emotional and spiritual experience of dying – encompassing support for patients, family, and loved ones.

In Western society, hospice can be traced to Europe as early as the eleventh century, originally serving as a place of rest for the ill enroute to pilgrimage, and later popularized through the Middle Ages with the rise of religious orders.[1] The modern hospice movement, including palliative care in hospitals, other care institutions, and at-home care, began in the United Kingdom during the 1960s. Dame Cicely Saunders, who began her career as a nurse, and then a physician, opened the first modern hospice in London in 1967 – *St. Christopher's Hospice* – catapulting what would soon become an international movement dedicated to providing a humane, comfort-focused and accepting approach towards illness, death, and grief.




**Figure 1.1**
**St. Christopher's Hospice**

Florence Wald, an early care provider at St. Christopher's, who was intrigued by Saunders' compassionate care approach, opened

1 Joy Robbins and Janet Moscrop, eds., *Caring for the Dying Patient and the Family* (Boston, MA: Springer US, 1995), https://doi.org/10.1007/978-1-4899-3376-8.



**Figure 1.2**
**Connecticut Hospice**

the first hospice in the United States in 1974 – *Connecticut Hospice.*[2] Around the same time, studies on the way in which people die were being conducted at the Royal Victoria Hospital in Montreal, determining that there was a general dissatisfaction in psycho-social and physical needs being met in hospitals. This brought the work of Saunders to the attention of Dr. Balfour Mount, who would go on to start the first palliative care unit of a hospital, at the Royal Victoria Hospital in Montreal, following a successful two-year pilot project.[3] Today in Canada, end-of-life care is provided in several settings including Community Hospices, Long-Term Care Homes, and Hospitals.



**Figure 1.3 Royal Victoria Hospital**

The emergence of hospice in North America during the 1970s signifies a paradigm shift towards a more compassionate approach to healthcare, operating on a philosophy of care. This emerges in the shift from treatment-focused to patient experience-focused care practices, which take a more holistic approach to understanding patient needs and necessary medical intervention.

While early hospices tended to operate in pre-existing buildings or hospitals that were modified to suit palliative care delivery, the design of modern hospices are typically purpose-built. Intended to provide a more home-like environment than a typical acute care environment, they also offer associated spaces that enable a resident/patients' family to be on-site to support them during the end-of-life experience. Crucial to this understanding of space is the prioritization of personal agency and dignity in end-of-life care. For most people who enter hospice, this is the last place they will reside in their life. There is a sense of finality upon arriving, intense emotions can arise when one is faced with their mortality or the prospect of imminently losing a loved one. These spaces are not inherently sorrowful though; there is a profound sense of peace and life in hospice. Allowing for life to end in a space that aims to provide comfort and nurtures ease, acknowledges the beauty of life, and inevitability of death, that the maze-like, institutional halls and closed doors of a hospital seek to hide.

2 "About - Connecticut Hospice," Hospice Residence Website, Connecticut Hospice, accessed October 1, 2024, https://www.hospice.com/about/.

3 Shuchita Das, "Made to Pioneer Compassionate End-of-Life Care," Health e-News, October 22, 2021, https://healthenews.mcgill.ca/made-to-pioneer-compassionate-end-of-life-care/.

Considering that there is much research and architectural exploration of early-life environments, similar research focused on end-of-life environments – especially in a Canadian context – is limited. The interdisciplinary team of care providers in hospice requires the expertise of an architect in designing a building that best supports the nuanced spatial needs of all occupants (patient, visitor, and care provider). The architect understands how to facilitate different atmospheres through design, how environments impact the experience of time, and how to foster space for connection. In this way, they can contribute to healthcare environments by promoting human-centered, sustainable, evidence-based design for a critical phase of life.

There are a growing number of hospices offering in-patient care services however there is still a general lack of accessibility to care and spatial sensitivity in the requirements that govern hospice environments.[4] This puts emphasis on the need for a more holistic approach and standards in hospice palliative care design. The intention of this thesis is to address these issues and generate a more sensitive approach to designing these spaces of care.

This chapter seeks to establish a general understanding of the key regulatory bodies that oversee the delivery of hospice palliative care in Ontario, the existing network of hospices offering in-patient care services, and the primary demographics currently accessing hospice in-patient care. This foundational knowledge will serve to contextualize the thesis research and design proposal specific to Ontario.

## *HOSPICE PALLIATIVE CARE*

*Health Canada* defines palliative care as:

> *"a holistic approach that treats a person with serious illness of any age, and in any setting. It involves a range of care providers and includes the person's unpaid caregivers. If you have a serious*

4 Olivia Pereira, "Nurturing Ease: A Holistic Design Approach for Hospices in Ontario" (Master's Thesis, University of Waterloo, 2024), Chapter 6: Catalogue of Hospice Residences in Ontario.

*illness, palliative care can: help improve your quality of life; reduce or relieve your symptoms; help you make important decisions; provide grief support to you, your friends and your family (or chosen family); support you and your caregivers throughout your illness, from the time of diagnosis."*[5]

The term *hospice palliative care* is often used interchangeably with palliative care, and involves management of mental and physical symptoms, as well as providing psychosocial and spiritual support.[6] These support services are also available to caregivers and families to help cope with grief. In Ontario, many hospices offer inpatient hospice palliative care, as well as community programming, volunteer opportunities, support/counselling services, and fund development/charitable outreach departments, bundled within a single center. In the context of this thesis, the focus will be specifically on hospices offering in-patient care services, also referred to as hospice residences.

There is limited spatial planning and regulation for hospice, considering the profound impact that the physical environment has on the well-being and overall quality of life of individuals utilizing these spaces. Across the country, hospices provide care as nonprofit charitable organizations and rely on a combination of community and government support operations. In terms of governance and administration of hospice palliative care in Canada, Ontario more specifically, most of the policy is focused on healthcare practices and access to care.

Beginning at the federal level, *Health Canada*, one of the key regulatory bodies overseeing hospice palliative care delivery in the country, introduced a document called "Framework on Palliative Care in Canada'' in 2018. The document identifies key players in palliative care as individuals, families, caregivers, nonprofit and voluntary sector, and health care systems/organizations and generally looks at palliative care through a medical lens.[7] However, architectural design and environmental

5 "Palliative Care: Overview," Government Website, Health Canada, February 25, 2016, https://www.canada.ca/en/health-canada/services/health-services-benefits/palliative-care.html.

6 "Palliative Care."

7 "Framework on Palliative Care in Canada," Government Website, Health Canada, December 4, 2018, https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html.

considerations for care are integral missing components of *Health* Canada's proposed framework. At the provincial level, hospice palliative care is overseen by various ministries and health system partners, including Ontario's Ministry of Health, Ministry of Long-Term Care, and Ontario Health.[8] Although its predecessors span back to the 1980s, in 2011 the Hospice Palliative Care Ontario (HPCO) was formed as "a provincial association for hospices and palliative care providers, professionals, and volunteers." It is the current governing body overseeing the spatial regulation of hospice environments, advocating for quality hospice palliative care in Ontario. [9]

In 2018, a study completed in partnership by the Canadian Hospice Palliative Care Association and Canadian Institute for Health Information, surveyed 37 residential hospices to establish a dataset of pan-Canadian information on delivery of palliative care.[10] From the survey, it was found that all hospice residences rely on some amount of public funding, receiving between 30% and 100% of their funding from the government (varies provincially), where funding variations are attributed to factors such as the number of funded beds, service contracts with regional or provincial health authorities, and the amounts obtained through fundraising initiatives.[11]

More recent developments in provincial governance of hospice palliative care in Ontario include the Compassionate Care Act (2020), which

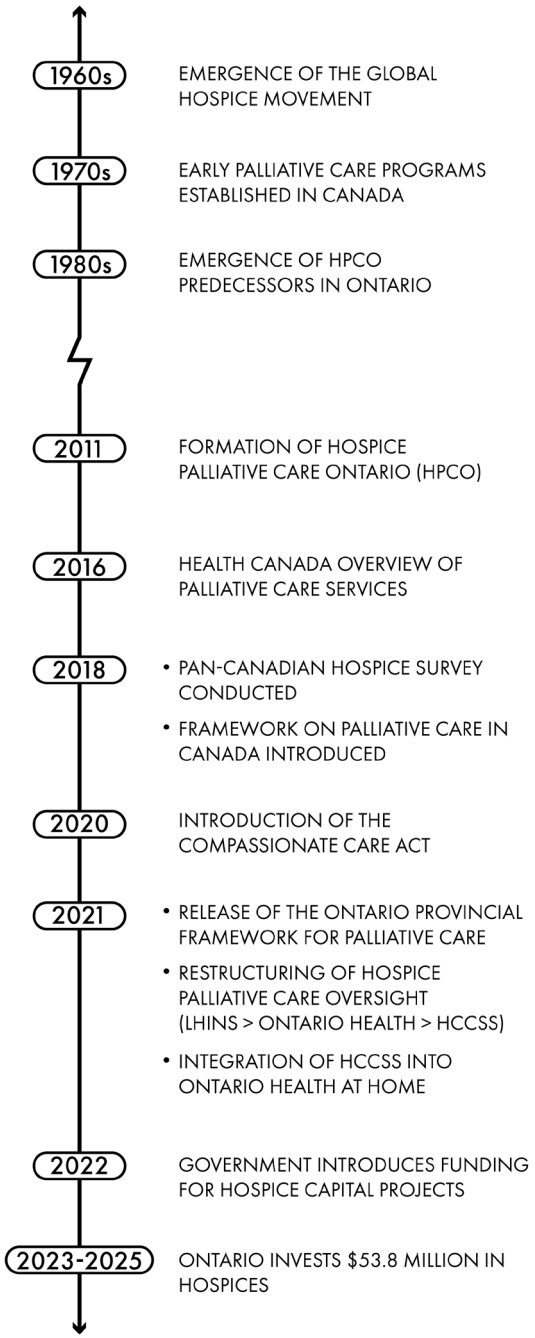



**Figure 1.4 Timeline of key events**

8 "About Us," Government Website, Ontario Health atHome, accessed January 10, 2024, https://ontariohealthathome.ca/about-us/.

9 "About HPCO," Organization Website, Hospice Palliative Care Ontario, n.d., https://www.hpco.ca/about/.

10 "Access to Palliative Care in Canada" (Canadian Institute for Health Information, 2018), 18, https://secure.cihi.ca/free_products/access-palliative-care-2018-en-web.pdf.

11 "Access to Palliative Care in Canada," 18.

established a framework for all Canadians to be able to access essential palliative care services.[12] The Act required Ontario's Minister of Health "to develop a provincial framework designed to support improved access to palliative care."[13] As part of this act, active reports on the status of palliative care in the province were to be conducted periodically in the years following – allowing researchers to gain insight into developments in the delivery of care.

One year later, in 2021, the Ontario Provincial Framework for Palliative Care was presented to identify key priorities for strengthening the delivery of hospice palliative care. It outlined seven building blocks to support better integrated care; Leadership and Accountability, Funding, Provider Education and Mentorship, Integrated Care, Person and Family-Centred Care, Evidence and Data, and Public Awareness.[14] Since 2020, an increasing number of hospices have been established across the province. With new government funding, more communities have been able to mobilize efforts to establish hospice centers. However, since most hospices operate as non-profit charitable organizations, funding remains limited, especially relating to the affordability of building new facilities.

The province's health system has since undergone various phases of restructuring over the last few years, with the coordination of hospice palliative care previously being overseen by the Ontario Ministry of Health and Long-Term Care via LHINs (Local Health Integration Networks). In 2021, this responsibility was transferred to Ontario Health which coordinated care via Home and Community Care Support Services (HCCSS), the HCCSS have since been integrated into the new *Ontario Health at Home*,[15] which currently "coordinates in-home and community-based care for thousands of patients across the province every day."[16] Multiple shifts in the overseeing of hospice palliative care in the province

12 Oosterhoff S., "Bill 3 - An Act Providing for the Development of a Provincial Framework on Palliative Care" (Legislative Assembly of Ontario, December 2, 2020), https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-3.

13 "The Framework on Palliative Care in Canada-Five Years Later" (Health Canada, December 2023), https://www.canada.ca/en/health-canada/services/publications/health-system-services/framework-palliative-care-five-years-later.html#a4.3.

14 "The Framework on Palliative Care in Canada-Five Years Later."

15 "Ontario Taking Further Steps to Support Integrated Patient Care," Government Website, Ontario - Newsroom, March 17, 2021, https://news.ontario.ca/en/release/60748/ontario-taking-further-steps-to-support-integrated-patient-care.

16 "About Us."

has increased difficulty for Canadians trying to access up-to-date information about their options for care beyond a hospital, contributing to a widespread perception that accessing care at the end-of-life is challenging - nevertheless there are more options for end-of-life care than ever before.[17]

HPCO defines a hospice as a place that "provides specialized hospice palliative care services in a homelike setting for the residents it serves and their families. It may be an independent free-standing healthcare facility or a dedicated hospice suite(s) which is co-located within a larger facility. The Hospice is designed to ensure the comfort, privacy, safety, and security of all residents.[18]" Through HPCO accreditation, new funding is available to support hospices across the province as part of Ontario's plan to invest "over $53.8 million over the 2023-24 and 2024-25 fiscal years."[19] The HPCO does not fund the full cost of the total hospice capital project but provides a funding contribution based on the number of beds approved for each project, up to a maximum dollar contribution per bed cost. As of September 30, 2022, the funding contribution that the provincial government will provide for newly approved Hospice Capital Program capital projects is up to $250,000 per ministry-approved hospice care bed.[20] Hard construction and ancillary costs (both with exclusions) are eligible for ministry funding, whereas land or building acquisition, site development, demolition, furniture and equipment (with exceptions) are ineligible for ministry funding and up to the hospice organization to fundraise.[21] These costs can add up depending on the goals of the hospice organization and needs of the community, and have critical implications on the architectural design of the hospice.

Many of the recent changes affecting the governance and administration of hospice palliative care in the province have emerged concurrently with the COVID-19 pandemic. A report, titled *Analyzing Hospice Palliative Care Across Canada,* by the *Canadian Cancer Society* identified that the COVID-19 pandemic overwhelmed the healthcare

17 "Ontario Provincial Framework for Palliative Care" (Ministry of Health, 2021), 15, https://files.ontario.ca/moh-ontario-provincial-framework-for-palliative-care-en-2021-12-07.pdf.

18 "Module 3, Section 3: HPCO Hospice Residence Standard" (HPCO, June 2020).

19 "The Framework on Palliative Care in Canada-Five Years Later."

20 "Hospice Capital Program Policy Version 1.3" (HPCO, September 2022), 5.

21 "Hospice Capital Program Cost Share Guide Version 1.3" (HPCO, September 2022).

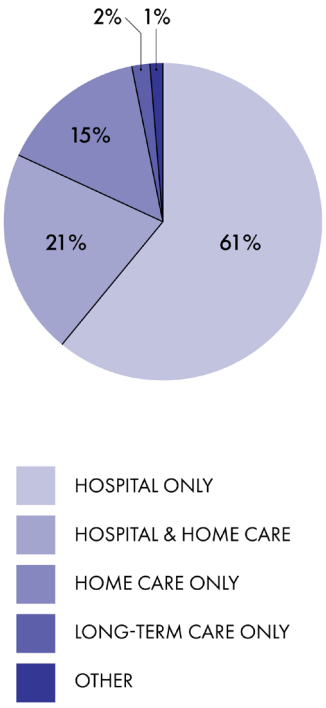



**Figure 1.5 Patients identified as palliative, by care setting, 2020-2022**

system and care providers, resulting in many people dying "in isolation and alone, isolated from their families, whether from COVID-19 or other illnesses...The impact and isolation of COVID-19 deaths in hospitals and long-term care homes led to significant demand for home care." [22] The pre-existing gaps in the province's healthcare system were further exacerbated, leaving many individuals and families grappling to have their care needs met and intensifying the need for grief and bereavement support services following the peak of the pandemic. As a result of public health measures, many people were restricted from seeing their loved ones in their final moments, further complexifying the grieving experience.[23]

## *EXISTING NETWORK OF HOSPICES IN ONTARIO*

The Auditor General of Ontario provides a ratio of seven beds per 100 000 people to deliver consistent palliative care in Canada.[24] In Ontario, the ratio is 3.47 hospice residence beds per 100.000 people.[25] So, for Ontario's current population of 15.6 million people, there would need to be about 1092 beds available.[26] While there has been a steady increase in the amount of hospice residences being built in the last decade (almost half of the hospice beds in the province), Ontario would need to double the number of hospice beds to meet the base mark for consistent palliative care.[27] This results in many people experiencing end of life care in hospitals or their family homes.

This lack of spatial/environmental considerations in the administration of hospice care suggests that the regulatory perspective on quality care does not fully align to the philosophy that distinguishes hospice from palliative care in hospital settings, and that it is left to external organizations to advocate for a more holistic and compassionate

22 "Analyzing Hospice Palliative Care Across Canada" (Canadian Cancer Society, 2023), 6, https://cancer.ca/en/about-us/media-releases/2023/palliative-care-report.

23 "Ontario Provincial Framework for Palliative Care," 13.

24 "Analyzing Hospice Palliative Care Across Canada: A Report on Federal, Provincial, Territorial and Community Actions" (Canadian Cancer Society, 2017), 9, https://cancer.ca/-/media/files/about-us/media-releases/2023/palliative-care-report/adv23163palliative-care-report85x11en04.pdf.

25 "Analyzing Hospice Palliative Care Across Canada," 9.

26 "Ontario Demographic Quarterly: Highlights of First Quarter," Government Website, Ontario, 2024, https://www.ontario.ca/page/ontario-demographic-quarterly-highlights-first-quarter.

27 Pereira, "Nurturing Ease: A Holistic Design Approach for Hospices in Ontario," #.

approach to hospice. An insightful revelation from the infographic, titled "Why We Need a Quality Standard for Palliative Care in Ontario," is that "earlier palliative care can lead to better quality of life...and a 50% reduction in the likelihood of dying in a hospital."[28] This would also require more hospice facilities to be built across the province to give access to more of the population in need. Further to this point, providing palliative care in acute-care hospitals (and even in hospitals with dedicated palliative care units) is estimated to cost more than double the cost of providing care in a hospice.[29,30]

The main challenges for hospice administration relate to budget limitations in building, operating and maintaining the establishment in addition to ensuring accessibility for individuals seeking hospice palliative care services. New hospices are most often established by community members and organizations, sometimes requiring many years of fundraising, and planning in the community to bring it to fruition. In many cases, materials and labor will be donated by community members to help reduce construction costs, highlighting community as a catalyst for hospice. While there is government funding available to support the establishment, much of the financial weight is placed on the community. This also extends into annual operating costs, which average just over $1 million dollars for a typical 10-bed hospice.[31] So, the majority of a hospice's budget is relying on the community it seeks to support. This also makes establishing hospices for rural, smaller, and/or lower-income communities less financially feasible and results in individuals seeking hospice palliative care having to travel away from their homeplace (and sometimes far distances) to access the facility closest to them. Thus, most hospices are in high-density, urban/suburban communities and the majority are in southern Ontario.

28 "Why We Need a Quality Standard for Palliative Care in Ontario" (Health Quality Ontario, 2018), https://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-palliative-care-infographic-en.pdf.

29 "Ontario Provincial Framework for Palliative Care," 11.

30 "Section 3.08 - Palliative Care," 265.

31 "Environmental Scan for Strengthening Residential Hospice Care in Ontario," March 2015, 17.

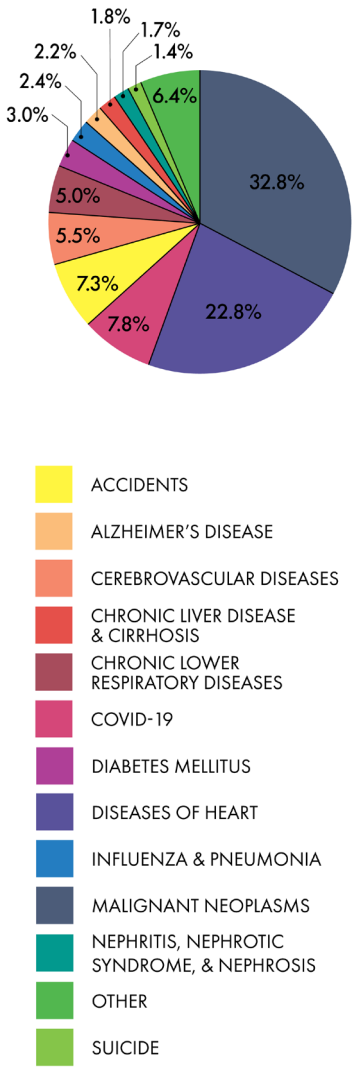



**Figure 1.6 Leading causes of death, 2022**

## *MAIN DEMOGRAPHICS IN HOSPICE*

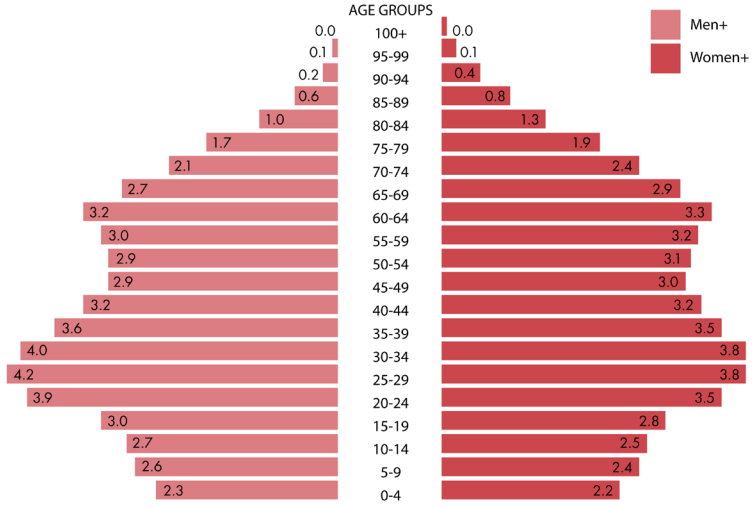
*Palliative care should be accessible to all Canadians regardless of their age, their sex or gender, the expected path of their illness, their community, their socio-economic status or their culture.* - Canadian Institute for Health Information, 2023[32]

Currently admission to most hospices is for those with a terminal diagnosis and is dependent on the patient's life expectancy, usually required to be in the range of four weeks to six months. However, considering the limited availability of beds, this range is typically capped at 3 months.[33] For this reason also, hospice care differs from palliative care, where patients in palliative care are still receiving treatment so the hospice residence beds are specifically for those no longer receiving treatment and are focused on quality of life for the end-of-life phase. This distinction is also why many hospice residences do not allow medical equipment, like breathing machines (mechanical ventilators), to allow patients to experience a natural death. However, if the philosophy of care advocates for dignity and agency at the end-of-life, then perhaps it should be within the right of the patient to choose to use equipment that allows them to live the rest of their days more comfortably.

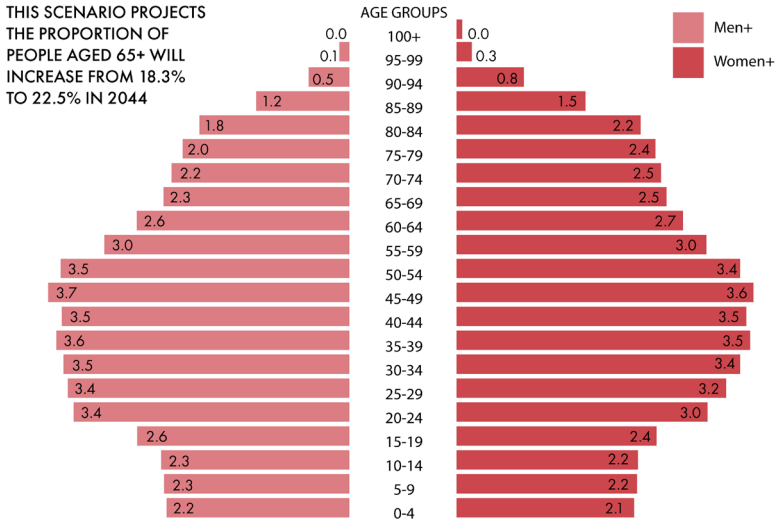
According to *Health Canada,* the primary recipients of palliative care are adults, aged *45-75*, and most commonly those with a cancer diagnosis.[34] Of the common diseases or conditions included in the study (including dementia), the predictability of cancer was identified as a key aspect for informing decisions to transition to palliative care: "cancer is well understood and has a relatively predictable progression, which makes the decision of when to start palliative or end-of-life care more clear-cut."[35] In fact, those diagnosed with cancer were "up to three times more likely to have received palliative care in their last year of life."[36] However, hospice palliative care is beneficial to those with other conditions as well – including "heart failure, lung disease, renal failure, dementia and other

32 "Access to Palliative Care in Canada, 2023" (Canadian Institute for Health Information, 2023), 15, https://www.cihi.ca/en/access-to-palliative-care-in-canada.
33 "Access to Palliative Care in Canada, 2023," 18.
34 "Framework on Palliative Care in Canada."
35 "Access to Palliative Care in Canada, 2023," 15.
36 "Access to Palliative Care in Canada, 2023," 31.

neurodegenerative diseases."[37]




2024




2044
*MEDIUM-GROWTH SCENARIO*

**Figure 1.7**
**Population projections by age demographics**

Based on recent census data, Canada's elderly population is steadily increasing.[38] In a study done titled, *The impact of age on palliative care*, age inequities identified older seniors as less likely to have received palliative care in their final year of life, where the "complexity of older age, frailty and a lack of a defined terminal condition may also make it

37 "Access to Palliative Care in Canada, 2023," 32.

38 "A Portrait of Canada's Growing Population Aged 85 and Older from the 2021 Census," Government Website, Statistics Canada, April 27, 2022, https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-X/2021004/98-200-X2021004-eng.cfm.

more challenging to predict the end-of-life trajectory...,"[39] Lack of access to adequate hospice palliative care can be a burden for individuals and their families seeking care, and results in increased reliance on emergency medical services. Current population trends indicate that the baby boomers (Canada's largest age demographic, born between 1946 and 1965) will gradually increase pressure on the health and home-care systems as they become senior adults.[40]

The 2023 study titled *Access to Palliative Care in Canada*, identified that there is "still work to do to meet the needs of diverse populations and to improve access to palliative care."[41] There is disproportionate access to palliative care particularly for those with lower socioeconomic status, people residing in remote/rural areas, First Nations communities, people of colour, new immigrants, those who identify as part of the LGBTQIA+ community, and individuals experiencing homelessness.[42] Especially within the Canadian context, First Nations, Inuit, and Metis communities lack adequate healthcare services, especially those that are considerate of their distinct cultural practices and traditions. Only recently have there been medical spaces beginning to accommodate smudging practices. An "Indigenous-led engagement on palliative and end-of-life care" is currently in the works with Health Canada and other government departments.[43] Research also shows that less than a fifth of children who would benefit from palliative care actually receive it.[44] Pediatric palliative care is highly specialized and there are very few hospices in the province that can support this level of care currently, instead relying on centralized pediatric care centers that can result in children and their families having to travel great distances to receive quality care.[45]

A consequence of the limited access to hospice beds is that many people are dying in hospitals. In 2016-2017, 42% of Canadians died in hospital settings, often initially admitted for acute health problems and

39 "Access to Palliative Care in Canada, 2023," 15.
40 "A Generational Portrait of Canada's Aging Population from the 2021 Census," Government Website, Statistics Canada, April 27, 2022, https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-X/2021003/98-200-X2021003-eng.cfm.
41 "Access to Palliative Care in Canada, 2023," 15.
42 "Ontario Provincial Framework for Palliative Care," 12.
43 "The Framework on Palliative Care in Canada-Five Years Later."
44 "Access to Palliative Care in Canada, 2023," 15.
45 "Ontario Provincial Framework for Palliative Care," 8.

later designated as palliative patients. The vast majority of those who died in hospitals had an unplanned admission on their final hospitalization, meaning they were admitted through emergency services or ambulance. Hospitals are undesirable settings for dying, because they are designed for clinical functionality, where visitors are restricted and less privacy is available. Earlier integration of hospice palliative care could potentially reduce the strain placed on emergency departments in hospitals, where those admitted often wait many hours in crowded wait rooms or curtained bed zones before receiving care. This suggests a larger issue in the organization of hospitals, both spatially and in the delivery of care, exacerbated through the COVID-19 pandemic and impacting present-day access to healthcare. The lack of accessibility to dedicated hospice care facilities will continue to grow as a challenge with Canada's aging population.

# 1.2 THESIS OVERVIEW:

This thesis highlights the role of designers in spaces of care and the power of design to influence the human experience in the context of hospice. In order to address the research question, it is important to understand the diverse perspectives and spatial needs of the occupants, integrate a holistic design approach that incorporates concepts learned and synthesized from the research and case studies, and recognize the role of governance and advocacy as the drivers of the quality of hospice palliative care in Canada and how architectural thinking can create a more encompassing quality of care.

**1_Introduction -** The introduction seeks to establish a foundational understanding of the modern hospice movement and the philosophy of hospice to situate the thesis research. Building upon this with the current context of hospice palliative care in Ontario/Canada and future population growth and projected healthcare needs identifies the exponential need for widespread hospice palliative care spaces.

**2_Human Experience at the End-of-Life -** To design effectively, we must understand the people we hope to serve through the design. Seeking to understand the human experience in space, specifically at the end-of-life (whether that be personally, familially, or professionally) which has its own sensitivities and spatial implications. Combining architectural and psychosocial research with field work from hospice visits allows for the merging of hospice philosophy with spatiality.

**3,4,5_A Holistic Design Approach -** Now understanding the human experience in hospice space and the values of the hospice philosophy, a holistic, evidence-based design approach with specific spatial considerations to drive the design proposal is established. Part of this research is analyzing existing design standards that guide current hospice design and the implications of the lack of consideration for human experience in design, aiming to fill gaps using existing research and analysis of the current design approaches in places of care.

**6_Catalogue of Hospice Residences in Ontario -** This thesis work seeks to build upon the existing practices for hospice design in Ontario and understand the varied approaches to hospices of communities of various scales and geographic contexts. A catalogue of the current network of independent hospices, and tiered regional case studies to explore applications of the current design standards and design theories explored relating to human experience in space.

**7_Architectural Brief -** The Architectural Brief defines the goals and requirements for the design proposal based on existing standards and research, synthesizing the human experience and evidence-based design considerations through the holistic design approach. Building upon this, key elements of hospice are established, defining the key functional program spaces that define hospice and the specific considerations for each space that serves the needs of occupants.

**8_Site and Context -** The site and context of a hospice has its own implications on the built form and design approach. This chapter explores the site selection process and subsequent site analysis that informs that design proposal.

**9_Design Proposal –** The design proposal seeks to address the architectural brief and apply the holistic design approach that prioritizes the human experience in space.

**10_Conclusion –** Reflecting on the role of the designer and what compassionate, evidence-based design can contribute to the architecture of care spaces.

# 2. HUMAN EXPERIENCE AT THE END-OF-LIFE

Successful hospice residences are designed to accommodate the death experience of the human being. *Embodied* refers to how a person perceives and interacts with their environment in a physical and emotional capacity. In this way, the architect is tasked with imagining the human experience before conceptualizing the space. Hospice stems from the recognition of the importance of the environment in quality care by prioritizing the comfort and agency of the patient, giving space to patients and their loved ones to be present, and for their complex feelings to be acknowledged and supported. Human-oriented design studies argue that space influences health, healing, and sensory engagement.[1] Where hospitals tend to prioritize efficiency, sterility, and function; a hospice residence prioritizes peace, home/domesticity, and holistic care (caring for mental/physical/spiritual needs of residents).

Hospice has always been driven by community engagement for establishing and sustaining operations that establish a space of care for individuals facing terminal illness – different from the anti-death and sterile environments of hospitals.[2] The grassroots origins of hospice residences means that the nuanced needs and cultural specificities of the community they support are spatially prioritized. Place-making is at the very root of hospice residences, which are directly informed by the communities they serve. They are fundamentally community spaces meant to be accessible to all people seeking hospice palliative care, seeking an alternative environment to die peacefully. Most people don't like going to the hospital, and even fewer have an intention to die there. A study titled "Where would Canadians prefer to die? Variation by situational severity, support for family obligations, and age in a national study" identified

1 Charles Spence, "Senses of Place: Architectural Design for the Multisensory Mind," *Cognitive Research: Principles and Implications* 5, no. 1 (December 2020): 20, https://doi.org/10.1186/s41235-020-00243-4.

2 Allan Kellehear, *Compassionate Cities: Public Health and End-of-Life Care* (Oxfordshire: Routledge, 2005), 6, https://doi.org/10.4324/9780203019955.

that home is not a universally preferred setting for dying.[3] Adults over 65 were identified as having greater preference for palliative care, rather than relying on family members to provide care, and generally preference for palliative care (over family care) increased for all age demographics when considering increased severity of the circumstances of death.[4] Hospice provides a home-like alternative – a calm, safe, and comfortable environment where the specific needs of hospice care can be supported. Especially important as not all homes are accessible to the varying needs of hospice palliative care patients, sometimes families are not able to provide necessary care on their own, not everyone has family to care for them or a home to stay in.

While the start of life is marked in time, the end of life is uncertain. Hospices are environments where occupants are facing complex and often strong emotional responses to the end of their life or the life of a loved one. There is an opportunity in this sense to create moments for reflection on life and the passage of time. The profound experience of death and dying is one that engages mind, body, and spirit. Despite its religious ties at the beginning of the modern hospice movement, spirituality in hospice has transitioned to a more secular one in present day, where designers tend to aim at supporting all religious denominations and spiritual leanings though multi-faith spaces or spaces of contemplation and reflection on life and death.

In considering perspectives on death & dying, we can look to the work of Elisabeth Kubler-Ross, specifically *On Death & Dying*, which promotes a compassionate healthcare model and awareness of death through breaking down the components of the human experience of grief.[5] Kubler-Ross, a Swiss-American psychiatrist, published her work in 1969, pioneering a "death-and-dying movement" at a time when death was a taboo subject.[6] This text was published around the time that hospice

3 Laura M. Funk et al., "Where Would Canadians Prefer to Die? Variation by Situational Severity, Support for Family Obligations, and Age in a National Study," *BMC Palliative Care* 21, no. 139 (December 2022): 7, https://doi.org/10.1186/s12904-022-01023-1.

4 Funk et al., "Where Would Canadians Prefer to Die?," 7.

5 Elisabeth Kubler-Ross, *On Death & Dying: What the Dying Have to Teach Doctors, Nurses, Clergy & Their Own Families* (New York, NY: Scribner, 2014).

6 Holcomb B. Noble, "Elisabeth Kübler-Ross, 78, Dies; Psychiatrist Revolutionized Care of the Terminally Ill," *The New York Times*, August 26, 2004, sec. U.S., https://www.nytimes.com/2004/08/26/us/elisabeth-kubler-ross-78-dies-psychiatrist-revolutionized-

palliative care was emerging on the healthcare scene in Canada, directly informing this newly compassionate approach to caring for the dying. Kubler-Ross' work remains relevant today and has had a lasting impact on the healthcare industry. She defines the 5 Stages of Grief: denial, anger, bargaining, depression, and acceptance.[7] Highlighting the importance of open communication between patients and doctors - to talk openly about dying, living out one's final moments in a meaningful way.

PLACEHOLDER

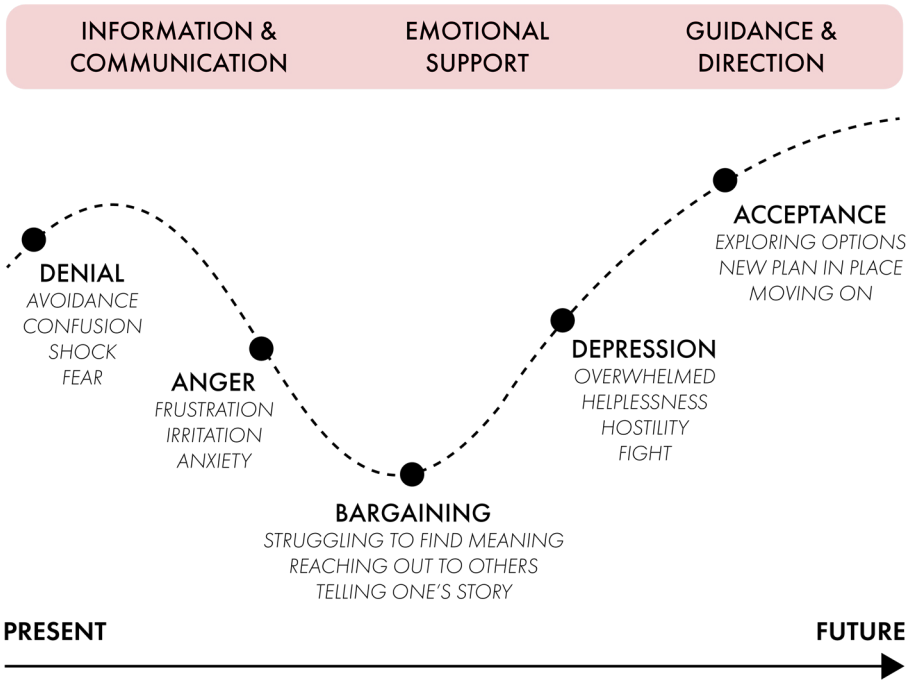



**Figure 2.1 5 stages of grief: denial, anger, bargaining, depression, acceptance**

In his book, *A Grief Observed*, C.S. Lewis documents his grappling with life, grief, and his faith following the passing of his wife. He writes: "[g]rief is like a long valley, a winding valley where any bend may reveal a totally new landscape."[8] Grief is unique to each person, having the support of counselling and bereavement services through hospice before and after the passing of a loved one can make a big difference in a person's ability to process it. Lewis wrote to process his complex thoughts and feelings of grief for his late wife, releasing the built-up emotion through the written word.

care-terminally-ill.html.

7 Kubler-Ross, *On Death & Dying*, 251.

8 C. S. Lewis, *A Grief: Observed* (San Francisco: HarperCollins Publishers Inc., 2001), 60.

In a similar vein, Joan Didion's *The Year of Magical Thinking* explored how grief is specific to each person, how it can alter the way we think, and something we all experience at some point in life: an inherent companion of death.[9] Understanding of the nuances of the end-of-life experience is essential to establishing an appropriate foundation from which to define a holistic design approach that is considerate of the human experience at the end-of-life.

## *FIELD WORK*

Field work has been a critical component of my design research, as gaining an understanding of the atmosphere and feel of a space is something only achievable by visiting places in person. The senses are sharp observers of space. By combining field work with theoretical perspectives offered in the literature, a clearer image of the story emerges.[10] Prior to this thesis, my experience relating to hospice was solely in the context of hospital wards and private homes, providing some foundation for this empathy-driven inquiry. Field observations were paramount to understanding and defining the needs of specific human experiences in hospice. Beginning my inquiry, I determined that I would focus on the Region of Waterloo (where I resided for most of my architectural education), as there are three hospice residences located in the area – Lisaard House, Innisfree House, and Hospice Waterloo Region. I was able to interview architects of two out of three of the hospices, Laird Robertson of *Neo Architecture Inc.*[11] (Hospice Waterloo Region) and Deb Westman of *+VG Architects – The Ventin Group Ltd.*[12] (Innisfree House), which gave insight into the architectural design process and hospice from the perspective of the designer and further enhanced the case studies. I was later able to visit all three hospices in person, touring the facilities and interviewing care providers.[13] Earlier research greatly enriched my experience and understanding of the space upon touring and conversing with the staff members during my field work

9 Joan Didion, *The Year of Magical Thinking* (New York, NY: Alfred A. Knopf, 2005), 154.

10 Ray Lucas, *Research Methods for Architecture, Research Methods for Architecture* (London: Laurence King Publishing, 2016), 78.

11 Laird Robertson, Designing Hospice Waterloo Region, Conversation, February 2, 2024.

12 Deb Westman, Designing Innisfree House, Virtual Call, February 9, 2024.

13 Following an Ethics Clearance with the University of Waterloo (See Appendix)

visits. By having the opportunity to experience hospice residences as an outsider, I was able to observe the spatial layouts, sensory elements, and nature integration that influence the daily lives of the occupants and provide invaluable insights that cannot be captured through the literature alone. Interactions with staff and volunteers of the space emphasizes the ethical dimensions of hospice design. Empathy and compassion are central to the design process, ensuring that the proposed spatial practices respect the dignity, privacy, and comfort of individuals during their end-of-life experience. First-hand experiences serve as a reminder of the human aspect of design, grounding the research in the ethical responsibility of creating settings that offer comfort and support during a complex part of life.

## 2.1 LANGUAGE, METAPHORS, AND RITUALS OF DEATH AND DYING

*How do we experience death and dying? In what ways do our cultural traditions and rituals influence the experience of death and dying, for both patient and their families? How can hospice be designed to accommodate diverse end-of-life practices or rituals that respects the needs of both the individual and their community?*

Broader societal perspectives towards hospice, death, and dying should also inform design considerations. Instances of hospice residences changing their names to create a more welcoming impression highlight a prevailing perception of these environments as potentially dreary or depressing.[14] Many hospices in Ontario opt to use *home* or *house* instead of *hospice* in their names to present as more community- and residentially integrated environments. In *A Theory of Creating At-Homeness Across the Long-Term Care Continuum,* Sheila L. Molony and Jude Rabig describe the concept of *at-homeness* as, "[a] situational lived experience of personal power, refuge, meaningful relationships, and self-reconciliation,"

14 Shalini Dalal et al., "Association Between a Name Change from Palliative to Supportive Care and the Timing of Patient Referrals at a Comprehensive Cancer Center," *The Oncologist* 16, no. 1 (January 1, 2011): 105–11, https://doi.org/10.1634/theoncologist.2010-0161.

relating to the connection between a person a their environment.[15] While focused on long-term care centers, this concept aligns with the philosophy of hospice, which seeks to provide a comfortable, caring environment – essentially a home – for the end-of-life.

A common metaphor used by care providers to describe a patient's experience in hospice is *the final journey*.[16] This was evident in the design and ritual at one of the field work sites, where a procession takes place following the passing of each resident: "*So, what we do is we do a little procession and if they have a favorite song, we play their procession and we all walk out to the service room with them out that door. One of the people from the family carries a candle that we keep going for a day or so, and we wrap them in a ton of quilts, so we always put a nice quilt over top.*"[17] In this ritual, the same door a patient first enters the hospice through is the one their body leaves through, representing a cyclical relationship between life and death within hospice.

## *ACCOMMODATING DIFFERENT CULTURAL TRADITIONS AND RITUALS OF DEATH IN HOSPICE*

During field work interviews, it became apparent the challenge care providers face in navigating the cultural traditions and rituals relating to death for, not only patients, but also their families (whose views and wants are not always aligned). Two anecdotes emerged; the first was one where the wishes of the family did not necessarily match up with the needs of the patient, who came from an Italian family where the cultural tradition relating to end-of-life in this case is more focused on the family as a whole. This resulted in a large group (of a similar size to the previous) with lots of kids entering the hospice, where not everyone was able to fit into the patient's room and the overflow of people became disruptive to other patients and visitors in the same space. In this case, the experience was

15 Farhana Ferdous and Emily Roberts, eds., *(Re)Designing the Continuum of Care for Older Adults: The Future of Long-Term Care Settings* (Cham: Springer International Publishing, 2023), 74, https://doi.org/10.1007/978-3-031-20970-3.

16 Ken Worpole, *Modern Hospice Design: The Architecture of Palliative and Social Care*, 2nd ed. (London: Routledge, 2023), 31, https://doi.org/10.4324/9781003306818.

17 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

overstimulating to the patient.

In another instance, an anecdote comes from an indigenous woman whose cultural tradition viewed death as a communal event. "So, they had probably 20 people that they wanted to get in and needed to get in, and those were elders, they were medicine people, there were some drummers, there was family."[18] The value of community and ritual at the very end of one's life, the sense of love and belonging that is created, is possible in spaces like hospice. In this specific case, the events that transpired were aligned with the wishes of the patient and possible to accommodate within the space.

Considering occupancy in hospice is more complex than identifying key staff members and the number of patient beds, in addition, as one care provider from the field work interviews explains, "you have lots of visitors coming and going and lots of people and bigger families sometimes that are challenging" to accommodate.[19] Is there overflow space if everyone cannot fit in the patient room? How does this impact parking? Having forethought in design for the commonplace events that permeate everyday life is essential. Even considering the visitors for patients, and the potential for larger groups to come into the space for celebrations of life), "because events, they're going to happen, whether someone has a wedding or a big birthday party or like having a staff event or bereavement thing at the same time."[20] Fundraising and community events are a big part of hospice, especially in sustaining community support and engagement.

For this reason, multi-purpose rooms are essential to allow the facilitation of these events. Along this vein, parking, paths of travel, coat storage, kitchen facilities, and washrooms should be designed with this in mind. Beyond the individual human experiences identified in hospice, recognizing the interrelatedness and connection between these experiences and how they interact is valuable to the architect's understanding of the role of space.

18 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
19 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
20 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

# 2.2 THE ETHICS OF CARE AND ARCHITECTURE

## *WHAT IS CARE?*

Clearly defining what encompasses care is challenging, as it permeates all aspects of the lived experience. Palliative care is recognized as a human right by the *World Health Organization (WHO),* who provides the following definition:

> *"Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual."* [21]

While palliative care can be provided at various stages of illness, hospice care specifically focuses on providing a supportive environment for the final stages of life – emphasizing comfort, dignity, and emotional-wellbeing. This definition of care reinforces the concept of the embodied experience of space and dignity at the end-of-life, extending beyond just our physical interactions and considering our mental, spiritual, and emotional experiences relating to grief, death, and dying.

## *GENDER & CARE*

Caregivers often experience negative impacts on their emotional and physical health because of caring for a loved one at the end-of-life, on top of the financial strain from expenses and time away from work. A survey from 2012 found that "13% of Canadians 15 years or older reported providing end-of-life care to a friend or family member at some point in their lives," and the majority were identified primarily as married women, aged 45 to 64, and typically either the child or partner of the patient.[22]

21 "Palliative Care," World Health Organization, August 5, 2020, https://www.who.int/news-room/fact-sheets/detail/palliative-care.

22 "Access to Palliative Care in Canada" (Canadian Institute for Health Information, 2018): 32,

Simultaneously while providing care for a loved one, they are also experiencing loss and grief.[23] For this reason, hospice offers dedicated services for families of patients to support their grieving experiences with psychosocial services and offering environments for spending quality time with loved ones.

There is distinct gender gaps imbued in the delivery of care and design of care spaces. A disproportionate amount of emotional, mental, and physical labor that goes into care is credited to women – who spend the most time in contact with the patient and their loved ones through the roles of nurses, therapists, social workers, administrators, and volunteers. While in medicine (and architecture), the roles of doctors or architect are often held by men. As Iris Marion Young writes in *House and Home: Feminist Variations on a Theme,* "[i]t will be women's world as much as men's only when women participate as much in their design and founding."[24] This lack of representation in roles where decisions with critical impacts are made is missing out on the experiential knowledge relating to care that can enhance the design of care plans and spaces for the delivery of care.

## *THE ETHICS OF DYING WELL*

A palliative care physician and contemporary of Kubler-Ross, Ira Byock, offers a key perspective to consider on the topic of navigating the experience of terminal illness in his book, *Dying Well: Peace and Possibilities at the End of Life.*[25] Byock advocates for a holistic medical approach to relieve suffering at the end-of-life with care that is based on open communication and dialogue between patients, loved ones, and care providers.[26] Through this, he proposes, that people can still live a meaningful end of life that allows a person to define for themselves what

https://secure.cihi.ca/free_products/access-palliative-care-2018-en-web.pdf.

23 BJ Miller and Shoshana Berger, *A Beginner's Guide to the End: Practical Advice for Living Life and Facing Death*, 1st ed. (New York, NY: Simon and Schuster, 2019), 133.

24 Iris Marion Young, "House and Home: Feminist Variations on a Theme," in *Intersecting Voices* (Princeton University Press, 1997): 118-119.

25 Ira Byock, *Dying Well: Peace and Possibilities at the End of Life,* 1st ed. (New York, NY: Riverhead Books, 1997).

26 Byock, *Dying Well,* 276.

it means to die in comfort and with agency, without resorting to assisted death.[27]

This view is somewhat contrasted in considering *Medical Assistance in dying* (MAID) and what agency at the end-of-life truly means. MAID became an option for Canadians as of 2021 with BILL C-7.[28] The decision to pursue this route is a difficult one to make nonetheless, and deeply personal. A 2018 study, Exploring the experience of supporting a loved one through a medically assisted death in Canada, found all participants to be supportive of their loved one's choice – even those who initially opposed changed their minds after witnessing the suffering of their loved one.[29] There are many ethical, moral, and religious stances that oppose assisted death, in fact, many doctors in Canada refuse to perform these procedures for those reasons, although more care providers in recent years are offering this medical aid.[30,31] Those involved with providing and facilitating MAID services challenge the notion that dying well (or as well as possible in the context of terminal illness) is the only option available, and that sometimes a quick and painless death is preferable.[32] Hospice seems like a logical choice of environment for these procedures; a dedicated building which would allow for a comforting environment for a person's final moments. However, a *Health Canada* studies from 2018 identify that 40.5% of assisted deaths occurred at the hospital, 43.3% at home, and 16.2% in assisted living facilities – where hospices are not currently used as the setting for this medical intervention.[33] Instead, non-profit organizations like MAiDHouse are working to reduce the gap in accessibility for those unable to die at home, providing "a home-like

27 Byock, *Dying Well, 75*.

28 "Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying)," Government Website, Department of Justice Canada, October 21, 2020, https://www.justice.gc.ca/eng/csj-sjc/pl/charter-charte/c7.html.

29 Sheila Holmes et al., "Exploring the Experience of Supporting a Loved One through a Medically Assisted Death in Canada," *Canadian Family Physician* 64 (September 2018): e392.

30 Lauren Vogel, "Many Doctors Won't Provide Assisted Dying," *CMAJ : Canadian Medical Association Journal* 187, no. 13 (September 22, 2015): E409, https://doi.org/10.1503/cmaj.109-5136.

31 Health Canada, "Second Annual Report on Medical Assistance in Dying in Canada 2020," datasets, June 30, 2021, https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2020.html.

32 Diane Rehm, *When My Time Comes: Conversations About Whether Those Who Are Dying Should Have the Right to Determine When Life Should End* (New York, NY: Alfred A. Knopf, 2020), 155.

33 "Fact Sheet: Hospice Palliative Care in Canada" (Canadian Hospice Palliative Care Association, 2020), 9, https://www.chpca.ca/campaigns/national-hospice-palliative-care-week/nhpcw-2020/.

setting for those eligible to receive MAiD."[34] There are also instances in typologies like funeral homes creating spaces to accommodate MAiD – streamlining the funerary process.[35] However, many challenges persist in establishing permanent spaces for MAid, relating to stigma, cost, and zoning limitations.[36] Hospices have the potential to normalize MAID as an option for the end-of-life, reducing stigma and shame currently surrounding it.

## *ARCHITECTURE AND AGENCY IN HOSPICE SETTINGS*

In hospice, the goal is to meet the unique needs of each patient - whatever is necessary to provide comfort and ease. In some cases, this includes activities that may not be conducive to health and wellness, like smoking. A point that came up during field work interviews with care providers was that a "big issue with some residents and hospice is they're not allowed to smoke in the building. Right, so if you have someone who has smoked their whole life. They're dying. They have to come here. When they come here, they're told they can't smoke because it's fire department regulations, and they must be 30-meters from the building."[37] This results in patients who smoke having to be transported outside by staff and considering the climate of Ontario that is not always something possible or pleasant for any parties involved. Agency for individuals at the end-of-life means being allowed to choose to do so. Besides changes being made in the fire code (and the Smoke-Free Ontario Act, 2017, which prohibits smoking in residential hospices), the other option is to provide dedicated smoking space on the site that is easily accessible, year-round for staff, visitors, and residents.[38]

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34 "Our History," Organization Website, MAiDHouse, accessed November 11, 2024, https://www.maidhouse.ca/our-history.

35 Andrew Lupton, "Funeral Homes Pivot to Offer Rooms for Medically Assisted Deaths," *CBC News*, October 26, 2021, https://www.cbc.ca/news/canada/london/funeral-homes-pivot-to-offer-rooms-for-medically-assisted-deaths-1.6224353.

36 Kate McGillvray, "Medically Assisted Death Nonprofit Says Fear Is Hampering Its Search for Permanent Space," *CBC News*, October 31, 2021, https://www.cbc.ca/news/canada/toronto/medically-assisted-death-nonprofit-says-fear-is-hampering-its-search-for-permanent-space-1.6230573.

37 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

38 "Where You Can't Smoke or Vape in Ontario," Government Website, Ontario Ministry of Health, accessed November 11, 2024, http://www.ontario.ca/page/where-you-cant-smoke-or-

Despite this, traditional smudging or incense burning practices are still permitted in certain environments, including residential hospices, as they are important rituals for certain cultural backgrounds.[39] While not always an option at every hospice residence (and even less so at hospitals), some of the newer-built hospice residences have been designed to have HVAC systems to specifically support these activities. Demonstrating innovation in hospice design in efforts to meet the spatial needs of local demographics, one hospice director explained that:

> *"[w]e built that in at the beginning because we knew we wanted to be able to accommodate indigenous traditions [of smudging]. We also know, for instance, that some of the Buddhist and Chinese communities like to burn incense as part of their cultural tradition around the end of life. So that was going to work, and there are often certain medical conditions where there's quite a lot of odor that comes either with wounds or something like that. So being able to manage that with this reverse air in the room was really important"*[40]

## 2.3 KEY OCCUPANTS IN HOSPICE

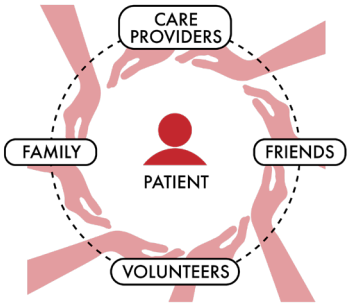



**Figure 2.2**
**Collaborative circle of care**

By acknowledging the diverse perspectives and needs of stakeholders, hospice residence design can better support compassionate, *person-centered care* (which takes an approach that focuses on tailoring care to suit the needs and preferences of the patient). The environment should be supportive and engaging for the patient, visitors, and care providers. Hospice residents, also known as patients, are at the centre of a collaborative circle of care composed of healthcare professionals, family, friends, and volunteers. This circle prioritizes the resident's comfort and dignity during the end-of-life stage, which is a complex and nuanced experience, individual to each person.[41] In the context of the time a patient

vape-ontario.

39 "Where You Can't Smoke or Vape in Ontario."

40 Hospice Director, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

41 "Palliative Care: Overview," Government Website, Health Canada, February 25, 2016, https://www.canada.ca/en/health-canada/services/health-services-benefits/palliative-

will typically spend in a hospice, they are fully transitioned into the space and establish personal boundaries defined by the programming. In designing spaces of care, it is critical to consider the diverse perspectives within hospice care to set the stage for human-centred design.

Due to the limited availability of hospice beds in the province and the fact that most hospice operate at close to full capacity, many hospices require a 3-month prognosis in order to admit a new resident - although the length of stay at hospice residences in Ontario currently averages around 10 days to 2 weeks.[42] For those who can access these residences, the length of their stay can vary from a few hours to days, weeks, and occasionally months. There are some individuals who leave hospice, who go on to find themselves in remission of their illness.

The end-of-life experience is a complex and individual one, it can be unpredictable and disorienting. A universal experience in hospice (and care spaces in general) is the act of waiting—for an appointment, a therapy session, to have vitals checked, for family and friends to arrive. The passing of time slows down and is drawn out whilst waiting, giving space to be present in the moment or take a moment of reflection - allowing our complex emotions to permeate to the forefront of our minds.[43] Spending time in the right space can be a source of comfort, therefore waiting spaces that are designed with this sensitivity in mind can greatly impact the experience of patients and especially visitors.

Space matters: we are sensitive to our environments. Thoughtful design is critical in spaces of care, where the human experience is rooted in search of comfort and support for varying lengths of limited time. For instance, integrating nooks or alcoves for big enough for a couple of people or a single person allows for moments of solitude or space for private conversations away from communal spaces. Or offering multi-purpose rooms of various sizes to support private and communal grief/bereavement counselling sessions. The types of spaces needed are ones that are accessible to individuals of various lived experiences

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care.html.

42 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.

43 Worpole, *Modern Hospice Design,* 174.

and backgrounds that make up our communities. Space that allows for community engagement and interaction and allows for families and friends to gather and feel supported in their time of grief.

There are emotional, social, and spiritual implications manifested in space, where thoughtful design cognizant of the experience of loss, grief, and death can provide support. This can look like a hospice offering a multi-faith spiritual space to support the varied spiritual and religious beliefs of patients and their loved ones, allowing them to practice their respective rituals, or simply find solace and engage in quiet reflection. There is much research today dedicated to design interventions in medical environments to support human well-being (like biophilia). Even within the literature, it is evident that creation in response to loss has served as inspiration for much of the research and development of ideas relating to the design of end-of-life spaces. Many of the major architectural writers who specifically focus on improving the spatial experience of hospice have been inspired by their own experiences of losing loved ones in environments that were subpar, for example for Stephen Verderber following the death of his father, Charles and Maggie Jencks following her diagnosis with cancer, even the founder of the modern hospice movement, Dame Cicely Saunders, herself was inspired following the death of a close friend. Sarah McGann prefaces her book, *The Production of Hospice Space* by describing the experience of both her parents passing away in hospitals, noting specifically that while the care provided was great, it was the space that majorly affected the experience for her and her siblings in a negative way.[44]

## *PATIENT/RESIDENT*

*What is the experience of dying like in respect to mind, body, and spirit?*

The experience of someone in palliative care is shaped by factors such as their health condition, personal values, and support network. In many cases, individuals at the end-of-life stage prefer to remain at home

44 Sarah McGann, *The Production of Hospice Space: Conceptualising the Space of Caring and Dying* (Surrey, England: Ashgate Publishing Limited, 2013), ii.

or in their community, requiring family and friends to take on caregiving roles to ensure the daily physical and emotional needs of patients and to participate in treatment decisions. Not all people come from positive home-life experiences, and some lack homes or support systems that they can rely on. Others may come from a fulfilling home environment but lack the capacity to provide the required level of care or cannot afford private in-home care. Hospice residences provide an alternative site of care with dedicated staff to relieve family and friends of the responsibility of overseeing all care.

Dying from a terminal illness has mental, physical, and emotional impacts on a person. Physically, there are many side effects depending on the illness that may cause discomfort and pain – these are addressed through medication, treatments, and 24/7 care from nurses in hospice. There is much stress and anxiety and anger and sadness that emerges when a person begins to face their mortality. Kubler-Ross discusses the experience of grieving one's own life and facing the reality of dying a slow death. This *preparatory grief* is why she strongly advocates for the importance of open communication with loved ones and care providers at the end of life.[45] In some hospices, pets can visit as well – greatly contributing to the emotional regulation and comfort of residents. Facing one's death forces a person to grapple to reflect on the life they have lived, and the people who will continue on without them. They face their mortality, their faith – most faiths have rituals or related practices dedicated to the dying and end of life. Spiritual reflection is a large part of dying, where many people draw strength and comfort from their respective faiths and spiritual beliefs.

Memory has a powerful influence on emotions, often prompting people to collect artifacts that evoke memories and emotional responses. Resident suites should give space to display these artifacts – like blankets, posters, framed photos, books, DVD collections, hobbies, and art – around the room, within sight of the patient in their bed. Making the space their own in this way provides a sense of comfort and ease. Personalization and adaptability in the space, such as visible storage for special belonging,

45 Elisabeth Kubler Ross, "What Is It like to Be Dying?," *The American Journal of Nursing* 100, no. 10 (2000): 96CC, https://doi.org/10.2307/3522329.

are key to creating a comforting space tailored to the patient and their lived experience, also extending to their loved ones.

## *VISITORS/FAMILY & FRIENDS*

*What* is it like *to lose a loved one? How is the experience of losing a loved one, and grief of family/friends supported in a hospice environment?*

Understanding the pivotal role of family and friends in end-of-life care reveals the need for dedicated spaces within hospice. Kubler-Ross identifies this *preparatory or anticipatory grief* in family members when a loved one enters palliative care, where they begin to grieve before the patient has passed.[46]

Families are encouraged to participate in the life and care of the patients and are sometimes able to stay at the hospice overnight (usually just for a few days). From the perspective of care providers: "It's very much like...hotel living...sometimes we really have to convince them to go home...because they're just kind of living out of a bag here." [47] Depending on the size of the hospice, there is not always space to support overnight stays for family members. If they are travelling long distances from home to receive hospice care, the family may stay in a hotel/other accommodation nearby.

The communal spaces, like the kitchen/dining rooms, living rooms, sunrooms, are meant for temporary usage primarily for the visitors, the family and friends of the patient, space to be in each other's company, share a meal, reminisce about shared history. These spaces facilitate private conversations and connection for loved ones, providing an alternative site of care that relieves them of the responsibility of overseeing all aspects of care and provide the space to be able to focus on their loved one instead. Considering the varying ages of visitors is also critical in planning effective communal spaces, sometimes the experience of hospice for children can be confusing or overwhelming so having space dedicated to supporting

46 Kubler-Ross, *On Death & Dying,* 70.
47 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

them through this experience can make a big difference for the whole family.[48] Activities like making art that they can give to their loved one can be facilitated in spaces like this.

Oftentimes, following the death of their loved one, family members can return to the hospice for bereavement services and to participate in commemorative celebrations for the deceased, allowing them to connect to a community of support to help process their grief. It can be therapeutic to return to an environment that brought so much comfort to a loved one in their final moments.

## *STAFF/CARE PROVIDERS*

*What is the mental, physical, and spiritual toll on the care providers?*

Palliative care is most effectively provided by an interdisciplinary team of healthcare professionals that work in tandem with family members, friends, and volunteers for a well-rounded circle of care. This team often includes nurses, physicians, chaplains, dietitians, pharmacists, psychologists, social workers, speech pathologists, integrative therapists, occupational therapists, physiotherapists, recreational therapists, etc.[49]

For staff, who are consistently delivering care to others, it is important that they themselves receive support and reprieve. Receiving adequate support at work, counselling services, private work and break areas make a big difference in their overall wellbeing. Caring for the dying and supporting individuals grieving and processing the death of a loved one is an emotionally challenging thing to be a part of consistently, revisiting their own experiences of grief.[50]

In her essay titled, "Caring Architecture," in the book *Critical Care: Architecture and Urbanism for a Broken Planet,* Joan Tronto and Berenice Fisher provide an intentionally broad definition based on the

48 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
49 "Palliative Care."
50 Elizabeth C. Pomeroy, "EDITORIAL: On Grief and Loss," *Social Work* 56, no. 2 (2011): 102, http://www.jstor.org.proxy.lib.uwaterloo.ca/stable/23719363.

notion that *"[c]are is a species activity that includes everything we do to maintain, continue and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we interweave in a complex, life-sustaining web."*[51] To work in hospice palliative care, one must be compassionate and caring, able to navigate complex conversations in a professional manner with patients and visitors. As one care provider explained: *"We're common, down-to-earth people. I think we know what life is about because we've seen everything. We're not afraid of what's coming, and I think you have to be that way and have an understanding and an appreciation to be able to impart that to the people that you're working with."*[52]

### VOLUNTEERS:

An extension of the staff and care providers are the volunteers, who can provide support and engage with residents and their loved ones in different ways, including having conversations about death and dying, providing kitchen support, community outreach, fundraising, garden maintenance, etc.[53] Volunteers are often community members who used the hospice services previously and volunteering is an opportunity to give back and honour the memory of their loved one. Considering the demographics of the volunteer base is essential to designing adequate and functional service spaces. Larger hospices typically will have facility or grounds managers to oversee the maintenance, housekeeping/janitorial duties. The constant influx of patients and visitors have an impact on the physical environment, so having strategically located support spaces can ease the task of regular maintenance.[54] Based on the field work interviews, the majority of volunteers tend to be seniors who often have more limited physical mobility.[55] Accessing

51 Joan C. Tronto, "Caring Architecture," in *Critical Care: Architecture and Urbanism for a Broken Planet* (Cambridge: MIT Press, 2019).

52 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.

53 Andrea Rodríguez-Prat and Donna M. Wilson, "End-of-Life Conversations about Death and Dying from Volunteer Perspectives: A Qualitative Study," *Palliative and Supportive Care* 22, no. 3 (2024): 527, https://doi.org/10.1017/S147895152300189X.

54 Stephen Verderber and Ben J. Refuerzo, *Innovations in Hospice Architecture* (New York, NY: Taylor & Francis, 2006), 82.

55 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

service spaces in basements with steep stairs or working in kitchens or the laundry room with counters that are too high are challenges that emerge spatially for volunteers.[56]

## 2.4 EMBODIED EXPERIENCE OF SPACE

Phenomenologist Maurice Merleau-Ponty describes the entire body, not the mind, as the vessel of human perception. *Peripersonal space* is a "highly charged field to which the body is acutely sensitive," and is defined by the space that can be reached by fully extending the arms.[57] It can be understood as the scientific explanation for how we can intuitively avoid a sharp corner on a table as we walk past it, or learn to ride a bike by pre-consciously accepting the bike as an extension of our body. These are body-centric, as opposed to *retino-centric*, visual receptive fields.[58] In "The Mind of the Environment," Juhani Pallasmaa states that "[h]ealthy architecture evokes an embodied experience of the world; I exist in the world, and the world exists through me." This healthy architecture that is engaging to the senses and connected to the world around us in a reciprocal relationship, considers the built form not as a static component that facilitates our everyday activities, but as an active participant in our lived experiences. Utilizing evidence-based and compassionate design approaches to enrich this human-environment relationship, allows the architect to create engaging spaces, preventing a sense of "alienation towards the environment."[59] Instead, key spaces can incorporate sensory-engaging elements in the design to support the embodied experience of space.

56 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.

57 Harry Francis Mallgrave, "From 'Object' to Experience," in *Intertwining: Unfolding Art and Science* (Mimesis International, 2018), 68.

58 Vittorio Gallese, "Interview on Architecture and Neuroscience with Sarah Robinson, Intertwining 2018.," *Intertwining* 1 (July 27, 2018): 79–80.

59 Saeid Soltani and Nazan Kırcı, "Phenomenology and Space in Architecture: Experience, Sensation and Meaning," *International Journal of Architectural Engineering Technology* 6 (June 10, 2019): 5, https://doi.org/10.15377/2409-9821.2019.06.1.

In an interview with architect Sarah Robinson, Vittorio Gallese, cognitive neuroscientist and professor, further delves into this body-centric visual perception that blends emotional, tactile, and motor sensations: "...I engage in this perception with a whole lot more than my visual system, basically I engage my emotional system, my tactile system, my motor system. So...we are synesthetes 24 hours a day--our perception is intrinsically synesthetic."[60] Sensory experiences in space can be described as the smell of fragrant flowers as we walk through a garden; the tactile experience of walking along a crunchy, gravel path and brushing your hand through the tall grass planted in the adjacent flowerbed; the intuitive understanding of where to walk along the path or pause to take in a view; the soundscape of the gentle whistling of wind through the trees and the occasional hum of cars passing by in the distance. "Our experience of architecture is a full-bodied affair," where our brains can map the space in the vicinity of our body.[61] In hospice, this is especially important considering the varied physical capabilities of occupants, emphasizing the need for different types of mobility accommodations wherever possible – like points to rest a long a hallways or path, railings, ramps, soft edges.

## 2.5 HOSPICE AS HOME

"Home" and "homelike" are common descriptors of hospice space, whether that be in the design standards, regulations, or the hospice residence website descriptions. Many of the hospice websites specifically use the term to differentiate hospice from hospice palliative care wards in hospitals or long-term care centers. Every person's experience of home and what it means to them is unique to their lived experience. Defining home and homelike spatially can be challenging for this reason. And while every hospice is context-specific in design, there are certain universal qualities of home that have spatial representations.

These qualities were adapted from a conversation with Barbara Miszkiel, Director of Health and Vice President at HDR, who specializes

60 Gallese, "Interview on Architecture and Neuroscience with Sarah Robinson, Intertwining 2018," 80.
61 Gallese, "Interview on Architecture and Neuroscience with Sarah Robinson, Intertwining 2018," 82.

in designing spaces of care, regarding a presentation about ways to think about home in a meaningful way. Core aspects that define a sense of home and support the emotional and psychological wellbeing of occupants include[62]:

1. Connection - Creating spaces that foster closer connection, or the nurturing of close relationships between residents, visitors, and care providers, fundamental to creating a comforting environment.

2. Sense of belonging - Developing a sense of belonging through an inclusive environment where residents feel that their identities, experience, and preferences are recognized. Feeling valued and accepted within hospice.

3. Providing choice - Enabling freedom of choice for residents to decide their own daily activities and routines (mealtimes, hobbies, etc.) is critical to preserving a sense of autonomy and dignity. Providing options for communal or personal gathering spaces for visitors (living, dining, etc.) enhances their sense of control and comfort.

4. Measurement of time and space - Utilizing natural elements, like the position of the sun throughout the day, intrinsically inform occupants about orientation in time and space, respective to the specific context of the building occupied. The connection to the natural world is grounding and aids in maintaining a sense of normalcy or consistency between days.

5. Sense of community - Cultivating a strong sense of community through spaces designed for communal activities and social interactions - including communal spaces, organized activities and events that encourage social engagement and support.

In the interviews conducted through the field work, all participants were asked to define what home means to them and what that means spatially. In describing the typical atmosphere in hospice, a care provider said: "Really, I would say that everything's kept calm and quiet, but you

62 Barbara Miszkiel, Defining a sense of home through design, Virtual Call, June 27, 2024.

can still hear the goings on in life, but it's not frantic in any way...So we make sure that people feel like it's their own space and they're not being intruded on by others. "[63]

One participant identified the private rooms with lots of natural light for residences as something that makes hospice homelike, patient privacy being a big challenge in traditional healthcare environments. Exposure to natural light has a large sensory impact on the human body and is especially important for spaces of care, also creating opportunities to integrate more nature into the interior of the space. Dedicated communal spaces where families can gather and engage in homelike activities like sharing a meal, playing games, and spending time together, stand out in hospice design.[64] Even the sensory experience of the scent of food wafting through a space can contribute to this sense of warmth and home. One hospice director mentioned that they encouraged their chef to bake cookies regularly because the smell was so pleasant for the visitors. Colour choice also came up as something that greatly differentiated institution and home space. Along this vein, texture and tactility of materials for finishes and furniture are important in creating a more domestic quality of space; quilts on beds, pillows and blankets on couches, carpets wherever possible.[65]

While these points are helpful especially for design, it is important to remember that not all people have the same home experiences or come from homes where these qualities were present. In "Home and/or Hospital: The Architectures of End-of-Life Care," Annmarie Adams, an architectural writer, critiques the major writers in hospice/palliative design, including Ken Worpole, Stephen Verderber and Ben J. Refuerzo, and the early design philosophies associated with the emergence of hospice. Adams specifically looks at the notion of hospice as home, arguing that home has different connotations for different lived experiences and that proposing home as the ideal final resting place is rooted in a "utopian middle-class ideal."[66] This also lends to the inconsistent and diverse approaches to

63 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
64 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
65 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
66 Annmarie Adams, "Home and/or Hospital: The Architectures of End-of-Life Care," *Change Over Time* 6, no. 2 (2016): 250-51, https://doi.org/10.1353/cot.2016.0015.

hospice residence space that have emerged over time. One response also brought up an experience they had where they were working with a client who was coming out of poverty and experiences of homelessness, and the hospice that they had been referred to was a converted mansion that was immediately intimidating to them and completely removed from their own experience of home.[67] Nitin Ahuja, builds upon this concept in their piece *End Stages*, where they identify the paradox of relating hospice design to home or homelike. Understanding that there are no "universally advantageous circumstances for death," Ahuja proposes instead that hospice design is continuously evolving as our understanding of varied desires for end-of-life environments continues to grow.[68]

# 2.6 CONCLUSION

Creating a space that can feel comforting in a homelike sense for people of diverse experience is a challenge that emerges as the philosophy of hospice is translated through design. Rather than replicating the architectural details and elements that comprise a traditional, typical single-family dwelling and translating them into a sort of domestic institutional space - which can result in situations like the above - imbuing the hospice with the philosophy of home and understanding of how we engage in space. Designing with an understanding of the key perspectives and incorporating evidence-based design methodologies to facilitate a holistic approach to hospice allows the architect to create opportunities for moments -of connection or reflection/introspection.

67 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

68 *Nitin Ahuja, "End Stages," Places Journal, May 2018, https://doi.org/10.22269/180515*.

# 3. EVIDENCE-BASED DESIGN CONSIDERATIONS

Evidence-based design is a process where design decisions are informed by credible research to achieve performance-based spatial goals, rather than a prescriptive list of requirements. The rigidity of a prescriptive list inhibits design innovation and alternative approaches to spatial problem solving, while further abstracting the human experience in space to be an idealized rather than an infinitely varying one. Establishing a foundation of evidence-based design research to define primary design considerations for hospice will reinforce the overall design approach. Fieldwork interviews with care providers further contextualizes these considerations with localized insights, attuning the design to the embodied needs of occupants.



**Figure 3.1 Paimio Sanatorium**

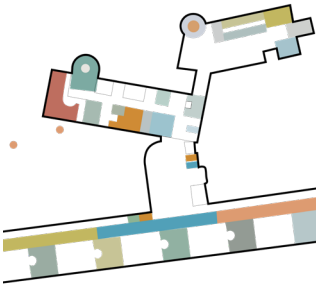


**Figure 3.2 Colour scheme plan of the sanatorium by Eino Kauria**

An early example of evidence-based design, Alvar Aalto's Paimio Sanatorium (1929-1933) was designed as a metaphor for healing and hope, where the architect is designing for "man at his weakest," following his own experience as a long-term hospital patient. There was no treatment for tuberculosis other than improving the general wellbeing of the patients – meaning exposure to good hygiene, fresh air, and nature. Access to the exterior was essential then to the wellbeing of patients, so Aalto introduced large sun decks and walking paths around the hospital grounds.[1] The interior was designed in collaboration with his wife, Eino, with special attention towards details of furniture and fittings – specifically their tactile quality (soft curves) and colour.[2] "They prescribed a palette of strong and soothing colours, vivid without being unduly cheerful."[3] In this

1 D. Anderson, "Humanizing the Hospital: Design Lessons from a Finnish Sanatorium," *Canadian Medical Association Journal* 182, no. 11 (August 10, 2010): E535–37, https://doi.org/10.1503/cmaj.090075.

2 Ellis Woodman, "Revisit: 'Aalto's Paimio Sanatorium Continues to Radiate a Profound Sense of Human Empathy,'" The Architectural Review, November 17, 2016, https://www.architectural-review.com/buildings/revisit-aaltos-paimio-sanatorium-continues-to-radiate-a-profound-sense-of-human-empathy.

3 Joe Lloyd, "Architecture Icon: The Paimio Sanatorium and Its Humanistic Approach to Modernism," *ICON*, September 21, 2023, https://www.iconeye.com/architecture/tuberculosis-sanatorium-paimio-humanistic-modernism.

case, the lived experience of the designer informed the design approach, and specific challenges identified through Aalto's experience as a patient translated into design strategies.

In 2005, Verderber discussed the challenge of the profession of architecture operating from lack of evidence-based research to inform design, instead relying on intuition and design instincts.[4] Since then, there has been increasing research on how buildings impact health and that the designed environment is essential for providing non-medical support for the embodied experience of all occupants.[5] In the 2018 study "Environmental Design for End-of-Life Care: An Integrative Review on Improving the Quality of Life and Managing Symptoms for Patients in Institutional Settings," the synthesis analyzed 225 documents focused on environmental design factors that improve quality of life for palliative care patients and identified: "The key environmental factors shown to affect end-of-life care were those that improved **1) social interaction, 2) positive distractions, 3) privacy, 4) personalization and creation of a home-like environment, and 5) the ambient environment.**[6]

The primary design consideration for a holistic approach to hospice design include:

1. A strong connection to nature
2. Balancing privacy and communal spaces
3. Adaptability, personalization, and multi-functionality of space
4. The importance of accessibility and ease of movement in space
5. Fostering a sense of home/ease/domesticity through design

4 Stephen Verderber, Compassion in Architecture: Evidence-Base Design for Health in Louisiana (Lafayette, Louisiana: Center for Louisiana Studies, 2005), 5.

5 Knox M. (2023). Design-Related Impacts on End-of-Life Experience: A Brief Report of Findings from an Exploratory Qualitative Study. *The American journal of hospice & palliative care*, *40*(7), 758. https://doi.org/10.1177/10499091221129203

6 Rana Sagha Zadeh et al., "Environmental Design for End-of-Life Care: An Integrative Review on Improving the Quality of Life and Managing Symptoms for Patients in Institutional Settings," *Journal of Pain and Symptom Management* 55, no. 3 (March 2018): 1018, https://doi.org/10.1016/j.jpainsymman.2017.09.011.

# 3.1 A STRONG CONNECTION TO NATURE

Biophilia, *love of nature*. Naturalist Edward O. Wilson defines biophilia as the "innate affiliation people seek with other organisms and especially with the natural world."[7] Humans share a profound connection with the natural world; existing within the same life-death cycles. This embodied connection with the living is something that the artificial cannot replicate. Biophilic design "seeks to create a good habitat for people as a biological organism in the modern built environment that advances people's health, fitness, and wellbeing."[8] By establishing sustained engagement with nature through design, a reciprocal, contextual relationship between person and place is formed. This engagement can be attributed to direct (encounters with natural elements) or indirect (representations of nature in space) encounters with nature corresponding to experiences rooted in space and place in hospice.




**Figure 3.3 Direct and indirect encounters with nature**

People naturally gravitate towards environments that combines the following features: elevated views, open terrain with scattered trees, and proximity to a body of water.[9] This neurological connection to nature engages the autonomic nervous system, which includes the sympathetic (stimulates cognitive function) and parasympathetic (calms the body) nervous systems. Stressful environments activate the sympathetic system,

7 Edward O. Wilson, "The Nature of Human Nature," in ***Biophilic Design***, ed. Stephen R Kellert, Judith H Heerwagen, and Martin L Mador (Hoboken, New Jersey: John Wiley & Sons, 2008), 23.

8 Stephen R Kellert and Elizabeth F Calabrese, "The Practice of Biophilic Design," n.d., www.biophilic-design.com.

9 Wilson, "The Nature of Human Nature," 23.

suppressing the parasympathetic system and leading to energy drain and mental fatigue.[10] The built environment often stimulates the sympathetic system, whereas natural environments have the opposite effect – the presence of nature in our environment creates a calming sensation on a neurological level. Dozens of studies in the healthcare sector have been published on the topic of identifying biophilic elements as primary influences on quicker recovery rates, reduced medication dependency, overall stress-reduction, and improved emotional wellness of all users.[11]

Robert Ulrich's influential 1984 study on patient recovery rates in hospital settings found that patients who had a view of nature from their room has faster recovery rates leading to shorter hospital stays.[12] This finding is reiterated by care providers through the field work, where fresh air is identified as a big aspect of comfort, so outdoor access and views are essential for patient rooms.[13] Having operable windows and doors with screens, large enough for beds to be moved outdoors, creates a permeable threshold connecting humans with nature. Care providers can attest to this based on feedback from patients and visitors: "For so many of them it is the sounds and the feeling of the sun and the warmth that they really comment on all the time. You know the fact that we've got the gardens up to the windows so you can get some scent of flowers and vegetation...."[14]

Creating further opportunities on site to be immersed in the natural world, like implementing a hospice garden or greenhouse whether they are simply sitting or actively engaged in the space through activities, can have a positive impact on all occupants.[15] Through the field work, a care provider noted "windows are the heart of our place because they really allow them to be able to experience nature," where each patient room had a bird feeder placed outside the window. Birds singing, or perching

10 "How Biophilic Design Can Help Manage Chronic Disease," Architectural Firm, *HDR* (blog), November 24, 2023, https://www.hdrinc.com/insights/how-biophilic-design-can-help-manage-chronic-disease.

11 Rory Martin and Stephen Choi, "Biophilic Design: An Introduction for Designers," *Environment Design Guide*, 2018, 1–15, https://www.jstor.org/stable/26496280.

12 R. S. Ulrich, "View through a Window May Influence Recovery from Surgery," *Science (New York, N.Y.)* 224, no. 4647 (April 27, 1984): 420–21, https://doi.org/10.1126/science.6143402.

13 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

14 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

15 Ken Worpole, Modern Hospice Design: The Architecture of Palliative and Social Care, 2nd ed. (London: Routledge, 2023), 160, https://doi.org/10.4324/9781003306818.

to feed, being common observances at this hospice.[16] Simulated natural environments or nature-immersion rooms are particularly innovative especially in climates with winter seasons or when outdoor access may not be an option for patients. There is potential for applications of this in interior rooms (without windows) as well, such was the case when I was interviewing a care provider in an office of one hospice - who had ambient bird sounds playing on a speaker in the room (which I only noticed part way through the conversation that there were no windows):

*Author:*
*I was just about to ask - are those real birds we're hearing right now?*

*Care Provider:*
*I put that on because it's very relaxing. It's one of those things that helps me to do my charting really fast. It just helps me focus, keeps me calm.*[17]

# 3.2 BALANCING PRIVACY AND COMMUNAL SPACES

Having communal spaces of varying sizes to facilitate private conversations or provide breakout "spaces for a family or group of families can make a big difference in establishing a sense of privacy and ease for occupants. Maintaining acoustic or aural privacy requires consideration of adjacencies and spatial organization, but also foresight to incorporate sound absorptive or acoustically insulative materials into the construction of key spaces, including circulation spaces, patient rooms, staff offices, psychosocial therapy rooms, and restrooms. While materiality plays a big part in acoustic privacy, the design of transition spaces/thresholds (doors, windows, porches, etc.) can also function as sound buffers.[18]

Considering the complex and varied experiences of those in hospice, acoustic privacy is essential not only to maintain occupant comfort but also to support the sensitive or confidential conversations that often occur between care providers and patients and/or visitors. Being

16 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
17 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
18 Stephen Verderber and Ben J. Refuerzo, Innovations in Hospice Architecture (New York, NY: Taylor & Francis, 2006), 62.

able to hear patients potentially in distress can cause disturbances for other patients and visitors, and loss of hearing can also result in louder than average conversations or the sounds of television/music.[19] One care provider who specialized in bereavement counselling described challenges in facilitating private conversations: "So if I'm having a conversation with someone in this room...You can hear it if we're talking loud, but we can also hear - not words, but you can hear laughter, and depending how loud, it can be a bit distracting if someone's in a sensitive space."[20]

Privacy in space should also be considered from the care provider's perspective, creating spaces for moments of reprieve from their duties and other occupants. The toll of care is often overlooked, resulting in small staff spaces and offices with only interior windows - lacking the views of nature so prioritized in communal and patient spaces. In fact, one care provider described their interior staff room akin to "a fishbowl."[21] To always be in the line of sight of another occupant increases the likelihood of interruptions, which is often the case particularly for nurse's stations: "...everywhere has windows, so people are watching you. And for the clinical staff, sometimes it can be challenging to leave the floor."[22] This can also make focusing on tasks more difficult, where arterial workspaces could create opportunities for privacy.

Understanding views and sightlines is critical in maintaining privacy and comfort in hospice design. Whether that be maintaining clear sightlines to staff in communal spaces for visitors or ensuring that a patient is not visible in their bed from the door for anyone walking down the hallway to peer in and see. This is also important for external sightlines, depending on site design, for example, if external visitors can see inside through the windows. Site planning should prioritize communal and clinical spaces towards more active parts of the site, allowing for private or resident spaces to be oriented closer to the interior of the site to maintain respectful sightlines.

19 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
20 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
21 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
22 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

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## 3.3 ADAPTABILITY, PERSONALIZATION, AND MULTI-FUNCTIONALITY OF SPACE

Adaptability at varying scales in hospice residences is important for the use of space. In the scale of the building, many hospices are designed with potential for expansion depending on future community need and funding availability. In the scale of the resident room, adaptability that addresses both varying accessibility needs (some patients are bedridden, where other can move around freely) as well as opportunities for personalization (how do we make a room our own? What makes a space feel like home to us?) is critical to providing comfort and ease. As well as on the care-focused spaces – adaptability to provide different forms of treatments. For visitors, adaptability of communal spaces – living rooms, kitchen/dining spaces, multi-purpose rooms, and outdoor space – is important for establishing a sense of agency and comfort – which has varying definitions for all people. Even spaces dedicated to faith/spirituality are often designed to evoke sensory engagement without defining a specific denomination or that can be adapted to different uses (multi-faith spaces, accessible to just an individual or larger groups, different religious ceremonies, even celebrations like weddings) Functional adaptability for staff/care providers is also important, since the space should support the efficiency in which care can be delivered.

Balancing neutrality in space without becoming generic can be challenging, especially considering the duration of use typical for a resident suite. Neutrality is a component of hospice residence design; however, its purpose is to allow for personalization or customization of space to better serve the occupants – whether that be a resident and their

family's cultural practices or religious needs, or the variance in treatment plans that the care providers and staff work to accommodate and deliver effectively. The space must be dynamic and adaptable to the constant flux of occupants and needs.

Adaptability and opportunities for personalization/customization of key spaces in hospice gives a sense of agency to occupants. The ability to personalize a space can help ease the transition from home to hospice, where fixed elements, like shelves or pinboards, allows the occupants to imbue the space with a reflection of themselves and their lived experiences.[23] Customization depending on occupancy needs for key spaces can look like flexible partition walls or adjustable table heights, which allow occupants to modify the space for their specific needs (including optimizing views, privacy, etc.). Especially in the resident rooms, prioritizing "the ability of those spending time in it to control vital matters of temperature, access to light when wanted, and of course fresh air," are all conducive to providing as much agency of space one would have in their own homes, in hospice.[24] In this sense, a holistic design approach should encompass both personalization and adaptability.

## 3.4 THE IMPORTANCE OF ACCESSIBILITY AND EASE OF MOVEMENT IN SPACE

Accessibility is a priority for all users in hospice design. There must be a sensitivity to transitioning between public and private space in the residence, offering adaptability to suit different user engagement scenarios. Enriching hospice design through *normative methodologies*, as discussed by architect and lecturer Sarah Gunawan in *Starting From "New Normal(s)": Non-Normative Design Methodologies in Architecture Education,* can challenge traditional standards and the idealized body type perpetuated in the architectural canon to promote a more inclusive environment.[25] Gunawan posits that a *post-humanist perspective* supports

23 Worpole, Modern Hospice Design, 69.
24 Worpole, Modern Hospice Design, 109.
25 Sarah Gunawan, "Starting From 'New Normal(s)': Non-Normative Design Methodologies

design that can accommodate diverse physical, cognitive, and sensory needs for each occupant type – using the *lens of aging* to understand the body's changing abilities over time, informing a more diverse understanding of the embodied experience in space.[26] This perspective encourages adaptable and flexible design that can accommodate varied abilities of occupants, including considering circulation, thresholds, and support spaces.[27] This methodology aligns with a compassionate approach to accessibility, that relates to the holistic approach needed for hospice.

The Rick Hansen Foundation (RHF) has been advocating for accessible and inclusive design for people with disabilities since 1988.[28] RHF also publishes various accessibility design guidelines to support improving accessibility in buildings and communities. Referring to these guidelines in addition to the RHF Accessibility Certification Rating Survey will support thoughtful, accessible design in hospice.[29] Referring to existing accessibility design standards available from the City of Toronto's *Accessibility and Design Guidelines* and the City of Vancouver's Accessibility Building Bylaw, both documents provide a comprehensive framework for accessible, barrier-free environments for all individuals.[30,31] Key insights to be gained from these documents to support more accessible hospice design for all occupants (especially considering mobility with wheelchairs, crutches/canes, and patient beds) relate to site/landscape, entrances, doors/thresholds, hallways/paths of travel, and washrooms, primarily. These documents serve as an important reference to ensure critical dimensions for barrier-free, accessibility is provided throughout

in Architecture Education," The Funambulist, no. 19 (August 31, 2018), https://thefunambulist.net/magazine/space-of-ableism/starting-new-normals-non-normative-design-methodologies-architecture-education-sarah-gunawan.

26 Gunawan, "Starting From 'New Normal(s).'"

27 Gunawan, "Starting From 'New Normal(s).'"

28 "About Us," Organization Website, Rick Hansen Foundation, accessed November 11, 2024, https://www.rickhansen.com/about-us.

29 "RHFAC Rating Survey v3.0 Pre-Release (May 2020)" (The Rick Hansen Foundation, 2020), https://www.rickhansen.com/become-accessible/accessibility-resources.

30 "Toronto Accessibility Design Guidelines," 2021, https://www.toronto.ca/city-government/planning-development/official-plan-guidelines/design-guidelines/toronto-accessibility-design-guidelines/.

31 "BUILDING ACCESSIBILITY HANDBOOK 2020" (Office of Housing and Construction Standards British Columbia, 2020), https://vancouver.ca/people-programs/building-for-accessibility.aspx.

the hospice design.

Prioritizing ease of accessibility for occupants of varying mobility is critical to consider in spatial organization and circulation design. Accessibility for visitors can often be overlooked in hospice design, specifically bathrooms and other support spaces where patients are not likely to occupy. In this case, care providers are needed to provide support that the building lacks: "...we've had family members that come in and they're quite frail and they need a lot of help, or they use a walker. It's hard for them to just walk all the way around, so oftentimes they will use the bathrooms that are in the residence rooms..."[32] Circulation should be considerate of patient beds being moved between spaces, especially for the care providers who can face difficulties maneuvering beds around tight corners, narrow hallways and doorways. This was a challenge for one of the hospices visited through field work, where a care provider mentioned the "movability of the beds...We can take our beds out, but if you look at where they turn the corners, we've chipped and smashed into the walls."[33] Even moving beds outside proves to be a challenge, even though there are dedicated pergolas outside of each resident room in this case which demonstrates it was designed specifically to accommodate this movement of the patient bed.[34]Smooth transitions at thresholds where beds are meant to be moved are essential to prevent disturbances that significant bump from a door sill could evoke for the patient.

Considering Sequence of Movement Through Adjacencies and Circulation for the layout of a hospice requires a nuanced understanding of the relationship between key spaces, and the implications of adjacencies on the sensory experience of the occupants.[35] Each occupant group has its own distinct sequence of movement through key spaces, and the path is determined by the circulation that connects these spaces. Circulation/ paths of travel should strive to minimize the number of steps required to move between spaces and create visual interest to foster a sense of home and community for occupants by defining thresholds and creating moments for pause throughout (like nooks or alcoves) - strikingly different

32 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
33 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
34 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
35 Worpole, *Modern Hospice Design,* 60.

from the long-winding hospital corridors we are used to.[36] It is crucial to define thresholds, or transition spaces between room and corridor or other rooms, to offer a moment of adjustment as the occupant moves between areas. This is especially important for moments where occupants are transferring from communal to private zones and vice versa. Accessibility and ease of movement in hospice design is critical to providing inclusive spaces for all occupants.

## 3.5 FOSTERING A SENSE OF HOME/ EASE/DOMESTICITY THROUGH DESIGN

In efforts to counter the neutrality and genericism characteristic of healthcare environments, replicating a homelike or domestic environment has been the dominant approach, as previously mentioned. Part of the challenge for designers is understanding the transition of care from the private home to the care home, and what elements contribute to the home-like atmosphere that can be translated from this private to communal space.[37] As previously established, the implications of home and homelike spatial qualifiers assumes home as a safe space where one feels at ease, although this is not applicable for all people. Domesticity can be used as a reflection of human experience in space, an anti-institutional lens. In considering the elements of design that contribute to a sense of domesticity in space, paying particular attention to scale/proportion, material/ colour, and lighting/views can have a large impact on psychological and physical comfort of occupants.[38]

### SCALE/PROPORTION

Scale and proportion focus both on the scale and massing of the building itself in relation to its surroundings, and the individual interior spaces in

36 Sarah McGann, *The Production of Hospice Space: Conceptualising the Space of Caring and Dying* (Surrey, England: Ashgate Publishing Limited, 2013), 62.

37 Worpole, *Modern Hospice Design,* 8.

38 Considerations of Interior Design in Domestic Space between Multiplicity of the Concepts and Determination of Constants Donia M. Bettaieb, Abeer A. Alawad - p57

relation to the human body. As Worpole writes, "there are issues of scale when dealing with such sensitive issues as the care of the sick and the dying, that make intimacy and personalised care difficult," especially when considering the scale of a hospital versus a domestic space, and even large wards that do not enable the fostering of community between occupants.[39] The massing of a hospice building should be complementary to its surroundings, without appearing monumental or intimidating in stature compared to the occupants. Whether accommodating a large group or an individual person, varied occupancies should be accounted for in the scale and proportion of interior spaces. Balancing spaces big enough for a group or multiple groups to coexist without creating a sense of intruding on adjacent spaces and occupants. Whereas at the scale of one person, the space should neither be too small (creating a sense of incarceration) nor too large (creating a sense of abandonment).[40] Within interior spaces, considering the scale and proportion connects back to ideas regarding circulation and accessibility. Understanding who the space is being designed to be functional for, like the fact that most care providers are women and volunteers are seniors - these have direct spatial implications that need to be accounted for.

## MATERIAL/COLOUR

Research from the Healthy Materials Lab at Parsons School of Design focuses on building awareness about the health implications of chemicals found in many common building materials and instead promoting healthier material choices that can improve occupant wellbeing.[41] For architects, especially in spaces of care it is important to challenge conventional material choices when healthier or more sustainable options are available. In Canada, for example, fire and building codes limit the use of many natural building materials like wood in care spaces, even though it is a timeless and sustainable material that can be sourced locally in

39 Worpole, *Modern Hospice Design,* 26.
40 Worpole, *Modern Hospice Design,* 171.
41 Jonsara Ruth and Allison Mears, Architectures of Wellness: Healthy Materials Lab On Our Material Future, interview by Hiba Zubairi, August 22, 2023, https://thisismold.com/process/materials/architectures-of-wellness?fbclid=PAAaZfrqoNJPnMlWCw-hbMi7YQ_NFy38WzzijDmnmIMJq_XBqnt7e7LFapRqs.

abundance and is used widely across international hospices.[42] Materials that are natural (and ideally sustainable) is a way to integrate biophilia into hospice space, with further poetic associations to the cycle of life, as suggested in the context of wood. Colour and light affect our perception of space, but there is limited research focused on colour in relation to hospice palliative care environments. Perception and meaning of colours also vary across different cultures, although certain commonalities persist. The colour of all surface finishes (floors, walls, ceilings, etc.) should be coordinated in each space to foster a calm and domestic atmosphere. Material choice in design greatly informs the sensory experience in space through tactility. Cleanliness and ease of maintenance should also be a factor informing material choices. Soft surfaces can make all the difference in distinguishing institutional and domestic space - consider the rigid leather-esque (easily wipeable) chairs of a hospital waiting room versus a plush, fabric armchair that one might find next to a resident bed in a hospice. Field work interviews brought to light the need for innovation in material choices in care spaces, noting the traditional institutional finishes typically justified for infection control purposes, despite new technology (especially following the COVID-19 pandemic) to sanitize most surfaces, including fabrics.[43] Adequate flooring is crucial for clinical functionality and occupant comfort, for instance, considering nurses spend much of their time standing or walking, flooring with some cushioning would make a big difference in comfort at the end of a shift.[44] Further to this point, there is potential for better acoustic privacy in selecting flooring with sound-absorption properties.

## LIGHTING/VIEWS

Light is the foundation of our visual experience of the world. Architects can manipulate light in space through design, working both with artificial and natural lighting. Adjustable artificial light is essential not only for patient and visitor comfort, but also for clinical functionality in resident rooms. Dim lights along circulation paths and automatic fixtures in communal

42 Verderber and Refuerzo, *Innovations in Hospice Architecture,* 80.
43 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
44 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

spaces can be helpful in this way. Also, considering the role of technology in creating a homelike versus institutional spatial experience, field work visits brought up critiques of automation relating to occupant-sensing fluorescent lighting (which emits a continuous dull buzzing sound) and self-flushing toilets (that occasionally go off when no one is present).[45] Details the designer perhaps considered efficient and supportive in terms of functionality, but neglect to consider certain sensory sensitivities. Generally, natural light should be prioritized wherever possible - aiding occupants in orienting themselves in time and space. In resident's rooms, using clerestory windows could be a method to bring diffused, natural light into the room whilst also creating visual interest for patients from their beds. This is also important for staff-dedicated spaces, which tend to be neglected in terms of natural lighting since they are usually interior rooms. Artificial lighting becomes especially important for the space to transition from day to night use, where lighting becomes a source of wayfinding for occupants. As mentioned previously, views of nature comfort and positively impact the wellbeing of occupants, by supporting a meaningful understanding of time and orientation in space.[46] Considering occupant orientation, like a patient lying down, should also influence design of key spaces where residents spend time.[47]

# 3.6 CONCLUSION

The design of hospice requires a holistic, evidence-based approach that prioritizes comfort, accessibility, personalization, and meaningful connections to nature. Grounding these principles in research and considering the nuanced needs of each occupant group in hospice, designers can create environments to support the embodied experience (emotional, physical, and spiritual) of the end-of-life stage. The next section will examine precedent case studies that demonstrate these evidence-based design principles in practice, serving as inspiration for compassionate architectural design.

45 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
46 Verderber and Refuerzo, *Innovations in Hospice Architecture,* 76.
47 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

# 4. PRECEDENTS FOR A HOLISTIC DESIGN APPROACH

## 4.1 THE SPATIALIZATION OF HOSPICE

Understanding that care providers are the primary, daily occupants of care spaces versus patients who typically come for brief, scheduled visits explain the emphasis on functional design in hospitals and other care environments. But, in the context of the time a patient will typically spend in a hospice (ranging from weeks to months), they are fully transitioned into the space. The environment should be supportive and engaging for the patient, visitors, and care providers. A primary design challenge in this regard is resolving auditory, olfactory, visual, and hygienic boundaries between key spaces.[1] In her book *The Production of Hospice Space,* Sarah McGann *"proposes that hospice philosophy is underpinned by spatial practices,"* where the environment is a critical component of the philosophy of care.[2] She identifies the "inside-out design" approach as critical to the early stages of conceptualizing modern hospice design.[3] Inside-out design is an earlier iteration of human-centered design, considering design from the view of the occupant on the inside versus the exterior. McGann further defines three thematic pairs that intersect in the production of hospice space which will inform the design considerations; front/back, privacy/community, prospect/refuge.[4]

While research on hospice design remain limited, the past few decades have produced meaningful contributions driven by various international case studies.[5] *Modern Hospice Design* by Ken Worpole, a foundational text in hospice design, gives insight to the emergence of

1 Ken Worpole, Modern Hospice Design: The Architecture of Palliative and Social Care, 2nd ed. (London: Routledge, 2023), 60, https://doi.org/10.4324/9781003306818.

2 Sarah McGann, The Production of Hospice Space: Conceptualising the Space of Caring and Dying (Surrey, England: Ashgate Publishing Limited, 2013), 70.

3 McGann, The Production of Hospice Space: Conceptualising the Space of Caring and Dying, 62.

4 McGann, The Production of Hospice Space: Conceptualising the Space of Caring and Dying, 46.

5 Annmarie Adams, "Home and/or Hospital: The Architectures of End-of-Life Care," Change Over Time 6, no. 2 (2016): 249, https://doi.org/10.1353/cot.2016.0015.



**Figure 4.1**
**Maggie's, Nottingham**



**Figure 4.2**
**Maggie's, Hong Kong**



**Figure 4.3**
**Maggie's, Cardiff**

the hospice movement, its evolution, and an approach to hospice design based on many case studies.[10] In the first chapter, Charles and Maggie Jencks' work with the *Maggie's Centers* is presented as an important architectural case study that informs early hospice design.[11] The *Maggie's Centers* design manifesto and related projects, though rooted in cancer care, is extremely relevant to hospice design and mentioned throughout the literature. The architectural brief prioritizes evoking a sense of coziness, defining the hearth as the heart of the building – where preparing and sharing a meal becomes the "centre of the social universe" – and then breaks down the technical requirements to support this.[6]

The many *Maggie's Centers* today have been designed by various international architects using the same architectural brief – each designing vastly different buildings architecturally but all succeeding in presenting the hearth as the heart, demonstrating the value of a thoughtful design brief.[7] There is value in the use of adjacent architectural typologies – both traditional care institutions and other residential-type buildings – as case studies for understanding how design can further enrich human experience in spaces of care, where inspiration can be drawn even from the smallest of details.

In a similar vein, *Innovations in Hospice Architecture* by Stephen Verderber, architect and director of the Centre for Design + Health Innovation at University of Toronto's Daniels Faculty, and Ben J. Refuerzo, architectural designer and professor at UCLA Architecture and Urban Design, presents a comprehensive study of hospice design, highlighting the role of architects and the rise of hospice architecture and design values.[12] They emphasize that hospice design is deeply influenced by place-specific factors like demographic, socioeconomic, cultural, and logistical considerations – which contributes to why there is not a uniform, defined typology of hospice. Instead, hospice architecture is a category that is flexible and reflective of the varied contexts that the design is responding to. Through global case studies, they demonstrate how human-centered, compassionate design enhances the experience of hospice – making this

6 Worpole, Modern Hospice Design, 130.
7 Charles Jencks and Edwin Heathcote, The Architecture of Hope: Maggie's Cancer Caring Centres (London, England: Frances Lincoln, 2010).

work highly relevant to the focus of this thesis.

Building upon these various hospice design considerations, reference and analysis of accessibility design standards from the City's of Toronto and Vancouver, respectively, as well as the Rick Hansen Foundation's Accessibility Certification System will further support the establishment of a holistic design approach for hospices in Ontario. These guidelines emphasize the importance of universal, barrier-free access for all occupants in a space. Using these as reference for hospice design ensures that mobility of occupants is supported at any level of capability.

This chapter builds upon the understanding of the human experience in hospice, seeking to establish a holistic design approach through analysis of existing hospice design strategies, accessibility design guidelines, evidence-based design considerations, and related case studies and precedents for architectural and site design considerations for hospice.

## *HOSPICE VERSUS HOSPITAL*

Since the 1980s, hospital architecture has shifted towards a more patient-centered design, departing from the institutional models of the post-World War II era hospitals.[8] Moving away from maximizing efficiency for care providers, and prioritizing "making the institution more inviting and accessible."[9] There is still much progress to be made, as AnnMarie Adams identifies in her article *Home and/or Hospital*, that the lessons of palliative architectural research having limited impact considering new palliative care wards. She writes that new palliative care wards are seldom on the ground level of hospitals or near "therapeutic landscape," instead they are often built as extensions to cancer care departments."[10] The lack of consideration of patient experience in hospital space results in a sort of sensory deprivation, the sterility and seemingly endless maze of wards and rooms induces the notion of illness as punishment. A patient

8 Annmarie Adams, "Home and/or Hospital: The Architectures of End-of-Life Care," *Change Over Time* 6, no. 2 (2016): 257, https://doi.org/10.1353/cot.2016.0015.

9 Adams, "Home and/or Hospital," 257-258.

10 Adams, "Home and/or Hospital," 258.

is admitted into the space, and then their autonomy is lost in a sense - given to their care providers for safekeeping.[11] The scale of the hospital, especially in the age of the mega hospital campuses, reduces opportunities for fostering human connection and community amongst caregivers and recipients, further creating a sense of isolation. Hospices are designed primarily as places to die, and for many occupants it is the last building they enter, emphasizing the responsibility of the architect to minimize any sense of confinement in the space.[12]



**Figure 4.4 Hospital room**



**Figure 4.5 Hospice room**

User-oriented design in hospitals manifests as the prioritization of functional space for care providers, rather than the care recipients.[13] Comparisons between hospice residences and hospitals are often made in the literature to demonstrate the difference in the embodied experience of these care spaces. This also goes back to the origins of hospice which emerged in response to the traditional care practices in hospitals. Where hospitals can be characterized as sterile, efficient, and functional spaces versus a hospice residence that is home-like and comforting, prioritizing holistic care (encompassing the mental, physical, and spiritual needs of the residents and their families).

In hospitals (and long-term care homes) rooms for palliative care patients often look identical to those for cancer patients, which can also be attributed to cancer care patients being the original palliative care patients. Architecturally, many of the earlier designed hospices were inspired by cancer care centres – like Maggie's Centres in the UK, whose ethos prioritizes creating a sense of warmth and home, the hearth is presented as the heart of the space. The difference is that these centres are designed solely for day visits. Worpole writes that the modern hospice movement "has accelerated the move towards single rooms for all patients..." which at least affords the patient and their visitors more space and privacy during their time there.[14] Furthermore, he summarizes the advantages of the single room; identifying reductions in cross-infection and medical errors, and increased privacy, agency, and accessibility to care for patients,

11 Worpole, Modern Hospice Design, 26.
12 McGann, The Production of Hospice Space: Conceptualising the Space of Caring and Dying, 63.
13 Worpole, Modern Hospice Design, 101.
14 Worpole, Modern Hospice Design, 105.

visitors, and staff.[15] Cross-referencing design strategies used in hospital versus hospice space to address common spatial challenges gives insight into what perspective has been prioritized in the design. For example, a common approach in hospice design to minimize the institutional feel of the space is to hide any medical equipment, including medical carts which are typically used by nurses to do their clinical charting, allowing them to move from patient to patient and complete their observations. Without medical carts, they are limited to charting from the nurse's station in the hospice, where visibility of patients can be more limited, and more distractions are present with other nurse's performing their own clinical duties in the same space.[16] Integrating smaller spaces or nooks throughout the residential wing of the hospice that can be used by staff for easier charting. Within patient rooms it is possible to conceal medical apparatuses behind panels and other finishes/furnishings, but certain equipment - including mobility-assistive devices - is not possible to conceal. As Worpole puts it: "Dying people often lack mobility, and manual lifting and carrying creates problems of its own...While the equipment is admirable for the job it does, it nevertheless also appears somewhat ungainly and even menacing – if not to the patient and staff then certainly to visitors."[17] Design must be considerate of these mobility challenges, assisting in any way possible to mitigate the need for such devices.

Both the hospice and the hospital need to address "matters of ritual, time, being, and, ultimately, non-being."[18] The earlier prioritization of sterility and functionality of space has led to a reduction of agency and adaptability of space to serve the diverse needs of each occupant passing through the space over time. Occupants and their loved ones have been forced to find their own ways to adapt the space to make it more comfortable rather than the space itself being designed to support this.

15 Worpole, Modern Hospice Design, 105.
16 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
17 Worpole, Modern Hospice Design, 107.
18 Worpole, Modern Hospice Design, 169.

# 4.2 ADJACENT ARCHITECTURAL TYPOLOGIES/ CASE STUDIES

Referring to adjacent architectural typologies as alternative case studies for hospice design serves to provide inspiration relating to innovative approaches to supporting the human experience in spaces of care. While the functional purpose of each typology varies, all selected projects prioritize human-centered design methods that are responsive to their geographic and cultural context.

## 1. Research Centre/Hospital – Princess Margaret Cancer Centre (2020) in Toronto, Ontario

Originally established in 1952, the Princess Margaret Cancer Centre in Toronto, Ontario, has recently undergone significant renovations to transform the 40,000 square foot ground floor using a human-centered design approach.[19] The redesign goes beyond aesthetics; by incorporating natural materials and lighting, and considerately designing key spaces like waiting rooms, chemotherapy suites, and consultation rooms, both functionality of space for care providers and support of patient comfort and dignity is increased. The architects were inspired by architectural typologies that evoke a "familiar and welcoming" atmosphere, drawing from spaces like hotels, homes, and lounges.[20] In the design, specific attention is paid to ease of access and wayfinding for occupants to create a more open concept space.[21] The main entrance, designed to be particularly inviting, employs green walls with planter beds lining the urban street front. The project demonstrates how traditional, institutional care spaces can be thoughtfully transformed to blend functionality and patient-centeredness. Like hospice, the focus on the embodied experience in space supports a more inclusive environment for all occupants.

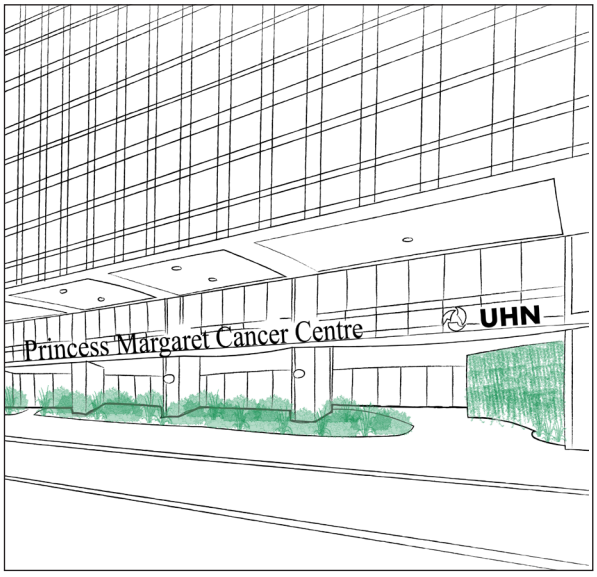



**Figure 4.6 Princess Margaret Cancer Centre, by Hariri Pontarini Architects**

19 "Space Transformation Project Princess Margaret Cancer Centre, Toronto, ON," Architectural Firm, Hariri Pontarini Architects, 2020, https://hariripontarini.com/projects/princess-margaret-cancer-centre-renovation/.

20 "Princess Margaret Cancer Centre Space Transformation," Company Website, NORR | Architecture, Engineering, Planning and Interior Design, 2020, https://norr.com/project/princess-margaret-cancer-centre-space-transformation/.

21 "Space Transformation Project Princess Margaret Cancer Centre, Toronto, ON."

## 2. Residential - Ronald McDonald House BC & Yukon (2014) – Shaughnessy, British Columbia

Initially a thirteen-bedroom house when it first opened in 1983, the Ronald McDonald House BC and Yukon has since been transformed into a seventy-three-bed facility.[22] Situated on the BC Children's Hospital campus, this residential facility offers temporary housing for families with children undergoing treatment for serious illnesses.[23] The design seeks to offer a "home-away-from-home," centered on a warm and calm atmosphere to support families during a difficult time.[24] This project achieved LEED Gold certification, and is a case study for its use of low-carbon and renewable materials.[25] Inspired by the natural beauty of the local environment, extensive use of cross-laminated timber (CLT) in both the structure and finishes, reflects a commitment to biophilic and sustainable design. Outdoor spaces and gardens are thoughtfully curated to offer moments of respite and peace for occupants. The Ronald McDonald House BC & Yukon exemplifies how care-related residential spaces can be designed holistically to meet the embodied needs of occupants.

**Figure 4.7 Ronald McDonald House BC & Yukon, by MGA**



22 "About Us | Ronald McDonald House BC & Yukon," Organization Website, Ronald McDonald House BC, accessed November 11, 2024, https://rmhbc.ca/about-us/.

23 "About Us | Ronald McDonald House BC & Yukon."

24 "Case Study: Ronald McDonald House BC & Yukon" (Government of British Columbia, n.d.), 1, https://www2.gov.bc.ca/assets/gov/environment/climate-change/cng/resources/lcm-casestudies-rmh.pdf.

25 Shannon Moore, "Governor General's Medal Winner: Ronald McDonald House BC & Yukon," Canadian Architect, May 19, 2016, https://www.canadianarchitect.com/governor-generals-ronald-mcdonald/.

## 3. Hospitality - Cabot Cliffs (2023) – Inverness, Nova Scotia

Completed in 2023, this project consists of eight seasonal homes, located on a golf course on the west coast of Cape Breton Island.[26] Architecturally, it is inspired by the maritime vernacular of coastal Nova Scotia, resembling a small village, of which the gabled roofs are a prominent feature.[27] This approach reflects the region's architectural heritage, establishing a strong connection to the dramatic coastal landscape. The interior is finished with warm, natural materials evoking a cozy atmosphere for occupants to rest in after a day outdoors.[28] While this hospitality project is not a space of care like the other case studies presented, it demonstrates how design can draw inspiration from local context, both architecturally and geographically, to facilitate an immersive and peaceful experience in space.

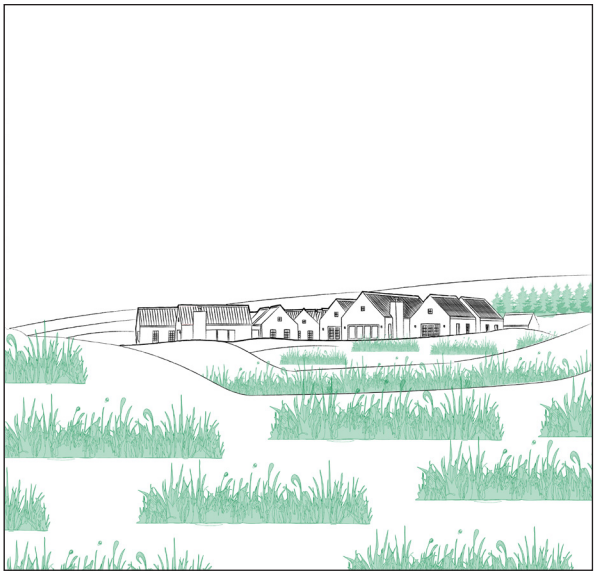


**Figure 4.8 Cabot Cliffs, by Fowler Bauld & Mitchell Ltd.**

26 Royal Architectural Institute of Canada, "Governor General's Medals in Architecture - 2024 Recipient - Cabot Cliffs," Text, Royal Architectural Institute of Canada (Royal Architectural Institute of Canada, June 11, 2024), https://raic.org/awards/gg-2024-cabot-cliffs.

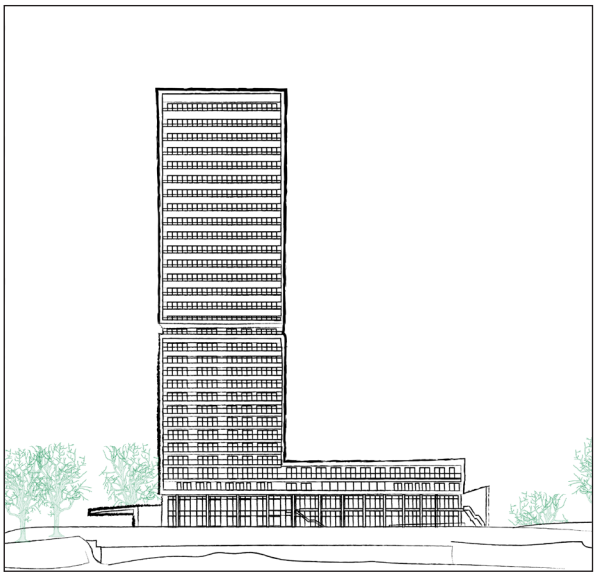
27 Sean Mott, "Cape Breton Golf Course Residences Win National Award," CTVNews, June 28, 2024, https://atlantic.ctvnews.ca/more/cape-breton-golf-course-residences-win-national-award-1.6945496.

28 "Cabot Cliffs: Cliffs Residences, Halfway Hut and Pro Shop," Architectural Firm, Fowler Bauld & Mitchell Ltd., 2023, https://www.fbm.ca/projects/cabot-cliffs.

## 4. **Retirement Residence - The Panorama (2019) – Laval, Quebec**

The *Panorama* tower is a 30-storey retirement complex in Laval, Quebec, designed to "avoid the trap of institutional designs."[29] This tower of 286 residential units seeks to offer a supportive environment specifically for the elderly. This tower is situated atop a podium that holds the community center, featuring a beauty salon, café, medical clinic, pharmacy, and convenience store amongst other amenities.[30] Considering Canada's aging population, this design seeks to address the challenges of independent/autonomous living for the elderly by providing a bright and open community-centered living environment. The design is both encouraging of community interaction and autonomous living, where all the amenities in this facility have been designed specifically to support the needs of elderly individuals. Making use of the beautiful landscape and river nearby, thoughtful views have been framed throughout the building. This project demonstrates how innovative design can create a non-institutional space that provides safety and comfort for elderly individuals to continue leading independent lives.

**Figure 4.9**
**The Panorama, by ACDF Architecture**



29 Antonio Graniero, "A Retirement Residence in Quebec Helps Senior Citizens Live Better, by Empathetic Design," Frame, September 13, 2024, https://frameweb.com/article/a-retirement-residence-in-quebec-helps-senior-citizens-live-better-by-empathetic-design.

30 Résidences Québec, "Panorama | RPA Ste-Dorothée - Laval," Organization Website, Résidences Québec, accessed November 11, 2024, https://residences-quebec.ca/en/retirement-home/panorama/2518.

## 5. **Dementia Village – Village Langley (2021) – Shaughnessy, British Columbia**

Dementia Villages are a newer architectural typology emerging to address the alternative forms of care for people living with dementia, where nursing homes are the current institutional standard for caring for people with dementia.[31] Currently one in twenty adults over 65 and one in four adults over 85 are living with some level of dementia. Village Langley, the first dementia village in Canada, seeks to deinstitutionalize dementia care and provide patients with a sense of freedom and safety, inspired by early dementia villages (like the Hogeweyk) which opened in the Netherlands in 2009[32] Located just outside of Vancouver, this gated 5-acre property hosts a neighbourhood of six colourful homes to support the seventy-five residents, a community centre, and farm, where residents roam freely and are supported by care providers.[33] Similar to hospice, this newer typology seeks to support patient autonomy and comfort in a safe and calm environment – intentionally moving away from the traditional, institutional care space.[34] The scale of the village and community design approach could also translate to a larger-scale hospice, allowing for more members of a community to access hospice care.



**Figure 4.10 Village Langley, by NSDA Architects**

31 Aleksandra Sagan, "Canada's Version of Hogewey Dementia Village Recreates 'normal' Life," CBC News, May 3, 2015, https://www.cbc.ca/news/health/canada-s-version-of-hogewey-dementia-village-recreates-normal-life-1.3001258.

32 Alley Wilson, "A Care Revolution: Inside Canada's First Dementia Village | Globalnews.Ca," Global News, May 6, 2023, https://globalnews.ca/news/9663849/dementia-village-canada/.

33 Wilson, "A Care Revolution."

34 Elroy Jesperson, "I Opened Canada's First Dementia Village. Here's How It Works.," Maclean's, June 6, 2023, https://macleans.ca/society/health/dementia-village/.

Shifting the focus from spatial efficiency or functionality instead to an environment that is supportive and anticipatory of the needs of occupants each of these case studies demonstrates innovative, human-centered design rooted in a Canadian context.

## 4.3 Selected Hospice Design Guidelines

As modern hospices began to proliferate internationally, various architectural writers and hospice organizations have established design guidelines to enhance occupant experience. Each guideline is based on architectural theory, international case study research and interviews of occupants from existing hospices. This section gives an overview of key guidelines contributing to a holistic approach to hospice design:

### 1986 - HOSPICE INPATIENT ENVIRONMENTS – DEBORAH CAREY

Deborah Carey's *Hospice Inpatient Environments* is one of the earliest design guidelines dedicated to hospice architecture, published in 1986. Broken into three parts; where first the history of hospice and key occupants and spaces are defined; the second focuses on detailed case studies on inpatient hospice and palliative care units (mainly in the United States); and the third outlines architectural guidelines for hospices and palliative care units.[35] These guidelines, which also reference early work of Stephen Verderber, focus on the architectural elements of "homelike design" which best support emotional and physical comfort of residences in hospice, including privacy/community, adaptability/multi-functionality, finishes/furnishings, personalization/choice/variety, and quality of life.[36]

35 Deborah Allen Carey, Hospice Inpatient Environments: Compendium and Guidelines (New York, NY: Van Nostrand Reinhold Company Inc., 1986), 5.

36 Carey, Hospice Inpatient Environments: Compendium and Guidelines, 213-215.

## 2006 (UPDATED 2020) – INNOVATIONS IN HOSPICE ARCHITECTURE – STEPHEN VERDERBER AND BEN J. REFUERZO

As previously mentioned, in *Innovations in Hospice Architecture,* Verderber and Refuerzo provide a comprehensive list of sixty-six architectural planning and design guidelines that balance the prioritization between functional and experiential needs of occupants, broken down programmatically into seven sections: 1. Site and context; 2. Arrival spaces; 3. Residential milieu/common spaces; 4. Residential milieu/ private spaces; 5. Transitional spaces; 6. Connections with nature; and 7. Administration and the total environment.[37] Verderber has continued to develop and contribute to these guidelines in later works, including *Residential Hospice Environments: Evidence-Based Architectural and Landscape Design Considerations* (published in 2014) and the second edition of *Innovations in Hospice Architecture* (published in 2020).[38]

## 2008 (UPDATED 2020) – DESIGN & DIGNITY GUIDELINES - IRISH HOSPICE FOUNDATION

Worpole references the *Design & Dignity Guidelines for Physical Environments supporting End-of-Life Care* in *Modern Hospice Design,* produced by *The Irish Hospice Foundation's Hospice Friendly Hospitals Programme* in collaboration with architect, Ian Clarke, describing it as "one of few documents that treats location decisions as central to the whole design."[39] The importance of site and site planning relating to architectural design are a critical consideration for hospice, as will be explored further. While many iterations of these guidelines have been produced over the years, the original 2008 document features watercolour vignettes to demonstrate the embodied experience of key spaces in the design that are particularly inspiring in terms of representation.[40] The guideline breaks

37 Verderber and Refuerzo, Innovations in Hospice Architecture, 59.

38 Stephen Verderber and Ben J. Refuerzo, Innovations in Hospice Architecture, Second edition. (Abingdon, Oxon ; New York, NY: Routledge, 2020).

39 Worpole, Modern Hospice Design, 81.

40 The Irish Hospice Foundation, "Design & Dignity Guidelines for Physical Environments of Hospitals Supporting End-of-Life Care" (Hospice Friendly Hospitals Programme, 2008), https://hospicefoundation.ie/wp-content/uploads/2022/05/Design-Dignity-Guidelines-for-Physical-Environments-of-Hospitals-Supporting-End-of-Life-Care.pdf.

down each space in the sequence of movement for a patient visiting a hospice palliative care ward to emphasize the need for thoughtful design to support the dignity and comfort and of all occupants.




**Figure 4.11 Design with dignity vignette, p11**




**Figure 4.12 Design with dignity vignette, p13**

## 2009 (UPDATED 2024) – MODERN HOSPICE DESIGN – KEN WORPOLE

Introduced earlier in the text, Worpole's *Modern Hospice Design* is a key reference for hospice design. Considering the emotional and spiritual experience of the occupants, guidelines are divided thematically to demonstrate the importance of context, time, nature, and privacy in hospice design – based on case studies of contemporary hospices and related architectural typologies (Maggie's Centers) in the United Kingdom.[41] Worpole especially demonstrates the importance of nature in hospices, relating it back to the "ultimate home" in the primal world – dedicating a whole chapter to the hospice garden, as a return to nature, reinforcing the relationship between occupant and environment.[42]

41 Worpole, Modern Hospice Design, 72-73.
42 Worpole, Modern Hospice Design, 144.

# 4.4 CONCLUSION

Ultimately, these considerations form the basis for a compassionate, holistic approach to hospice design that prioritizes human experience at the end of life. Across the four selected sources, several overlapping considerations emerge:

1. A strong connection to nature
2. Balancing privacy and communal spaces
3. Adaptability, personalization, and multi-functionality of space
4. The importance of accessibility and ease of movement in space
6. Fostering a sense of home/ease/domesticity through design

# 5. SITE CONSIDERATIONS FOR HOSPICE

## 5.1 SITE SELECTION

The choice of site and context significantly shapes the hospice experience and design approach. Research focused on user-oriented design in medical and care spaces demonstrates that our environments are extremely influential on our health, healing, and sensory engagement. While cost is the primary driver behind site acquisition, there are additional points relating to sites that have key influences on occupant-experience and design. A site's physical characteristics like topography and zoning can have implications on architectural and site design. Although these are typically bigger challenges for residences in rural contexts. Adjacencies become more critical design influences within urban contexts, as the design should complement surrounding built forms whilst also curating a sensory experience for the occupants in the interior.

Site area informs the architectural and site planning approach immensely. In considering topography, adjacent sites, and road networks, the site should ideally be large and flat enough for the building to be single-storey and to accommodate adequate parking for visitors and staff away from primary sightlines from the interior. Sloped sites will require more innovative design approaches and can result in multi-storey hospice buildings in response. Zoning can have implication on design like building height and green space on site. Circulation paths on site have implications relating to privacy and accessibility for residents, visitors, and staff. Considering circulation and location of key spaces inside and their relationship to the landscaping surrounding the building makes a big impact on occupant experience – consider having a view of a parking lot versus a lush garden. There should be quiet and calm outdoor space like natural areas/gardens for occupants to spend time in and enjoy (i.e. away from roads or parking).

As evidenced by the many geographic contexts in which hospices are situated, there is not one ideal location or set of conditions to define a perfect site.[1] Hospices are needed wherever people will continue to live or die. Whether urban or rural settings, each has their own set of challenges and benefits that the architect will address and accommodate through the design to shape occupant experience. Specifically, looking at death in suburban/urban areas brings a nuance of *death in the midst of life* to the hospice residence experience, versus *death as a return to nature* on a more expansive rural site.

**URBAN/SUBURBAN:** Locating hospices in urban/suburban areas brings the benefits of increased accessibility to hospice care for larger populations (and potentially more familiarity with surroundings), reduced travel times to relevant health/care services and facilities, and increased community integration.[2] Furthermore, being situated near public transportation routes enables further accessibility for visitors and staff (perhaps contributing to better staff retention) and site visibility. Accessing municipal utilities and services further eases the design process, where rural sites often require costly utility and service adaptations to support occupant needs relating to water, waste management, fire safety systems, and heating/cooling.

Urban centers, due to the presence of more multi-storey buildings, can bring challenges for landscaping and optimizing views while balancing privacy concern. Hospices in suburbs can be a middle ground to mitigate the urban challenges of noise and pollution that come with higher population density. Building hospices in existing residential neighbourhoods requires active communication with community members from the beginning to avoid issues; often building code and zoning allowances need to be made in this case.[3] In commercial or mixed-use settings, there are less challenges in this regard, and minimal conflicts with

1 Ken Worpole, Modern Hospice Design: The Architecture of Palliative and Social Care, 2nd ed. (London: Routledge, 2023), 179, https://doi.org/10.4324/9781003306818.

2 Worpole, Modern Hospice Design, 80.

3 Stephen Verderber and Ben J. Refuerzo, Innovations in Hospice Architecture (New York, NY: Taylor & Francis, 2006), 60.

neighbours. Generally, suburban/urban contexts bring higher costs of land for smaller parcel sizes, which limits opportunities for landscaping and connections to nature, more efforts to balance community and privacy/nature and development by addressing issues of noise and pollution in urban contexts especially.

**RURAL:** In evaluating the suitability of rural contexts for hospice residences, notable advantages include lower cost of land for larger properties and that majority of development is limited to low-rise buildings, increased opportunities for landscaping and views of nature, more fresh air and tranquility, and an overall, an alignment with the concept of *death as a return to nature*. However, potential challenges relating to a rural site include limited access to municipal utilities and services which can result in costly renovations/additions on site, limited (if any) public transportation connections which requires visitors and staff to travel by car only. When rurally located, hospices become distant from acute medical services, commercial areas, and other amenities which will require longer travel times for everyday needs to be met and can contribute to difficulties with staff and volunteer retention. This can also be an unfamiliar surrounding for patients who have to travel in order to receive hospice care, contributing to the perception of such locations as a retreat from the community.[4]

Hospice sites should be visually engaging and offer opportunities for all occupants to spend time outdoors, capitalizing on the human-nature connection. It is important to create opportunities for community engagement on hospice site both for building awareness of available care services and volunteering opportunities for community members. Choosing sites with the capacity to accommodate growth, for the building to be able to evolve with the community; planning for future expansions should be considered early in the design process. Considering the often-limited budgets for hospice, sites are often donated by the community or private individuals, and this can result in sometimes challenging site conditions that may require innovative solutions. A challenge that came

4 Verderber and Refuerzo, Innovations in Hospice Architecture, 60.

up in the field work interviews was that for emerging hospices, donated land can often bring its own challenges that may require costly solutions to resolve. In rural areas, site challenges relating to water and waste management emerge - where existing wells and septic systems may not be equipped to support the heavy water usage (laundry, bathing, cooking, etc.) that comes from a sizable group of staff, residents, and visitors. This also supports the current concentration of hospices in urban areas, where city services and other infrastructure is more easily accessible.[5] As Ken Worpole puts it: "Not everything about location and site details can be anticipated in advance," but approaching site selection with an informed understanding of key considerations will decrease likelihood of facing unexpected and/or expensive design challenges.[6]

## 5.2 SITE PLANNING

Climate, solar orientation, and geographic context will all inform the architectural design. Site planning and design should take ease of maintenance and seasonal changes into consideration. Ground management may be overseen by hospice staff or volunteers, and the amount of maintenance required depends on site scale and the landscaping. Site design should include a shed structure to store any land maintenance/gardening/related equipment.[7]

Natural site features like topography, slopes, and existing bodies of water will influence accessibility and design strategies. Taking advantage of these site conditions through strategic building orientation, massing, floor plan layout, material choices, and incorporating passive heating and cooling design approaches can reduce costs relating to mechanical/HVAC operations over the life cycle of the building.[8] Furthermore, these elements of the design have a direct impact on occupant experience relating to lighting/views, thermal and acoustic comfort. Acoustic considerations depend on the type and decibel scale of surrounding activity. Prioritizing

5 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
6 Worpole, Modern Hospice Design, 82.
7 Verderber and Refuerzo, Innovations in Hospice Architecture, 82.
8 Verderber and Refuerzo, Innovations in Hospice Architecture, 62.

natural light and framing views, especially in resident suites, is important not only for physical health but for mental stimulation – creating a feeling of connection with nature and the surrounding landscapes or human activities. In a similar vein, creating engaging landscapes with outdoor space like patios or gardens or walking paths is especially important to create opportunities for reflection and connection between residents and their loved ones.

Southern Ontario, where most hospices in the province are concentrated, has a continental climate where the winters are very cold and summers are hot and humid.[9] This means that the architectural and site planning design should accommodate the changing seasons to ensure occupant comfort and ease of access/accessibility during both hot, windy, rainy, or snowy conditions. Like planting trees along the entrance path to provide shading in the warmer seasons or using landscaping to create windbreaks for outdoor gathering areas - small design moves that have a big impact on occupant comfort. Strategic building orientation can maximize solar heat gain in the winter (passive heating) and minimize overheating in the summer with other architectural detailing (passive cooling).

## *SITE ACCESS & PARKING*

Accessing the site, identifying entrances, and parking should be intuitively designed for easy wayfinding through a welcoming front-of-site. Signs, planters/planter beds, lighting, paved walkways, and canopies/ pergolas are key elements of the site design to consider in curating an inviting and accessible first impression of the hospice. Parking areas must be approached sensitively through design, as there are sensory implications (sound, smell. views) that are critical to maintaining a calm and comfortable environment.  Ideally, adequate parking should be provided at key points on the site in close proximity to building entrances is essential to successful site accessibility.[10]Finding parking and accessing

9 Roger D. Hall et al., "Canada," in Britannica, November 10, 2024, https://www.britannica.com/place/Canada/Resources-and-power.

10 Worpole, Modern Hospice Design, 91.

the building should not be a source of stress for people entering the hospice. Especially in extreme weather conditions - whether its snow or rain - the path of travel between the parking area and the building entrance should be a short distance. If possible, having a drop-off point at the entrance so that patients/residents may be dropped off directly to the building. Depending on the site area, there may be limited space for parking. Hospices with smaller sites sometimes will have an off-site parking lot nearby for visitors to use instead. Considering sightlines, avoid placing parking in view of windows from resident rooms, spiritual spaces, therapy rooms, and family gathering spaces. Strategic landscape design (including lattices, fences, tall shrubs, trees) can also help buffer views of parking.[11] In a similar vein, these landscape elements can be used to create privacy for gardens or outdoor gathering spaces on site.

## *HOSPICE GARDENS & OUTDOOR GATHERING SPACES*

Hospice gardens, extensions of their built counterparts, provide sanctuary and immersive experiences in nature to support healing/ spiritual nourishment. While commonly conflated, the hospice garden is differentiated from the memorial garden by being "imbued with a sense of life, change and hope for the future," where a memorial garden seeks to immortalize life already lived and looks to the past.[12] Hospice gardens, like their architectural counterparts, are meant to engage the mind, body, and spirit. This sense of life is represented through landscaping that is engaging to the senses, endures and transforms with the seasons (4-season gardens), and invites contemplation and serenity.[13] Create intimate moments for meditation or respite in nature that are accessible and semi-private. We see the world around us as a reflection of ourselves, the landscape evolves just as we do. There is growth and decay and movement. Limiting fixed or static elements in the landscape, besides benches or some picnic tables, highlights the living presence of the landscape.[14]

11 Verderber and Refuerzo, Innovations in Hospice Architecture, 62.
12 Worpole, Modern Hospice Design, 159.
13 Verderber and Refuerzo, Innovations in Hospice Architecture, 38.
14 Worpole, Modern Hospice Design, 133.

Landscaping and gardens can be used strategically to mitigate and curate views, enhance privacy, and create opportunities for moments of connection or reflection in nature. Considering Ontario's climate, planting schemes should evolve with each season. Indigenous healing gardens, are a great point of reference for site-responsive outdoor spaces that can facilitate meaningful, restorative experiences – often including medicinal plants and other native species that are culturally significant to the Indigenous communities they are designed for.[15] Incorporating plant species native to the region of the site is another way in which the hospice can connect further with the community in which it is situated, forming visual connections to the fauna permeating the local geography. It can also support further integration of the hospice with the community from the perspective of occupants, offering glimpses of adjacent sites (natural areas, neighbouring houses, etc.) to avoid creating a feeling of isolation from the outside world.[16] In a similar way, Sensory gardens are designed to be therapeutic environments that offer opportunities to actively or passively engage the senses – sight, smell, sound, touch, and taste – in nature. Sensory gardens invite occupants to engage in the present moment and connect to the environment. Through incorporating biophilic principles in the landscape design, there are opportunities to strengthen and emphasize the human-nature relationship both indoors and outdoors. Quiet, natural settings can foster a sense of peace for all occupants. Views of and immersion in nature is proven to reduce stress and provide comfort, especially important for resident rooms, faith spaces, therapy/counselling rooms, and other family gathering spaces. As part of the site plan, outdoor gathering spaces of varying scales can be distributed around the site to support groups or individuals.

Hospices can invite community engagement through passive site initiatives, like introducing community garden plots, apiaries, or outdoor art projects, that invite volunteers and other community members to engage with the peripheries of the site. One of the hospices documented through the field work was in collaboration with local beekeepers and had an apiary located on a far corner of property - where the profits

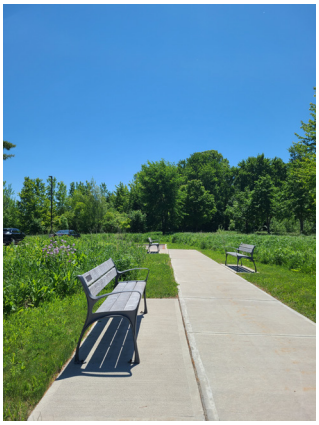


**Figure 5.1 Outdoor seating near parking lot, HWR**

15 "Indigenous Healing Gardens | Bruce Trail Conservancy," Bruce Trail Conservancy, June 21, 2023, https://brucetrail.org/indigenous-healing-gardens/.

16 Worpole, Modern Hospice Design, 132.

from the honey harvested is donated back to the hospice. This reciprocal relationship between people and nature can be replicated in many capacities. For larger sites or sites adjacent to other natural areas, there is an opportunity for walking trails or other exploratory garden spaces that can be enjoyed by hospice visitors and community members. If possible, creating opportunities for community engagement, whether it is a local resident or past/present hospice visitor. Having a reason and space to visit on site will further integrate the hospice as a fixture in the community. An example of this is the 9000 square foot Gosling Pollinator Gardens located on the site of Hospice Wellington in the City of Guelph.[17] *Pollination Guelph* designed the garden, which was planted in stages between 2012 and 2015, making use of plant species mostly native to Southern Ontario. Not only does this project contribute to the ecological stewardship of the land, but it is an active project that can be viewed from the hospice and brings community engagement on site. This garden is part of the *Pollination Guelph* initiative, which has developed pollinator gardens all over the city.[18] New donations have allowed for an additional expansion to double the size of the gardens over the next couple of years.[19]

**Figure 5.2 Gosling Pollinator Garden, Hospice Wellington**



17 "The Gosling Pollinator Gardens at Hospice Wellington," City of Guelph, accessed November 11, 2024, https://guelph.ca/living/recreation/parks/community-and-pollinator-gardens/get-involved-in-community-gardens/the-gosling-pollinator-gardens/.

18 "Pollinator Gardens in Guelph," Pollination Guelph, accessed November 11, 2024, https://www.pollinationguelph.ca/gardens.

19 "Pollinator Gardens in Guelph."

# 5.3 CONCLUSION

Site selection and planning have a large impact on shaping the hospice experience, where different settings present their own challenges and opportunities for innovation. While there is no perfect site for hospice, the site planning approach can strengthen the human-nature connection and provide a peaceful, immersive natural environment for all occupants.

# 6. CATALOGUE OF HOSPICE RESIDENCES IN ONTARIO

This chapter is a catalogue that seeks to identify and analyze the current network of hospice residences across Ontario to establish a comprehensive regional profile and design considerations to help inform future hospice design. The catalogue will consider the entire network of hospice residences, narrowing into regions in the province with multiple residences serving the same community, and then focusing on a regional case study for the hospices in Waterloo Region. This tiered approach serves to identify community connections at various scales and demonstrate the intrinsic relationship between hospice residences and the communities they serve, through site and context. While there are previously defined guidelines and considerations for best practices in hospice design, there is not currently an Ontario-specific architectural analysis.

Furthermore, the design of hospice spaces is underrepresented and poorly defined spatially in most official documentation regarding the delivery of hospice palliative care. Even accessing the program recommendations that hospices must strive towards are only accessible by directly contacting the HPCO. Considering the grassroots origins of hospice, this information on creating spaces of care should be more accessible online.

There is quite a range of visual representation of hospices online via the organization websites – some had photo galleries, fewer had immersive walkthroughs, and a large group of the hospices had no visual information available to inform potential residents of the quality of space. In some cases, architects/builders/engineers/etc. featured floor plans on their project profiles, but this is also inconsistent across the data pool.

Hospice residences were catalogued by cross referencing web searches of “hospice” and “hospice residence” with the CHPCA directory and the provincial directory map (which identifies local health and community services across 14 branches).

**Figure 6.1 Ontario Health atHome regional map**




From the catalogue, analysis will provide clarity on the scope of hospice residence care in Ontario and the architectural implications on care. Using the following list, all locations were plotted on a map to create a geographic perspective of the span of hospice residence availability across the province. Hospices are sorted chronologically and then by region, and the data collected includes:

- Location
- Site map/image and photo of exterior
- Site type
- Residence name
- Year established
- Affiliation(s)
- Residence type
- Plans (if available)
- Number of storeys
- Number of resident beds
- Architect/Builder/etc. (if applicable)
- Additional notes regarding building/care specializations

# 6.1 PROVINCIAL OVERVIEW

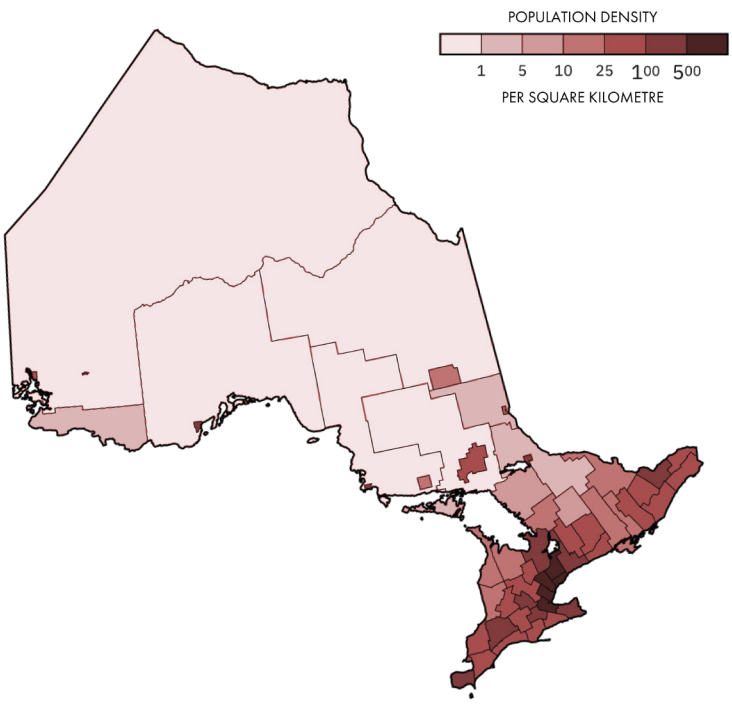
The 10-bed funding model provided by the Ministry of Health and Infrastructure Ontario also dictates the scale of the new residences being built, almost half of all residences in the province have a 10-bed capacity. The 10-bed model considers 10-beds to be the ideal (and maximum size) for establishing a "home-like" atmosphere. Although the definition of "home-like" will vary from person to person the number of people does not necessarily define the embodied experience in space, perhaps it is more accurate to describe the intentions for the space as "non-institutional." Not all hospice residences are newly built facilities either - a third of active hospice residences in Ontario are adaptive reuse projects of existing residential or institutional buildings. But adaptive reuse projects can face challenges with modifying existing accessibility, circulation, and room sizes to meet the nuanced needs of hospice residences.

In Ontario, 82.8% of the population lives in urban areas, establishing it as the second-most urbanized province after British Columbia.[1] Southern Ontario, particularly, stands out as one of the country's highest-density regions, encompassing both the national capital city, Ottawa, and the financial center and most populous city, Toronto. This urban concentration accounts for most residences being situated in densely populated areas. However, there is still a significant population (~1.5 million people) living in rural areas, with limited access to quality medical services.[2] The current network of hospice residences is concentrated in the southern part of the province, with additional facilities in development. Many of these residences are purposefully positioned in urban or suburban areas to maximize accessibility to densely populated regions. There is a lack of access to hospice residences in rural communities and especially in communities located outside of southern Ontario.

1 Statistics Canada Government of Canada, "Canada's Population Estimates: Subprovincial Areas, July 1, 2023," Government Website, Statistics Canada, May 22, 2024, https://www150.statcan.gc.ca/n1/daily-quotidien/240522/dq240522b-eng.htm.

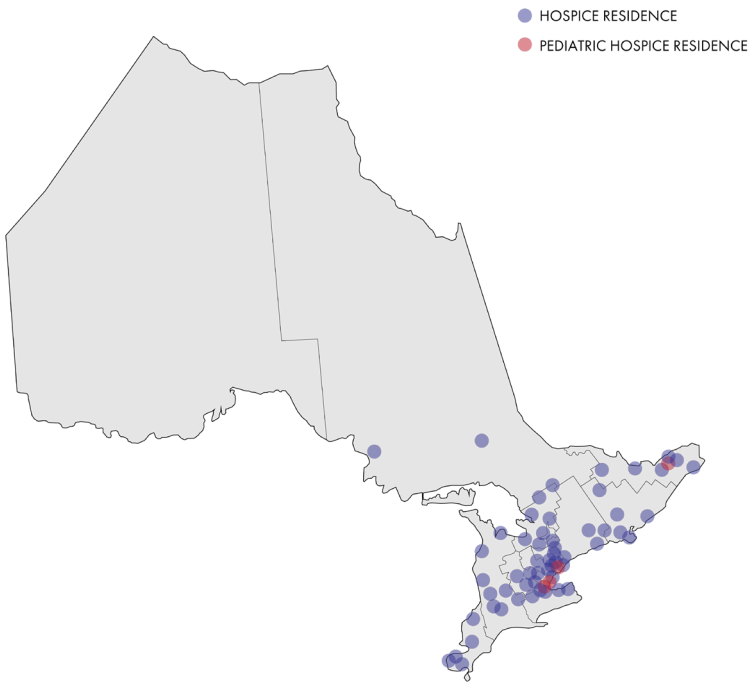
2 Government of Canada, "Canada's Population Estimates."

**Figure 6.2**
**Population density map of Ontario, 2022**




As of April 2024, there are 60 active hospice residences operating across the province and with a total of 535 beds. There are at least eight hospice residences set to open their doors in the next three years, adding a combined estimate of 79-beds.

**Figure 6.3 Network of hospice residences in Ontario, 2024**



# 6.2 METHOD OF CATEGORIZATION - SITE TYPES

In *Innovations in Hospice Architecture,* Stephen Verderber identifies 4 types of hospice architectural settings, including hospices on medical/ hospital campuses; independent hospices; adaptive reuse hospices (pre-existing buildings converted to hospices); and independent children's/ pediatric hospices.[3] Expanding upon these settings, this catalogue proposes a deeper exploration of architectural form and site contexts. Whilst also identifying these 4 settings through the catalogue, there are values and challenges associated with each type of adjacency, and categorizing the residences in this way allows for a better understanding of the implications of site on occupant experience.

**Site types** are labelled as follows: **(context)_(adjacency)**.

In terms of setting, sites will be identified as either **urban or rural**.

> ***Urban contexts*** include inner city/downtown and surrounding suburban areas.
>
> ***Rural contexts*** include small towns, villages, and remote areas.

Site types can have various adjacencies which will inform design in different ways.

**Site adjacencies** are elements or characteristics of the land surrounding the site, each with their own advantages and challenges influencing occupant experience. These include:

**Natural area:** Natural areas are considered one of the ideal adjacencies for hospice residences and refer to parks, bodies of water, agricultural land, and other areas of land undisturbed by human activity (grasslands, wetlands, forests, etc.).

- Being close to and immersed in nature has therapeutic qualities, which can be amplified through design.

3 Stephen Verderber and Ben J. Refuerzo, Innovations in Hospice Architecture (New York, NY: Taylor & Francis, 2006), 59.

- Challenges can include maintenance of the landscape in all-seasons and ensuring accessibility for all occupants.

**Religious institution**: Hospices located adjacent to or on the grounds of religious institutions often serve as extensions of faith-based care.

- For those with strong connections to their faith, it can be a source of comfort and spiritual support to be near one's religious community at the end of life. This adjacency can also influence the architectural details of the hospice.
- The challenge can be finding a balance between honoring religious affiliations and creating a welcoming space respectful to people of any or no faith.

**Medical campus, Assisted living community:** Being located on or near a hospital campus or assisted-living community are logical choices of adjacency as it allows for easier accommodation of treatment plans for residents.

- Locating hospice residences near medical care providers allows for the sharing of resources and existing infrastructure (parking, utility, laundry, etc.) and the establishment of a hub of care.[4]
- An architectural challenge is that the hospice should be clearly distinguishable from the other medical/institutional.

**Residential area:** Hospice in residential areas can integrate into the local fabric, close to other homes, parks, and schools.

- This adjacency creates opportunities for residents to observe everyday life going on beyond the hospice and brings visibility and community engagement to hospice.
- A key design consideration is ensuring privacy for residents and their families, by addressing views/sightlines, noise levels, and pedestrian traffic from surrounding homes.

4 Verderber and Refuerzo, *Innovations in Hospice Architecture*, 61.

**Mixed-use area:** Mixed-use areas lend themselves to creating a "home-like" atmosphere, whilst still benefiting from accessibility to local shops, services, and other community amenities.[5]

- These adjacencies can foster a sense of normalcy and connection to the activities of everyday life.
- The challenge lies in finding a balance in contrasting the activity of the surrounding area through the creation of private, quiet spaces - both inside and outdoors.

# 6.3 TYPES OF HOSPICE RESIDENCES

Through cataloguing the residences, certain differences and similarities appear between the organization and delivery of care established across southern Ontario. By categorizing the types of residences, trends and unique design approaches to hospice can be identified. Residence types are labelled in the following format: **(status)_(building type)**

**New builds** are designed and built specifically to meet the needs identified by the community for hospice palliative care. New builds incorporate considerate design details that optimize comfort, accessibility, and connections to nature. The building types to distinguish new builds includes:

**Dedicated Hospice Residences** are hospices that primarily provide in-patient/residence care services. New builds of this type fully embody the vision of the homelike atmosphere, and have the advantage of ensuring privacy, comfort, and accessibility through the design.

**Hospice Care Centers with Residence Suites** are primarily care centers, where the residence and related inpatient care is part of the facility's larger range of services. In this type, the

5 Ken Worpole, *Modern Hospice Design: The Architecture of Palliative and Social Care*, 2nd ed. (London: Routledge, 2023), 85, https://doi.org/10.4324/9781003306818.

hospice residence suites benefit from access to shared community resources.

**Adaptive reuse builds** are existing buildings which were designed and built originally to suit different purposes, and instead the interior (and sometimes the exterior) of the building have been adapted to suit the needs of the hospice. Adaptive reuse of existing buildings reduces construction costs, but preexisting building issues or complicated retrofits (relating to accessibility upgrades, room sizes, circulation, and outdated infrastructure) can have costly problems that eat into tight budgets.[6] The building types to distinguish adaptive reuse builds includes:

**Existing Residential Buildings** refers to typical, single-family homes that have been adapted for hospice care. Although retrofitting for accessibility and medical needs can be challenging, this type provides a familiar and home-like environment.

**Existing Institutional Buildings** refers to offices, schools, or other institutional type buildings. These structures often provide larger spaces than existing residential buildings that can be transformed into hospice space. However, the challenge lies in establishing a comfortable, non-institutional atmosphere.

**Institutional Residential Buildings** refers to long-term care, retirement, and assisted living communities - buildings that are typologically like hospices and sometimes considered to be long-term forms of hospice. The challenge in these environments is to move away from the traditional, clinical atmosphere.

In some cases, the existing buildings (usually residential) have a **heritage designation** for historical significance or architectural value – evoking a more traditional sense of home and reinforces a connection to the community's history. The main design challenge for these buildings can be modernizing to meet accessibility, safety, and healthcare standards.

6 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

# 6.4 CATALOGUE OF RESIDENCES

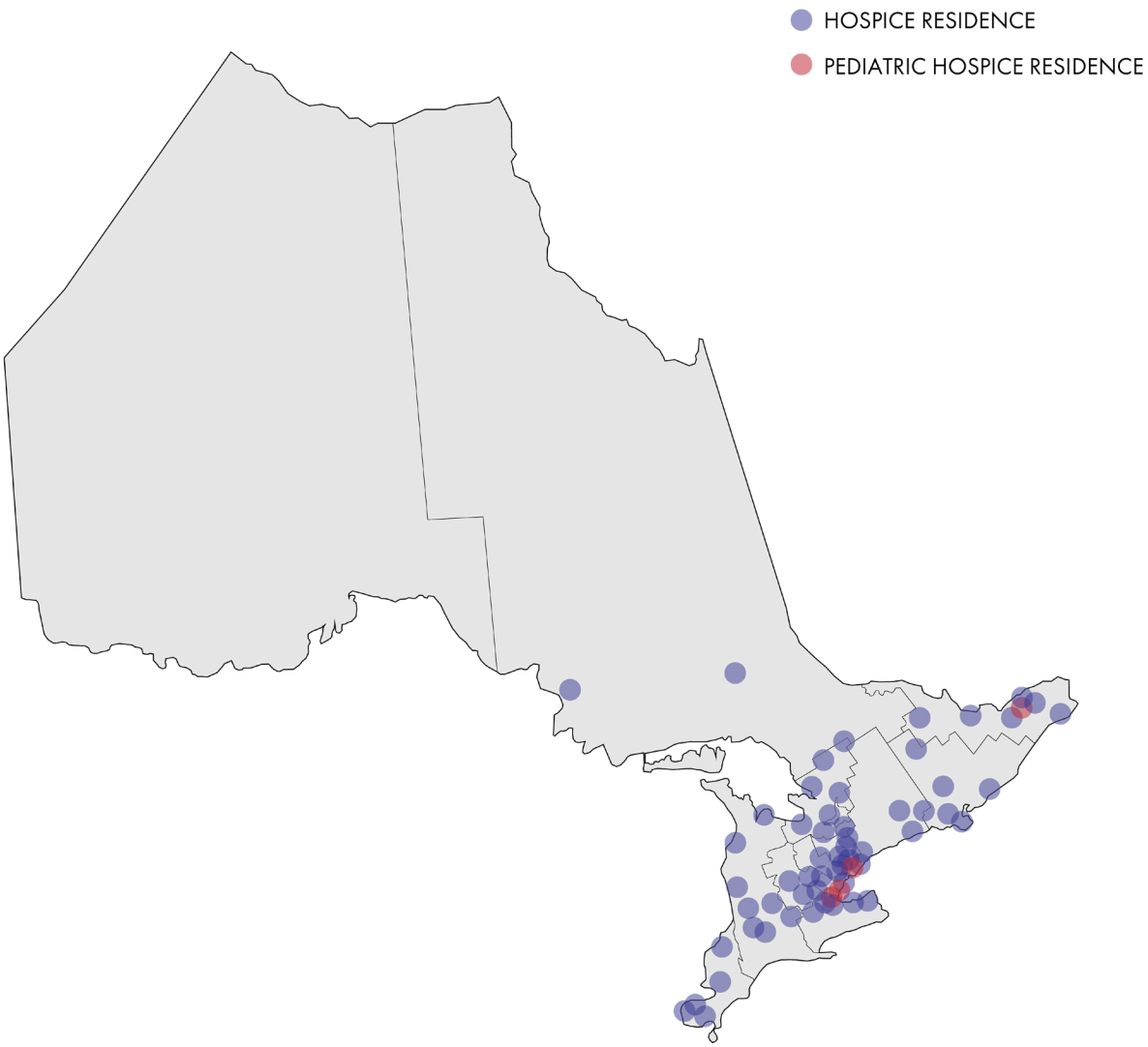



**Figure 6.4 Network of hospice residences in Ontario, 2024**

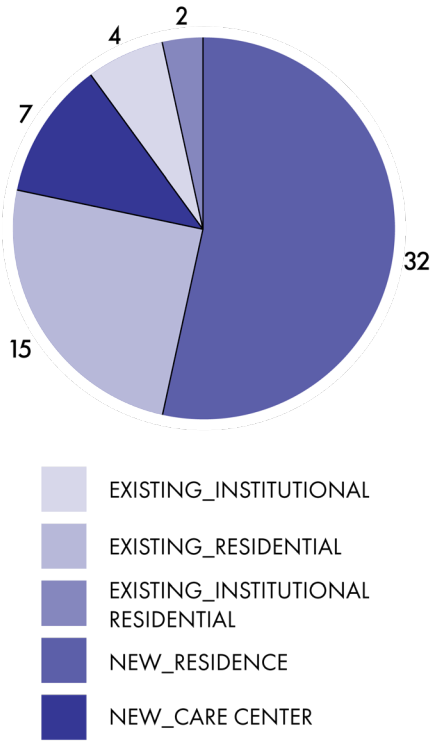



**Figure 6.5 Distribution of hospices by building type**

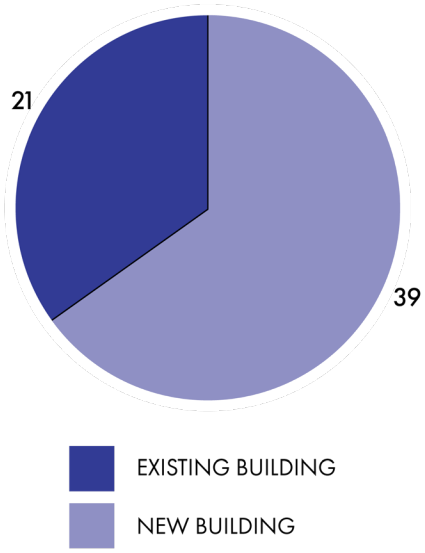



**Figure 6.6 Existing vs new buildings**

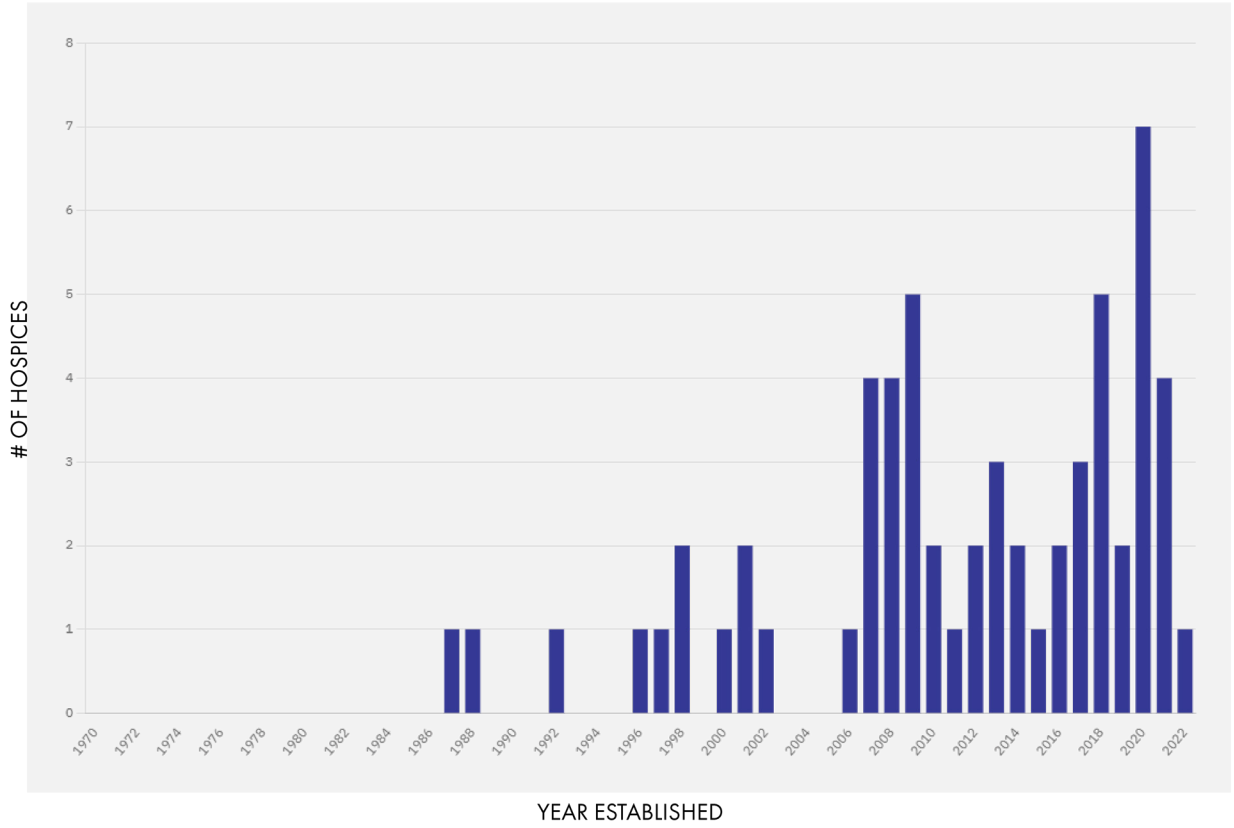



**Figure 6.7 Emergence of hospice residences in Ontario**

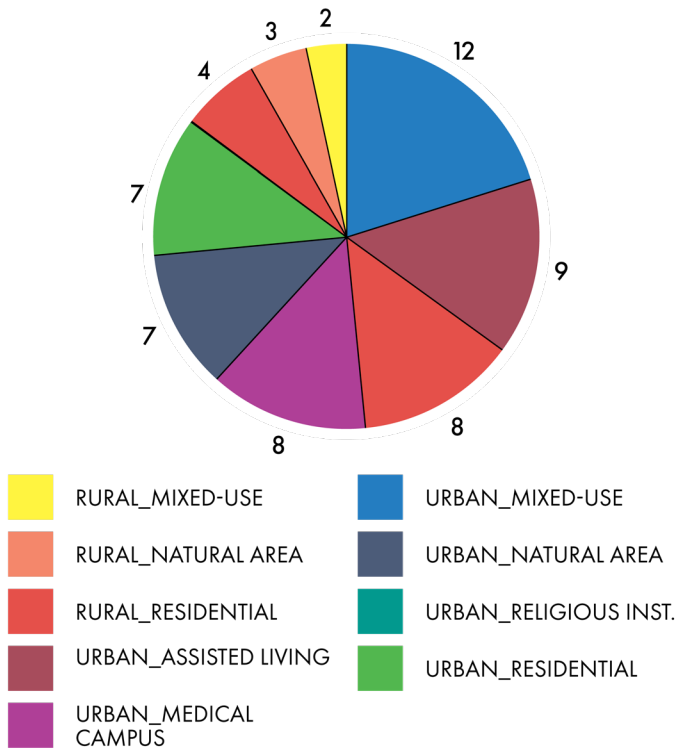



**Figure 6.8** **Distribution of hospices by adjacency**

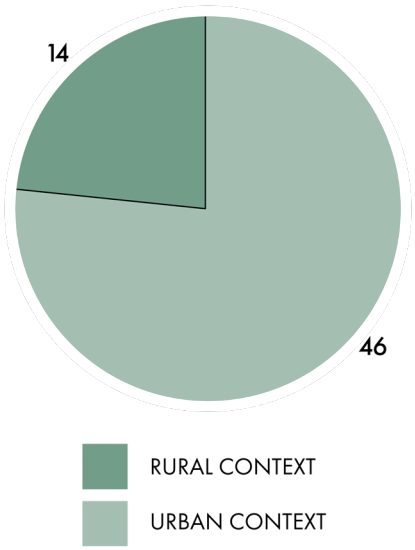



**Figure 6.9** **Rural vs urban hospices**

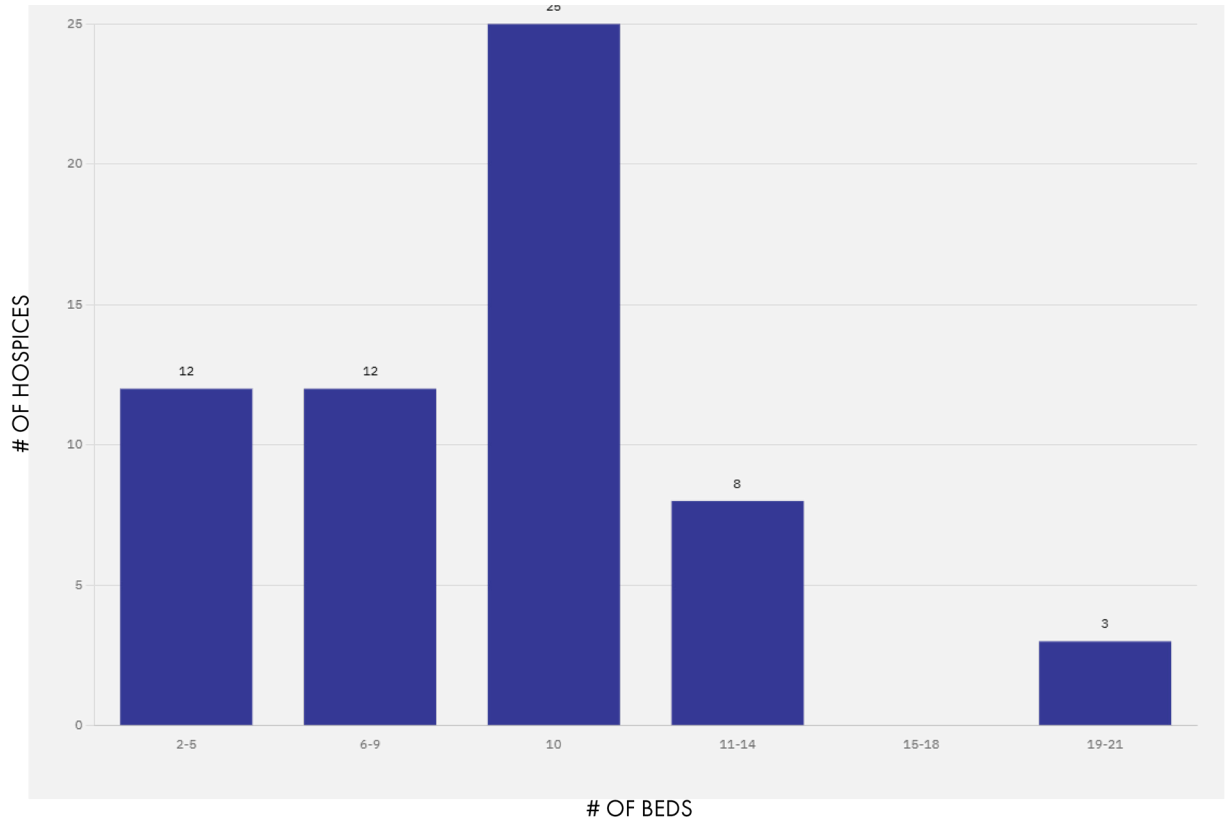
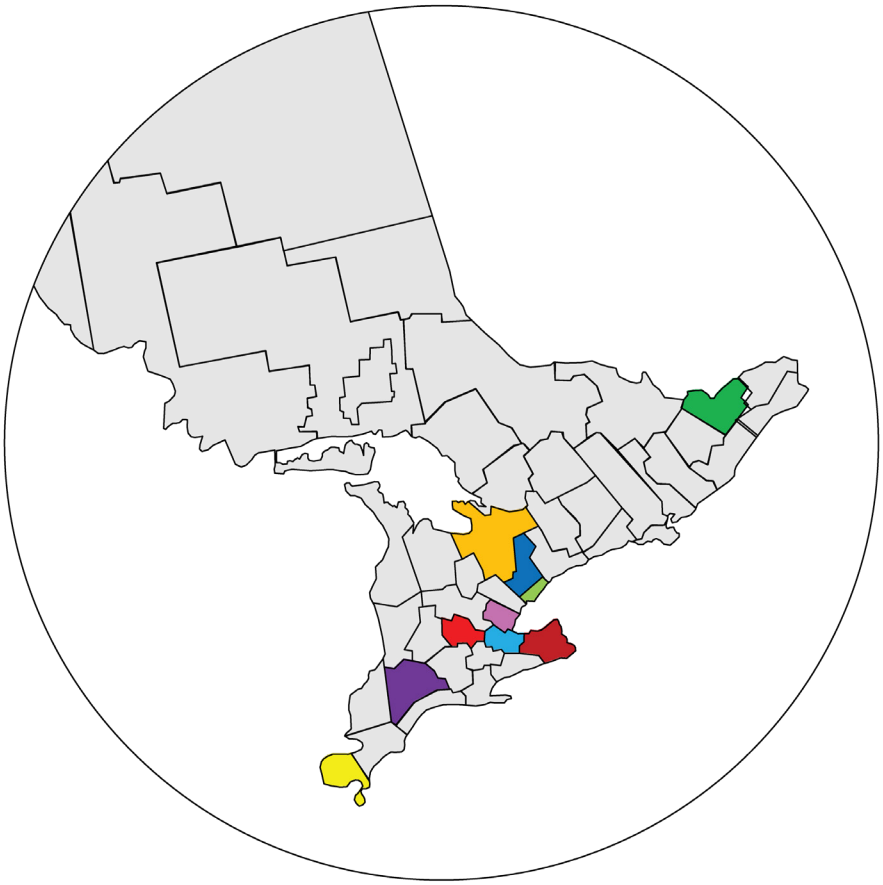



**Figure 6.10** **# of beds per hospice**

# 6.5 REGIONS WITH MULTIPLE HOSPICES

A second-tier analysis of the catalogue focuses on the ten regions or communities in Ontario that are served by 2 or more hospice residences to cross-examine the design and relationship to context, identifying shared regional specificities or alternate approaches to design. The regions were selected also as they correspond to the overlapping but varying borders that the Ontario Health atHome branches (14) - formerly Home Community Care Support Services (HCCSS) and LHIN (Local Health Integration Network) – and Ontario Health Regions (6) and related public health units (34) that Canadians use to access critical healthcare services.[7]

**Figure 6.11 Regions with multiple hospices**



7 "Find Your Local Branch | Ontario Health atHome," Government Website, Ontario Health atHome, accessed November 11, 2024, https://ontariohealthathome.ca/find-my-hccss/.

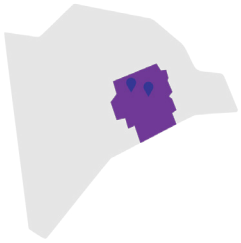
1. SIMCOE COUNTY



2. CITY OF TORONTO



3. CITY OF LONDON



4. HALTON REGION



5. CITY OF HAMILTON



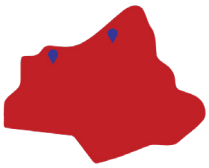
6. WATERLOO REGION



7. CITY OF OTTAWA



8. NIAGARA REGION



9. CITY OF WINDSOR



10. YORK REGION



# SIMCOE COUNTY



**Figure 6.12 Hospice Georgian Triangle - Campbell House**

*NEW_RESIDENCE*

*NON-PROFIT - HOSPICE*

*GEORGIAN TRIANGLE*

*10 BEDS | 1 STOREY*

*1987*

*(UNKNOWN)*

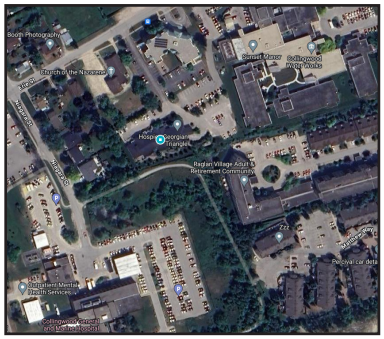


**Figure 6.13 240 Erie St, Collingwood, ON L9Y 0X8**

*URBAN_MEDICAL CAMPUS*

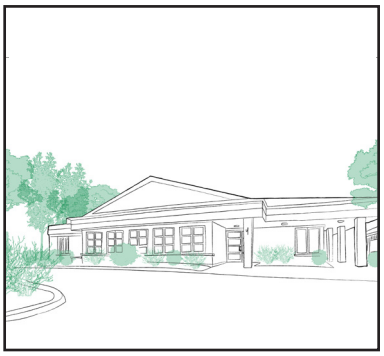


**Figure 6.14 Hospice Simcoe**

*NEW_RESIDENCE*

*NON-PROFIT - INDEPENDENT*

*10 BEDS | 1 STOREY*

*2009*

*(UNKNOWN)*

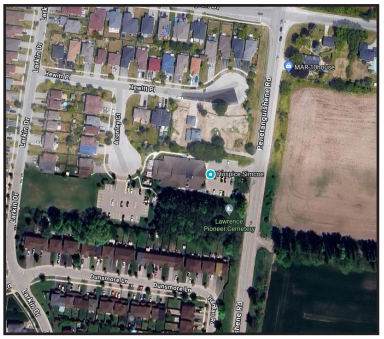


**Figure 6.15 336 Penetanguishene Rd, Barrie, ON L4M 7C2**

*RURAL_NATURAL AREA*



**Figure 6.16 Matthews House Hospice**

*NEW_CARE CENTRE*

*NON-PROFIT - INDEPENDENT*

*10 BEDS | 2 STOREYS*

*2018*

*BAILEY DESIGNS*

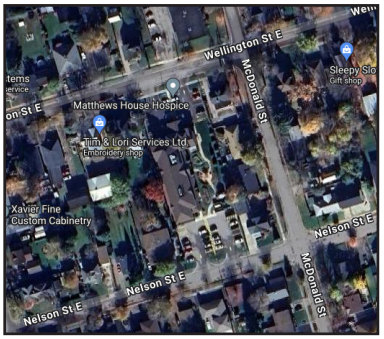



**Figure 6.17 131 Wellington St E, Alliston, ON L9R 1G7**

*URBAN_MIXED-USE*

Five hospices currently provide a combined 40 beds to support Simcoe County's population of 533,169.[8] Campbell House, part of *Hospice Georgian Triangle*, is one of the earliest hospices to have opened in the province, operating since 1987 in Collingwood, Ontario.[9] In 2009, Hospice Simcoe opened in Barrie, Ontario.[10] The following three hospices opened more recently between 2018 and 2020. Matthews House Hospice, opened first in Alliston, Ontario, and both Hospice Huronia – Tomkins House and Mariposa House Hospice opened in 2020, serving the communities of Penetanguishene and Severn, respectively.[11] [12] [13] All five hospices are newly-built residences, where the first two are in urban, mixed-use contexts. Campbell House, specifically, is adjacent to a medical campus. Hospice Simcoe is in a rural community next a green area.

8 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Simcoe, County (CTY) [Census Division], Ontario," February 9, 2022. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E.

9 "Home," Hospice Georgian Triangle, accessed November 11, 2024, https://hospicegeorgiantriangle.com/.

10 "Hospice Simcoe Residence," Hospice Simcoe, accessed November 11, 2024, https://hospicesimcoe.ca/hospice-simcoe-residence/.

11 "Our Story," accessed November 11, 2024, https://www.matthews.house/our-story.

12 "Tomkins House | Hospice Huronia," accessed November 11, 2024, https://hospicehuronia.ca/services/service.php?id=6.

13 "About Us - Mariposa House Hospice," accessed November 11, 2024, https://www.mariposahousehospice.com/about-us/.

# SIMCOE COUNTY (CONT'D)

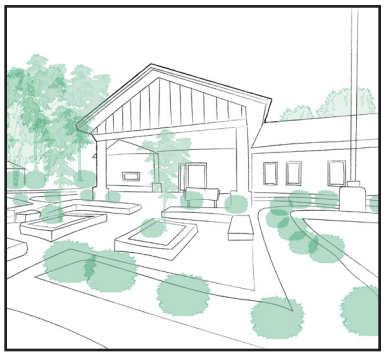


**Figure 6.18 Mariposa House Hospice**

*NEW_RESIDENCE*
*NON-PROFIT - INDEPENDENT*
*5 BEDS | 1 STOREY*
*2020*
*COOLEARTH ARCHITECTURE INC.*



**Figure 6.19 1140 Brodie Dr, Severn, ON L3V 0V2**

*RURAL_RESIDENTIAL*

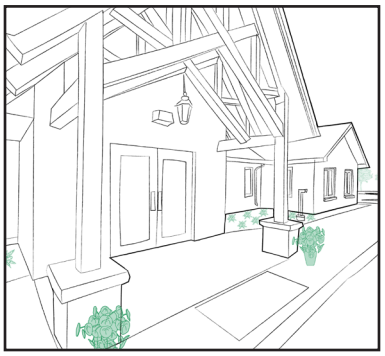


**Figure 6.20 Hospice Huronia - Tomkins House**

*NEW_RESIDENCE*
*NON-PROFIT - INDEPENDENT*
*5 BEDS | 1 STOREY*
*2020*
*(UNKNOWN)*



**Figure 6.21 948 Fuller Ave, Penetanguishene, ON L9M 1G7**

*RURAL_RESIDENTIAL*

The two newest hospices are both rurally located with residential adjacencies, surrounded by dense forest areas. Architecturally, except for Matthews House Hospice, they are all single-storey buildings. All five are residential in design, although the scale is more suggestive of a multi-unit residence or small-scale hospitality building (motel, lodge, inn) than single-family dwelling. They all feature pitched roofs, and use typical residential material pallets, including stone veneer brick, and horizontal siding. The parking lot is in front of each building, allowing for patient drop-offs at the generously deep main entrances framed by, often timber, columns and planters.

# CITY OF TORONTO

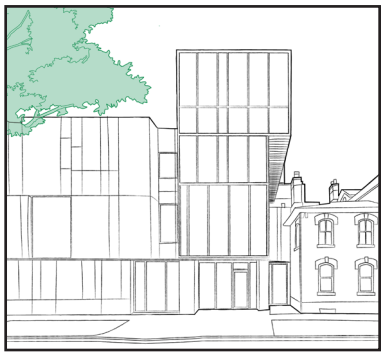


**Figure 6.22 Casey House Hospice**

***NEW_RESIDENCE***

***NON-PROFIT - INDEPENDENT***

***14 BEDS | 4 STOREYS***

***1988***

***HARIRI PONTARINI ARCHITECTS (2017 RENOVATION)***




**Figure 6.23 119 Isabella St, Toronto, ON M4Y 1P2**

***URBAN_MIXED-USE***

*Specialized in HIV/AIDS care. 2017 renovation and expansion essentially doubled the patient capacity for the facility*

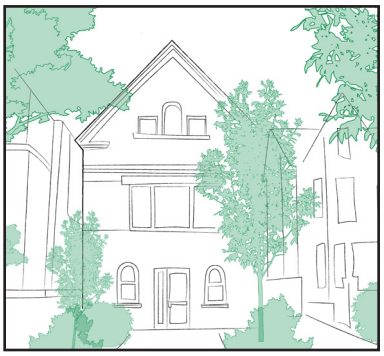


**Figure 6.24 Kensington Hospice**

***EXISTING_RESIDENTIAL***

***NON-PROFIT - KENSINGTON HEALTH***

***19 BEDS | 3 STOREYS***

***2011***

***PILLON ARCHITECT INC.***




**Figure 6.25 38 Major St, Toronto, ON M5S 2L1**

***URBAN_MEDICAL CAMPUS***

*Originally the Chapel of St. John the Divine, built in 1888. A 9-bed addition completed in 2023 makes it one of the largest hospices in ON.*



**Figure 6.26 Emily's House**

***NEW_RESIDENCE***

***NON-PROFIT - PHILIP AZIZ CENTRE***

***10 BEDS | 2 STOREYS***

***2013***

***HILDITCH ARCHITECT INC.***




**Figure 6.27 45 Jack Layton Way, Toronto, ON M4M 0B7**

***URBAN_NATURAL AREA***

*Specializing in pediatric care. Built adjacent to the Philip Aziz Care Centre in Hubbard Park*



**Figure 6.28 Journey Home Hospice**

***EXISTING_RESIDENTIAL***

***NON-PROFIT - SE HEALTH***

***10 BEDS | 10 STOREYS***

***2018***

***HILDITCH ARCHITECT INC.***

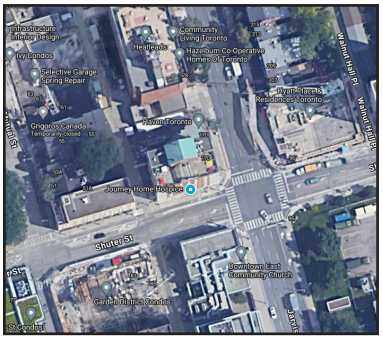



**Figure 6.29 90 Shuter St, Toronto, ON M5B 2K6**

***URBAN_MIXED-USE***

*Specialized in care for individuals facing homelessness. Renovations to existing 10-storey social housing building.*

The biggest city in the country, with a population of 2,794,356 people, is currently served by a combined 53 beds from four hospices built between 1988 and 2018.[14] Another pioneering hospice in the history of hospice palliative care in Canada is Casey House Hospice, a new build which opened in a mixed-use area in 1988, specializing in care for those with HIV/AIDS.[15] Following an expansion in 2017, the patient capacity was doubled. Kensington Hospice was the second to emerge within the city in 2011, adjacent to the *Kensington Health* medical campus.[16] This adaptive reuse of a heritage church became one of the largest in the province following a 2023 addition of 9 beds. Emily's House, a newly built pediatric hospice, opened in 2013 as part of and adjacent to the *Phillip Aziz Center* located in Hubbard Park.[17] Affiliated with *SE Health,* the most recent addition to the city is Journey Home Hospice, an adaptive reuse of an existing social housing building that specializes in care for individuals facing homelessness.[18] All four hospices in this urban setting are in relatively high-traffic and high density, mixed-use areas. Architecturally, they appear residential and blend into the varying architectural styles found across the city – mostly clad in the reddish-brown brick found on older buildings mixed with the more contemporary panel cladding used in newer construction. They are all multi-storey buildings with main entrances opening onto the sidewalk lining the busy streets, sometimes with grass or gardens to create a more welcoming entry.

14 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Toronto, Census Division (CDR) [Census Division], Ontario." Government Website. Accessed November 11, 2024. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Toronto&DGUIDlist=2021A00033520&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0.

15 "Our Origins | Casey House," accessed November 11, 2024, https://casey-house.ca/about-us/our-origins/.

16 "About Us," Kensington Health, accessed November 11, 2024, https://www.kensingtonhealth.org/hospice/about-us.

17 "Mission and History," Philip Aziz Centre & Emily House, accessed November 11, 2024, https://paceh.ca/who-we-are/mission-and-history/.

18 "About Us," Journey Home Hospice, accessed November 11, 2024, https://journeyhomehospice.ca/about-us/.

# CITY OF LONDON

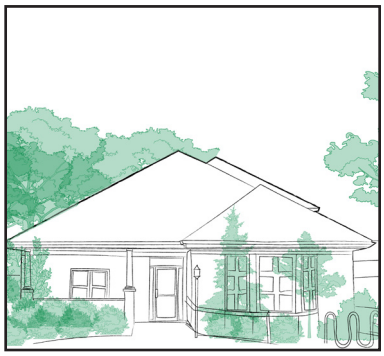


**Figure 6.30 John Gordon Home**

***EXISTING_RESIDENTIAL***
***NON-PROFIT - INDEPENDENT***
***8 BEDS | 1 STOREY***
***1992***
***(UNKNOWN)***



**Figure 6.31 596 Pall Mall St, London, ON N5Y 2Z8**

***URBAN_MIXED-USE***

*Specializing in HIV/AIDS care, addiction issues*

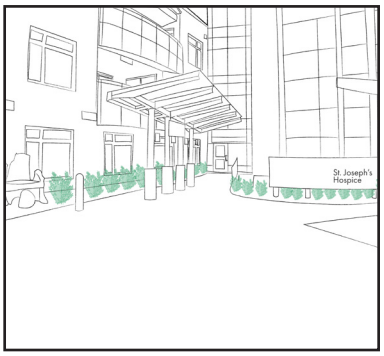



**Figure 6.32 St. Joseph's Hospice of London**

***EXISTING_INSTITUTIONAL***
***NON-PROFIT - ST. JOSEPH'S HEALTH CARE SOCIETY***
***10 BEDS | 3 STOREYS***
***2014***
***(UNKNOWN)***

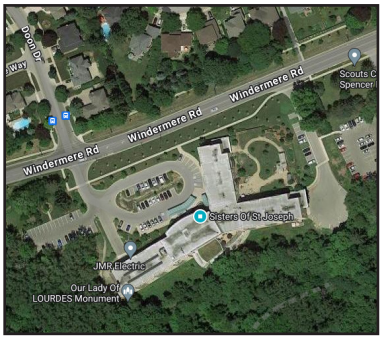



**Figure 6.33 485 Windermere Rd, London, ON N5X 2T1**

***URBAN_RELIGIOUS INST.***

*Building is LEED gold, though third floor has been adapted for the hospice.*

The city of London has two hospices, built between 1992 and 2014 respectively, with a combined total of 18 beds serving a population of 500,563.[19] John Gordon Home, specializing in care for HIV/AIDS, is an adaptive reuse of an existing residential building donated to the non-profit.[20] St. Joseph's Hospice of London, also an adaptive reuse project, was built on the third floor of an existing institutional building.[21] While only St. Joseph's Hospice has religious affiliations, both are located in low-density mixed-use, urban areas. John Gordon Home has a more exposed frontage, facing a multi-lane intersection versus the St. Joseph's building more tucked away on a quieter street. Architecturally, these two hospices are very different. John Gordon Home is a traditional, single-family dwelling versus the not-at-all domestic St. Josephs' Hospice which is an institutional, care center. However, as a result accessibility in these adapted spaces proves more of a challenge in the pre-existing residential as the institutional building has more generous circulation and communal spaces inherent to its typology.

19 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Middlesex, County (CTY) [Census Division], Ontario." Government Website, February 9, 2022. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E.

20 "John Gordon Home - Our Mission," Regional HIV/AIDS Connection, accessed November 11, 2024, https://hivaidsconnection.ca/about/john-gordon-home.

21 Craig Glover, "St. Joseph's Hospice Begins a New Future Monday, Opening a Residential Centre Unlike Anything the London-Middlesex Area Has Had before. Craig Glover Reports.," *The London Free Press*, January 12, 2014, https://lfpress.com/2014/01/12/a-new-dawn-for-twilight-centre.

# HALTON REGION

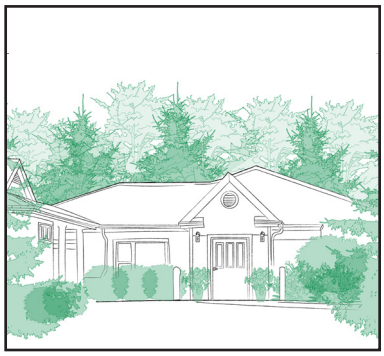


**Figure 6.34 Ian Anderson House**

***EXISTING_RESIDENTIAL***

***NON-PROFIT - INDEPENDENT***

***6 BEDS | 1 STOREY***

***1997***

***(UNKNOWN)***

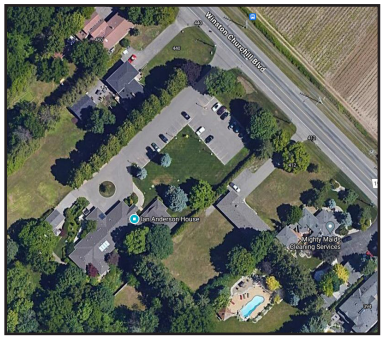


**Figure 6.35 430 Winston Churchill Blvd, Oakville, ON L6J 7X2**

***RURAL_RESIDENTIAL***

*Specialization in cancer care.*



**Figure 6.36 Carpenter Hospice**

***NEW_RESIDENCE***

***NON-PROFIT - INDEPENDENT***

***11 BEDS | 2 STOREYS***

***2002***

***CHAMBERLAIN ARCHITECT SERVICES LIMITED***

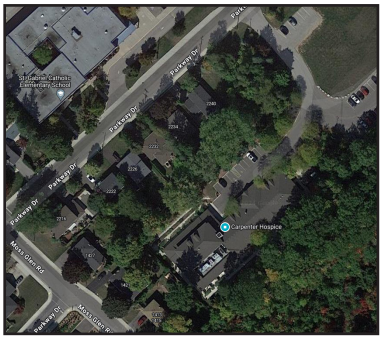


**Figure 6.37 2250 Parkway Dr, Burlington, ON L7P 1T1**

***URBAN_NATURAL AREA***

*Community endeavor to establish hospice - Rotary Community Hospice Project (1999). Renovated in 2017.*

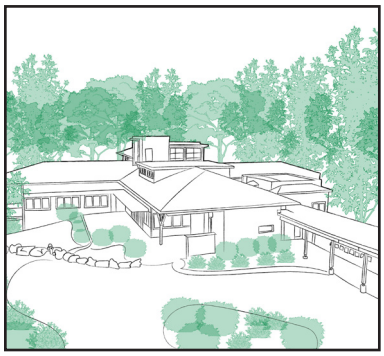


**Figure 6.38 The Darling Home for Kids**

***NEW_CARE CENTRE***

***NON-PROFIT - INDEPENDENT***

***12 BEDS | 1STOREY***

***2007***

***RED STUDIO INC. ARCHITECTS***



**Figure 6.39 5657 15 Side Rd, Milton, ON L9T 2X7**

***RURAL_NATURAL AREA***

*Ontario's first pediatric hospice. Featured in Innovations in Hospice Architecture. Multiple renovations since opening. 12 beds, 7 rooms.*

There are currently three hospice residences in Halton Region, with a combined total of 29 beds serving a population of 596,637.[22] Halton region's hospices were built between 1997 and 2007. The Ian Anderson House in Oakville, Ontario, was established in 1997, following the donation of the Anderson family house and subsequent renovations.[23] Carpenter Hospice, established in Burlington, Ontario in 2002, is a new-build residence, central to the community.[24] The Darling Home for Kids was established in 2007 in Milton, Ontario.[25] It began as a pediatric cancer care centre in 2004, and following an expansion, began offering in-patient care. All three are located on sites with lots of surrounding green, where the urban hospice has a generous site affording privacy through trees that line the backyards of adjacent neighbours. Only two are rurally located, although one is in a residential area and the other is in a remote, natural area. Ian Anderson house is nestled into a residential street, prioritizing neighbourhood connections. Carpenter Hospice is also adjacent to a wooded park and community centre. Ontario's first pediatric hospice, The Darling Home for Kids, is the most remote, surrounded by dense forest. Architecturally, all three resemble warm, country homes, using typical cladding materials found in the region – including vinyl siding, slate stone walls, exposed wood columns – with expansive landscaping with lots of opportunity for outdoor leisure. Of the three, Ian Anderson House most resembles a traditional single-family home, where the massing and scale of the other two are more multi-residential (although this makes sense considering Darling Home for Kids was a care center first).

22 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Halton, Regional Municipality (RM) [Census Division], Ontario." Government Website. Accessed November 11, 2024. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Halton&DGUIDlist=2021A00033524&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0.

23 "About," Ian Anderson House, accessed November 11, 2024, https://www.ianandersonhouse.com/about-us/.

24 "Carpenter Hospice Renovations Scheduled to Begin This Summer," *Burlington Post*, February 16, 2016, https://www.insidehalton.com/news/carpenter-hospice-renovations-scheduled-to-begin-this-summer/article_35fcc87a-ecf4-559f-abb8-284bbc707267.html.

25 "DARLING HOME FOR KIDS," Architectural Firm, Red Studio, accessed November 11, 2024, https://red-studio.ca/?portfolios=darling-home-kids.

# CITY OF HAMILTON

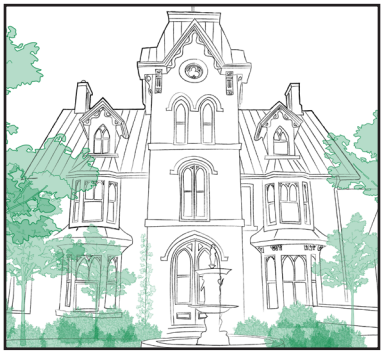


**Figure 6.40 Emmanuel House Hospice**

***EXISTING_RESIDENTIAL***

***NON-PROFIT - GOOD SHEPHERD***

***10 BEDS | 3 STOREYS***

***1998***

***(UNKNOWN)***

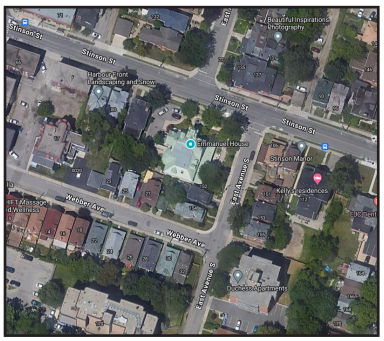



**Figure 6.41 90 Stinson St, Hamilton, ON L8N 1S2**

***URBAN_MIXED-USE***

*Originally specializing in HIV/ AIDS care. Located in a converted heritage building - "Fearman House" (c.1860s).*

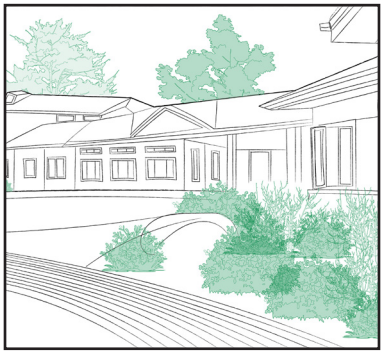


**Figure 6.42 Dr. Bob Kemp House**

***NEW_RESIDENCE***

***NON-PROFIT - KEMP CARE NETWORK***

***10 BEDS | 2 STOREYS***

***2007***

***MMMC ARCHITECTS***

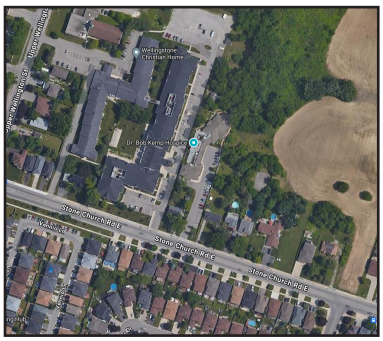



**Figure 6.43 277 Stone Church Rd E, Hamilton, ON L9B 1B1**

***URBAN_ASSISTED LIVING***

*2011 addition of garden pavilion, network is planning to open a new pediatric hospice.*

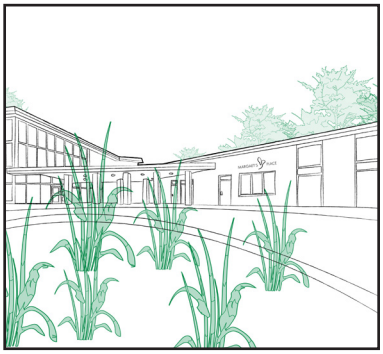


**Figure 6.44 Margaret's Place Hospice**

***NEW_RESIDENCE***

***LTC HOME - ST. JOSEPH'S VILLA***

***10 BEDS | 2 STOREYS***

***2021***

***MCCALLUMSATHER***

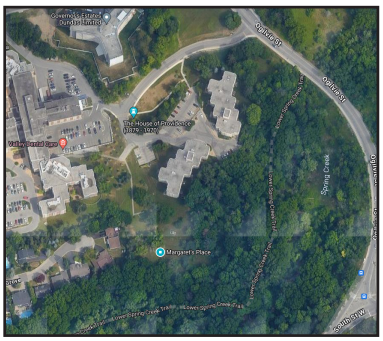



**Figure 6.45 170 Ogilvie St, Hamilton, ON L9H 3M4**

***URBAN_ASSISTED LIVING***

The city of Hamilton has three hospice residences with a combined total of 30 beds (split evenly across the residences) serving a population of 569,353 people.[26] The earliest hospice in the city was Emmanuel House Hospice, 1998, which adaptively reused a residential heritage building and originally specialized in HIV/AIDS care.[27] Dr. Bob Kemp House, established in 2007, is a new build with plans to open a new pediatric hospice wing.[28] The most recently built hospice is Margaret's Place Hospice, which opened its doors in 2021.[29] All three are situated in mixed-use, urban settings – where Emmanuel House Hospice and Dr. Bob Kemp House are adjacent and affiliated to assisted living facilities. Further development of mixed-use, residential areas surrounding Dr. Bob Kemp House will occur in coming years. Only Margaret's Place has a natural area with walking paths nearby, although all three have thoughtful landscaping framing the fronts of the properties. Architecturally, the two newer residences resemble the wide-spanning institutional-residential type buildings that they are adjacent to, with driveways that come right up to the entrance for patient drop-off. Whereas the renovated multi-level residential heritage building retains its "home-like" quality, although it is slightly less accessible compared to the others due to challenges with adaptive reuse.

26 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Hamilton, Census Division (CDR) [Census Division], Ontario." Government Website. Accessed November 11, 2024. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Hamilton&DGUIDlist=2021A00033525&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0.

27 "Emmanuel House Hospice," Organization Website, Good Shepherd Centres, accessed November 11, 2024, https://goodshepherdcentres.ca/services/emmanuel-house-hospice-palliative-services/.

28 "Residential Hospice Palliative Care," Organization Website, Kemp Care Network, accessed November 11, 2024, https://kempcarenetwork.org/dr-kemps-house/.

29 "Margaret's Place Hospice," St Joseph's Villa, accessed November 11, 2024, https://sjv.on.ca/hospice/.

# REGION OF WATERLOO

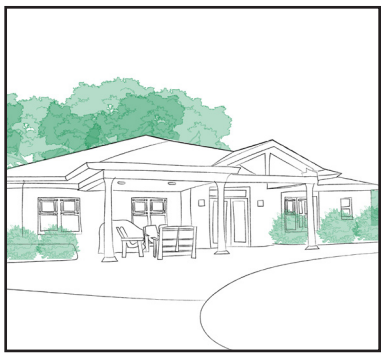


**Figure 6.46 Lisaard House**

*EXISTING_INSTITUTIONAL*
*NON-PROFIT - LISAARD & INNISFREE HOSPICE*
*6 BEDS | 1 STOREY*
*1999/2000*
*(UNKNOWN)*

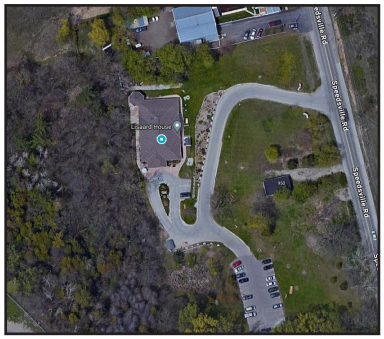


**Figure 6.47 990 Speedsville Rd, Cambridge, ON N3H 4R6**

*RURAL_MIXED-USE*

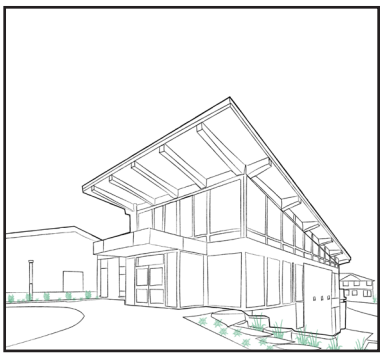


**Figure 6.48 Innisfree House**

*NEW_RESIDENCE*
*NON-PROFIT - LISAARD & INNISFREE HOSPICE*
*10 BEDS | 2 STOREYS*
*2015*
*THE VENTIN GROUP LTD.*

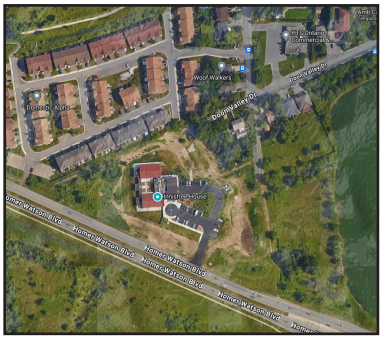


**Figure 6.49 2375 Homer Watson Blvd, Kitchener, ON N2P 0E9**

*URBAN_RESIDENTIAL*



**Figure 6.50 Hospice Waterloo Region**

*NEW_CARE CENTRE*
*NON-PROFIT - INDEPENDENT*
*10 BEDS | 2 STOREYS*
*2020*
*NEO ARCHITECTURE INC.*

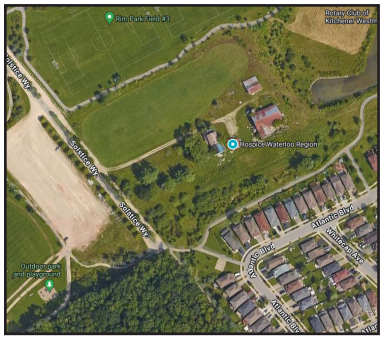


**Figure 6.51 100 Solstice Way, Waterloo, ON N2K 0G3**

*URBAN_NATURAL AREA*

There are three residences serving Waterloo Region, two of which are in Kitchener-Waterloo and the third in Cambridge, serving a population of 578,165 people.[30] Of the three, two have been built in the last 10 years in low-density urban areas. The third and oldest, Lisaard House, located in Cambridge, ON, is in an existing institutional building from the turn of the century located on a large rural site in a mixed-use area.[31] In 2015, its newly built sister site, Innisfree House, opened in a residential neighbourhood in nearby Kitchener, ON.[32] By 2020, the brand new care center, Hospice Waterloo Region, opened its doors, setting a new standard for hospice design.[33] This is a larger site than usual which also allows for potential future expansion and the ring road on site that was driven by acoustic considerations (mainly reducing vehicle sounds). All three hospices are surrounded by large spans of natural areas. Architecturally, they are all quite different. Lisaard House most resembles a residential building of the three, whereas the other two appear more as institutional care centers. Both are institutional in scale but use design elements more typical to residential buildings to create a more inviting atmosphere – including the pitched-roof house shape entrance clad in wood panelling on HWR and the wood soffit of the shed roof with a long overhang from which the warm yellow lighting of the interior dayroom shines through the floor to ceiling windows on Innisfree House.

30 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Waterloo, Regional Municipality (RM) [Census Division], Ontario." Government Website, February 9, 2022. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E.

31 "Virtual Tour – Lisaard House / Innisfree House," accessed November 11, 2024, https://lisaardandinnisfree.com/virtual-tour/.

32 "Innisfree House," Architectural Firm, +VG Architects, November 16, 2018, https://www.plusvg.com/2018/11/16/innisfree-house/.

33 "About Us," Organization Website, Hospice Waterloo Region, accessed November 11, 2024, https://www.hospicewaterloo.ca/about-us/.

# CITY OF OTTAWA



**Figure 6.52 The Ottawa Mission - Diane Morrison Hospice**

***EXISTING_INST. RESIDENTIAL***

***NON-PROFIT - THE OTTAWA MISSION***

***21 BEDS | 3-4 STOREYS***

***2001***

***HOBIN ARCHITECTURE INC.***

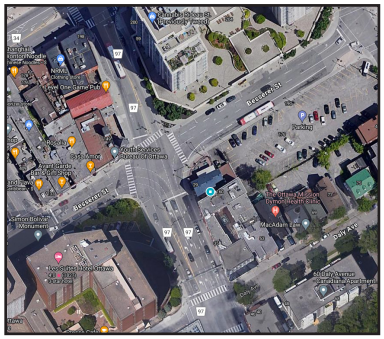


**Figure 6.53 35 Waller St, Ottawa, ON K1N 7G4**

***URBAN_MIXED-USE***

*First (and only, until 2018) shelter-affiliated hospice in North America. Originally specialized in HIV/AIDS care.*

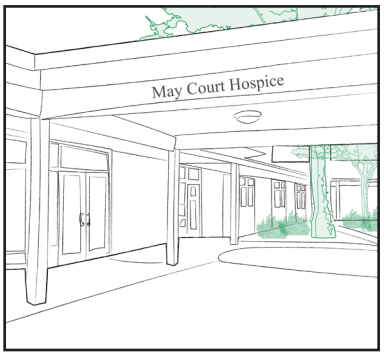



**Figure 6.54 May Court Hospice**

***EXISTING_RESIDENTIAL***

***NON-PROFIT - HOSPICE CARE OTTAWA***

***9 BEDS | 1 STOREY***

***2001***

***(UNKNOWN)***

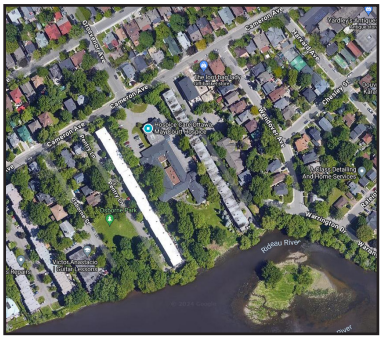


**Figure 6.55 114 Cameron Ave, Ottawa, ON K1S 0X1**

***URBAN_RESIDENTIAL***

*Addition/renovation to introduce residence program.*



**Figure 6.56 Roger Neilson House**

***NEW_CARE CENTRE***

***NON-PROFIT - OTTAWA SENATORS FOUNDATION***

***8 BEDS | 2 STOREYS***

***2006***

***MORLEY HOPPNER***

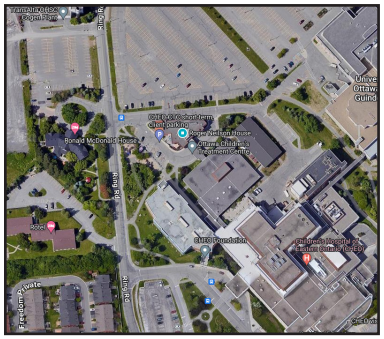


**Figure 6.57 399 Smyth Rd, Ottawa, ON K1H 8L2**

***URBAN_MEDICAL CAMPUS***

*Modelled after Canuck House, specializing in pediatric care.*

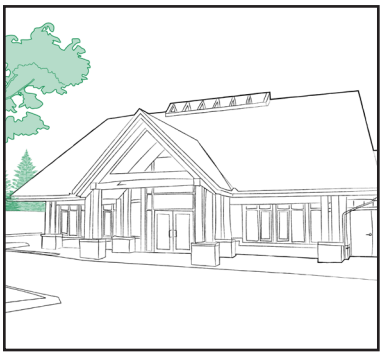


**Figure 6.58 Hein House - Ruddy-Shenkman Hospice**

***NEW_RESIDENCE***
***NON-PROFIT - HOSPICE CARE***
***OTTAWA***
***12 BEDS | 1 STOREY***
***2017***
***(UNKNOWN)***

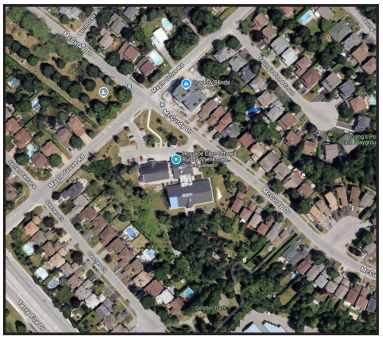


**Figure 6.59 110 McCurdy Dr, Kanata, ON K2L 2Z6**

***URBAN_RESIDENTIAL***

*Residential wing expansion for Ruddy-Shenkman Hospice.*

Built between 2001 and 2017, the nation's capital currently has four hospices offering in-patient care to support a population of 1,017,449 with 50 beds.[34] Both the Diane Morrison Hospice (*The Ottawa Mission Hospice)* and May Court Hospice, affiliated with *Hospice Care Ottawa,* opened their doors in 2001 in the City of Ottawa. Diane Morrison Hospice specializes in support for people experiencing poverty, addiction, and homelessness.[35] Both are adaptive reuse projects in an urban setting. Where Diane Morrison Hospice, a former institutional-residential building, is in a mixed-use area near a busy intersection; versus May Court Hospice, a former multi-unit residence tucked away in in a neighbourhood the city. In 2006, Ottawa's first pediatric hospice – Roger Neilson House – opened.[36] Modelled after the Canuck House in BC, the first pediatric hospice in the country, this newly built care center is located on a large medical campus. The newest hospice addition in the region came in 2017 with the new Hein House residence as part of the Ruddy-Shenkman Hospice care center (also affiliated with *Hospice Care Ottawa)*, located in Kanata, a suburb of the city.[37] *Hospice Care Ottawa* is also planning to offer a new in-patient care site for the francophone population later this year, adding additional beds to the region. Architecturally, the first three hospices in the region are larger-scale and more institutional, which makes sense considering they are part of larger care centers. Instead, Hein House is more of a residential scale, and with natural finishes and details that feel more "home-like," although it resembles more of a residential care center than the typical single-family homes surrounding it. This distinction is apparent even through the site entrance and the large parking lot that sits right in front without any landscaping to act as a buffer, creating a more accessible but institutional first impression of the site.

34 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Ottawa, Census Division (CDR) [Census Division], Ontario." Government Website. Accessed November 11, 2024. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Ottawa&DGUIDlist=2021A00033506&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0.

35 "Our Story," The Ottawa Mission, accessed November 11, 2024, https://ottawa-mission.com/about/.

36 "Roger Neilson House," Organization Website, Morley Hoppner, accessed November 11, 2024, https://morleyhoppner.com/projects/roger-neilson-house/.

37 "Residential Hospice Care," Hospice Care Ottawa, accessed November 11, 2024, https://www.hospicecareottawa.ca/services/residential-hospice-care/.

# NIAGARA REGION



**Figure 6.60 Hospice Niagara - St. Catharines Hospice**

***NEW_RESIDENCE***

***NON-PROFIT - HOSPICE***

***NIAGARA***

***10 BEDS | 1 STOREY***

***2007***

***THE VENTIN GROUP LTD.***

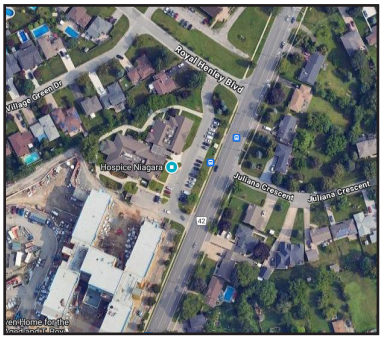



**Figure 6.61 403 Ontario St #2, St. Catharines, ON L2N 1L5**

***URBAN_ASSISTED LIVING***

*2 additional residences as part of Hospice Niagara set to open in 2025*

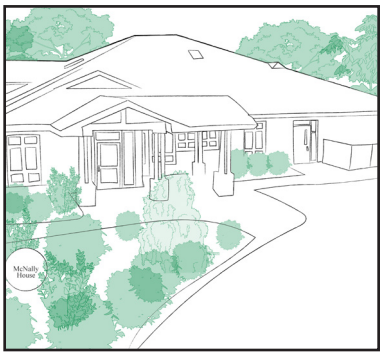


**Figure 6.62 McNally House Hospice**

***NEW_RESIDENCE***

***NON-PROFIT - INDEPENDENT***

***6 BEDS | 1 STOREY***

***2008***

***(UNKNOWN)***




**Figure 6.63 148 Central Ave, Grimsby, ON L3M 4Z3**

***URBAN_MEDICAL CAMPUS***

*Building a new 10 bed residence building starting MAY 2024*

Niagara Region has two hospice residences, established 2007 and 2008 respectively, to serve a population of 477,941 with a combined 16 beds.[38] Both are new-build residences located in urban settings. St. Catherine's Hospice, part of *Hospice Niagara*, opened first in the region. *Hospice Niagara* is set to open two new residences in the region in 2025.[39] McNally House Hospice opened the following year in Grimsby, Ontario, and are also fundraising to open a new 10-bed residence.[40] St. Catherine's Hospice is situated next to an assisted living facility whereas McNally House Hospice is on a medical campus; both are surrounded by residential areas. Architecturally, both hospices resemble institutional care centers, although generally less imposing than their multi-storey adjacencies. Both are wide, single-storey buildings with pitched roofs. Their entrances are prefaced by parking lots and tidy gardens, with drop-off zones directly in front of the door. Considering affiliations with the current hospices, it is likely that there will be more of these types of urban hospices emerging across the region in the coming years.

38 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Niagara, Regional Municipality (RM) [Census Division], Ontario." Government Website. Accessed November 11, 2024. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Niagara&DGUIDlist=2021A00033526&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0.

39 "Our Story," Organization Website, Hospice Niagara, accessed November 11, 2024, https://www.hospiceniagara.ca/our-story.

40 "The Road to McNally House," *Niagara This Week*, April 2, 2008, https://www.niagarathisweek.com/news/the-road-to-mcnally-house/article_2d4b76f1-d9c3-51e9-9756-4b87cae4be58.html.

# CITY OF WINDSOR

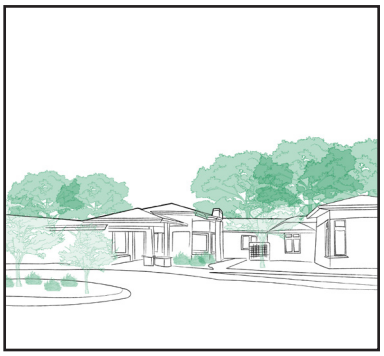


**Figure 6.64 The Hospice of Windsor & Essex County - Windsor Campus**

***EXISTING_INSTITUTIONAL***

***NON-PROFIT - THE HOSPICE OF WINDSOR & ESSEX COUNTY***

***12 BEDS | 1 STOREY***

***2007***

***(UNKNOWN)***

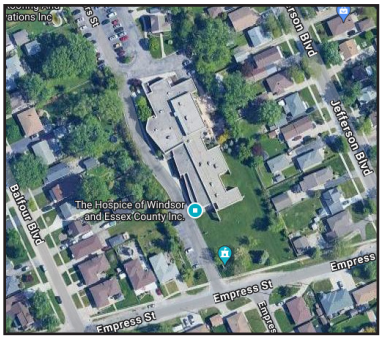



**Figure 6.65 6038 Empress St, Windsor, ON N8T 1B5**

***URBAN_RESIDENTIAL***

*Adaptive reuse of a vacated school.*

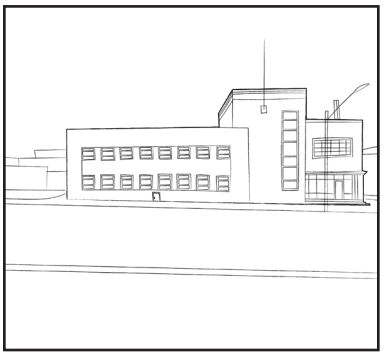


**Figure 6.66 Journey Home Hospice Windsor**

***EXISTING_RESIDENTIAL***

***NON-PROFIT - SE HEALTH***

***3 BEDS | 2 STOREYS***

***2022***

***(UNKNOWN)***

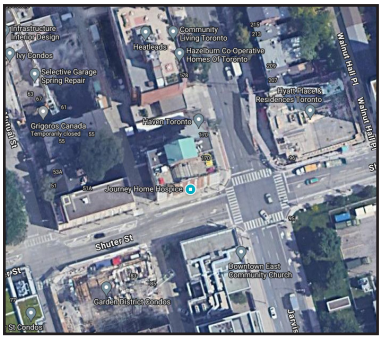



**Figure 6.67 1100 University Ave W, Windsor, ON N9A 5S7**

***URBAN_ASSISTED LIVING***

*Specializes in care for individuals facing homelessness. Modelled after the Journey Home Hospice in Toronto.*

There are currently two hospices serving Windsor, Ontario's population of 422,630 people.[41] First opening in 2007, The Hospice of Windsor & Essex County - Windsor Campus is located in a residential neighbourhood in an adaptively reused elementary school.[42] Over a decade later, *SE Health* opened the Journey Home Hospice Windsor in a mixed-use area next to an assisted living facility.[43] Like its Toronto-based counterpart, this hospice specializes in care for individuals facing homelessness and is based in a pre-existing multi-unit residential building. Architecturally, they are quite different from one another, which makes sense since neither have been modified much on the exterior. These hospices are unassuming buildings, still retaining much of the original qualities of their former uses and blending into the surrounding area. Journey Home Hospice does not have adjacent natural areas or landscaping to create outdoor refuge for occupants. Where the Hospice of Windsor & Essex County has simple landscaping that creates some privacy for patients being dropped off at the main entrance.

41 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - Windsor [Census Metropolitan Area], Ontario." Government Website. Accessed November 11, 2024. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Windsor&DGUIDlist=2021S0503559&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0.

42 "Hospice Residence," Organization Website, The Hospice of Windsor and Essex County Inc., accessed November 11, 2024, https://www.thehospice.ca/hospice-residence/.

43 "The Windsor-Essex Story," Organization Website, Journey Home Hospice, accessed November 11, 2024, https://journeyhomehospice.ca/about-us/journey-home-hospice-windsor-essex/.

# YORK REGION

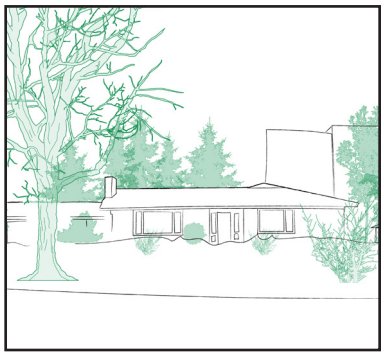


**Figure 6.68 Hill House Hospice**

***EXISTING_RESIDENTIAL***

***NON-PROFIT - INDEPENDENT***

***3 BEDS | 1 STOREY***

***1998***

***(UNKNOWN)***

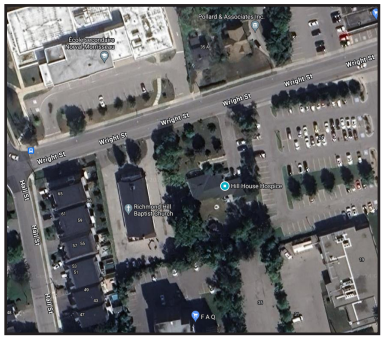


**Figure 6.69 36 Wright St, Richmond Hill, ON L4C 4A1**

***URBAN_MIXED-USE***

*Planning for expansion - new 12-bed facility on their current 1-acre site with HDR*

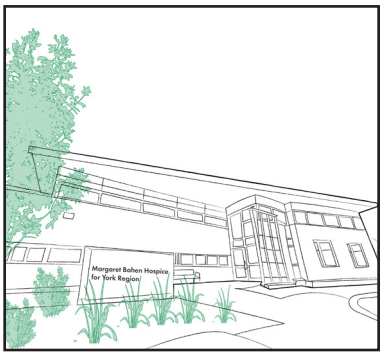



**Figure 6.70 Margaret Bahen Hospice**

***NEW_RESIDENCE***

***NON-PROFIT - BETTER LIVING HEALTH & COMMUNITY SERVICES***

***10 BEDS | 2 STOREYS***

***2017***

***STANTEC***

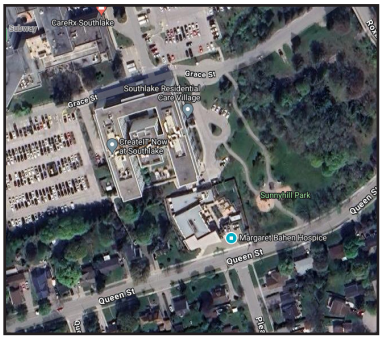



**Figure 6.71 653 Queen St, Newmarket, ON L3Y 2J1**

***URBAN_NATURAL AREA***

*Developed as response to Ministry EOI (Expression of interest) for integrated palliative care services for York Region.*




**Figure 6.72 Hospice Vaughan**

***NEW_CARE CENTRE***

***NON-PROFIT - INDEPENDENT***

***12 BEDS | 2 STOREYS***

***2021***

***MMMC ARCHITECTS***

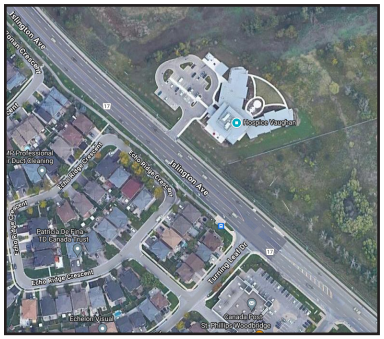



**Figure 6.73 9383 Islington Ave, Vaughan, ON L4H 3G7**

***URBAN_NATURAL AREA***

York Region, with a population of 1,173,334, is currently supported by three urban hospices with a combined 25 beds.[44] In 1998, a small, existing residential building was converted into Hill House Hospice, located in a mixed-use area in Richmond Hill, ON.[45] Hill House Hospice is currently planning a new facility set to open a new facility in the coming years, also in Richmond Hill to add an additional 12 beds for the region. In 2017, Margaret Bahen Hospice opened in Newmarket, ON, a newly built residence near a large natural area.[46] Years later in 2021, a new palliative care centre was built in Vaughan, ON.[47] Hospice Vaughan is also located adjacent to a large, natural area. Architecturally, Hill House Hospice is a traditional, single-family dwelling – fully retaining the original character of its single-storey building. It has a deep front lawn with trees and foliage to create some privacy, and only a driveway to the side of the building to support parking. Contrarily, the two newer built hospices are both two-storey buildings with shed roofs and large, open entrances. They both resemble institutional care buildings, rather than residential, but the colour palette and openness of the façade creating an inviting impression upon entering the site. They both have generously paved paths and accessible parking directly in front of the building.

44 Statistics Canada. "Profile Table, Census Profile, 2021 Census of Population - York, Regional Municipality (RM) [Census Division], Ontario." Government Website. Accessed November 11, 2024. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=York&DGUIDlist=2021A00033519&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0.

45 "Our History," Organization Website, Hill House Hospice, accessed November 11, 2024, https://hillhousehospice.com/history.

46 "Margaret Bahen Hospice," Margaret Bahen Hospice, accessed November 11, 2024, https://www.myhospice.ca/margaret-bahen-hospice/.

47 "Hospice Vaughan Residence," Hospice Vaughan, April 29, 2021, https://www.hospicevaughan.com/hospice-vaughan-residence/.

## *KEY INSIGHTS FROM CATALOGUE*

The regional case studies demonstrate a growing presence of hospices in high-density urban areas in the province over the last 40 years, emphasizing the need for evolving hospice design approaches and a changing perspective on the end of life.

1. The first tier of the catalogue demonstrates a growing presence of hospices in smaller communities, driven by community representation.
2. There is limited access to hospice palliative care, especially inpatient care, for communities in the central and northern regions of the province – a gap in the current network of care.
3. The catalogue reveals a wide range of site and residence types depending on the priorities of the community, whether that be proximity to existing services or community integration.
4. Both new builds and adaptive-reuse projects are facilitating human-centred, compassionate care. Some regions prioritize the domestic, "homelike" quality of space where others are more traditionally institutional in design.
5. Across the province, architectural adaptability, human-nature connections, and community engagement emerge as key design themes/needs for quality hospice care experiences.

# 6.6 FIELDWORK-BASED CASE STUDY: WATERLOO REGION

The following analysis explores the hospices in Waterloo Region with fieldwork research with architects and care providers. With much appreciation, the author was able to meet with architects of two out of three hospices in the region, allowing for insight into their perspective of the role of designers in spaces of care, their design processes, and specific details that contribute to enhancing occupant experience. Through field work tours and interviews with care providers from these three hospices, a more in-depth case study analysis can be completed. An ethics clearance was approved by the University of Waterloo for the field work interviews with care providers at the three hospices. (Please refer to Appendix for more information about the interview process.) This selection also provides hospices each in different hospice type categories and with differing adjacencies as identified in the regional analysis, allowing for a more nuanced understanding of how the benefits and challenges of each type impacts design approach and occupant experience.

## *LISAARD HOUSE*

Lisaard House is the first hospice and adaptive reuse residence in Waterloo Region. Lisaard and Innisfree House are connected and supported by overlapping care providers, allowing for a more nuanced perspective based on two different facilities.

Regarding what spatial qualities stick out to patients and their loved ones, staff identified connections to nature as very impactful – where all patient rooms have views of the peaceful, surrounding nature. Specifically, the bird feeders outside of each room provide visual stimulation and entertainment to occupants, viewing the birds feeding and chirping away outside their windows.[48] Patient rooms also have patio doors that allow the beds to be moved outdoors for full nature immersion. This connection to nature is not as prevalent in staff-dedicated spaces, where during an interview with one care provider I noticed that they had birdsong playing on a speaker in the background which also brought to attention the fact that there were not any windows in the room either.[49] This nature immersion simulation still made a difference to the care provider, who felt a sense of calm and focus that enhanced their ability to work.[50]

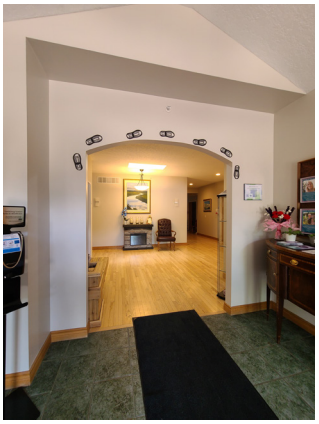


**Figure 6.74**
**Reception area, Lisaard**

When asked about the home-like qualities of the space, staff talked about how patients have private rooms, and the calm and quiet atmosphere really contributes to that differentiation from medical care spaces. The spaces that support families like the kitchen, dining room, and living room also contribute to making people feel more comfortable and that they have their own space.[51] Material choices and finishes impact the acoustic insulation of a space, creating possible issues with sound travel between spaces which can be especially challenging in environments where privacy and discretion are necessary and there are limited private spaces already for occupants to converse. Attention to material choices also extends to furniture where it is important that they are not only cleanable, but also comfortable and accessible as this might inhibit use of



**Figure 6.75 Kitchen/ dining, Lisaard**

48 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
49 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
50 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
51 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.

certain spaces (although furniture is often donated to hospice spaces).[52] In terms of potential space improvements, staff said having more communal gathering spaces for families with views of nature would enhance occupant experience. This also extends to outdoor spaces, where it was mentioned that more covered spaces outside that were accessible for the patient beds and their loved one to gather would make a big difference, considering there is only one sunroom shared between all six patients and their families/friends.[53]

According to staff, there has been limited work to the building since its opening around 25 years ago. There are some challenges relating to adaptive reuse, where Lisaard House is considered a "grandfather building," because of the age of the structure there are certain details that are no longer up to building safety or fire safety codes.[54] For example, the conversion of this residential building required massive fire suppression tanks to be installed in order to meet requirements at the time considering the site does not access municipal services, taking up the majority of the basement of the building. This "grandfathering" means that they are limited as to what renovations or upgrades can be made to the space, as once these changes are made, they will also require that the building be brought up to code – which would be a very costly endeavour for the hospice. Nevertheless, the staff do their best to make the space work for their needs and overall, the current state of the building still allows for a high-quality care at the end-of-life.

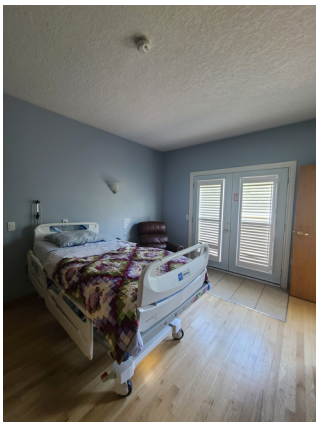


**Figure 6.76 Resident suite, Lisaard**

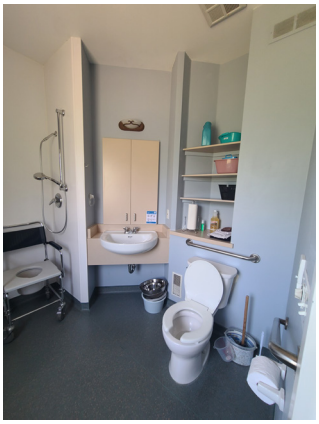


**Figure 6.77 Resident washroom, Lisaard**



**Figure 6.78 Sunroom, Lisaard**

52 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
53 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.
54 Hospice Care Provider, Fieldwork Interview – Lisaard House, May 23, 2024.

## *INNISFREE HOUSE*

Opening in 2015, the second hospice in Waterloo Region, Innisfree House, is a newly built residence designed by +VG. This 16 200 square foot residence was also designed to support palliative care training for students from the nearby Conestoga campus. Prior to touring Innisfree House, the author interviewed architects from +VG to gain insight on the design process and general design approach in their experience now having designed many hospices as evidenced by the catalogue. General notes from the meeting include:[55]

*Each hospice design should respond to the community in which it is situated and that the design process begins with engagement meetings with all stakeholders (doctors/healthcare providers/volunteers/ family members). Long-term community relationships are important, so these perspectives are valuable as many non-profits have their own defined philosophy of care and communities engage with death and dying in different ways, which impacts spatial needs and the design approach.*

- *They observed that post-covid, people like being outside more, even in colder weather – so it is important to facilitate those experiences through the landscape design*
- *Architects addressed the challenge of a complicated site topography with a steep decline away from street level by shifting service and educational spaces into a lower level of the building.*
- *Flexible communal spaces, prioritizing views for privacy of patients and staff, and providing breakout spaces for varying occupancies were identified as key considerations in design.*
- *Importance of natural materials to represent temporality in design, representing permanence and aging.*



**Figure 6.79**
**Dayroom, Innisfree**

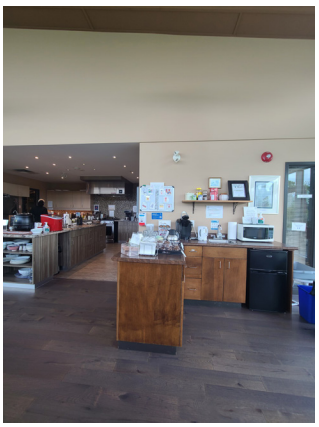


**Figure 6.80 Kitchen and family pantry, Innisfree**

Months later, interviews with care providers at Innisfree House shed light on how the space functions in practice, often operating close to full capacity.[56] Innisfree is a spacious, accessible facility with lots of natural light and views of nature integrated throughout. A special request during

55 Deb Westman, Designing Innisfree House, Virtual Call, February 9, 2024.
56 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

the design process was to include a family kitchen that allows for visitors to cook their own food, and according to staff this is a big comfort for people.[57] One care provider specifically referred to a younger family, where one parent was receiving care and their whole family was able to come and bake cookies together, allowing them to reminisce about experiences at home.[58] Care providers, who have worked previously at other hospices, identified that Innisfree definitely has a "homelike" feel, with a central fireplace and volunteer-made quilts on every patient bed.[59] They identify muted colour choices and lack of plush material surfaces as contributing to a more institutional atmosphere in many newer hospices.[60] Also pointing to more artwork and ambient lighting in communal spaces as details that could further contribute to the warmness of the space. Relating back to personalization of space, more display-type storage is needed than hidden-storage in patient rooms.[61]

Care providers identified that the generous storage in resident rooms limits the position of the patient bed in the suite, which can prove a challenge with sightlines when the doors must be kept open on occasion.[62] Sightlines can be challenging especially when moving between communal and private spaces, and sensitivity to privacy for both patients and other visitors (especially children) is an essential consideration. Certain suites receive more traffic outside their entrance depending on their position along the circulation, and staff have previously moved patients to quieter rooms upon request if vacancy permitted. Sense of privacy is also a personal thing that ranges. Balancing sightlines is further complicated by finding a balance to allow for sightlines between care providers and their patients, especially when the nurse's station is closer to certain rooms.[63]



**Figure 6.81**
**Workspace, Innisfree**



**Figure 6.82**
**Residence hallway, Innisfree**

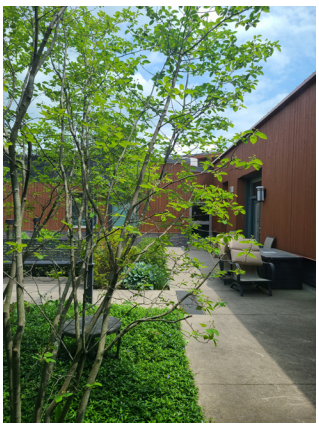


**Figure 6.83**
**Courtyard, Innisfree**

57 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024
58 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
59 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
60 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
61 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
62 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.
63 Hospice Care Provider, Fieldwork Interview – Innisfree House, May 22, 2024.

## *HOSPICE WATERLOO REGION*

The third hospice in the region, Hospice Waterloo Region, designed by NEO Architecture Inc. was completed in 2021 and is a 25,000 square-foot facility, dedicated to hospice palliative care.[64] Prior to this, the care center operated out of an existing commercial facility. HWR is one of the earliest hospices to have received government funding to support its construction. The new center combines a ten-bed residence, medical facilities, and educational/administrative spaces.[65] Its architectural design, combining symbolism with functionality, sets a new standard for compassionate healthcare facilities.[66] The barn-like design, featuring natural stone and wood, creates a comforting atmosphere, symbolizing the enduring human spirit.




**Figure 6.84 Sitting area, HWR**

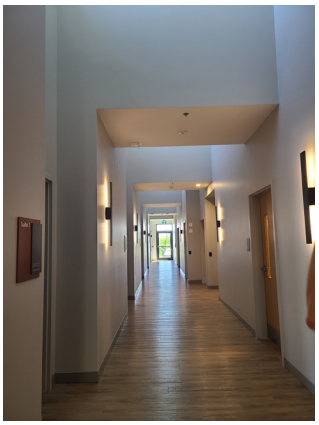


**Figure 6.85 Residence hallway, HWR**

Prior to touring Hospice Waterloo Region, the author had the privilege of meeting with Laird Robertson of NEO Architecture. General notes included:

- *This project had a collaborative design approach informed by stakeholders, including multiple sessions with care providers and touring existing hospice residences with clients to identify preferences.*
- *Specific requests from clients included: cultural consideration of Mennonite and Indigenous communities in the area, minimizing paths of travel for nurses, and establishing meaningful thresholds to facilitate a ritual procession following the passing of a patient.*
- *The architect used a "three-pronged" design approach – functional, contextual response, and narrative.*
    1. *Functional: All mechanical necessities were intentionally hidden in the design, like roof systems hidden with an intentionally depressed roof.*
    2. *Contextual: The form of the building is inspired by the agrarian history of the site - slots in street-facing facade refer to the*

64 "The Gies Family Centre: Hospice in Waterloo, Ontario," ***Canadian Architect***, November 30, 2023, https://www.canadianarchitect.com/the-gies-family-centre-hospice-in-waterloo-ontario/.

65 "Gies Family Donates $2.5M to Hospice of Waterloo Region," ***Waterloo Chronicle***, April 12, 2023, https://www.waterloochronicle.ca/life/health-wellness/gies-family-donates-2-5m-to-hospice-of-waterloo-region/article_61b42257-00b2-5b7d-992f-c08ad29c9918.html.

66 "The Gies Family Centre."

*vernacular of slots in barn walls.*

3. *Narrative: Representing duality in hospice - eternity of the spirit versus the fragility of the body - through materials that intentionally age or develop a patina.*

Later interviews with care providers and tour of the facility reiterated how the design intentions of the client and architect translated to the space in practice. Some design elements do not work out as planned, such is the case with the staff room that ended up being too small as the number of staff and volunteers was underestimated, requiring additional spatial solutions to accommodate needs.[67] There was also a plan for the volunteer reception desk to be a modular component that could be tucked away when not in use but in practice it ends up staying out.[68] The circular circulation with centralized service corridor becomes a challenge requiring redirection for moving laundry or garbage efficiently through the space, with staff members suggesting a walkthrough midway down the hall through the service corridor to make a shorter path of travel.[69] One staff provider also talked about how the architect's vision of home can differ from their client's, noting how the more contemporary design in recent hospices prioritizes clean lines and textured surfaces instead of the personal clutter and artwork that is more commonly found a traditional home.[70] Despite these minor spatial challenges, this hospice is fully accessible with lots of natural light and views of nature integrated throughout.

A key part of the patient experience is the ability to move the hospice beds directly outside of the rooms where there is a pergola that provides shade for each patient to spend time outside in during mostly warmer months.[71] The large hospice grounds are managed by a team of volunteers, especially framing the main entrances and patient rooms with lush gardens.[72] There are also large windows throughout the building. The silo, central to the building, is identified as a key space for families;

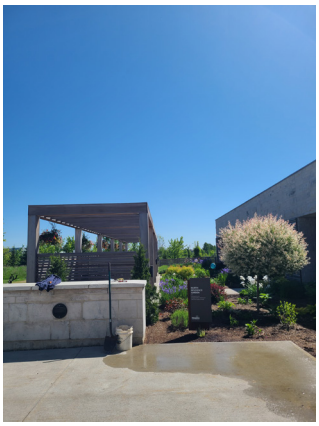


**Figure 6.86 Resident pergolas, HWR**

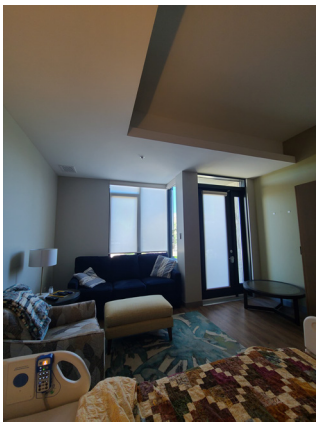


**Figure 6.87 Resident suite, HWR**

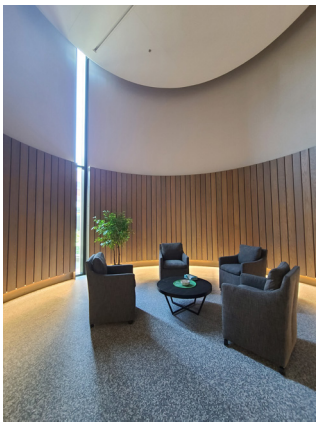


**Figure 6.88 Spiritual space, HWR**

67 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
68 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
69 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
70 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
71 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
72 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

having facilitated weddings and other ceremonies for patients and their loved ones.[73] Multiple entrances with decent lobby spaces surrounding this central circulation path are also key to accommodating overflow of occupants in both the care centre and residence wings of the hospice. These entrances, specifically the residential wing entrance, is part of the meaningful procession ritual that occurs following the passing of a patient, when their body is brought out through the same door from which they originally entered, giving their loved ones a ritual to finalize their time at the hospice.[74]

## *REGIONAL CASE STUDY: OVERVIEW*

An in-depth study of the three hospices in Waterloo Region demonstrates different approaches to hospice design for the same community over a few decades. All three hospices feature design elements to enhance occupant experience relating to comfort and human-nature connections. The architect's perspective highlights critical design considerations and the process of working closely with stakeholders for two of the hospices. Feedback from care providers at all three hospices gives insight into how the design intentions translate to reality, offering compassionate suggestions from first-hand users of the spaces on ways the space could potentially evolve to suit patient needs.

73 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.
74 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

# 6.7 CONCLUSION

The process of completing this catalogue research gives insight into the accessibility of information relating to hospice care spaces and patient experience for individuals and families seeking care. The first two tiers of the catalogue create a clearer image of the emergence and growth of the hospice residence network across southern Ontario, showing trends in growth in recent years corresponding to increased awareness and funding available for hospice palliative care. Especially focusing on the categorization that followed data collection for site and residence types allows for a refinement in the understanding of typology of hospice residences and how design principles can potentially be established to be adaptable for communities across the province. The third tier, the regional case study of Waterloo, looks closer at the relationship between architect and occupants through the design process and experience of the space in-practice, giving insight into architectural details that are successful and can further enhance occupant experience. Beyond this detailed regional study, the floor plans collected for the first tier of the catalogue will be useful in architectural analysis of key functional program spaces, circulation, and adjacency considerations – potentially allowing for definable approaches that could be the basis for an architectural kit of parts to inspire future hospice residences.

# 7. ARCHITECTURAL BRIEF

## 7.1 VALUE OF THE BRIEF

An architectural brief outlines requirements for the design, providing an overall description of key spaces. The brief is an opportunity for defining atmospheric goals for occupants and outlining overall design considerations. The *HPCO: Hospice Residence Standards* "Facility Requirements," provides a succinct overview of the aim for hospice residences, which shall provide:

> *"specialized hospice palliative care services in a homelike setting for the residents it serves and their families. It may be an independent free-standing healthcare facility or a dedicated hospice suite(s) which is co-located within a larger facility. The Hospice Residence is designed to ensure the comfort, privacy, safety, and security of all residents."*[1]

The HPCO definition of *homelike* means space that allows occupants to freely express themselves, provides shared common spaces, and allows for 24/7 or continuous access to all spaces.[2] There is no mention to site or outdoor spaces in the brief, only referring to interior space. In addition to *homelike,* the brief further identifies *privacy* and *accessibility* as essential priorities in hospice design. While not explicitly outlining key occupants, this brief only mentions *residents* and *their family/friends*, not considering the role and experience of staff in the space as part of their facility requirements. Instead, the spatial priorities can be interpreted as required only for key spaces occupied by residents/their family, where staff-dedicated spaces are purely functional. However, staff wellbeing should be prioritised as well, where incorporating holistic design in staff spaces can improve both workplace satisfaction and performance.

1 "Module 3, Section 3: HPCO Hospice Residence Standards" (HPCO, June 2020), 23.
2 "Module 3, Section 3: HPCO Hospice Residence Standards," 23.

Referring to the Maggie's Centres in the United Kingdom and abroad, many successful architectural projects have been built based on the Maggie's *Architecture and Landscape Brief*.[3] This thoughtful brief presents "the building, the landscape and the environment" as interconnected components that facilitate human experience in space.[4] Outdoor spaces and views of nature are especially important to the (physical, emotional, and spiritual) healing and comfort of occupants. Going further, an ethos of domesticity is presented through the detailed spatial requirements for key spaces in the centres.[5] These requirements describe how the space will be used, and what essential details are needed to support a quality patient/visitor experience. Architects are provided with a detailed overview of the challenging experience of facing cancer or supporting a loved one with cancer, directly relating the experiences to ways space can be supportive rather than isolating:

> *"Sometimes, all that a person can bear, if they are in acute distress, is to look out of the window from a sheltered place, at the branch of a tree moving in the wind. We would like there to be as many opportunities as possible to look out from wherever you are in the building, even if it is to an internal planted courtyard."*[6]

The brief considers the relationships between Maggie's centres and hospitals, and its integration in the local community. Residents and family/friends are welcome to return to the building and grounds during and after treatment whether they want to use additional services or to simply spend time and reminisce, establishing the centres as fixtures of care.[7] This brief is a great example of how a meaningful design approach can inspire innovative and unique spaces of care, that is highly translatable to hospice. The somewhat limited HPCO brief could develop to a more holistic design brief by further emphasizing integration of building, landscape, and the nuanced human experience in hospice.

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3 "Maggie's Architecture And Landscape Brief" (Maggie's Centers), accessed November 11, 2024, https://www.maggies.org/about-us/publications/.

4 "Maggie's Architecture And Landscape Brief," 3.

5 "Maggie's Architecture And Landscape Brief," 8.

6 "Maggie's Architecture And Landscape Brief," 5.

7 "Maggie's Architecture And Landscape Brief," 7.

# 7.2 SPATIAL REQUIREMENTS FOR HOSPICE

One of the early challenges in hospice design is understanding what exactly the spatial needs are, beyond functional/clinical spaces and what the existing design standards mandate. For the architect to be able to conceptualize hospice space, understanding the perspective and spatial needs of the people who will be using the space is critical. Hospice is an interdisciplinary approach to care, and thus the design should be too. People who are using this space – patients, families, and staff – should be involved and consulted throughout the design process, where critical details and considerations relating to privacy and circulation (amongst other things) can be lost in translation along the way between the architect's vision and the reality of the built space.[8]

Considering the grassroots origins of most hospices, not all individuals involved come from a background working in hospice or healthcare. Often people feel motivated to get involved because of an experience they had of a loved one passing and through an experience at a hospital/homecare/another hospice, understand the value of community and support at the end-of-life. What's driving their intentions is how they want people to feel in the space, and what they imagine a space that supports that experience would be - versus the perspective and understanding of space that people working directly in hospice would have.[9] This lack of access to adequate information regarding quality of space in hospice has resulted in a variety of approaches to addressing spatial challenges. One of the hospice directors interviewed through the field work identified a trend amongst emerging hospices, where:

> *"...they design what they think they want, without any background or experience of what the operations actually are and end up with architects who've never done it... and then buildings that aren't really sufficient to what you need to do."*[10]

8 Ken Worpole, *Modern Hospice Design: The Architecture of Palliative and Social Care*, 2nd ed. (London: Routledge, 2023), 74-75, https://doi.org/10.4324/9781003306818.

9 Hospice Director, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

10 Hospice Director, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

An example of this would be a hospice where the nurse's stations have been designed to function as standing desks, which are successful in many workplace environments, but negate the fact that the majority of a nurse's work is done on their feet, moving through the space, and being at their desks is one of the few spaces where they are able to sit while working.[11] Discrepancies like this can be avoided by involving intended users in the design process, where the existing design standards do not currently offer qualitative descriptions for the required program spaces.

Current spatial requirements for HCPO hospice accreditation come from the Ministry of Health and Long-Term Care, through the *Hospice Capital Program Design Standards Version 1.2* (last updated January 2019), which represents the minimum standards to "provide effective functionality and infection prevention and control, as well as the amount of space that the ministry will fund for that room type" in a hospice residence.[12] Essentially, these standards are required for any hospice seeking government funding. Whilst considering the "Ontario Building Code, Fire Code, Ontario Long-Term Care Home Design Manual 2015, and Canadian Safety Association industry standards" in the room sizes and requirements, the *OASIS principles* represent the ministry's priorities for capital projects and drive the standards, representing:[13]

**O**perational Efficiency

**A**ccessibility

**S**afety and Security

**I**nfection Prevention and Control

**S**ustainability

This list of room sizes does not include qualitative descriptions or specify needs relating to the function of the room, instead featuring only a room type, quantity, and area. There is no requirement relating to

11 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

12 "Hospice Capital Program Design Standards Version 1.2" (Ministry of Health and Long Term Care, January 2019), 6.

13 "Hospice Capital Program Design Standards Version 1.2," 6.

site planning and outdoor spaces, neglecting the importance of nature in spaces of care. While *OASIS* outlines Accessibility as a principle of the Ministry's priorities, there is no reference to accessibility in room sizes/requirements other than barrier-free washrooms, instead relegating additional details to the Ontario Building Code (OBC). Despite this lack of detail, accessibility and inclusive design dimensions should be utilized wherever possible to accommodate residents, visitors, volunteers, and staff. Circulation and occupancy are also not considered in these standards, although they are critical components of space planning and organization.

Referring to the OBC, more specific spatial requirements are available based on the occupancy classification of the building. As defined by *Article 3.1.2.1 Classification of Buildings*, a hospice is usually considered institutional, and falls under Group B, Division 2 or 3 (2 – Care and treatment occupancies, 3 – Care occupancies) depending on whether the hospice is solely a residence or also operates as a care center.[14] It is important to clarify that the OBC presents a minimum standard for space to ensure a basic level of safety for occupants, where human-centered design usually aims to exceed these expectations and incorporate additional considerations – this is especially important for hospice. The building code requirements most relevant to this classification relate primarily to fire safety and accessibility (including barrier-free design) to support and protect occupants with varied mobility and sensory capabilities. Although there are specific articles in the building code focused on hospitals and long-term care homes, hospice continues to fall under general care occupancies.[15]

Care occupancy classifications require a fire alarm system and sprinklers throughout the building – reflected in the sprinkler room requirement in the HPCO standard.[16] But exceeding an area of 2400 sq. m for a one-storey building requires additional fire separation measures.[17]

14 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.1.2.1, accessed October 17, 2024, https://www.buildingcode.online/11.html.

15 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.3.3.5, accessed October 17, 2024, https://www.buildingcode.online/354.html.

16 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.2.4.1, accessed October 17, 2024, https://www.buildingcode.online/233.html.

Fire-resistance ratings, typically in the range of 45-mintues to 1-hour, are required for walls to act as fire separation between private/sleeping rooms and communal spaces, and service spaces.[18] This is particularly important for care occupancies where more than six people require assistance for emergency evacuation, to give more time for occupants to be evacuated.[19]



**Figure 7.1 Symbol of Access**

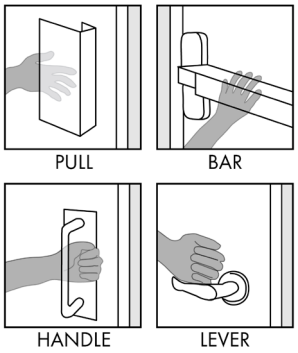



**Figure 7.2 Accessible door hardware**

For accessibility, the building code focuses on barrier-free design, considering paths of travel for individuals in wheelchairs and patients' beds being moved in all areas (excluding service/support spaces).[20] Accessibility signs using the International Symbol of Access must be displayed at a visible height in key locations like entrances, parking, and washrooms.[21] Universal washrooms, must have barrier-free paths of travel and accessible fixtures (toilets, sinks) with grab bars, and adult-size change tables, if applicable.[22] There are additional articles specifying dimensions to support barrier-free paths of travel, where doorways should have a minimum clear width of 1050mm and hallways narrower than 1600mm must provide a wider space of 1800mm at least every 30m for wheelchair maneuverability.[23] Entrance doors are also required to be "equipped with a power door operator," and generally, door handles should be accessible using a closed fist.[24] Small details like these make a big difference for those with limited mobility, and these minimums should be exceeded specifically to accommodate the movement of patient beds through the hospice, to allow those who are bedbound to spend time in different spaces with their loved ones. For truly inclusive design, additional references to accessibility design guidelines from sources like The Rick Hansen Foundation, or the Cities of Toronto and Vancouver offers a more

17 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.2.2.40, accessed October 17, 2024, https://www.buildingcode.online/166.html.

18 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.3.3.2, accessed October 17, 2024, https://www.buildingcode.online/351.html.

19 "Ontario Building Code," 3.3.3.2.

20 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.8.1.3, accessed October 17, 2024, https://www.buildingcode.online/506.html.

21 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.8.3.1, accessed October 17, 2024, https://www.buildingcode.online/514.html.

22 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.8.3.12, accessed October 17, 2024, https://www.buildingcode.online/525.html.

23 "Ontario Building Code," 3.8.1.3.

24 "Ontario Building Code" (Ontario Ministry of Municipal Affairs and Housing), 3.8.3.3, accessed October 17, 2024, https://www.buildingcode.online/516.html.

nuanced understanding of designing for varied physical abilities.

**Room Sizes and Requirements for Community Hospices[25]**

*10 bed (slight variations in room scale depending on number of beds)*

1. Vestibule – 1 – 75sf
2. Multi-use room (spiritual/quiet room) – 1 – 160sf
3. Reception – 1 – 125sf
4. Multi-use room (family activity room) – 1 – 160sf
5. Kitchen – 1 – 300sf
6. Dining room – 1 – 200sf
7. Living room – 1 – 300sf
8. Barrier-free washroom – 2 – 75sf
9. Multi-use room (meeting room) – 1 – 200sf
10. Staff washroom – 1 – 50sf
11. Staff room – 1 – 100sf
12. 1 patient bedroom w/ barrier free washroom – 1 per resident – 335sf
13. Medication room – 1 – 50sf
14. Clean utility – 1 – 120sf
15. Soiled utility – 1 – 130sf
16. Elevator machinery room – 1 – 75sf
17. Communications room – 1 – 50sf
18. General storage – 1 – 200sf
19. Mechanical room – 1 – 200sf
20. Electrical room – 1 – 100sf
21. Sprinkler room – 1 – 100
22. Laundry – 1 – 100sf
23. Janitor – 1 – 50sf
24. Parking – (HPCO funding applicable, just included in a different section of the standards (site components))

25 "Hospice Capital Program Design Standards Version 1.2," 6-8.

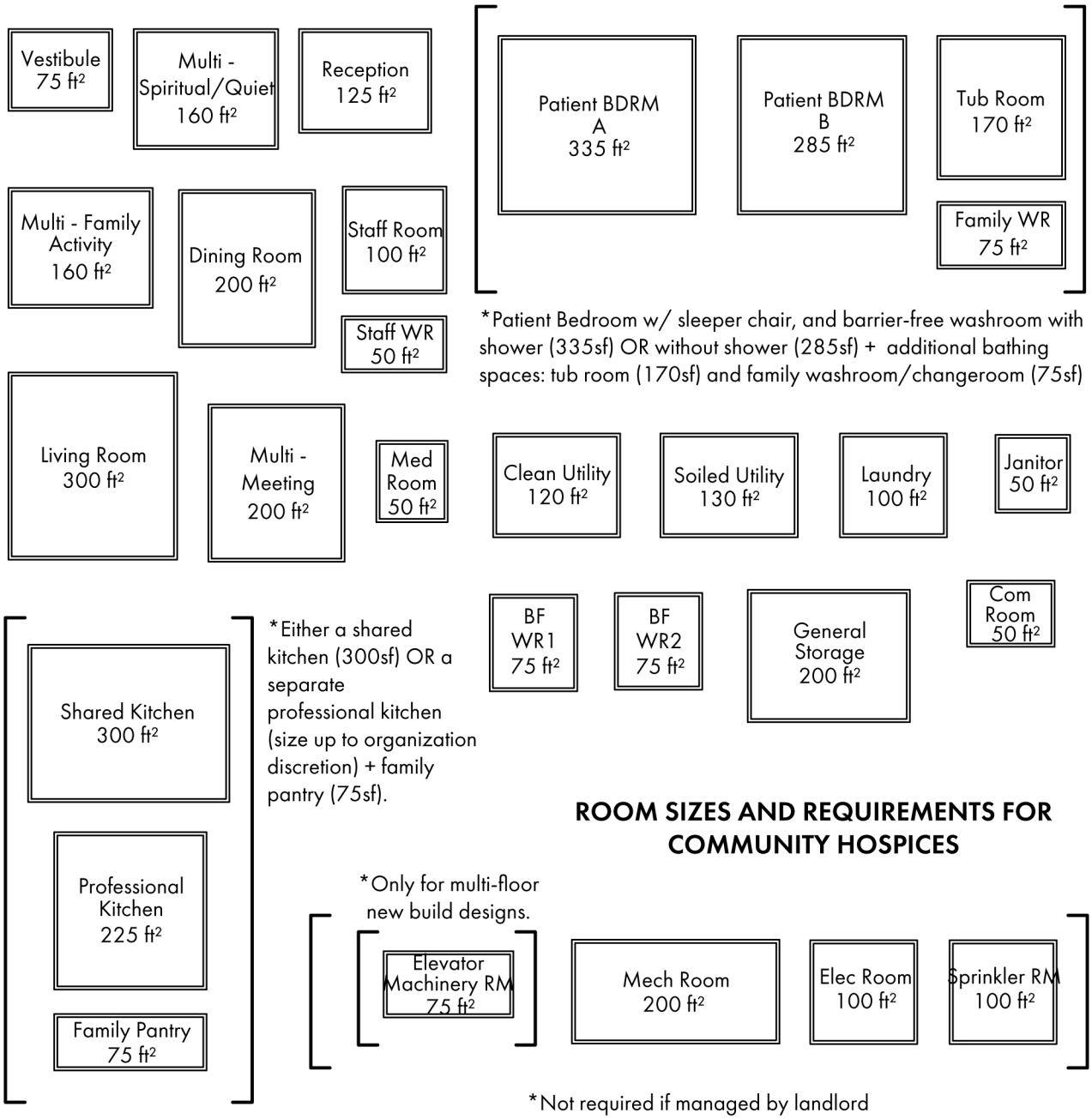



**Figure 7.3 Hospice room size requirements**

There is a deficiency in the current standards governing hospice space, where a list of rooms (with no descriptions) and required areas (sq ft) leaves a lot open to interpretation. To understand the spatial needs we need additional analysis. Grouping spaces programmatically helps to create more considerate adjacencies and circulation.[26] The groups that emerge include communal, patient, family, staff, service, and outdoor spaces.

26 Stephen Verderber and Ben J. Refuerzo, Innovations in Hospice Architecture (New York, NY: Taylor & Francis, 2006), 97.

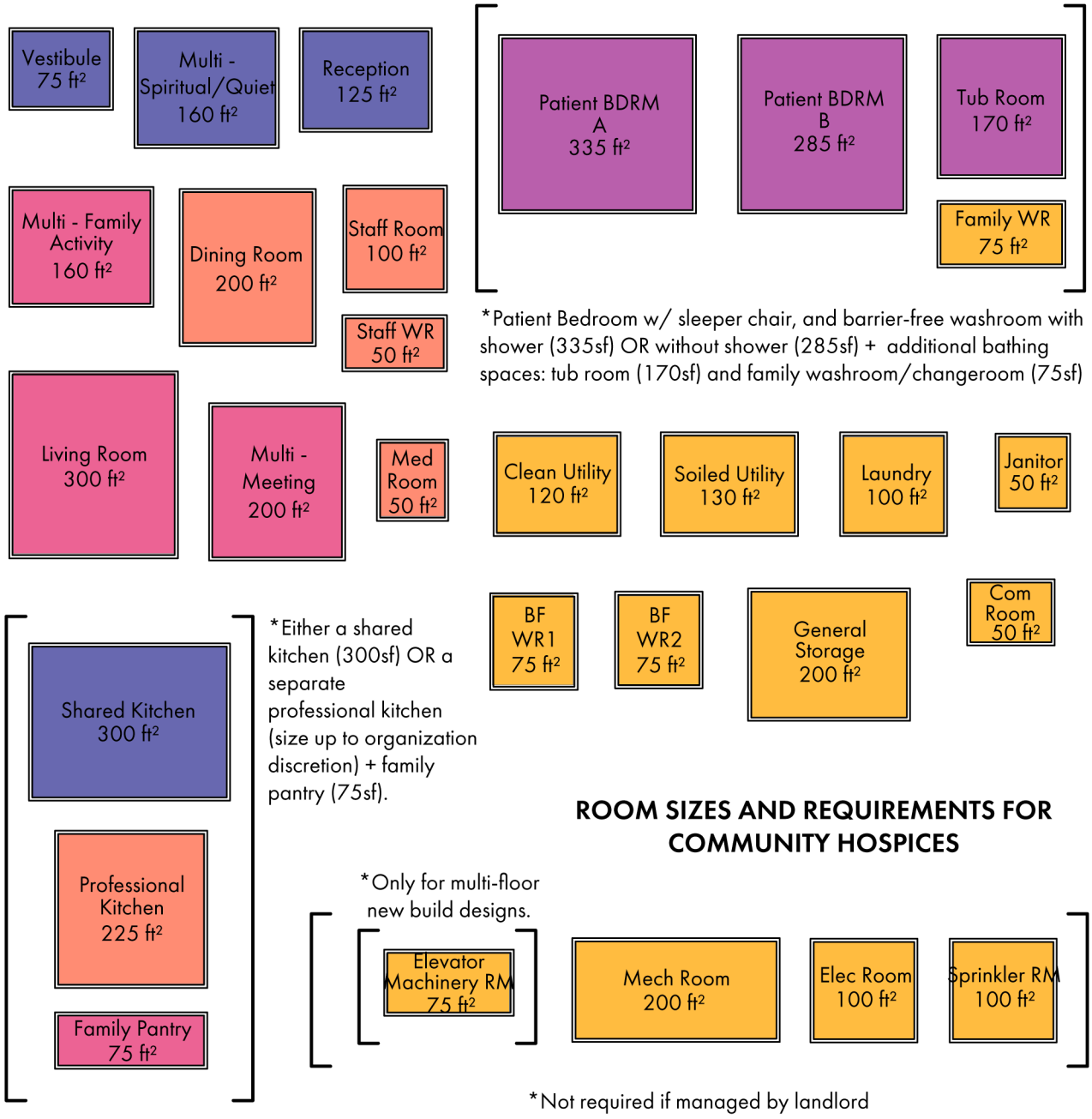



**Figure 7.4 Hospice room size requirements, by program**

By looking at existing hospice floorplans, these standards and spatial requirements can be further enhanced to support the embodied experience of occupants.

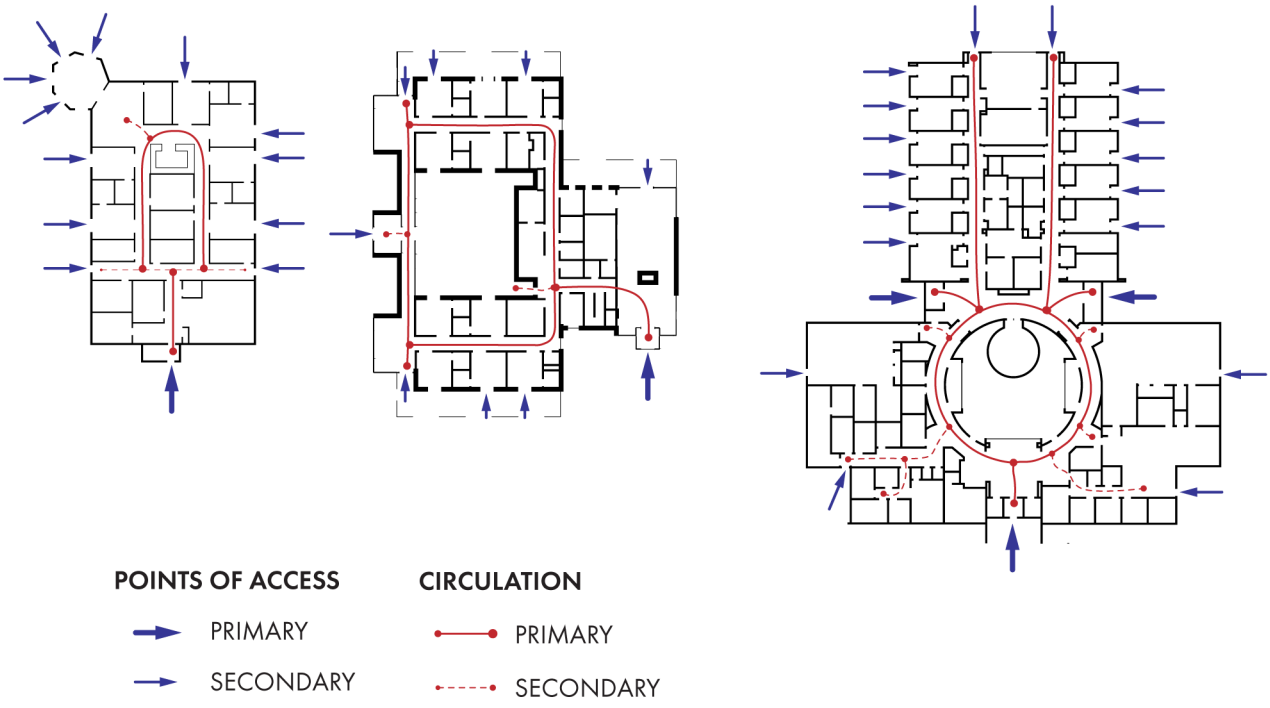



**Figure 7.5 Waterloo Region Plan Analysis, Circulation**

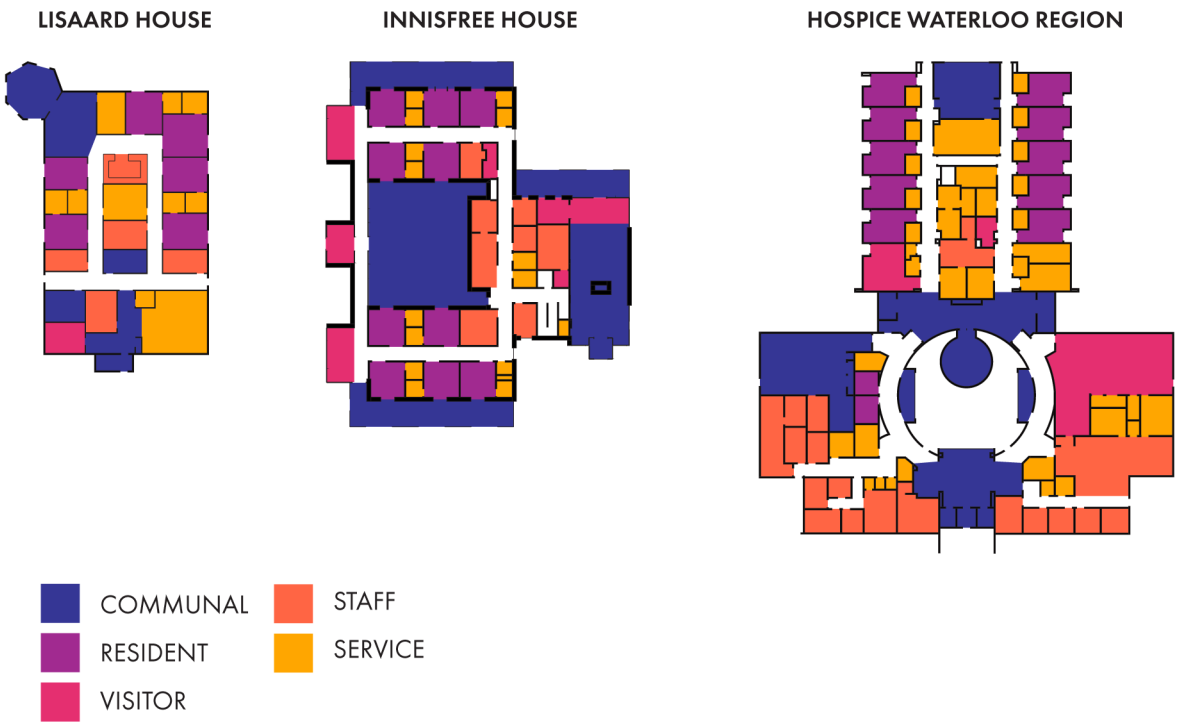


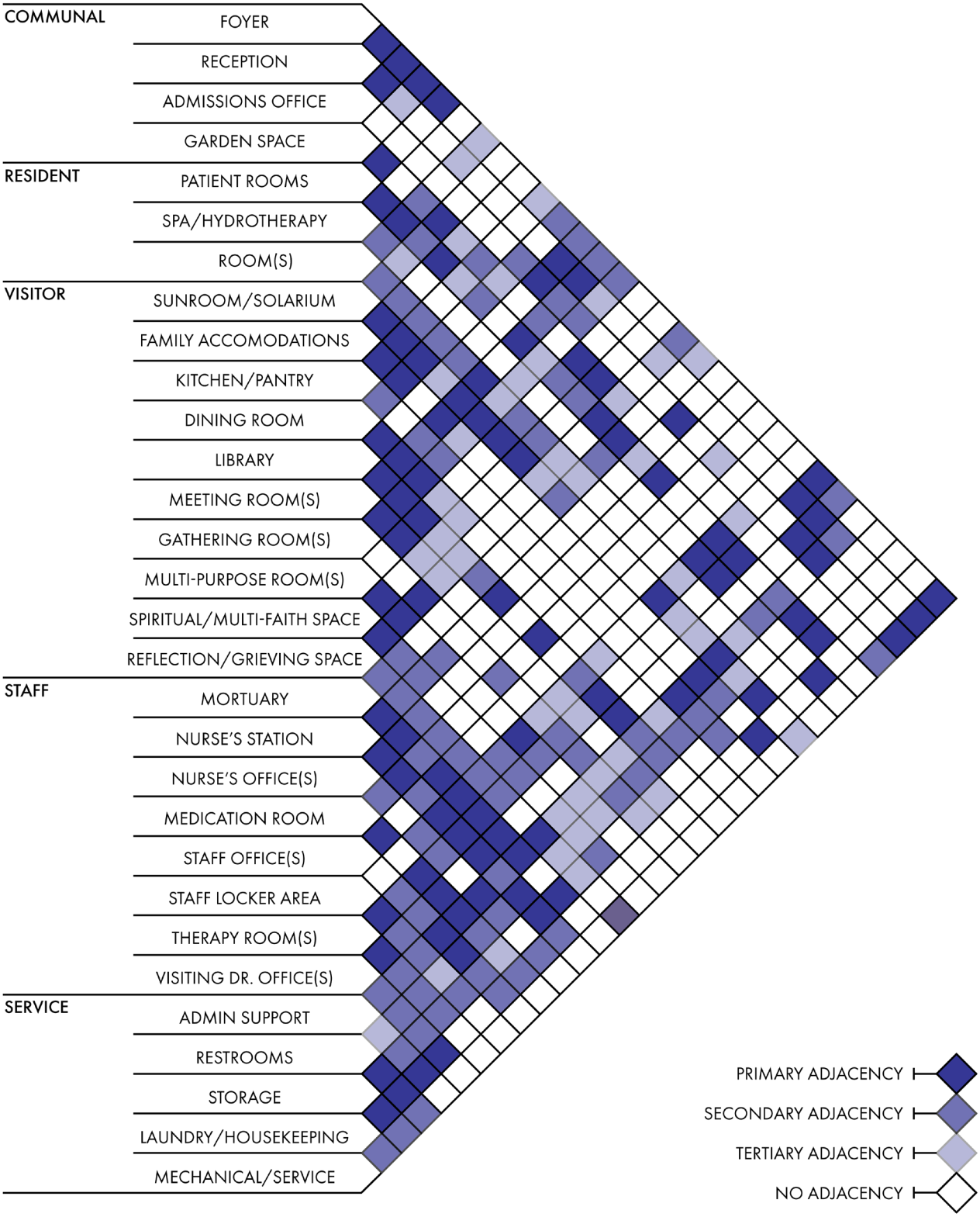

**Figure 7.6 Waterloo Region Plan Analysis, Program**

Through analysis, additional program areas emerge that contribute to quality hospice residence design:

1. Admissions office
2. Volunteer support space
3. Garden space
4. Spa/hydrotherapy room(s)
5. Sunroom/solarium
6. Family accommodations
7. Library
8. Reflection/grieving space
9. Mortuary
10. Nurse's station
11. Nurse's office(s)
12. Staff office(s)
13. Therapy room(s)
14. Visiting Dr. office(s)

The HPCO and OBC spatial standards for hospice act as important foundational guidelines that prioritize safety, accessibility, and functionality of space. As evidenced by the analysis of existing floorplans, hospices need to be designed to exceed the minimum standards and consider programmatic organization to facilitate a supportive environment, considerate of all occupant needs. The following architectural brief will incorporate these standards and findings with the previously defined holistic approach to inform the design proposal.

**Figure 7.7 Program adjacency matrix**



# 7.3 THE BRIEF: A HOLISTIC DESIGN APPROACH TO HOSPICE

The design proposal will explore how a human-centered design can be applied to hospice, enhancing current design standards to better support the nuances of the physical, emotional, and spiritual needs of residents, visitors, and care providers.

**Multi-phase approach:**

The proposal will be designed to be built in phases, exploring the potential for future expansion as community needs evolve, relating to the origins of many hospice residences that began primarily as care centers, later adding residential wings with new funding.

1. The first phase will be a hospice care center, where thoughtful site planning and landscape design establish site access, parking, outdoor gathering space, and connections to nature from the interior.
2. This sets the scene for the next phase, the addition of a small residential wing to contribute to the current hospice bed capacity in the region, adding relevant support spaces like nurse's stations, laundry, and storage.
3. The third and final phase in this exploration will be the expansion of the residential wing and adding additional gathering and support spaces to accommodate increased occupancy in the hospice. The site planning and landscaping will unfold further with each phase, emphasizing the importance of the human-nature connection and relationship between interior and exterior space.

**Occupancy:**

Staff and residents are expected to be on-site 24/7, while volunteers and visitors are most likely to be present during daytime hours. While occupancy varies amongst existing hospices, the proposal will accommodate an estimate of:

- 10 residents (based on a 10-bed capacity)

- 10-20 visitors (assuming each resident has 1-2 visitors at any given time)
- 5-10 staff (nurses, social workers, therapists, administrators, kitchen staff, housekeeping, maintenance, etc.)
- 5-10 volunteers (providing support both inside and outside of the hospice)

**Design Considerations:**

Building upon a vision for hospice as a space that facilitates meaningful moments of connection at the end of life, the design will incorporate holistic considerations into key program spaces that will make up a kit of parts, enhancing existing standards to foster comfort, peace, and a sense of agency for all occupants. A holistic design approach for hospice considers:

1. A strong connection to nature
2. Balancing privacy and communal spaces
3. Adaptability, personalization, and multi-functionality of space
4. The importance of accessibility and ease of movement in space
5. Creating a *homelike* atmosphere in an institutional setting

**Deliverables for the Design Proposal:**

- Site selection and analysis – providing an overview of site context and characteristics that make it suitable for hospice.
- Site plan proposal – highlighting key features like landscaping, site access, parking, and outdoor gathering spaces.
- Floor Plans – outlining each phase of development and identifying key program areas for each occupant group
- Diagrams – to analyze spatial relationships and characteristics like circulation/paths of travel, occupant views/relationships to nature, public versus private space, material/colour pallets in different program zones, etc.
- Kit of Parts – detailing applications of the design considerations in key program areas of the design that contribute to occupant experience.

# 8. SITE & CONTEXT

As evidenced by previous chapters, site and context of hospice has direct implications on design. For this thesis, a site will be selected in Waterloo Region, as the area is studied most in-depth through the catalog and case studies, in addition to the author having firsthand experience learning about the community perspective through field work. Waterloo Region is one of the fastest growing regions in Ontario, and the City of Waterloo is the fastest growing municipality in the region.[1] Looking closer at the population, age, and cultural demographics of the region gives additional nuance to the design approach and understanding of spatial needs for the community.

Waterloo Region currently maintains a ratio of about 4.5 beds for every 100 000 people (considering a population of 578,165 served by 26 hospice beds currently), falling short of the 7-bed minimum.[2] In order to achieve the minimum ratio, the region would need an additional 14-15 beds. My design proposal will align with the current HPCO 10-bed standard, which will bring the ratio to about 6 beds for every 100 000 people – still short of the target. However, my proposal serves as an example of how the 10-bed model can better serve a local community and suggests that implementing more hospices of this scale across a region to serve multiple communities will support a more inclusive and accessible hospice palliative experience. Considering the location of acute medical services and the existing three hospices – Lisaard & Innisfree Houses and Hospice Waterloo Region – a site will be selected to complement the existing care network.

1 "Population by Municipality," Government Website, Waterloo Region Community Profile, accessed October 21, 2024, https://wr-community-profile-rmw.hub.arcgis.com/pages/population-by-municipality.

2 Statistics Canada Government of Canada, "Profile Table, Census Profile, 2021 Census of Population - Waterloo, City (CY) [Census Subdivision], Ontario," February 9, 2022, https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E.

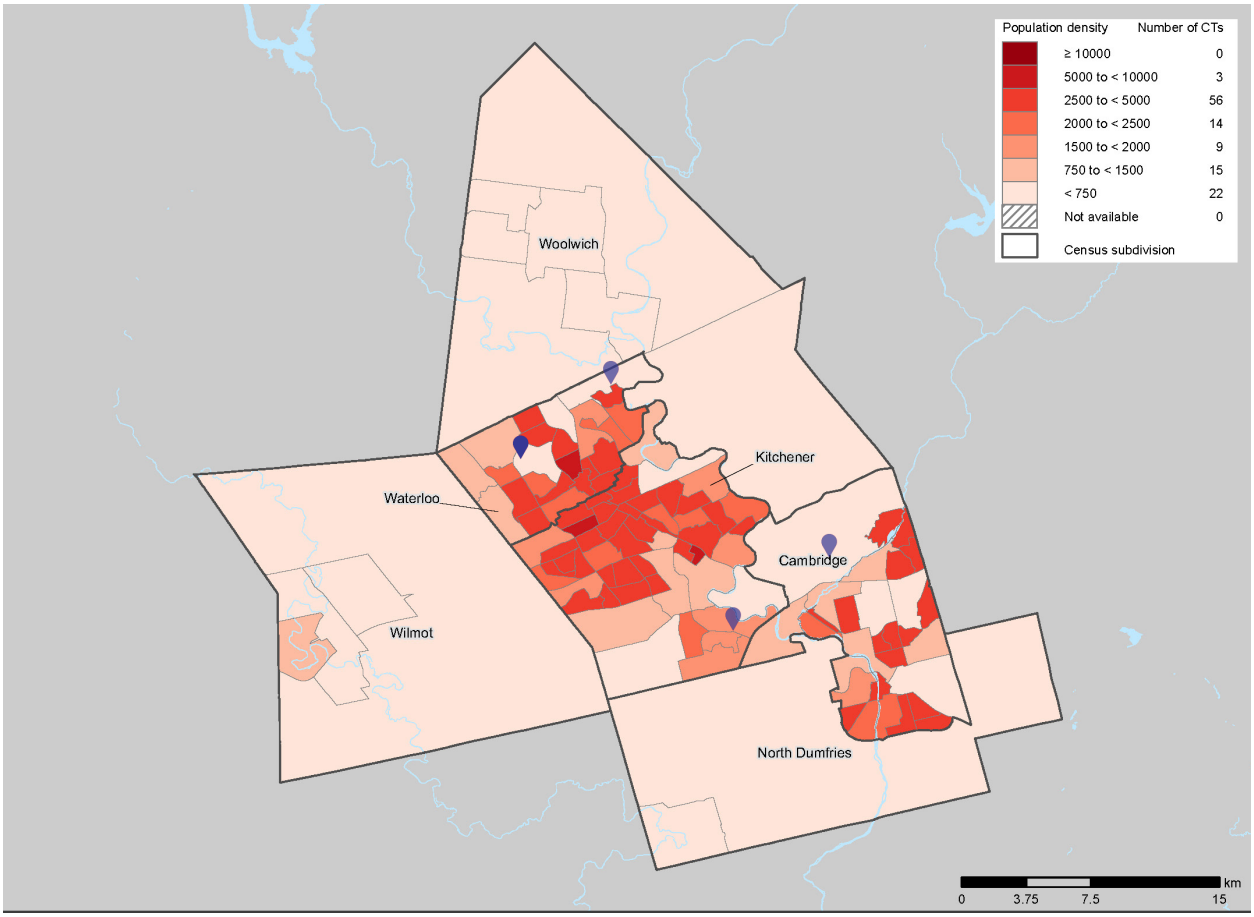



**Figure 8.1 Waterloo region population density, 2021**

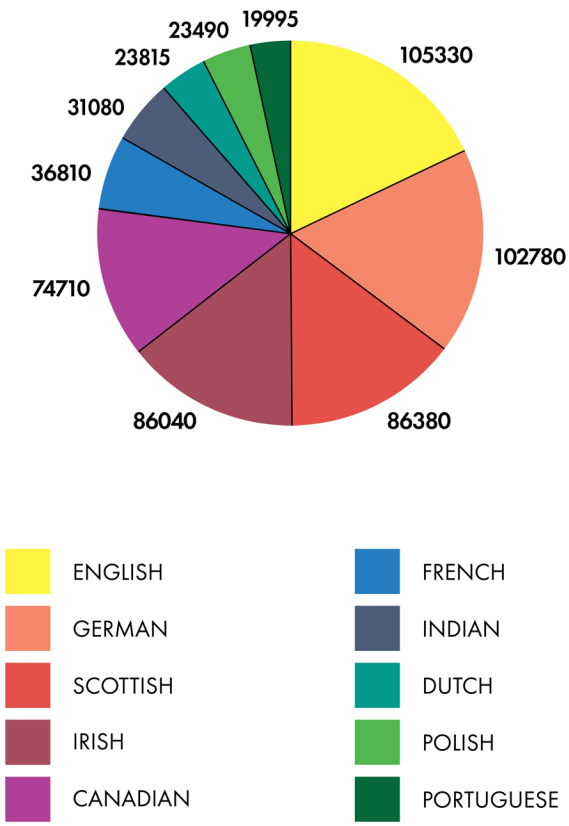



**Figure 8.2 Waterloo region population demographics, ethnicity**

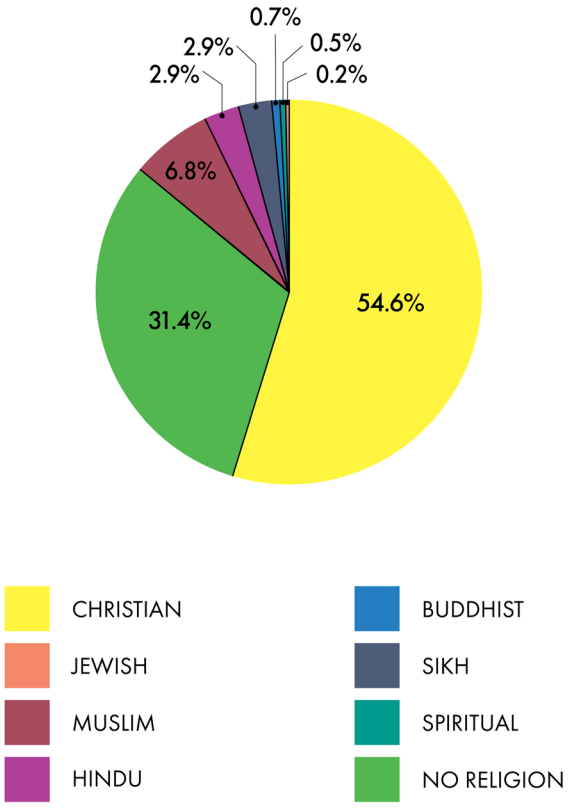
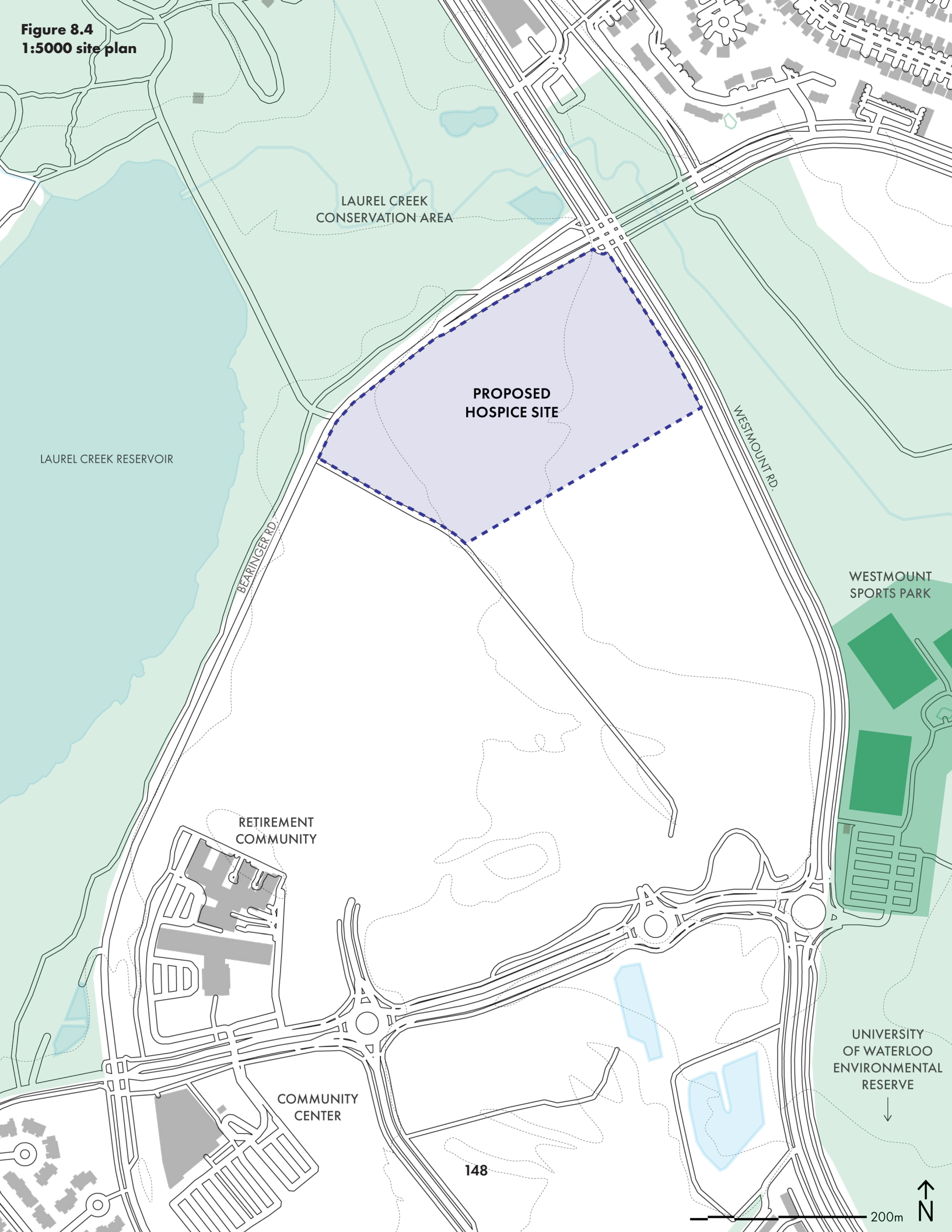



**Figure 8.3 Waterloo region population demographics, religion**

**Figure 8.4**
**1:5000 site plan**



# 8.1 SITE ANALYSIS

Based on the current network of hospices, many site contexts and adjacencies are possible and there are many suitable sites within Waterloo region to consider for the design proposal. In alignment with the original inspiration of a nature- and community-oriented hospice, the chosen site offers opportunities for strong connections to nature, community integration, and space to support

Located on the peripheries of the University of Waterloo campus, specifically the Environmental Reserve, and the Laurel Creek Reservoir and Conservation area, the existing site is highly accessible and already integrated with the local community (of various age demographics) and connections to nature. Although currently farm fields, this land is zoned as academic, there is already a retirement home and community center nearby that set a precedent for rezoning.[3] The land is highly accessible, framed by existing roads as well as some roundabouts prefacing future development in the area.

The early integration of a hospice here allows for strategic landscaping to ensure privacy and occupant comfort are maintained when that development occurs. Additionally, incorporating climate considerations into the design will inform building orientation, program layout, and landscape design to facilitate natural lighting, peaceful views, and comfortable space outdoors throughout the four seasons – all which impact occupant experience.

3 *The City of Waterloo Zoning By-Law Map*, 1:120000 (City of Waterloo, 2022), https://maps.waterloo.ca/Images/website/Waterloo_Zoning_Map.pdf.

**Figure 8.5**
**Zoning map**



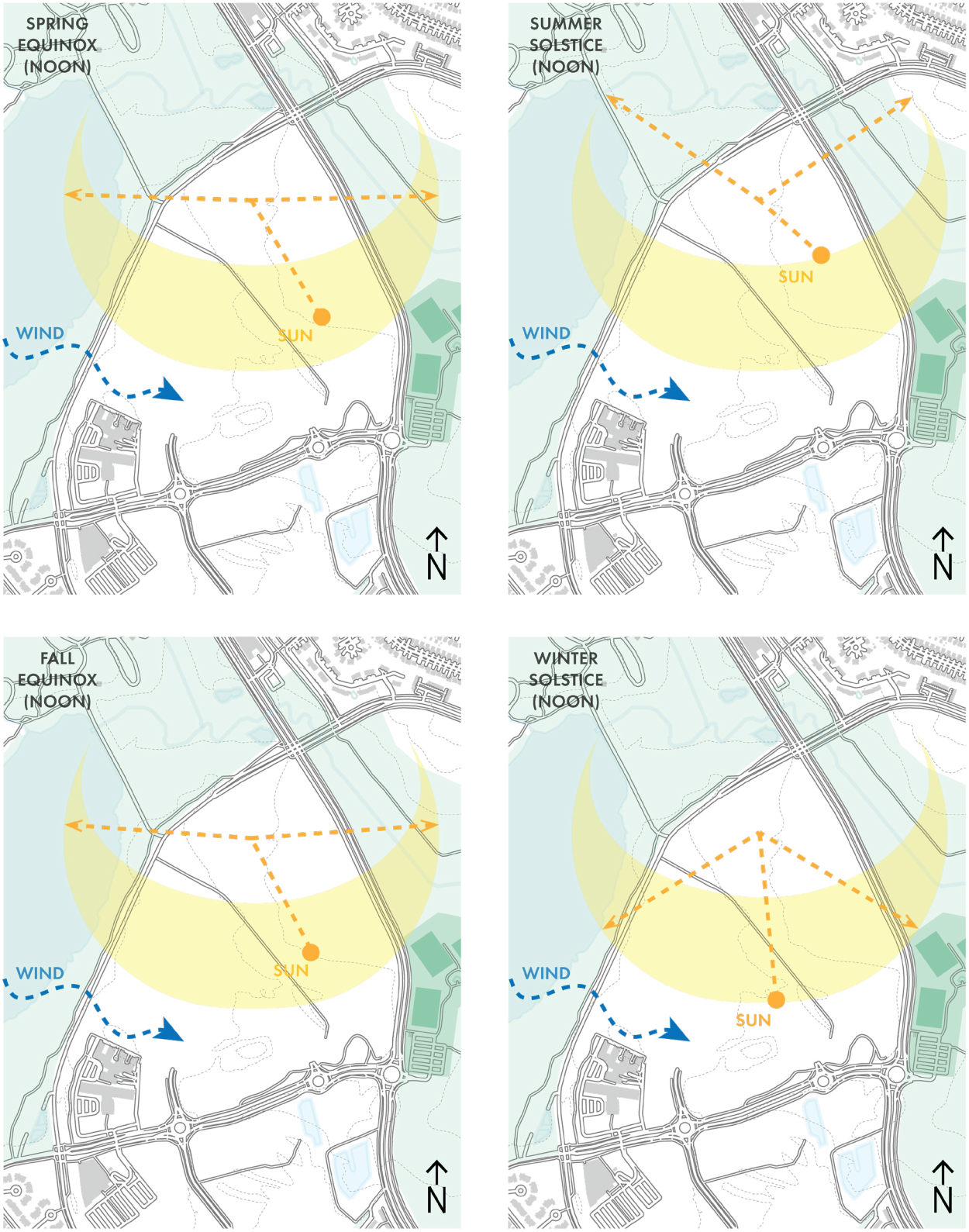



**Figure 8.6 Site solar study**

# 9. DESIGN PROPOSAL:

**The design proposal will explore how a human-centered design can be applied to hospice, enhancing current design standards to better support the nuances of the physical, emotional, and spiritual needs of residents, visitors, and care providers. This proposal is situated in a region already supported by hospices, contributing to an existing network of care for the region. Designed to be built in phases, to grow and evolve with the community - the hospice begins as a care center, then introduces a 6-bed residential wing, and later adding an additional 4-beds to meet the 10-bed ministry standard for hospice residences. The goal for the design is to create an environment that emphasizes the human-nature connection, built on the understanding of the impact of the built world on our embodied experience in space.**

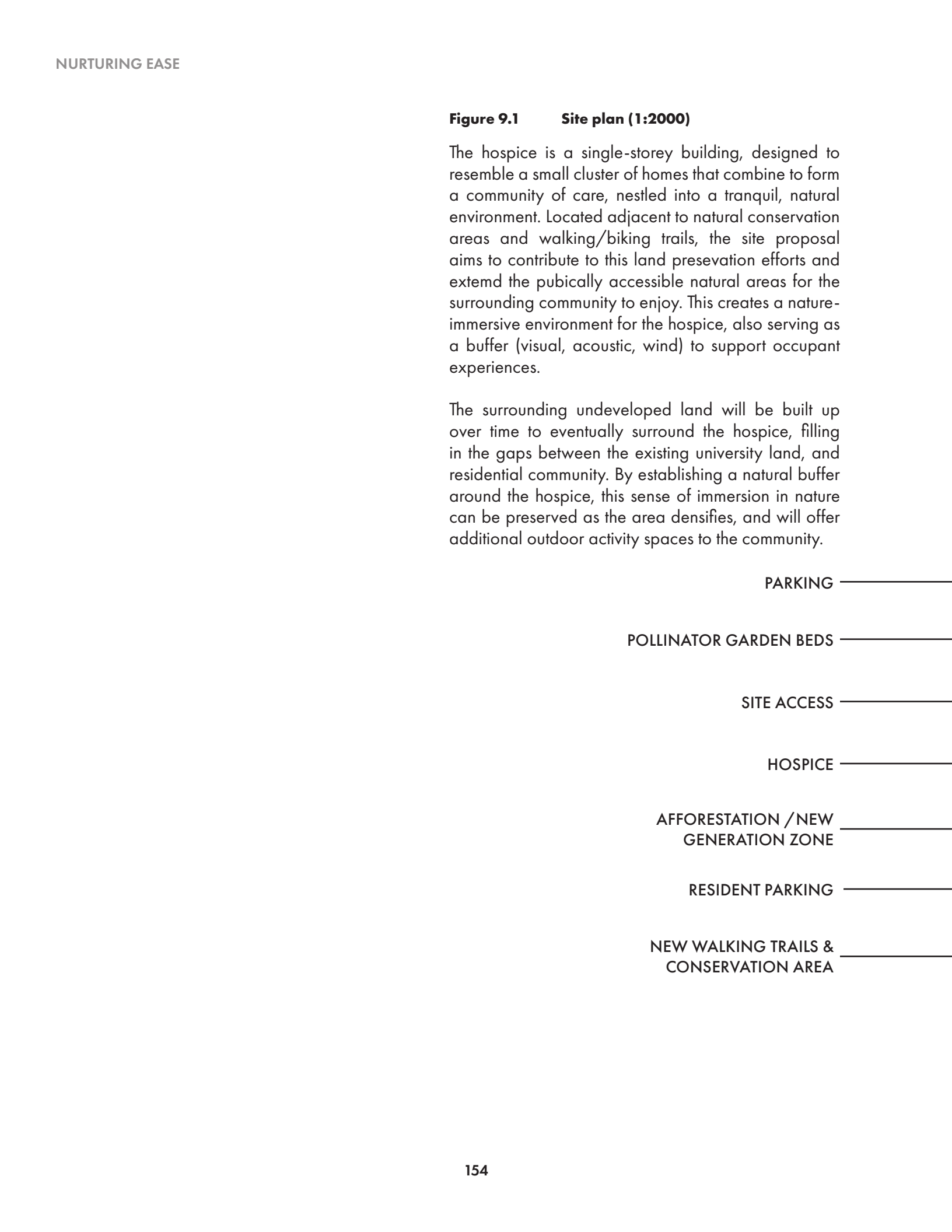
*Building upon a vision for hospice as a space that facilitates meaningful moments of connection at the end of life, the design will incorporate holistic considerations into key program spaces that will make up a kit of parts, enhancing existing standards to foster comfort, peace, and a sense of agency for all occupants. A holistic design approach for hospice considers:*

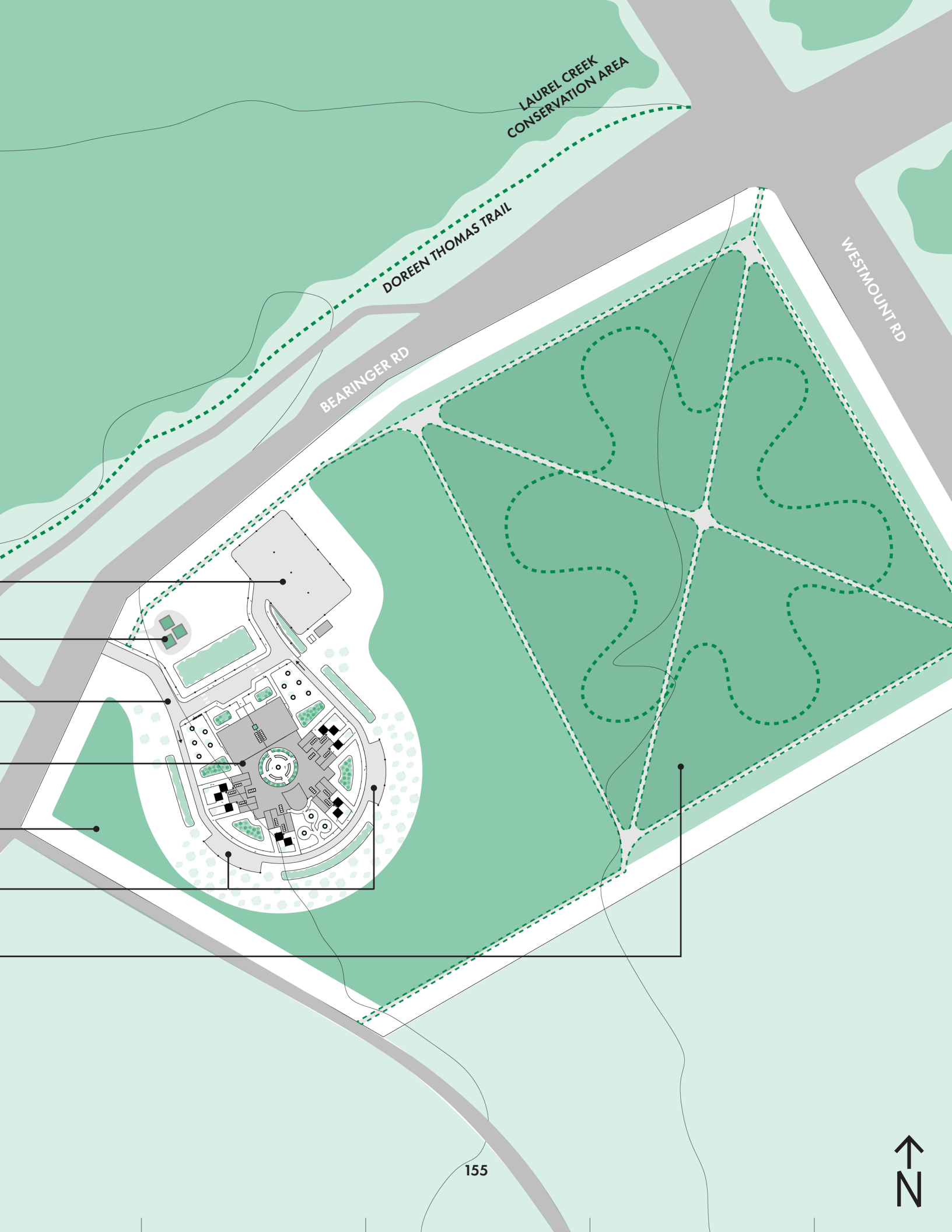
1. *A strong connection to nature*
2. *Balancing privacy and communal spaces*
3. *Adaptability, personalization, and multi-functionality of space*
4. *The importance of accessibility and ease of movement in space*
5. *Creating a homelike atmosphere in an institutional setting*

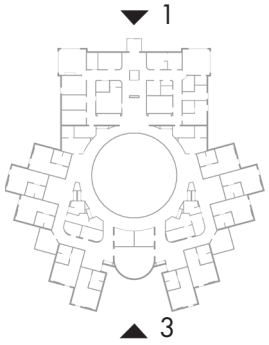
**Figure 9.1 Site plan (1:2000)**

The hospice is a single-storey building, designed to resemble a small cluster of homes that combine to form a community of care, nestled into a tranquil, natural environment. Located adjacent to natural conservation areas and walking/biking trails, the site proposal aims to contribute to this land presevation efforts and extemd the pubically accessible natural areas for the surrounding community to enjoy. This creates a nature-immersive environment for the hospice, also serving as a buffer (visual, acoustic, wind) to support occupant experiences.

The surrounding undeveloped land will be built up over time to eventually surround the hospice, filling in the gaps between the existing university land, and residential community. By establishing a natural buffer around the hospice, this sense of immersion in nature can be preserved as the area densifies, and will offer additional outdoor activity spaces to the community.




LAUREL CREEK
CONSERVATION AREA
DOREEN THOMAS TRAIL
BEARINGER RD
WESTMOUNT RD
N



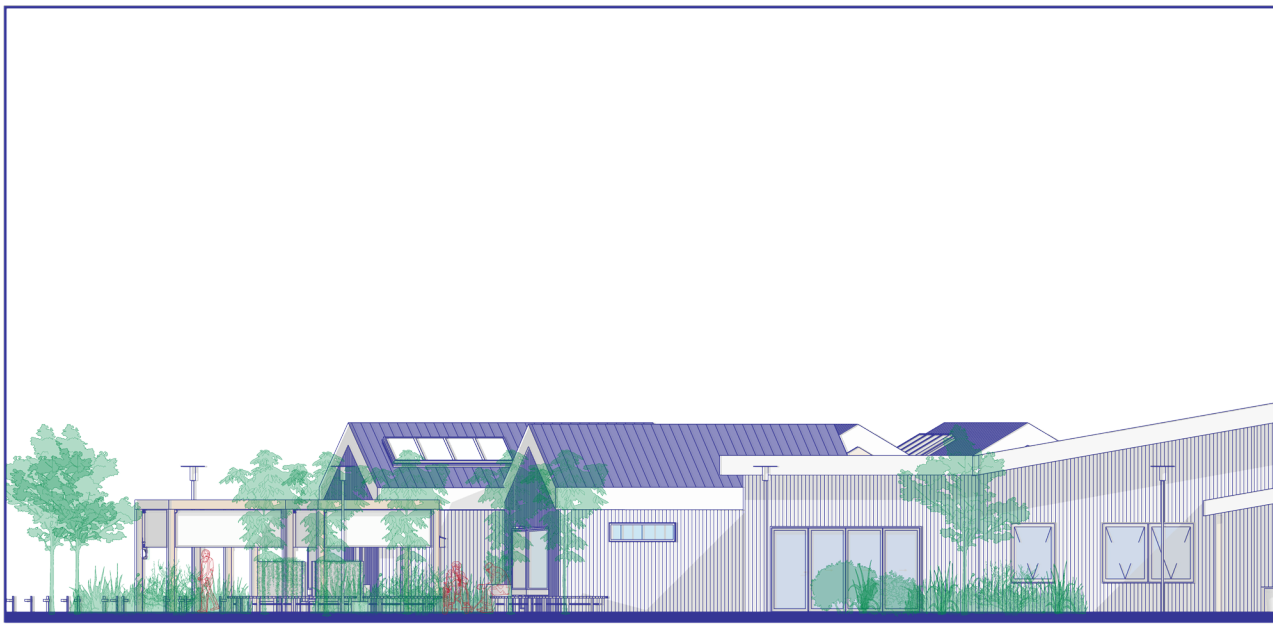



**Figure 9.2** **Elevation 1 - view of main entrance (1:200)**

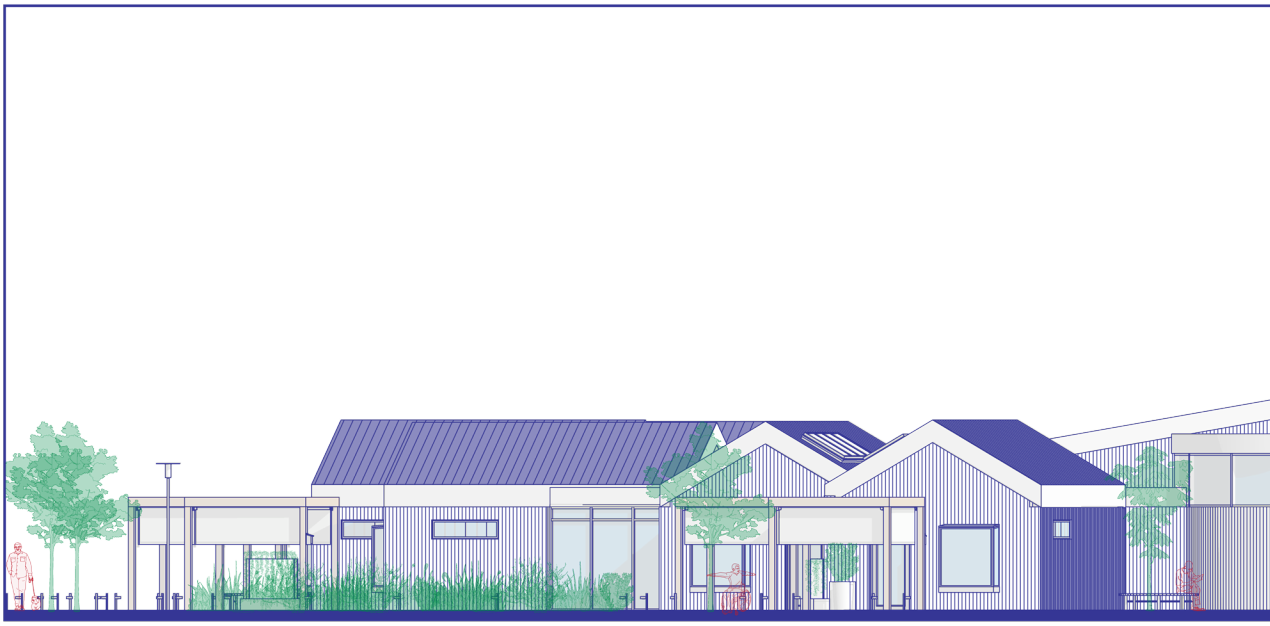
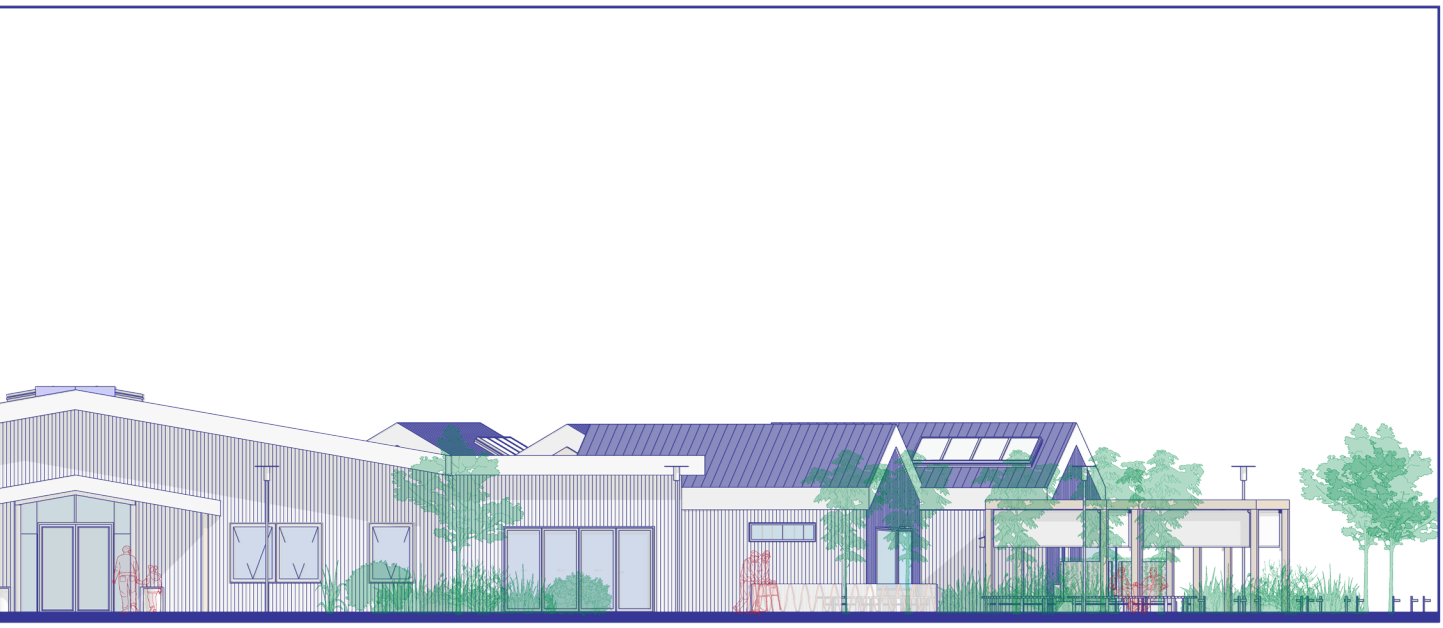
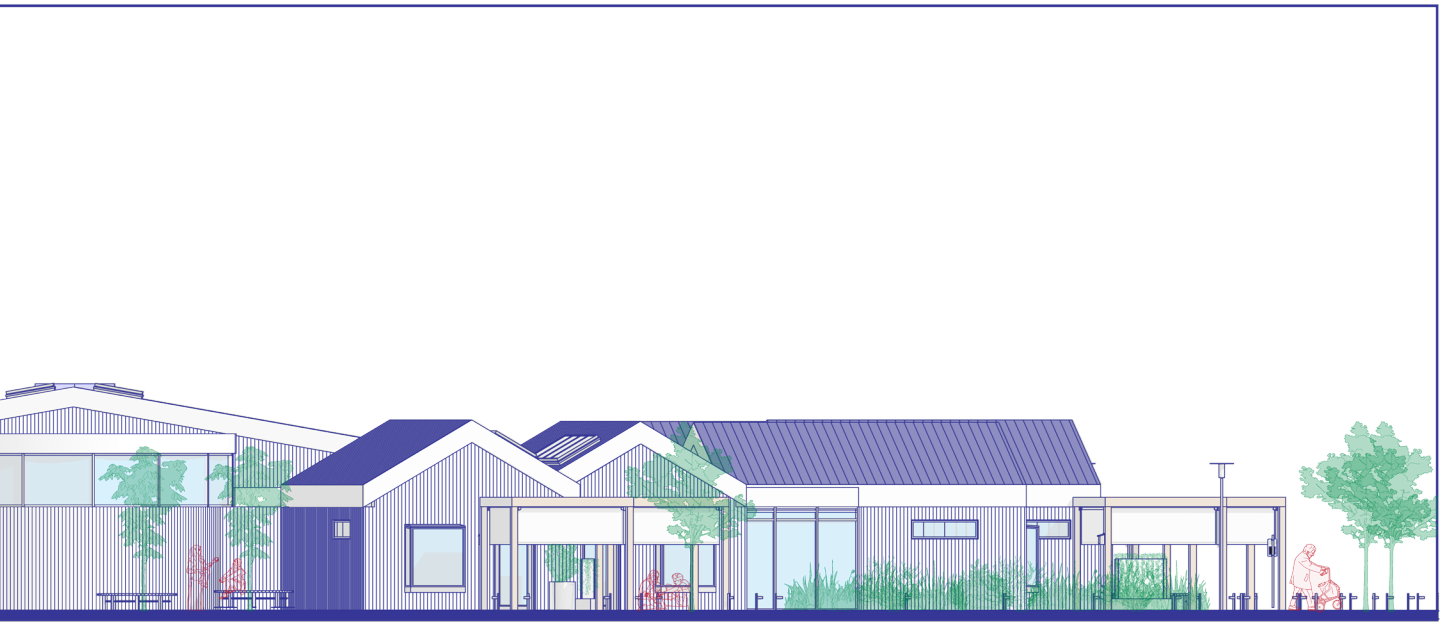


**Figure 9.3** **Elevation 3 - view of resident entrances (1:200)**





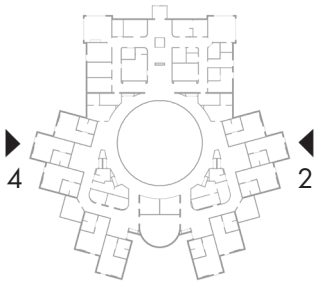


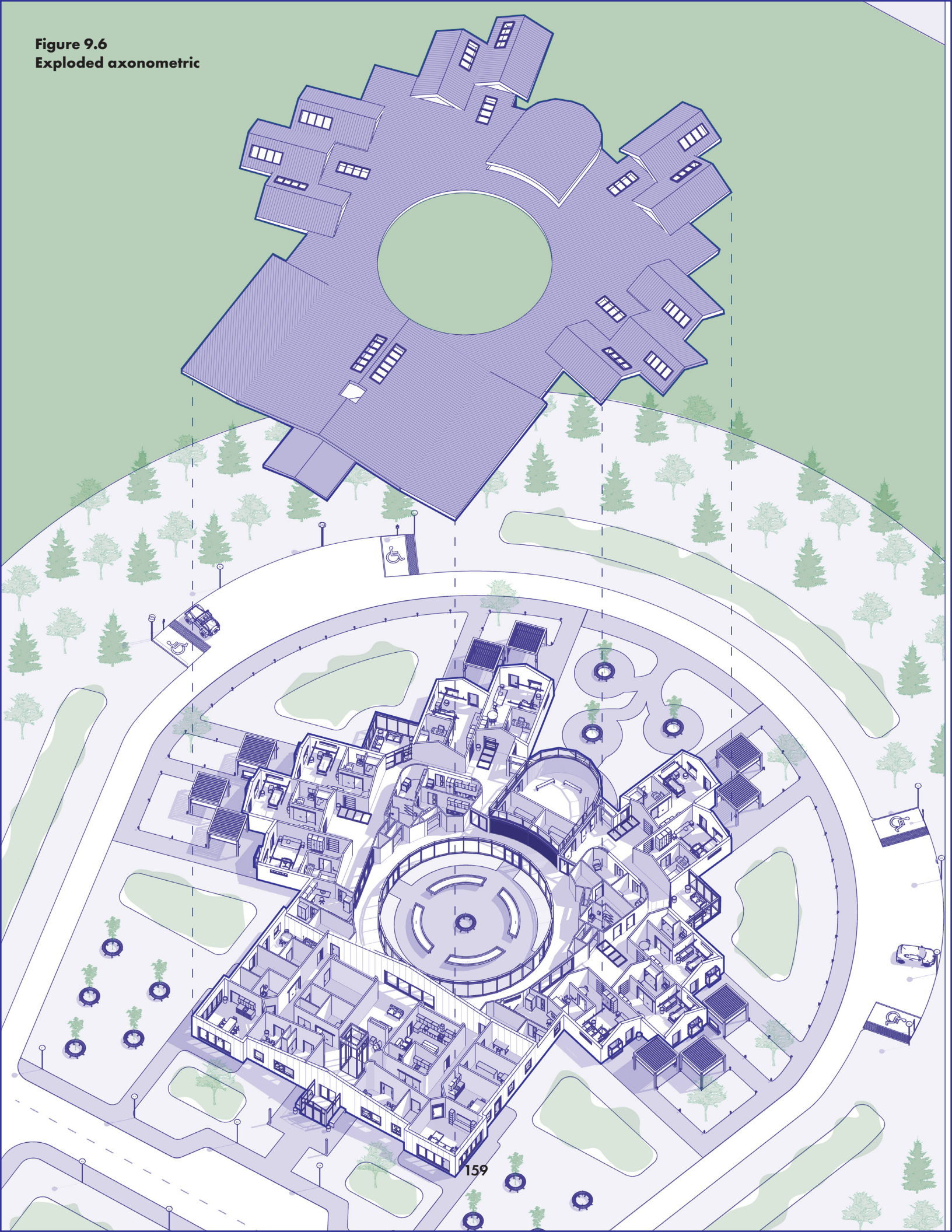



**Figure 9.4** **Elevation 2 - view of site access from staff/volunteer rooms (1:200)**



**Figure 9.5** **Elevation 4 (half) - view of front outdoor gathering space (1:200)**

**Figure 9.6**
**Exploded axonometric**



# A PHASED APPROACH

*The proposal will be designed to be built in phases, exploring the potential for future expansion as community needs evolve, relating to the origins of many hospice residences that began primarily as care centers, later adding residential wings with new funding.*

The site planning and landscaping will unfold further with each phase, emphasizing the importance of the human-nature connection and relationship between interior and exterior space.

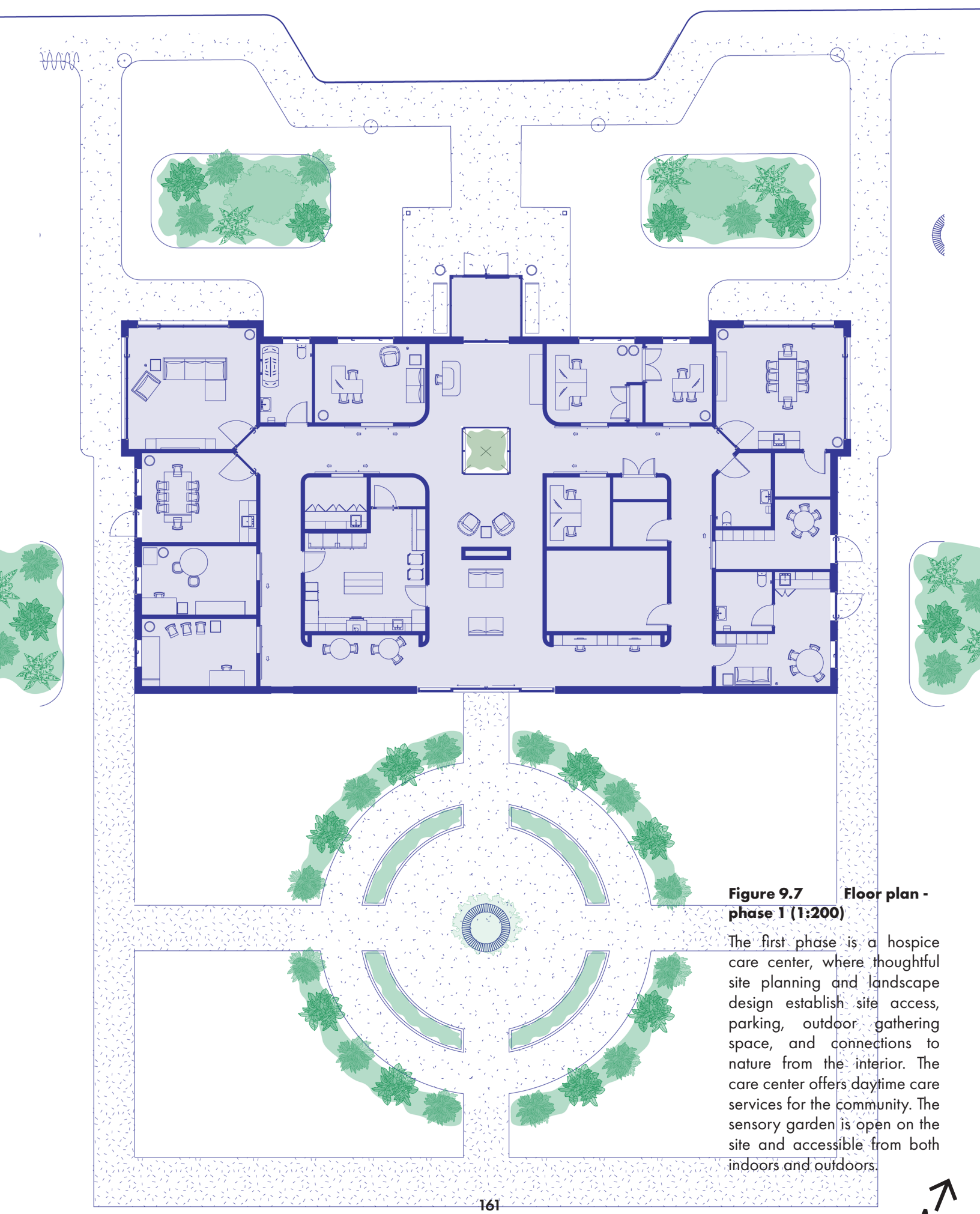


**Figure 9.7 Floor plan - phase 1 (1:200)**

The first phase is a hospice care center, where thoughtful site planning and landscape design establish site access, parking, outdoor gathering space, and connections to nature from the interior. The care center offers daytime care services for the community. The sensory garden is open on the site and accessible from both indoors and outdoors.

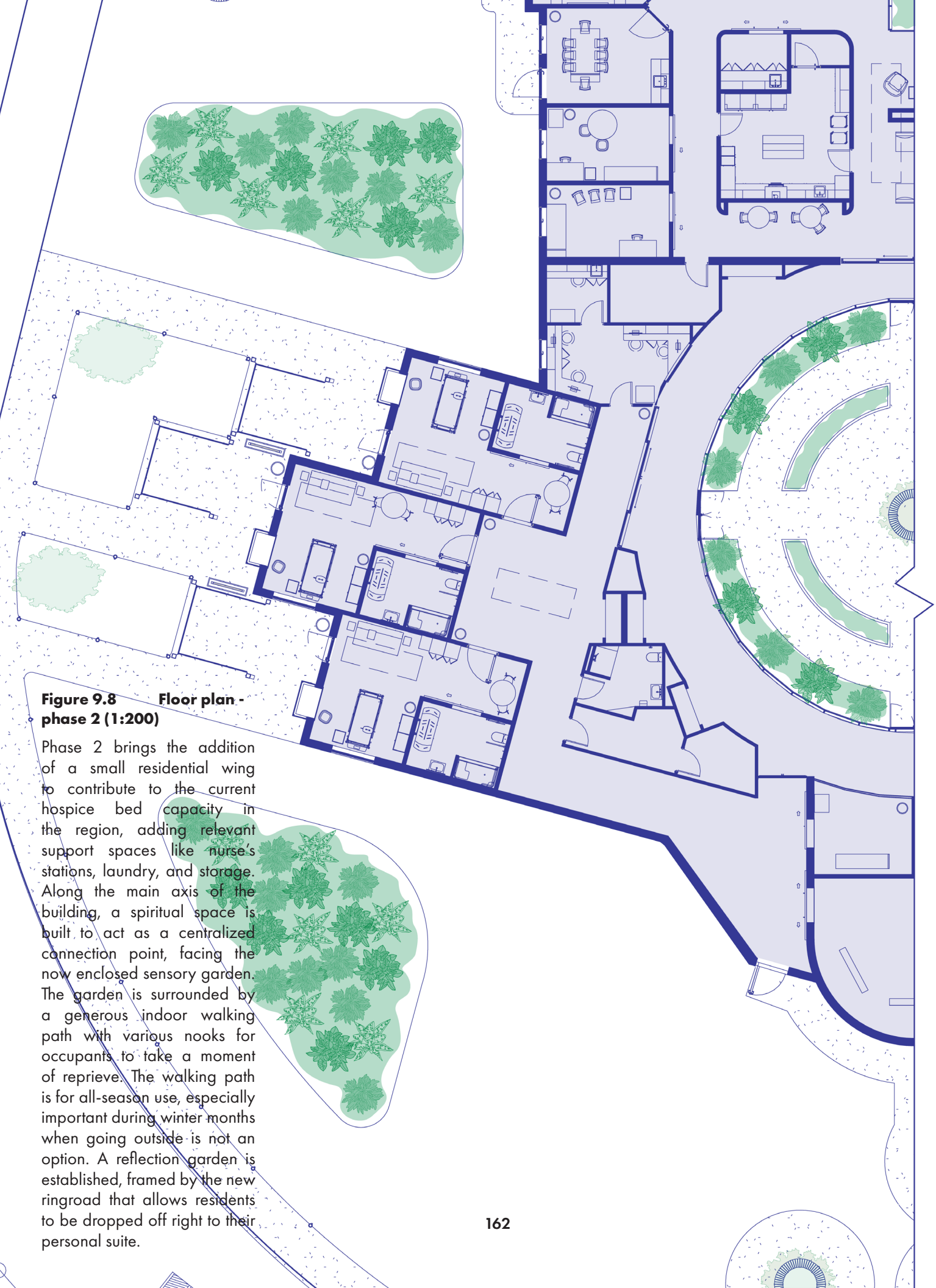


**Figure 9.8 Floor plan - phase 2 (1:200)**

Phase 2 brings the addition of a small residential wing to contribute to the current hospice bed capacity in the region, adding relevant support spaces like nurse's stations, laundry, and storage. Along the main axis of the building, a spiritual space is built to act as a centralized connection point, facing the now enclosed sensory garden. The garden is surrounded by a generous indoor walking path with various nooks for occupants to take a moment of reprieve. The walking path is for all-season use, especially important during winter months when going outside is not an option. A reflection garden is established, framed by the new ringroad that allows residents to be dropped off right to their personal suite.

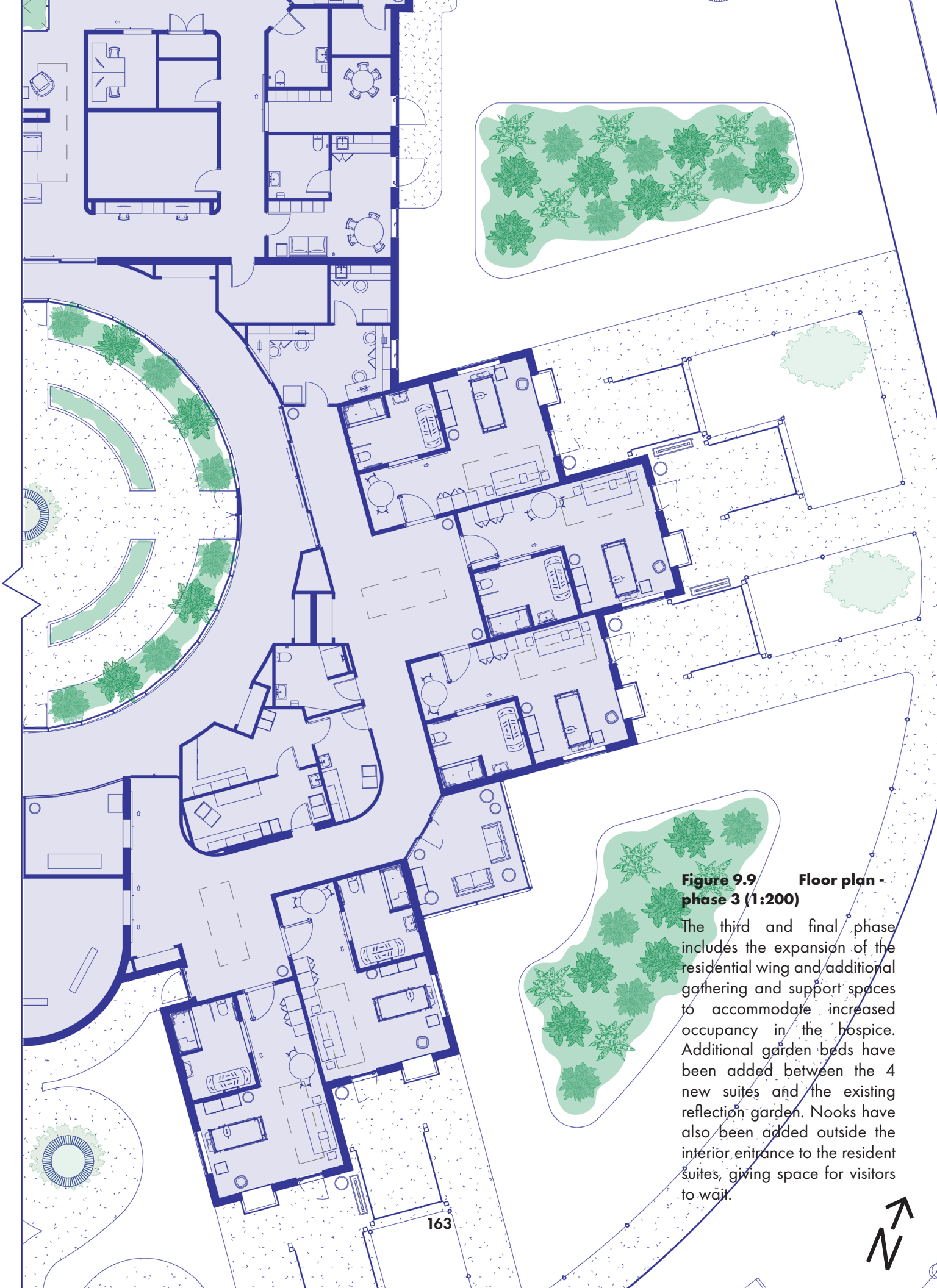
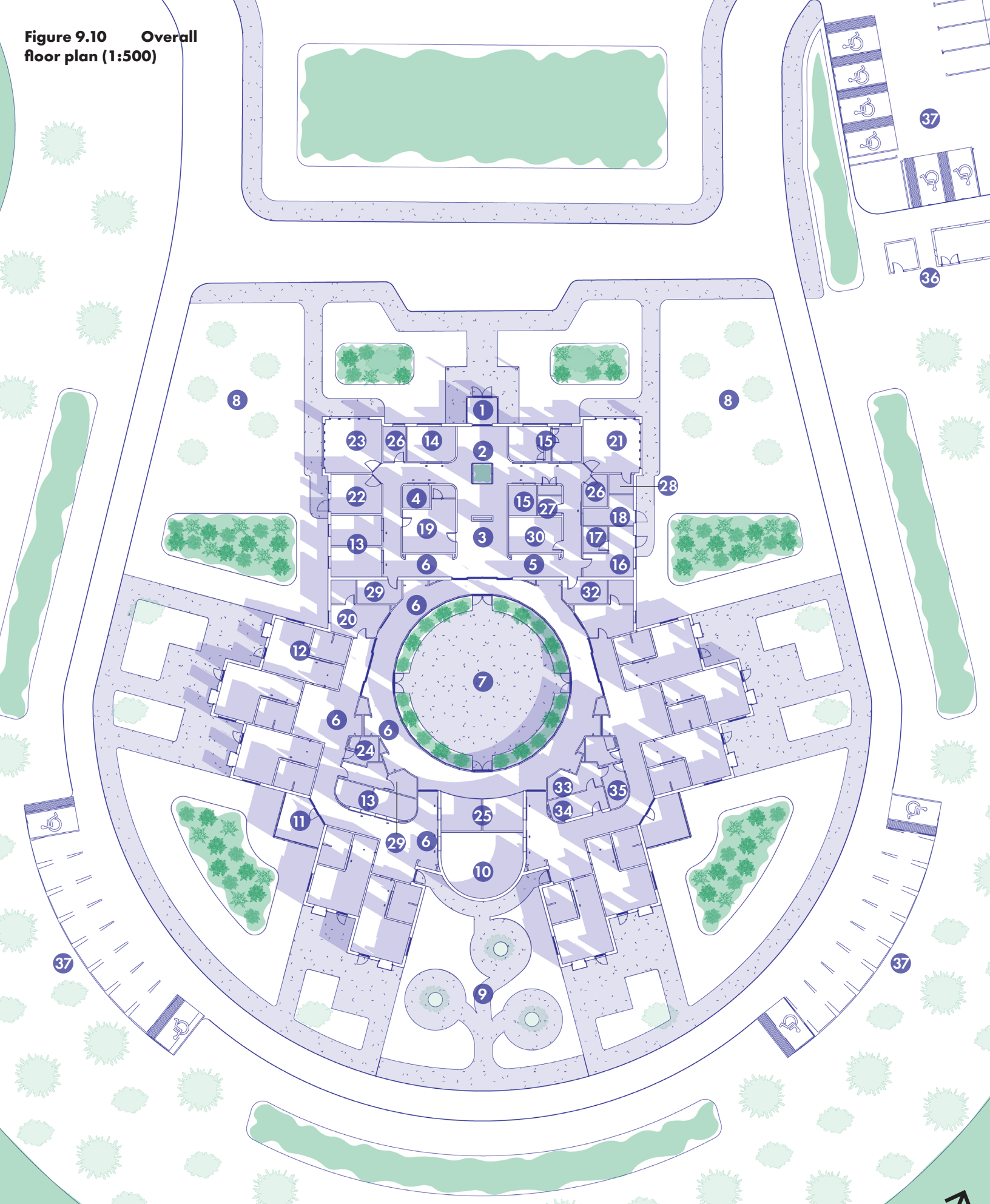


**Figure 9.9 Floor plan - phase 3 (1:200)**

The third and final phase includes the expansion of the residential wing and additional gathering and support spaces to accommodate increased occupancy in the hospice. Additional garden beds have been added between the 4 new suites and the existing reflection garden. Nooks have also been added outside the interior entrance to the resident suites, giving space for visitors to wait.

**Figure 9.10 Overall floor plan (1:500)**



**Communal Spaces**

1. Vestibule
2. Reception
3. Dayroom
4. Pantry
5. Library
6. Nooks
7. Sensory garden
8. Outdoor gathering spaces
9. Reflection garden
10. Multi-use room - spiritual
11. Sunrooms (2)

**Resident Spaces**

12. Resident suite (w/ barrier-free washroom) (10)
13. Therapy rooms

**Staff/Volunteer Spaces**

14. Admissions office
15. Offices (3)
16. Staff room
17. Staff washroom
18. Volunteer support space
19. Kitchen
20. Nurse's station (& medication room) (2)

**Visitor Spaces**

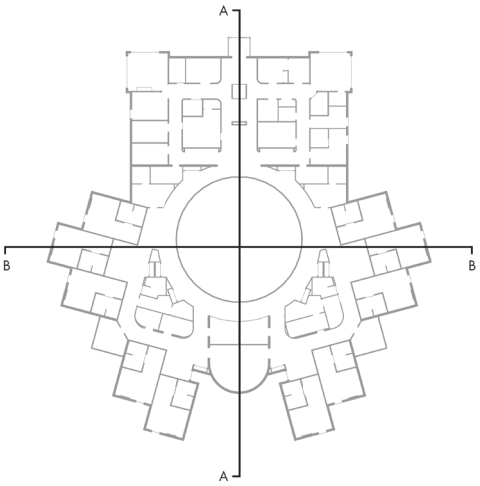
21. Multi-use room (meeting room)
22. Dining room
23. Living room
24. Family changerooms (2)
25. Quiet rooms

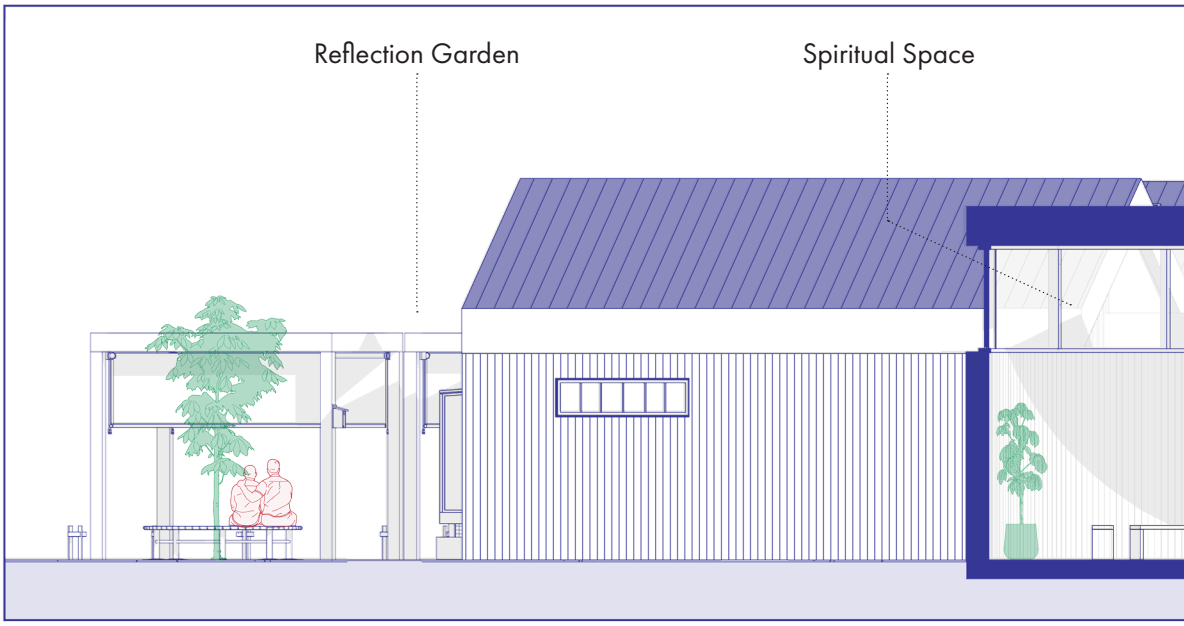
**Service Spaces**

26. Barrier-free washroom (2)
27. Janitor
28. Communications room
29. General storage
30. Mechanical room
31. Electrical room
32. Sprinkler room
33. Clean utility
34. Soiled utility
35. Laundry

36. Site Maintenance/Storage
37. Parking

*The list of programme spaces combines existing HPCO design standards with additional spaces that became relevant to the design via field work interviews.*



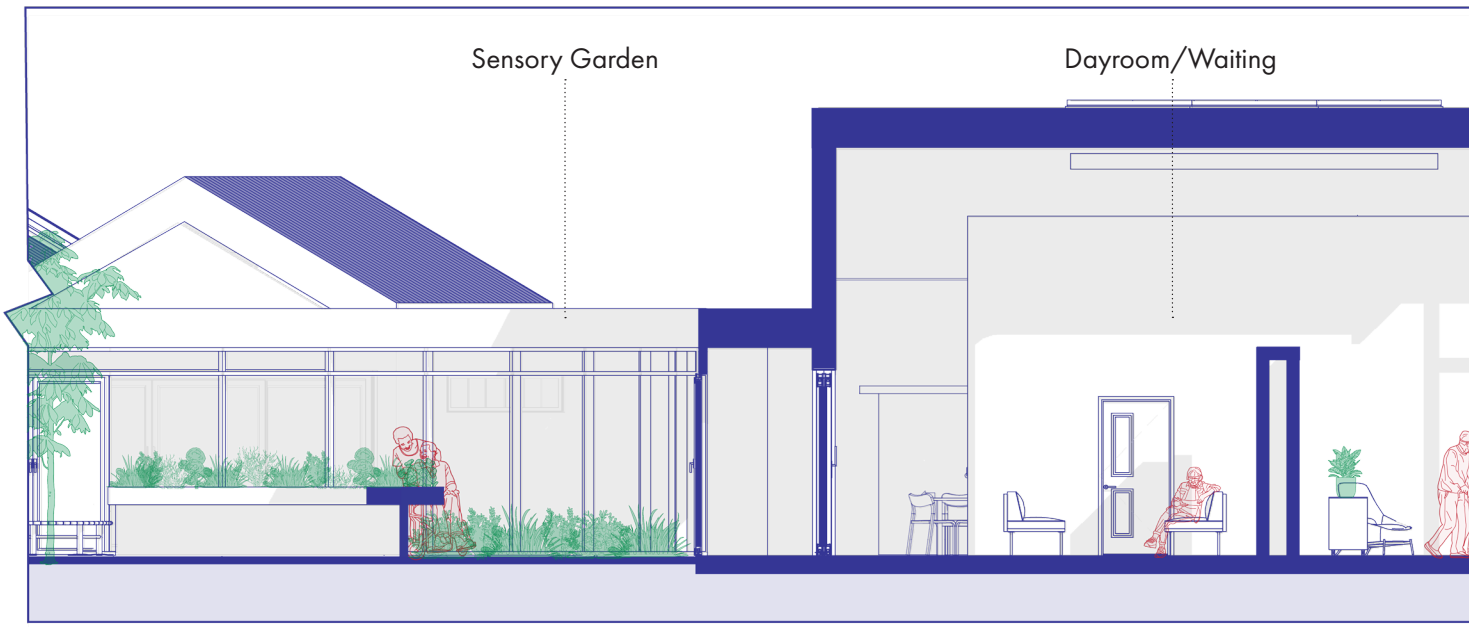
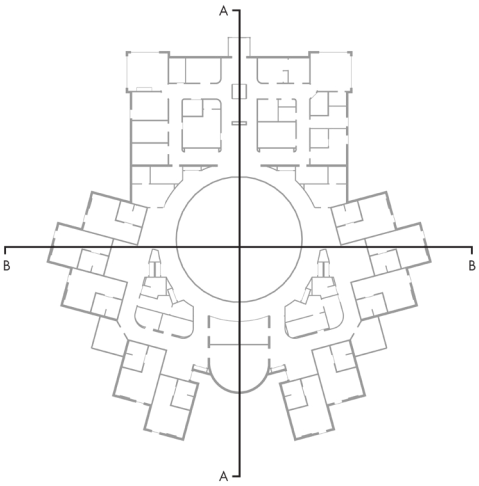




**Figure 9.11** **Section a (1:200)**


Quiet Room
Sensory Garden


Reception
Main Entrance



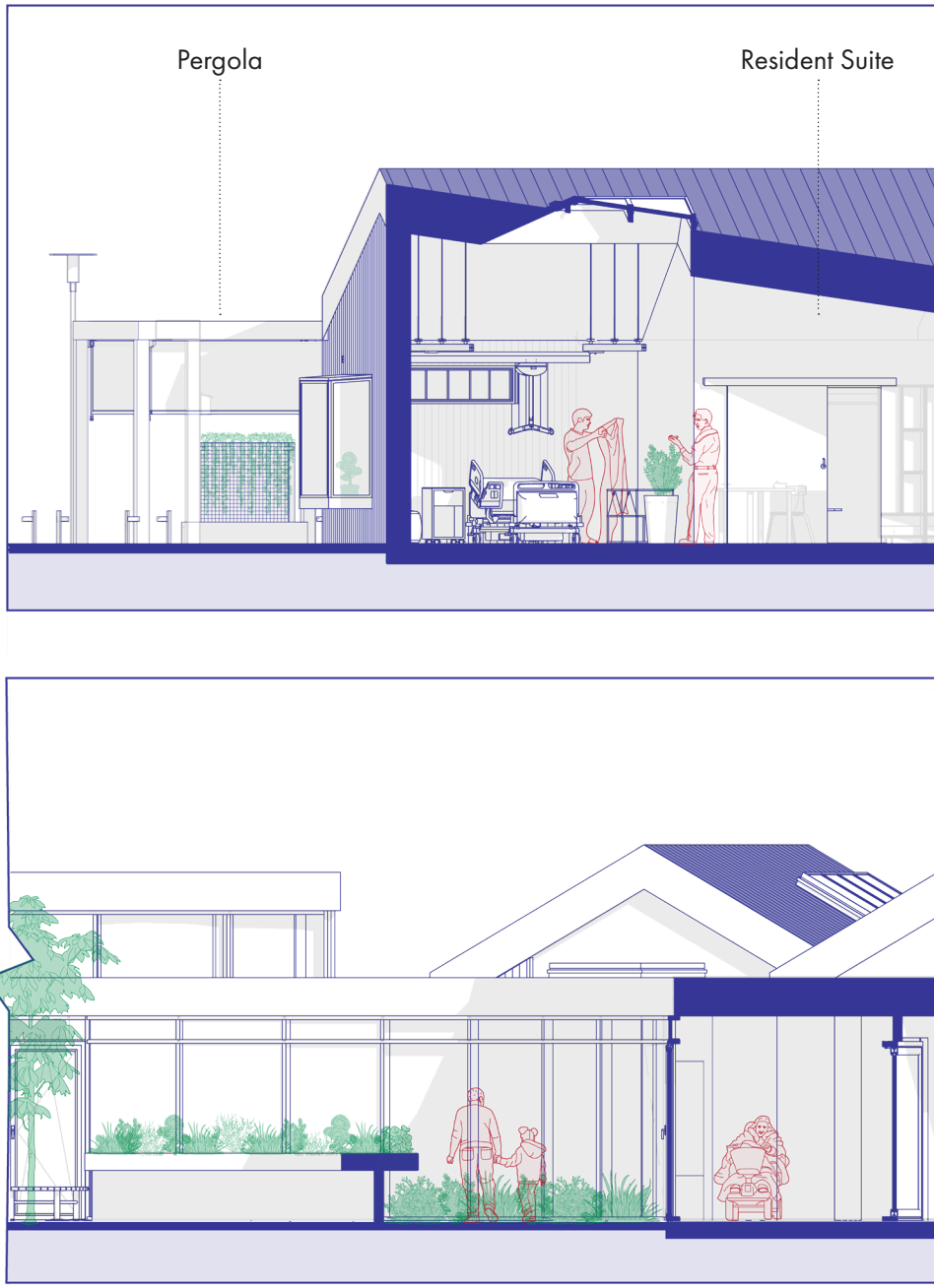
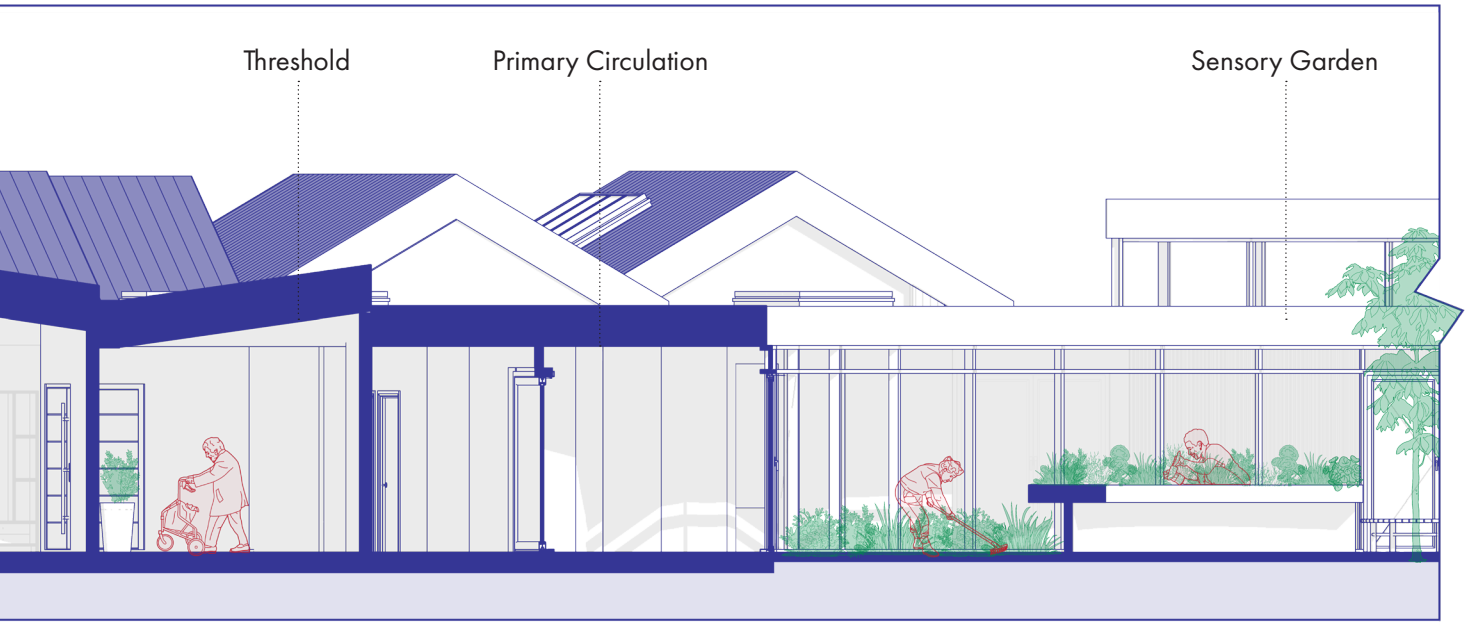




**Figure 9.12** **Section B (1:200)**


Threshold
Primary Circulation
Sensory Garden



# ANALYSIS DIAGRAMS

*A holistic design approach for hospice considers:*

- *A strong connection to nature*
- *Balancing privacy and communal spaces*
- *Adaptability, personalization, and multi-functionality of space*
- *The importance of accessibility and ease of movement in space*
- *Creating a homelike atmosphere in an institutional setting*

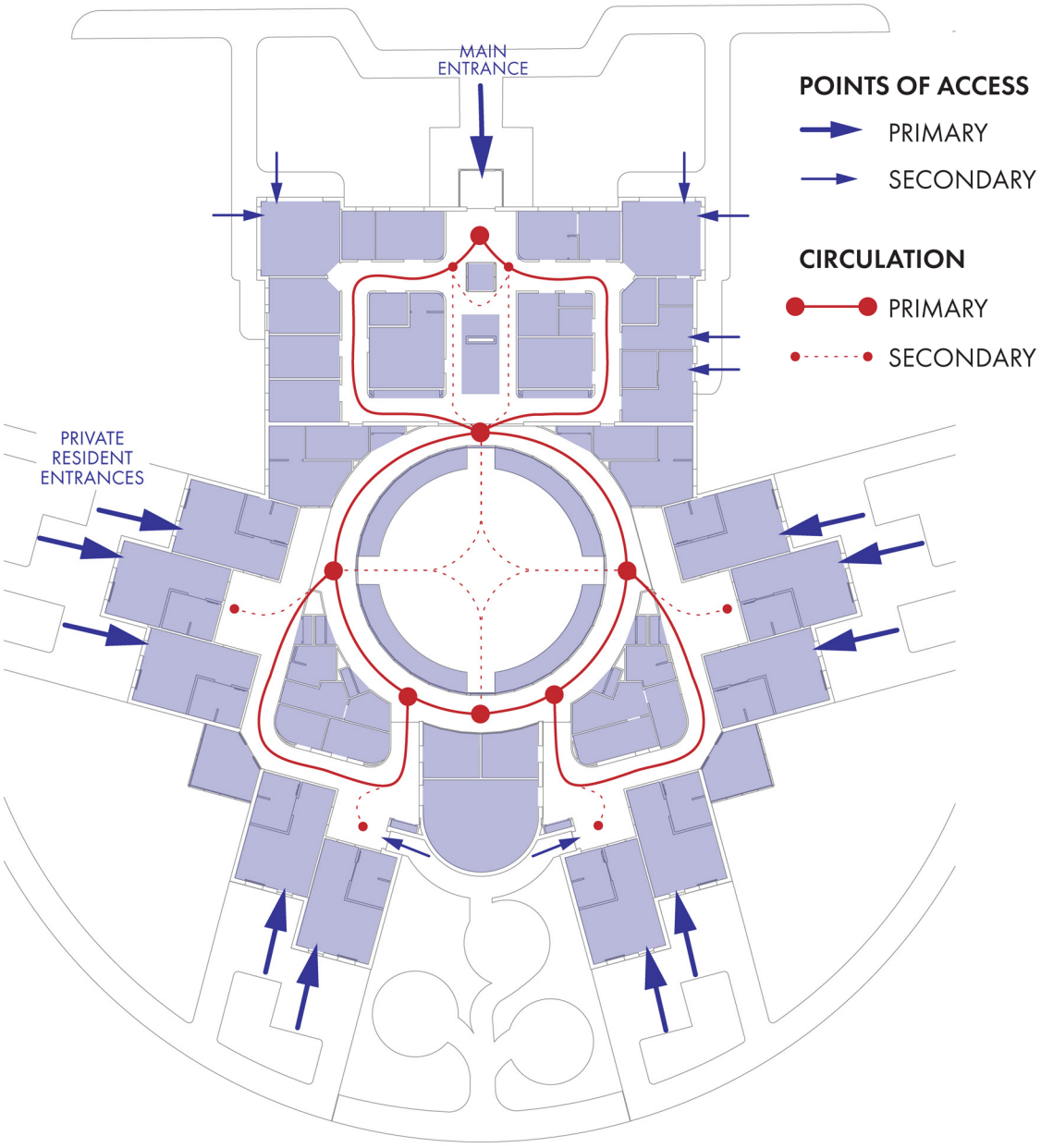



**Figure 9.13** **Diagram - circulation**

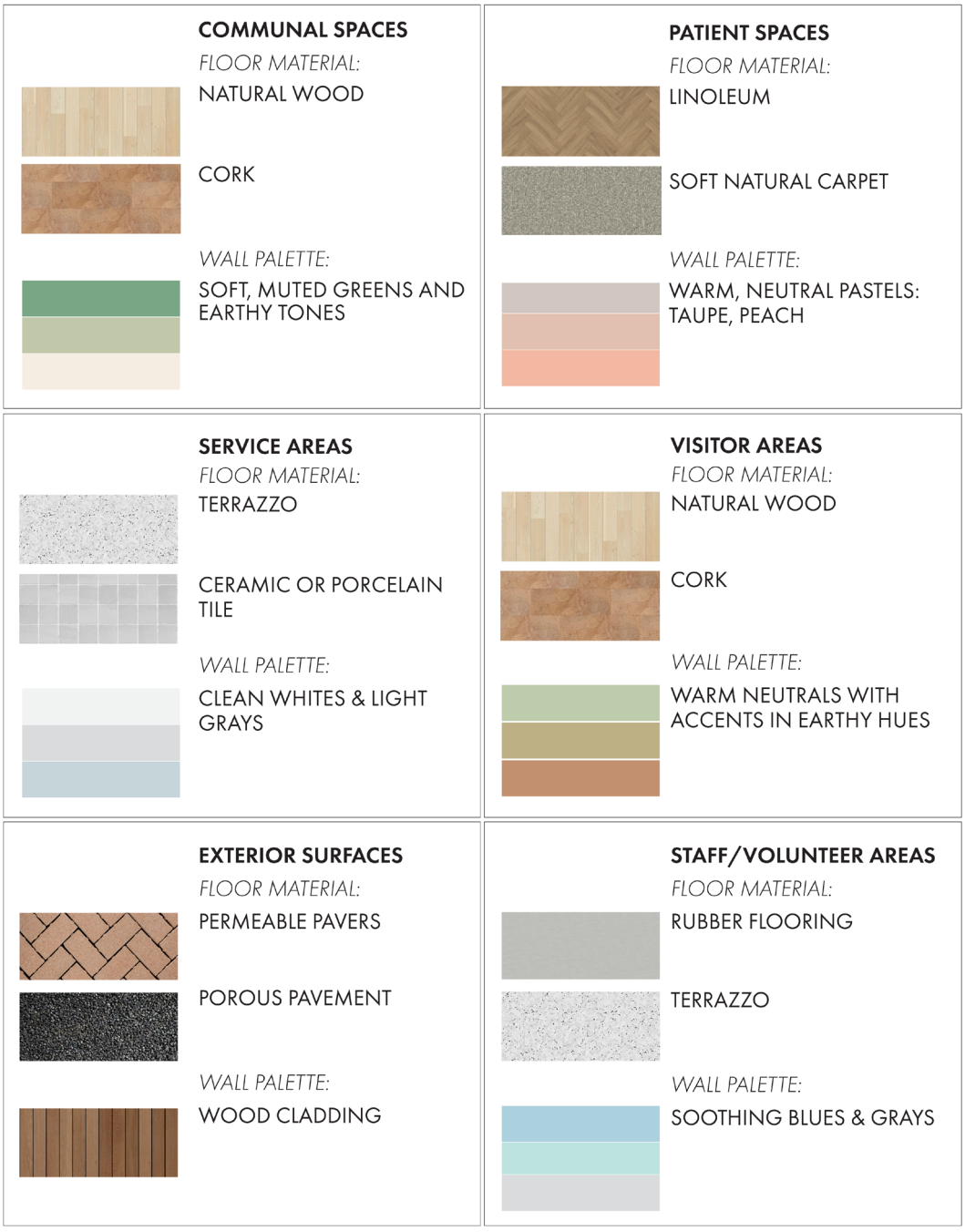



**Figure 9.14 Material palettes**

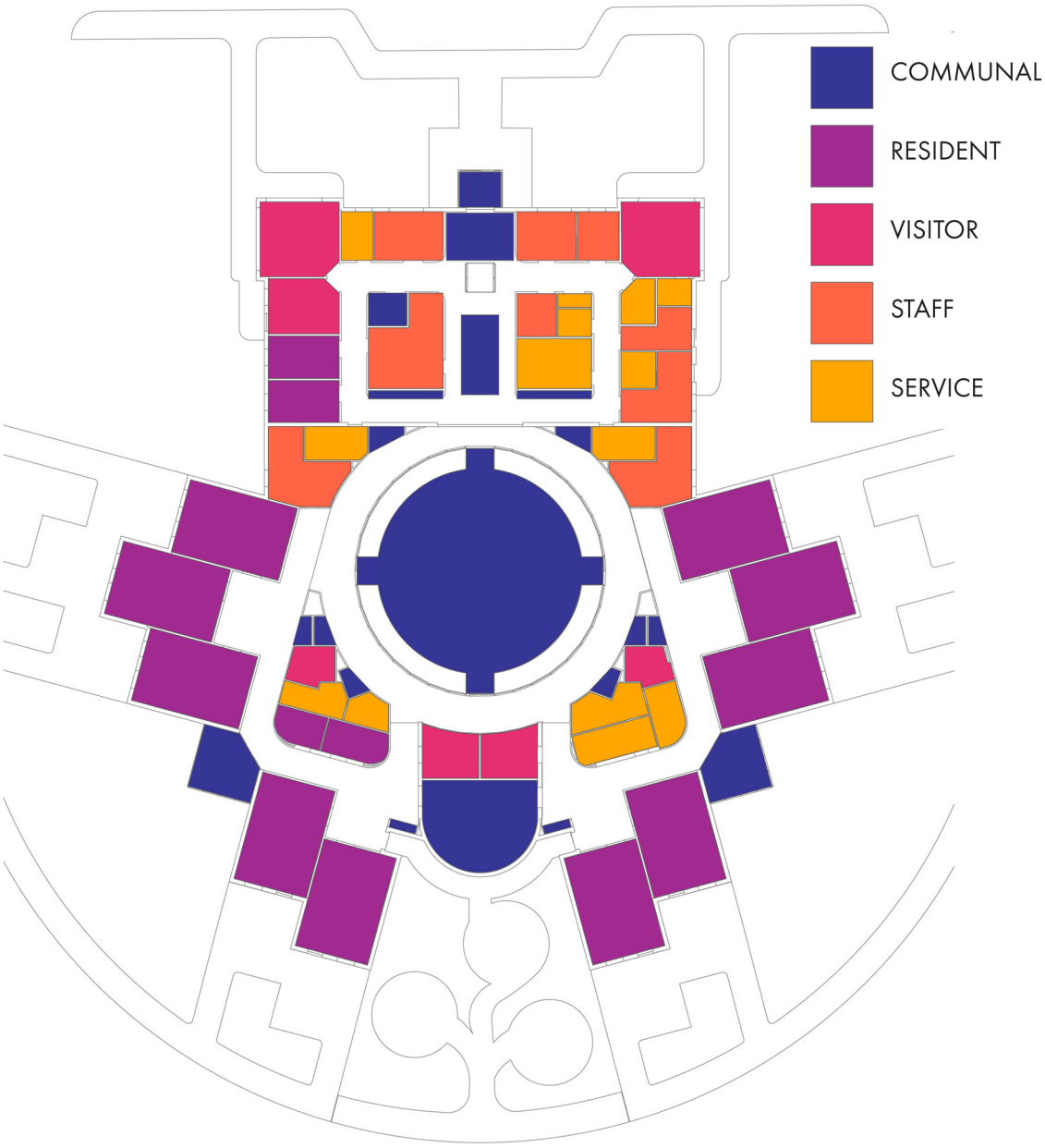



**Figure 9.15** **Diagram - program types**

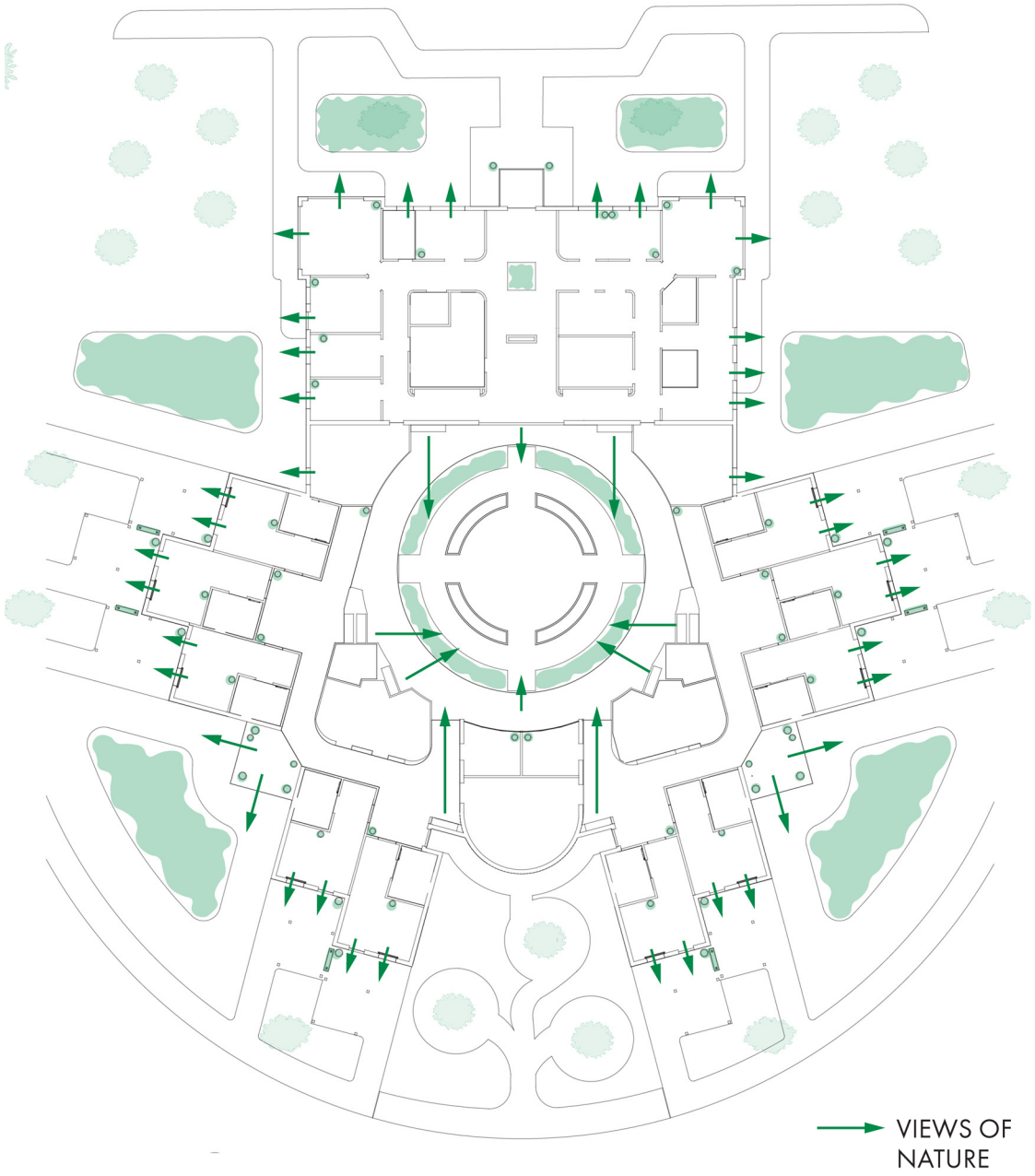



**Figure 9.16** **Diagram - connections to nature**

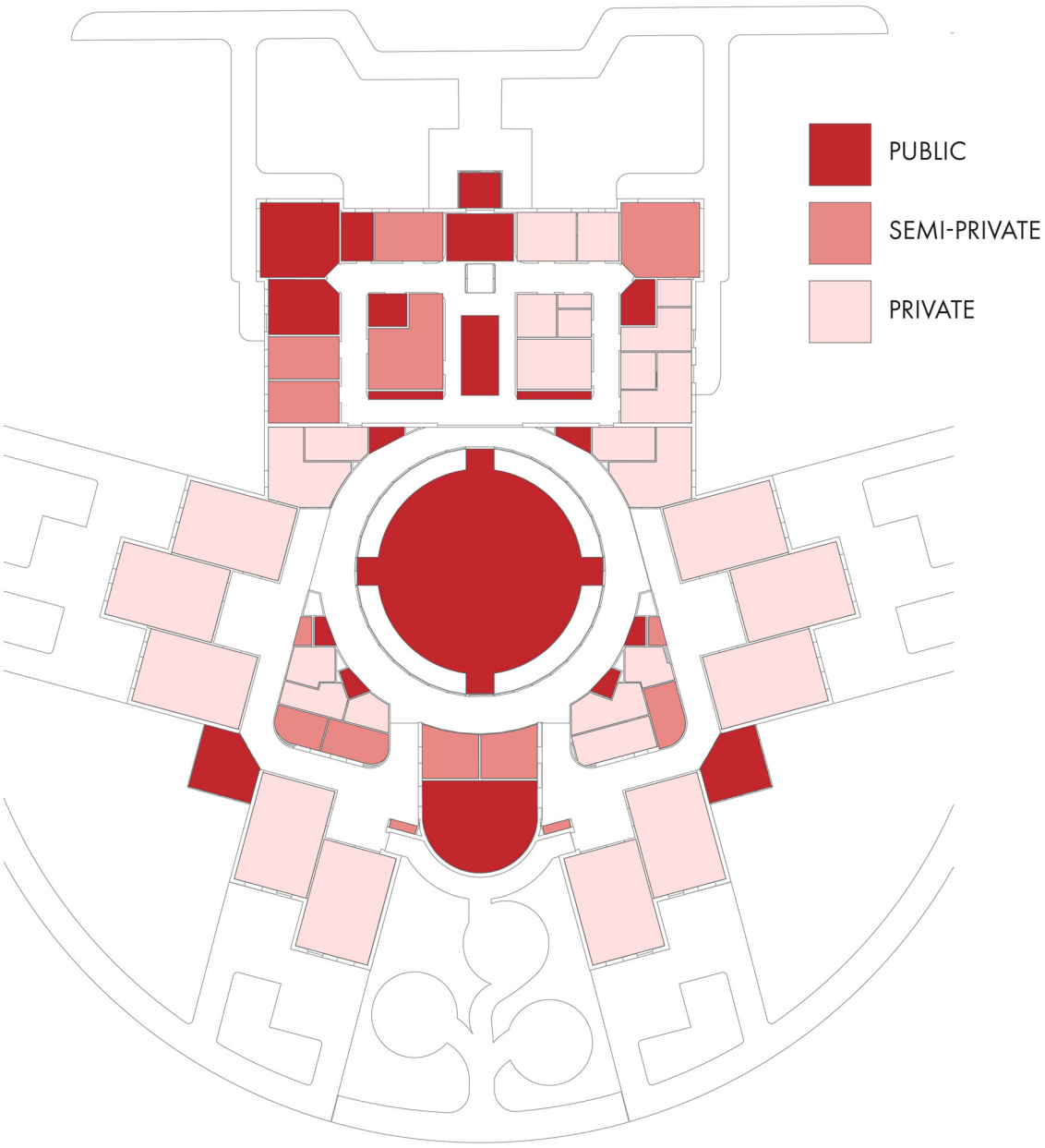
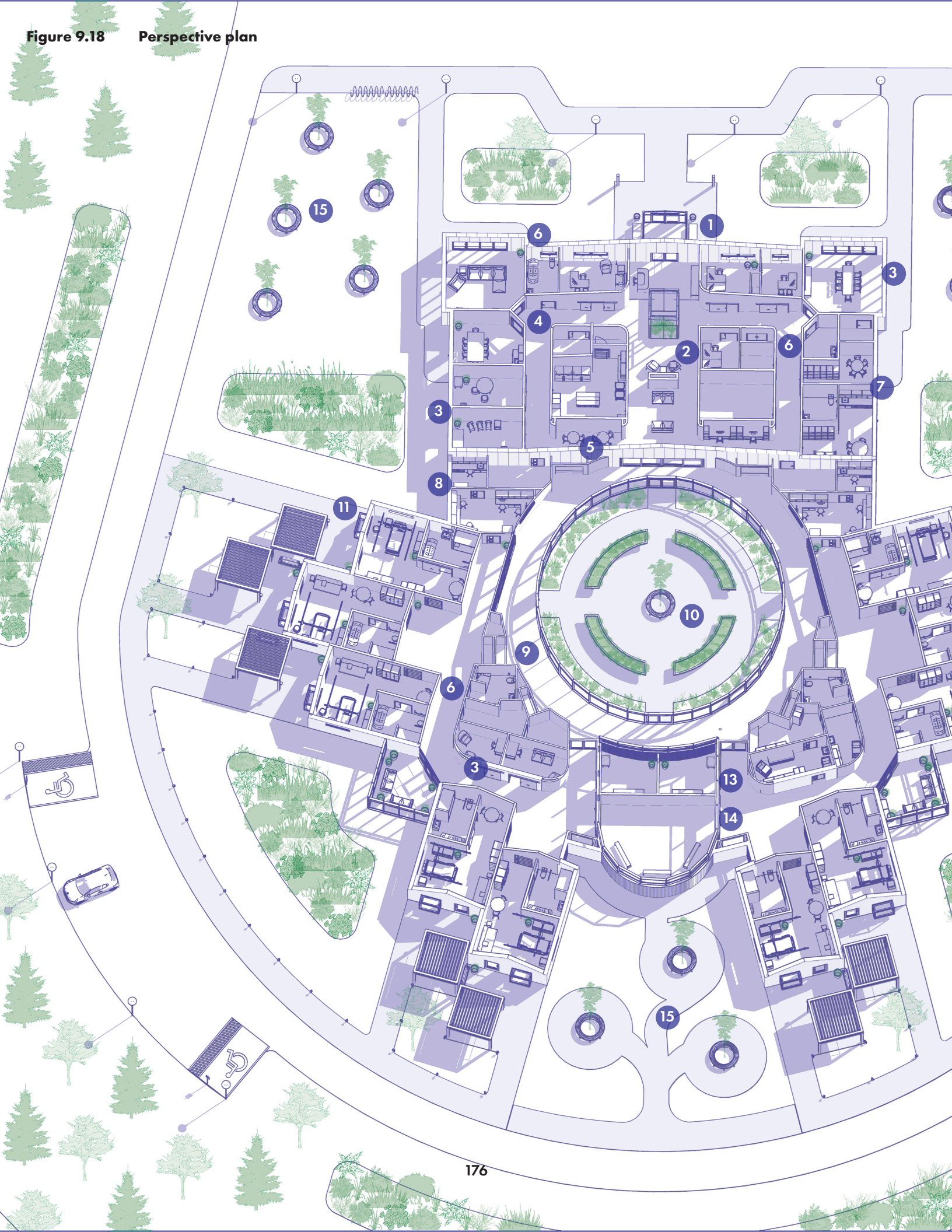



**Figure 9.17** **Diagram - public vs private space**

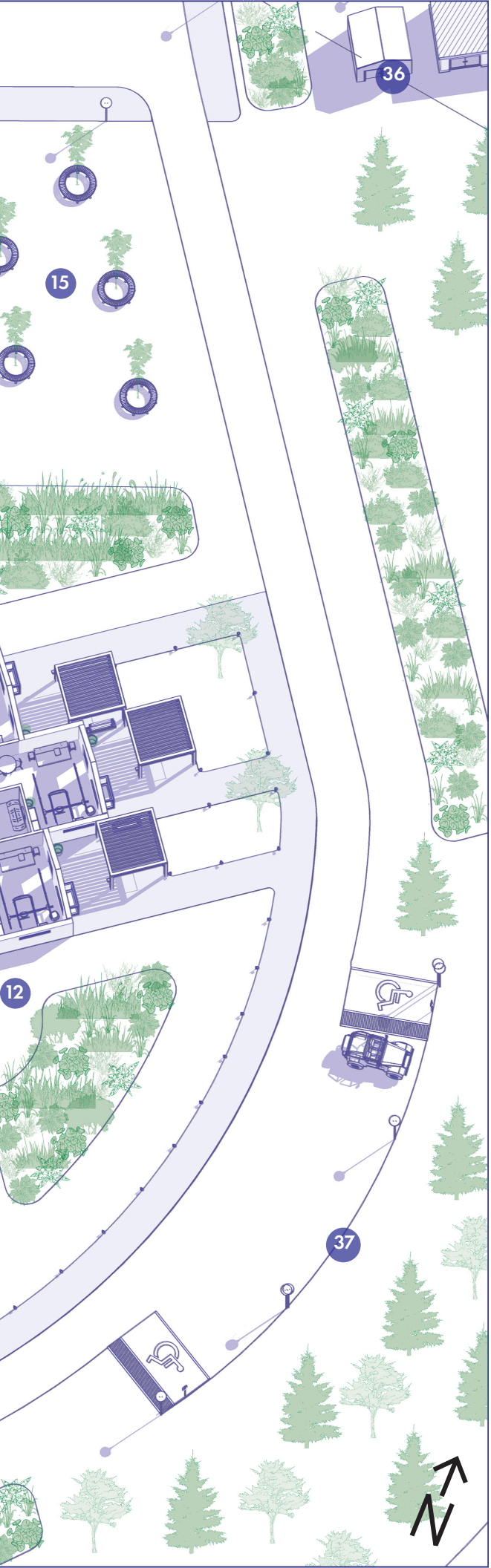
**Figure 9.18** **Perspective plan**

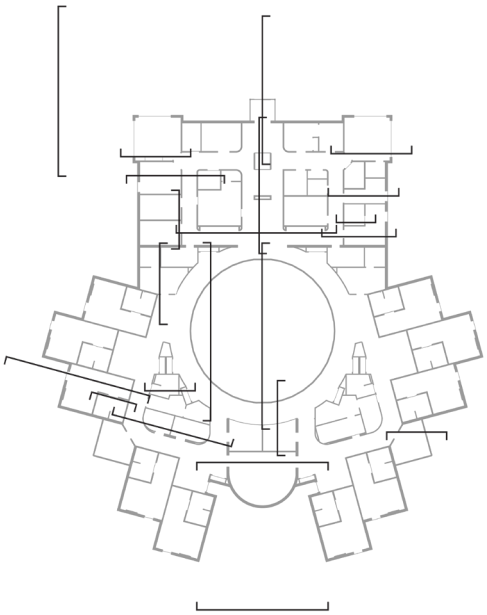


# KIT OF PARTS: HOSPICE

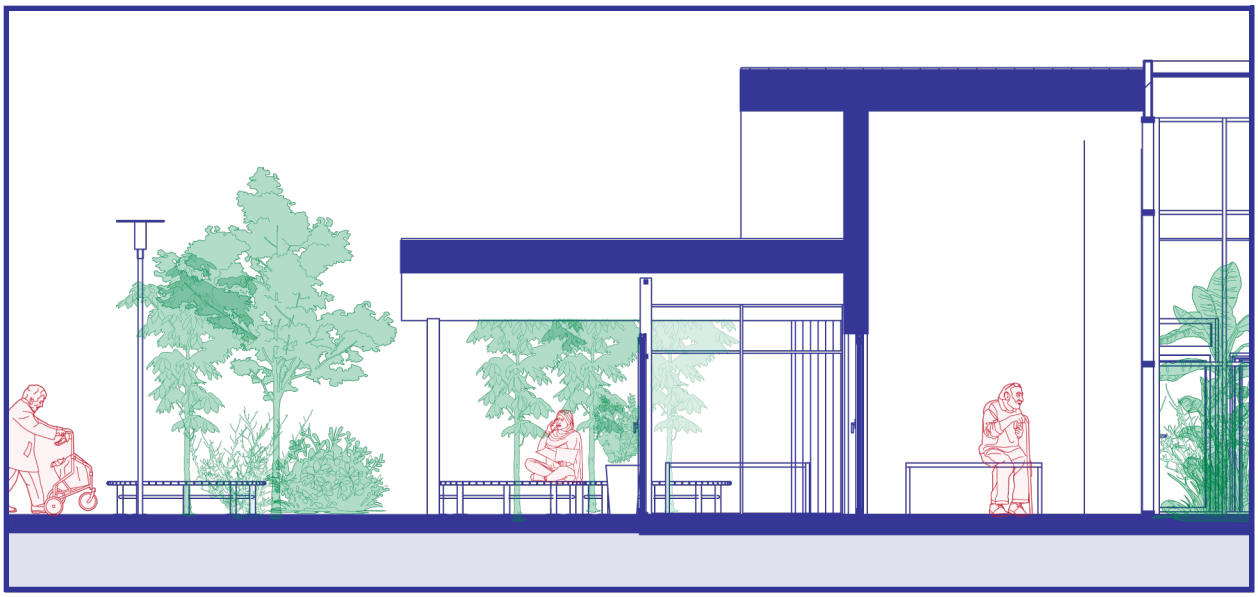
The following kit of parts identifies key program areas that support the embodied experience of each occupant group in hospice, building upon existing standards to establish a more thoughtful and engaging environment for the end-of-life.

1. Main entrance
2. Waiting spaces
3. Therapy rooms (group, offices, and art/music therapy)
4. Family gathering spaces (pantry/dining, living room)
5. Care center alcoves
6. Washrooms
7. Staff rooms
8. Nurse's station & med room
9. Residence Nooks
10. Sensory garden
11. Resident suite
12. Sunroom
13. Quiet rooms
14. Spiritual space
15. Outdoor gathering spaces (meditation garden, front gathering space)



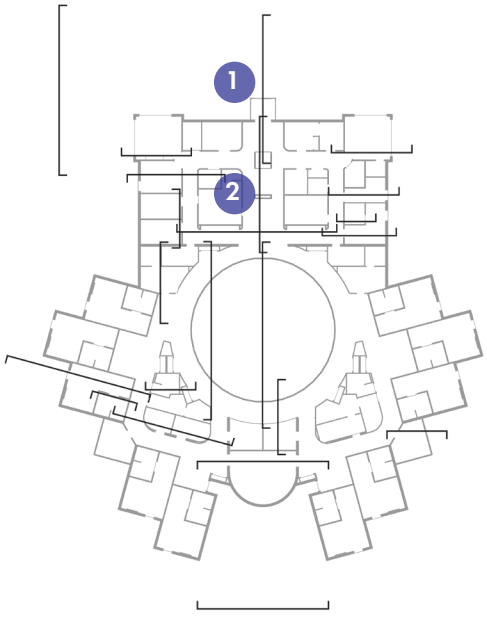



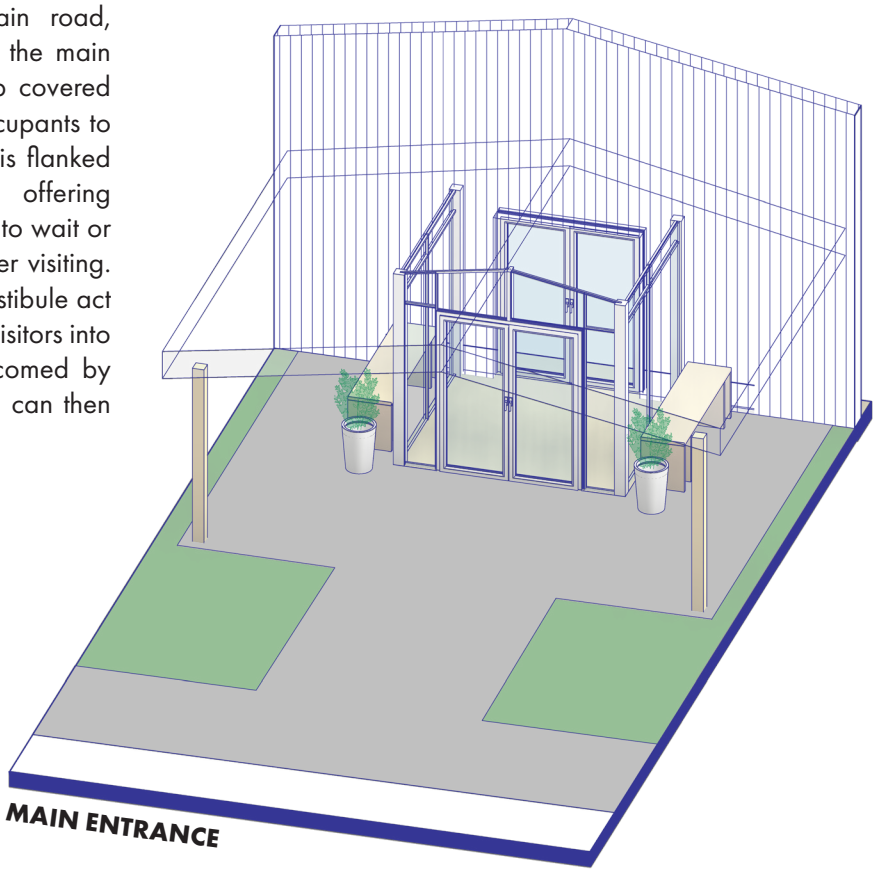
## FIGURE 9.19 MAIN ENTRANCE



**SECTION 1:100**

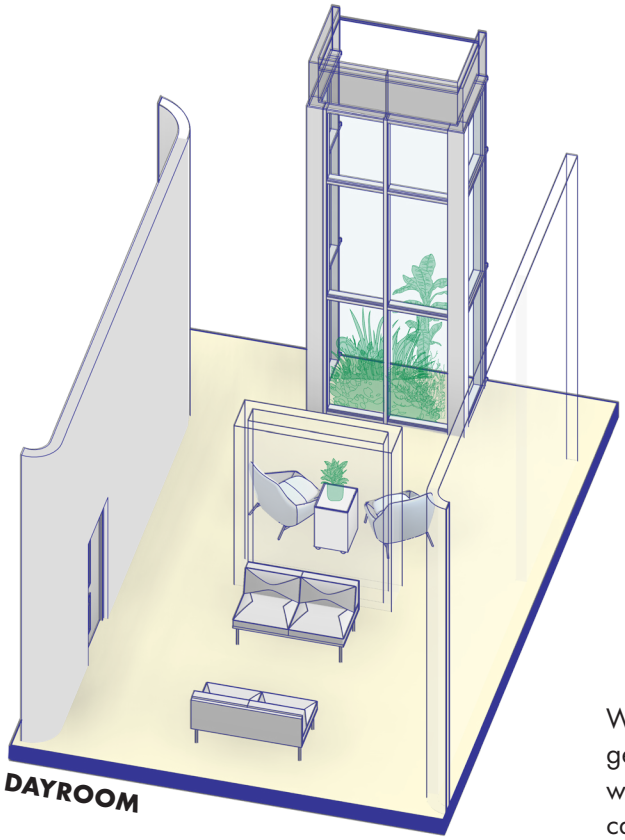
The main entrance is clearly visible upon first impression of the hospice, easing wayfinding and establishing a street front presence. Entering via the main road, patients can be dropped off at the main entrance, where there is a deep covered porch with benches allowing occupants to sit outdoors. The main entrance is flanked by outdoor gathering spaces, offering additional options for occupants to wait or spend time outside before or after visiting. The deep, covered porch and vestibule act as a generous threshold to ease visitors into the space, where they are welcomed by a hospitable reception area and can then move into communal areas.

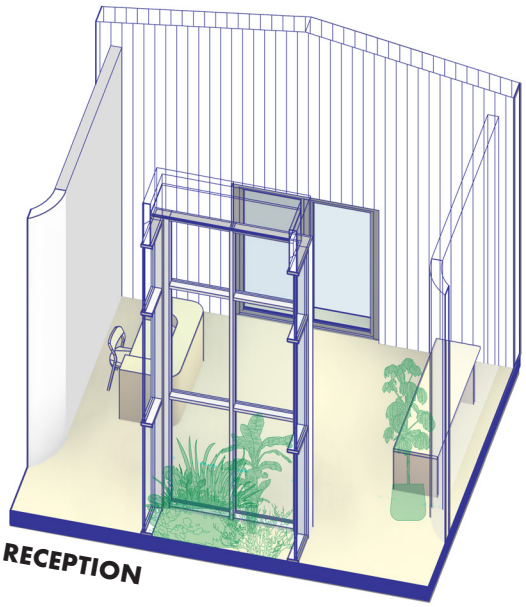


**MAIN ENTRANCE**

## FIGURE 9.20 WAITING SPACES



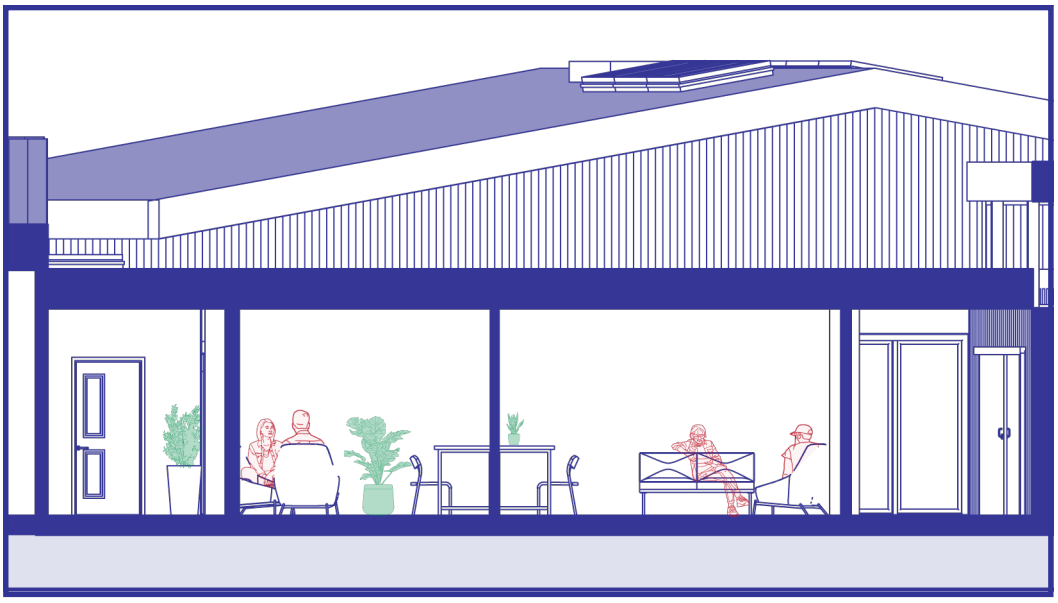

Waiting spaces are essential for spaces of care, offering generous open space with multiple options for visitors who may be waiting for a loved one while they receive care or waiting to receive care themselves.



**SECTION 1:100**

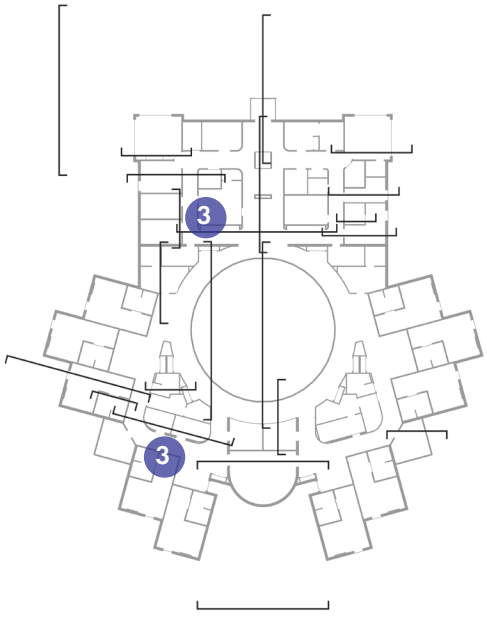
The interior garden acts as a visual buffer between the main entrance/reception space and primary path of circulation, as well as sightlines through the building to create a more intimate, less exposed space. The garden further provides direct views of nature for occupants in the interior of the building, fostering a calm environment for the act of waiting.

## FIGURE 9.21 THERAPY ROOMS



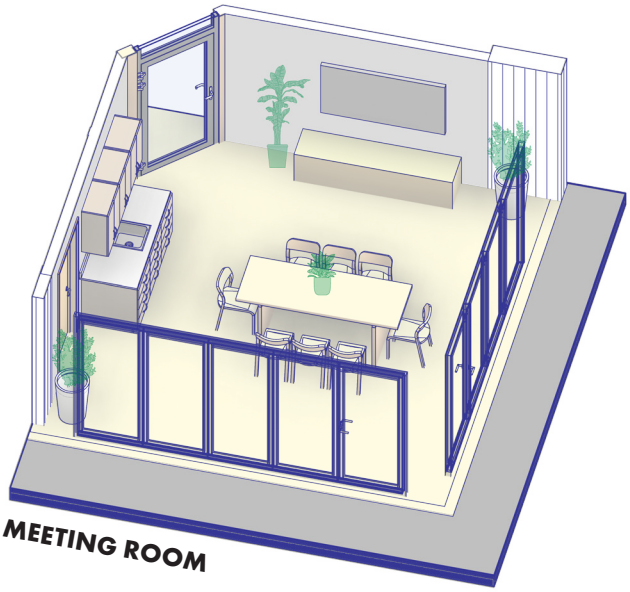
SECTION 1:100

Therapy rooms of various sizes offer space for individuals and groups seeking support for their emotional and psychological wellbeing, providing counselling, art therapy, music therapy. Whilst primarily located in the care center, the residence wing has dedicated therapy rooms nearby for residents and their visitors. Considering the sensitive nature of therapy, acoustic and visual privacy are essential considerations to ensure confidentiality and respect for all occupants.

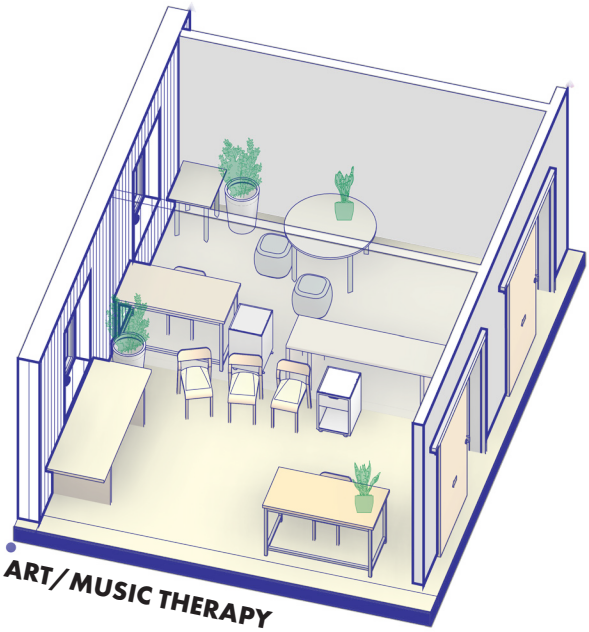





THERAPY ROOMS



MEETING ROOM



ART/MUSIC THERAPY

The meeting room is a multi-purpose space that can be used for group counselling, staff meetings, and other events. The two exterior walls feature expansive windows, with doors opening out to the gathering space and gardens outside, allowing for the site to act as an extension of the interior space.

The art and music therapy rooms are also able to accommodate one-on-one or small group sessions, with operable windows bringing natural light and fresh air indoors. The music room specifically is located in the furthest corner of the care center to mitigate sound travel and maintain a relatively low-volume central area.



**SECTION 1:100**



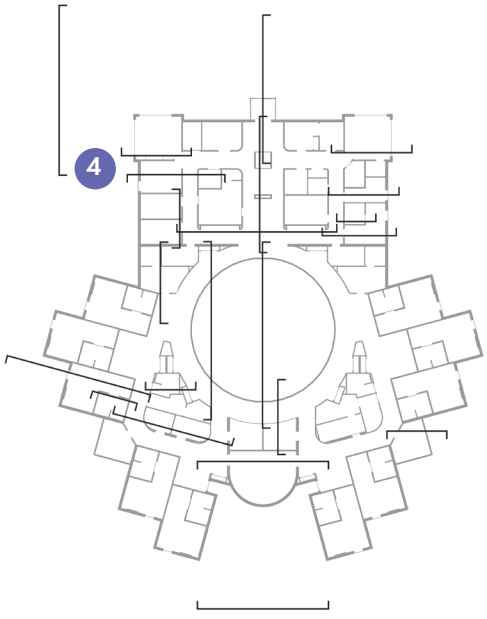
**SECTION 1:100**

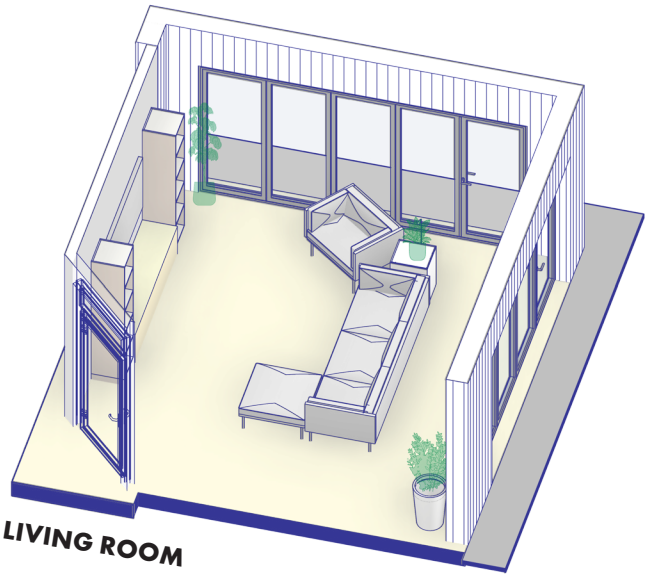
## FIGURE 9.22 FAMILY GATHERING SPACES



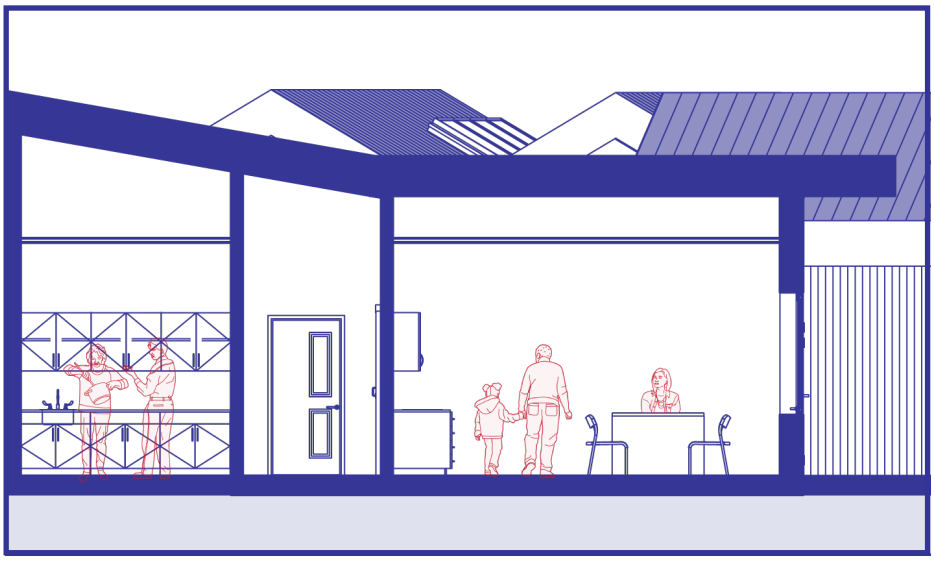
**SECTION 1:100**

The living room is a multi-purpose family gathering space, like the meeting room, which can accommodate small to medium groups and events. There are wide-spanning views of the gardens and gathering space outdoors, which are also directly accessible from the living room.



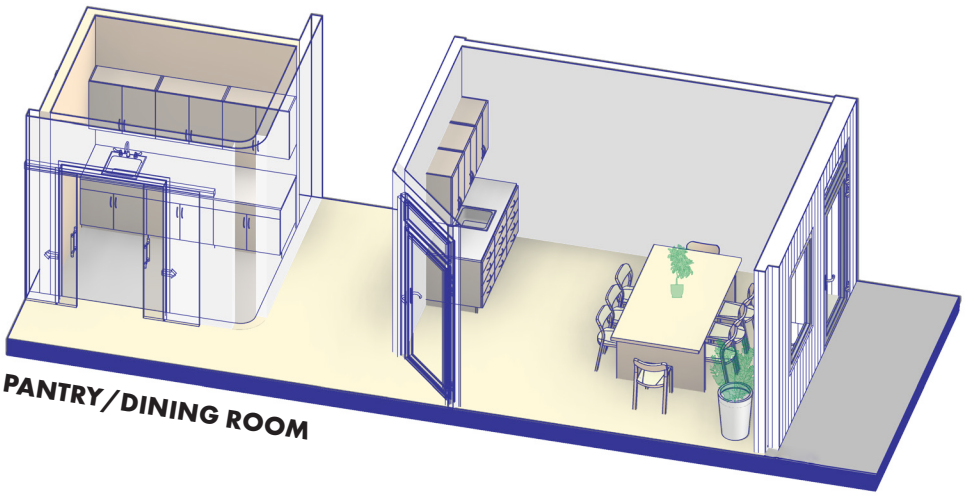



**LIVING ROOM**



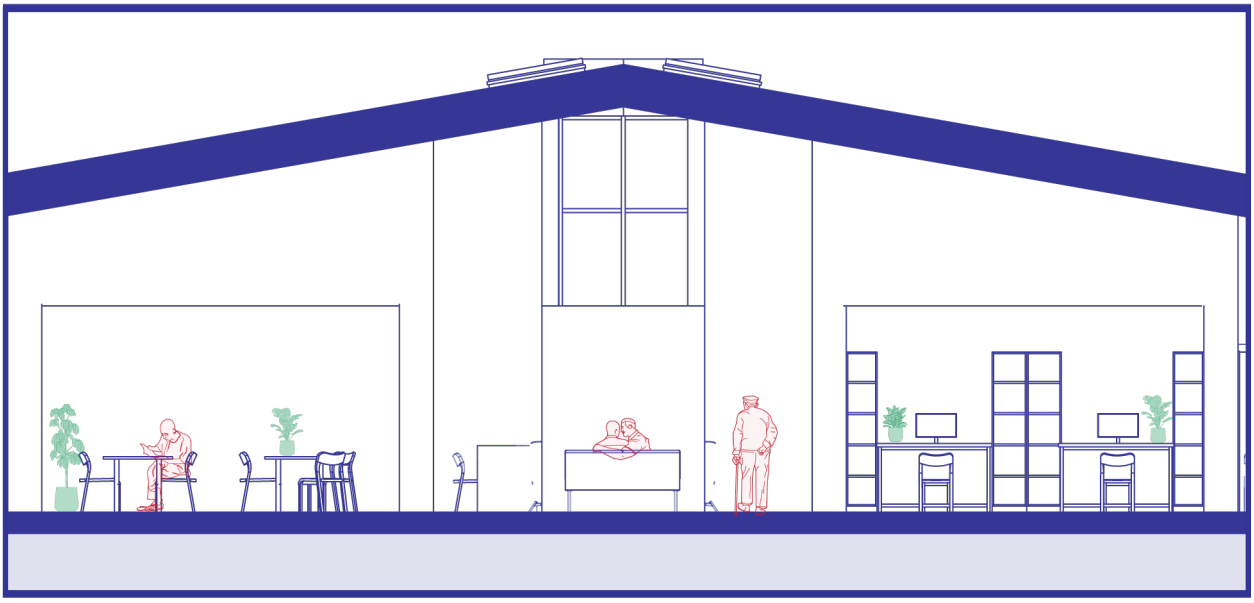
**SECTION 1:100**

Family gathering spaces like the pantry, dining room, and living room offer spaces for patients and their families to spend quality time together in a homelike atmosphere – whether that be sharing or preparing a meal, watching a movie, or playing board games. These spaces are grouped together, allowing for families to move between spaces without crossing the entire center – further contributing to a sense of home. The pantry space is consistently stocked with snacks and beverages and offers prep space and storage for simple meals made by visitors. The dining room also features a small kitchenette, and access to outside to allow occupants to enjoy a meal together either indoors or out.



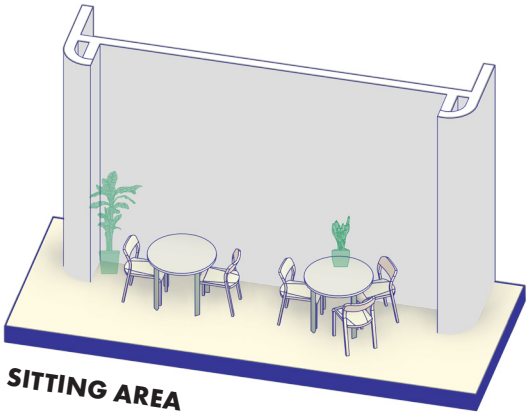
**PANTRY/DINING ROOM**

## FIGURE 9.23 CARE CENTER ALCOVES

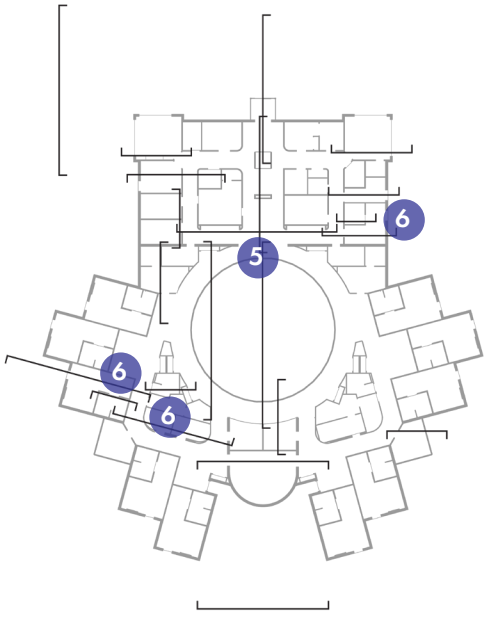


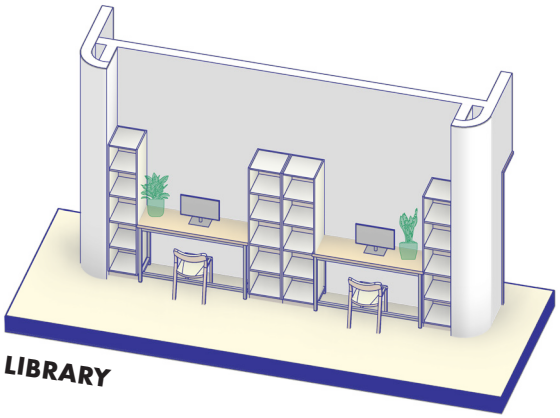
**SECTION 1:100**

Tucked away towards the back of the care center, the alcoves offer additional seating and a dedicated mini-library and workspace that can be used by all occupants. Conveniently located adjacent to the dayroom space, the alcoves offer a more private area for people to retreat or connect with others. The alcoves also act as overflow space for events or other busier occasions. These quieter communal spaces also face the threshold between the care center and the circular path surrounding the sensory garden, adding calming visual interest for these spaces.



**SITTING AREA**



**LIBRARY**

# FIGURE 9.24 WASHROOMS

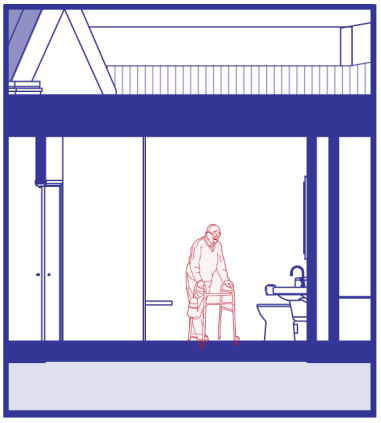


SECTION 1:100

All washrooms in the hospice are spacious and designed to be barrier-free and fully accessible. There are two washrooms in the care center for day patients, visitors and volunteers. The staffroom features a private washroom, allowing for additional privacy away from other occupants.



STAFF WR

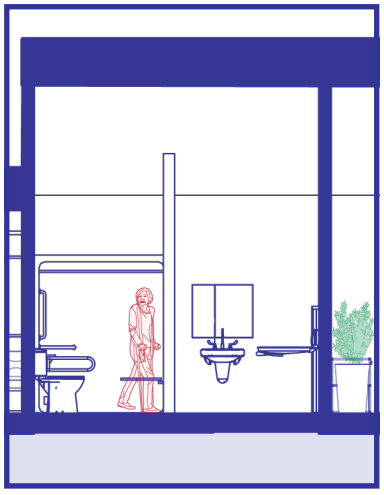


SECTION 1:100

Within the residence wing, there are dedicated family changerooms located on either side, conveniently located near the suite entrances. While family members can use the resident suite washrooms, having a dedicated washroom space with additional shelving to accommodate personal belongings is especially important for visitors staying overnight.

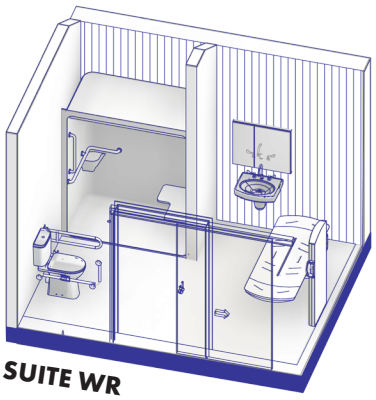


FAMILY WR



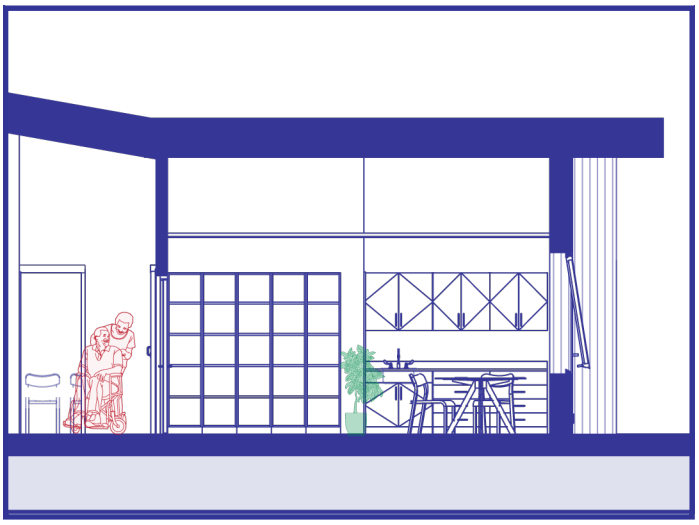
SECTION 1:100

Each resident suite has a spacious, fully accessible washroom, featuring showers and adult change tables to support all occupant capabilities. These washrooms are located towards the interior of the suite, acting as additional acoustic buffer between the private and communal space.

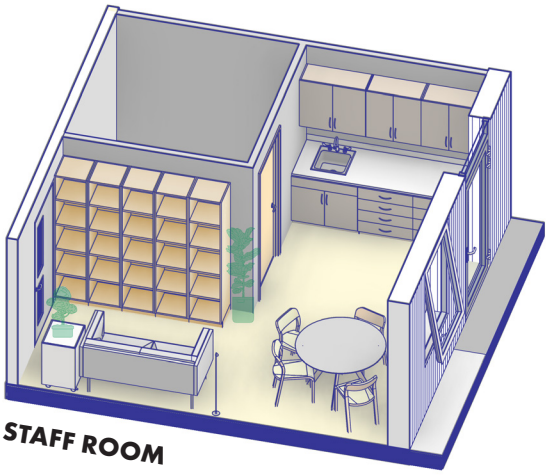


SUITE WR

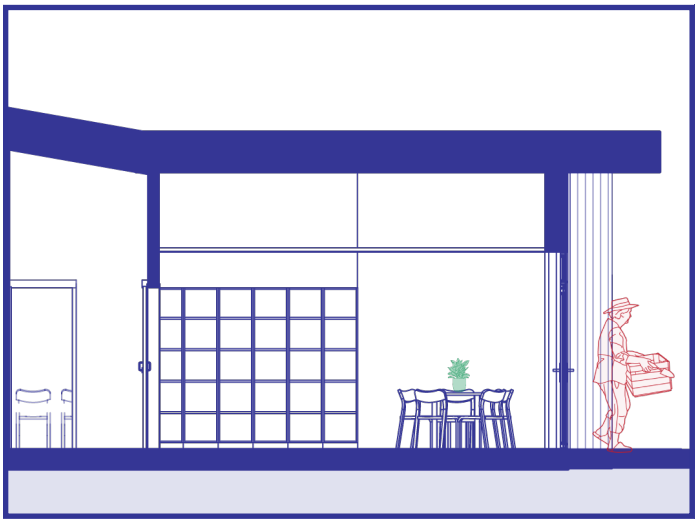
## FIGURE 9.25 STAFF ROOMS



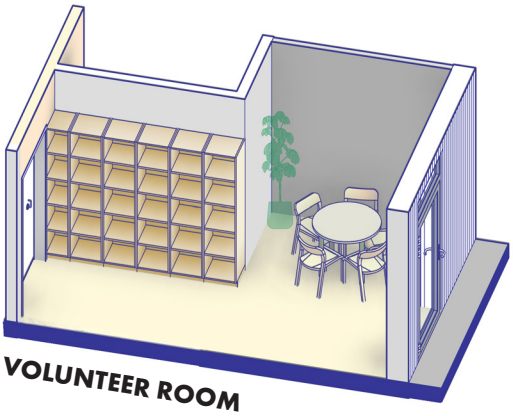
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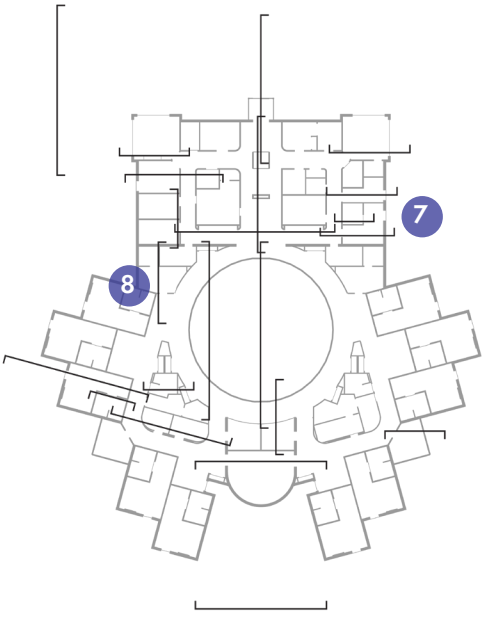
STAFF ROOM



SECTION 1:100

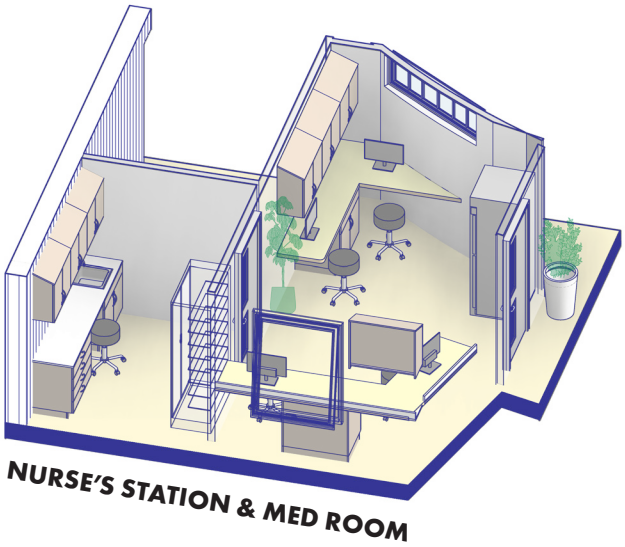


VOLUNTEER ROOM

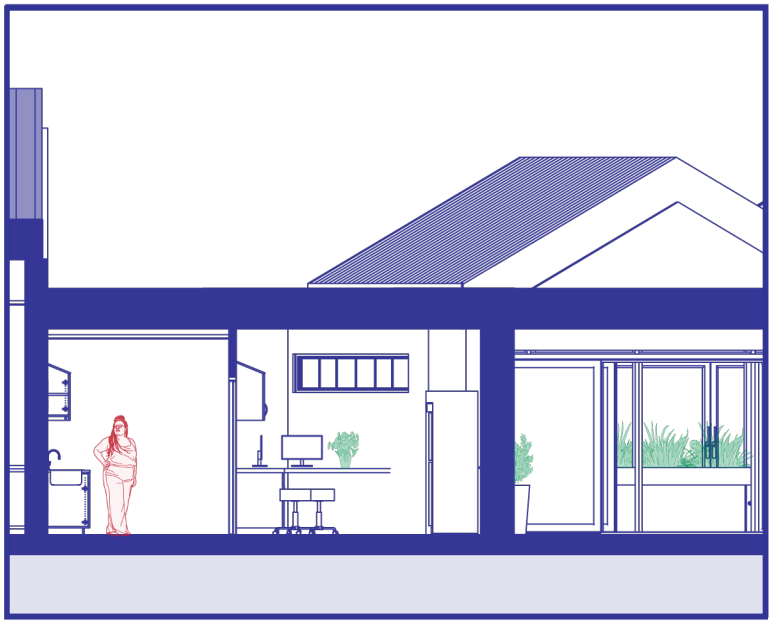



Staff rooms are private, comfortable spaces for care providers to rest and tend to their own needs. The staff room features a private washroom, kitchenette, storage for personal items, and multiple seating options with views of the gardens outside. Additional space to support volunteers is similarly provided, offering storage for personal items and volunteer projects with space for group collaboration. Both rooms have direct access to outside, allowing staff to get fresh air without travelling through the rest of the hospice and for volunteers working on landscaping to be able to directly access their worksite.

## FIGURE 9.26 NURSE'S STATION (& MED ROOM)



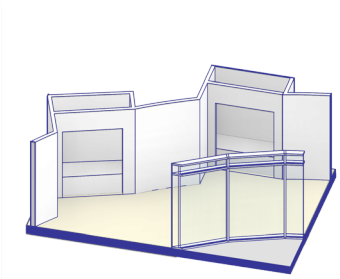

Each side of the residence wing has a nurse's station and attached medication room to support efficient care delivery. The nurse's station is located near the entrance of each side of the wing, allowing for direct sightlines on all occupants moving through the space also giving visibility to the suite entrances. Operable windows offer fresh air and views of nature to encourage focus during their clinical work, with generous worktops tucked out of site from the entry to give privacy away from other occupants. The interior med room offers additional workspace and thoughtful, secure storage for each resident's medication needs. Together these spaces aim to balance functionality with comfort for care providers to be able to work productively and efficiently.

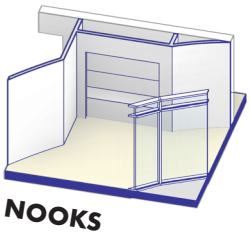


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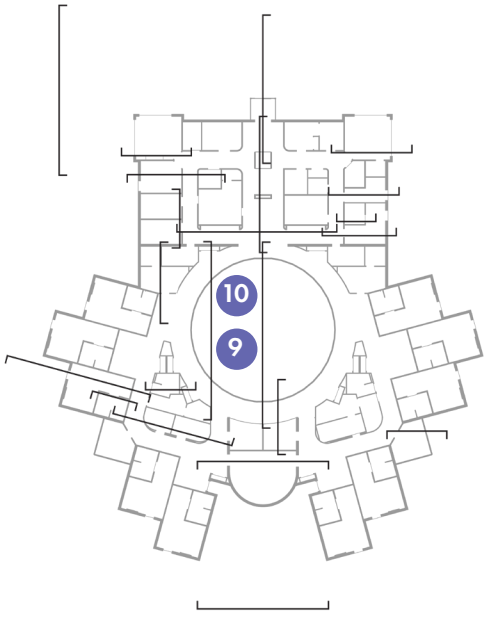
## FIGURE 9.27 NOOKS

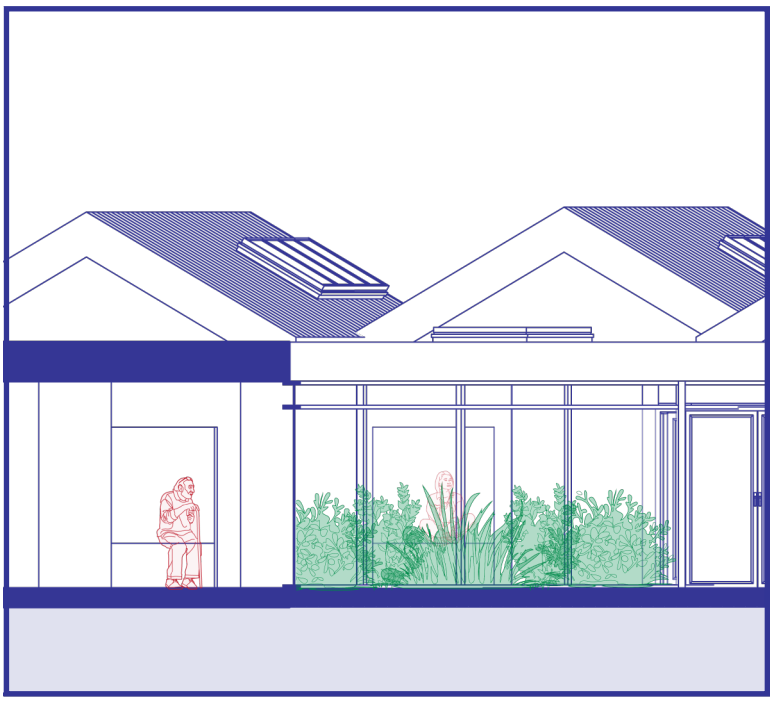
Strategically located around the interior walking path, nooks offer a moment of reprieve for occupants. The walking path is accessible from both the care center and residence wing, inviting occupants to explore. The nooks are small seating areas tucked away from the main circulation, facing into the sensory garden. Nooks are spaces for a quiet conversation, a phone call, a moment of reflection, meditating on nature, or observing other occupants moving through the space.



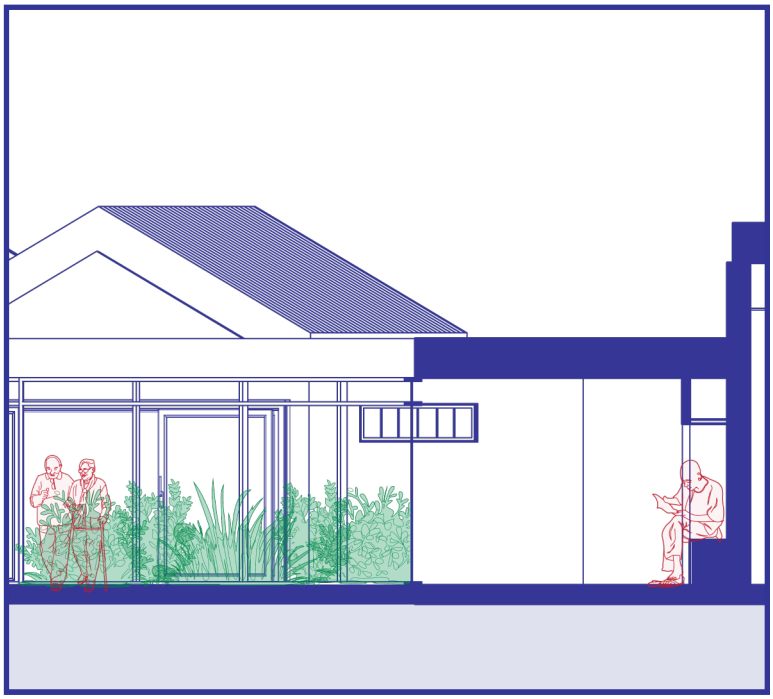


NOOKS



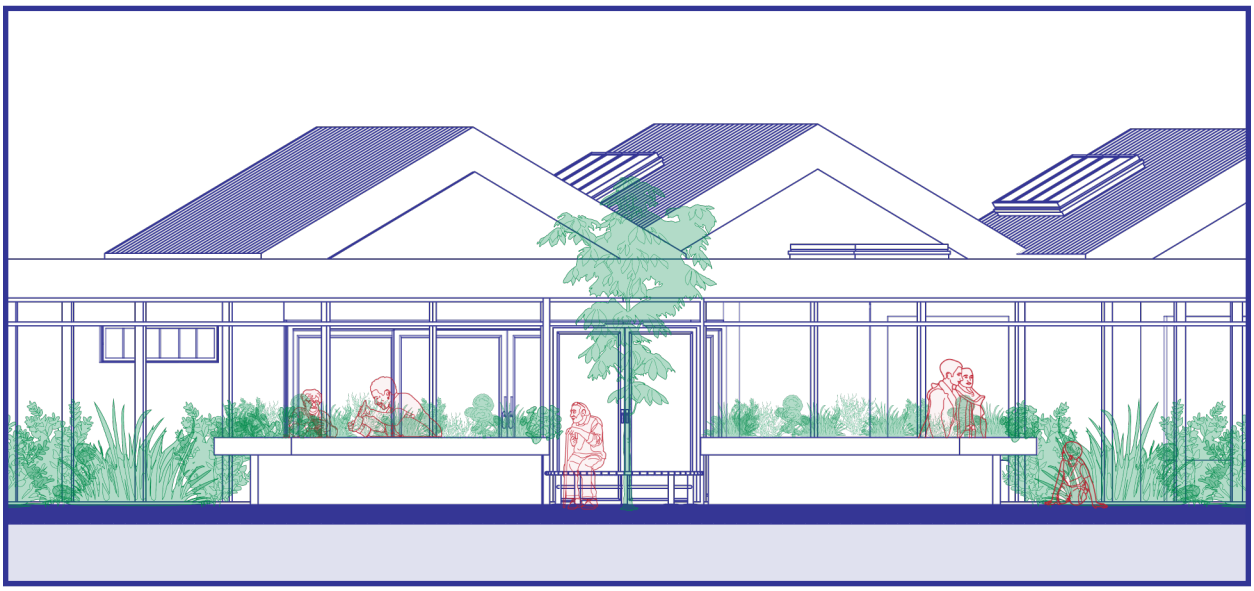



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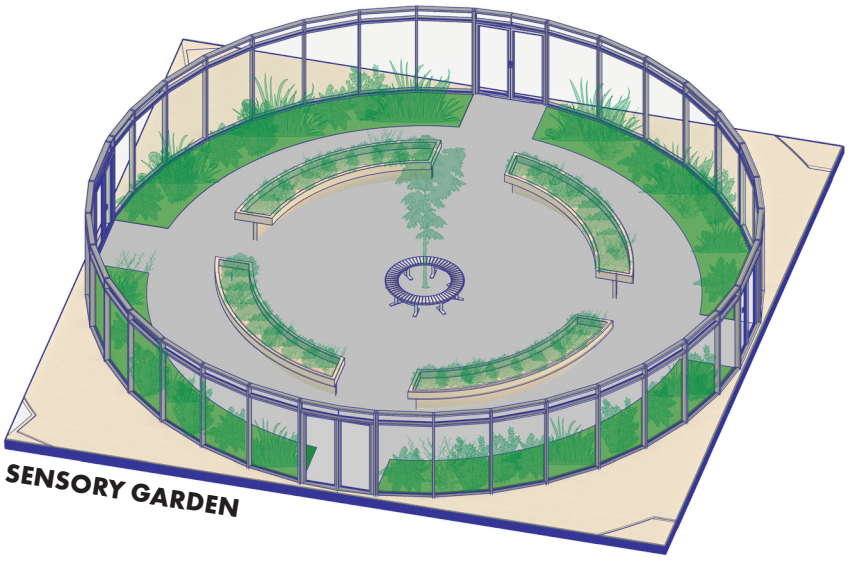
SECTION 1:100

## FIGURE 9.28 SENSORY GARDEN



**SECTION 1:100**

The sensory garden is a therapeutic space designed to engage the senses and celebrate the human-nature connection. There are four access points to the garden from the walking path, where the perimeter of the garden is filled with lush plants to evoke a sense of immersion in nature. The wide pathways lead to raised garden beds, which are accessible to those in wheelchairs, inviting occupants to interact with indigenous plants that engage the senses. The sensory garden evolves with each season, allowing occupants to observe natural cycles of growth.

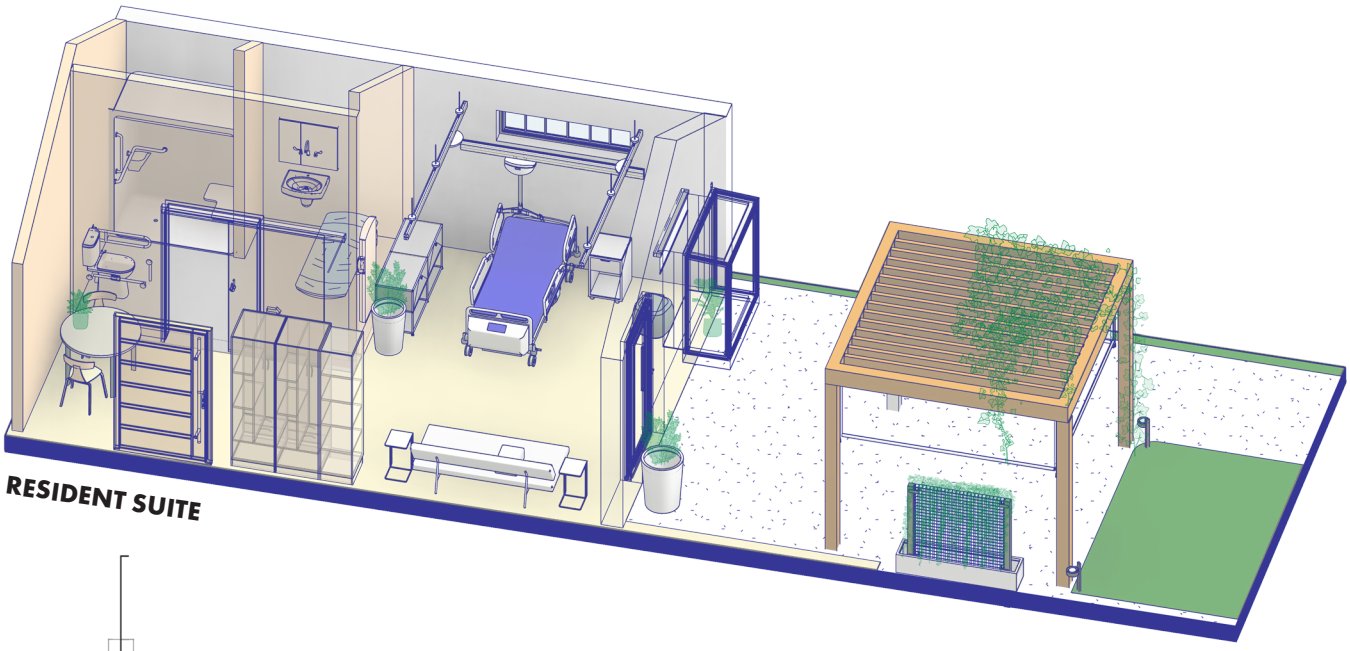


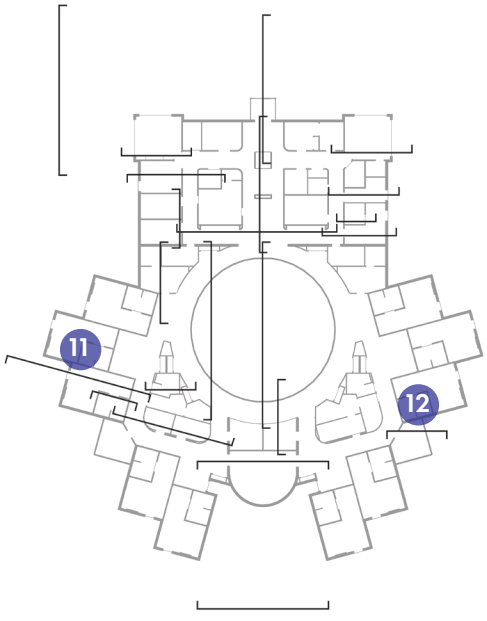
## FIGURE 9.29 RESIDENT SUITE



**SECTION 1:100**

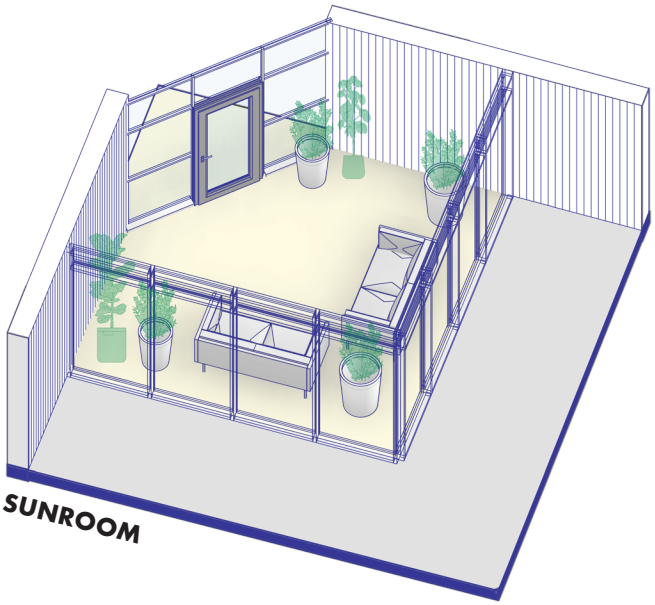
The resident suite is an adaptable, warm space designed to support privacy and dignity at the end of life. Ample natural light is provided through the skylight and window box, with views of the private pergola and gardens beyond. The pergolas feature a birdhouse and are flanked by trellises for privacy from adjacent suites. Patient

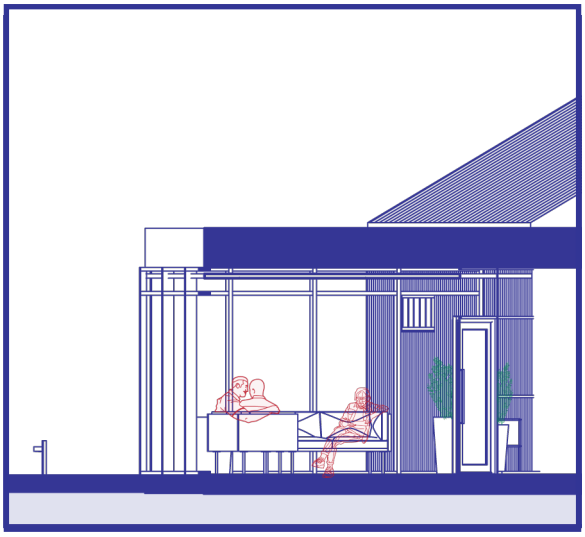



beds can be moved directly outside under the pergola, where roll-up blinds are also available for additional shading. The suite offers multiple surfaces for displaying personal artifacts and customization of space. Visitors can also be accommodated for overnight stays with modular furniture and additional support spaces elsewhere in the building. Although of course accessible from the interior of the residence wing, the primary entrance for the resident is from outside, where they can be dropped off directly to their suite from the on-site ring road. This entrance acts as a symbolic final threshold, where it is both the doorway they first enter through and the one through which they will eventually depart.

## FIGURE 9.30 SUNROOM



**SECTION 1:100**

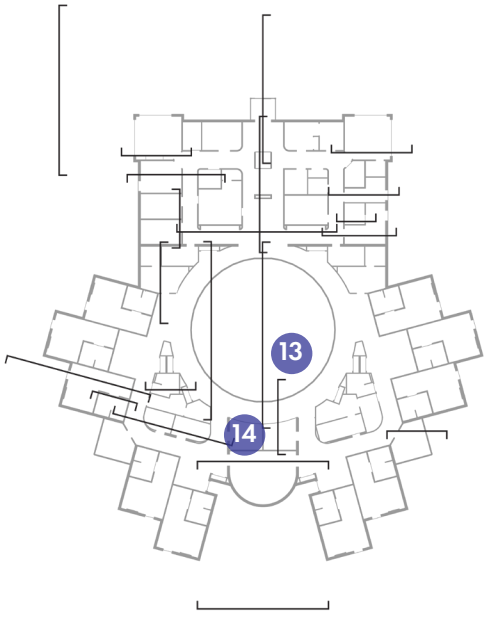
Both sides of the residence wing feature sunrooms where residents, visitors, and staff can spend time in a bright, restorative space. The sunrooms are alternative gathering spaces outside of the resident suites where occupants can spend time together or in solitude, offering comfortable seating and warm ambiance with views of the expansive landscape.

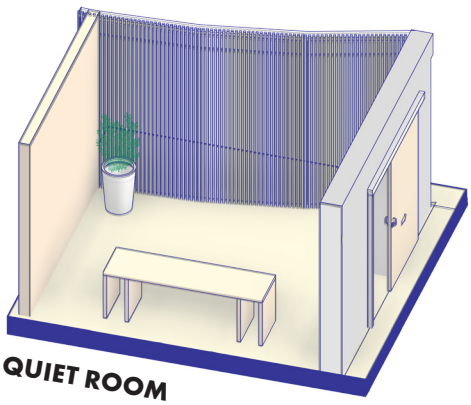
## FIGURE 9.31 QUIET ROOM



**SECTION 1:100**

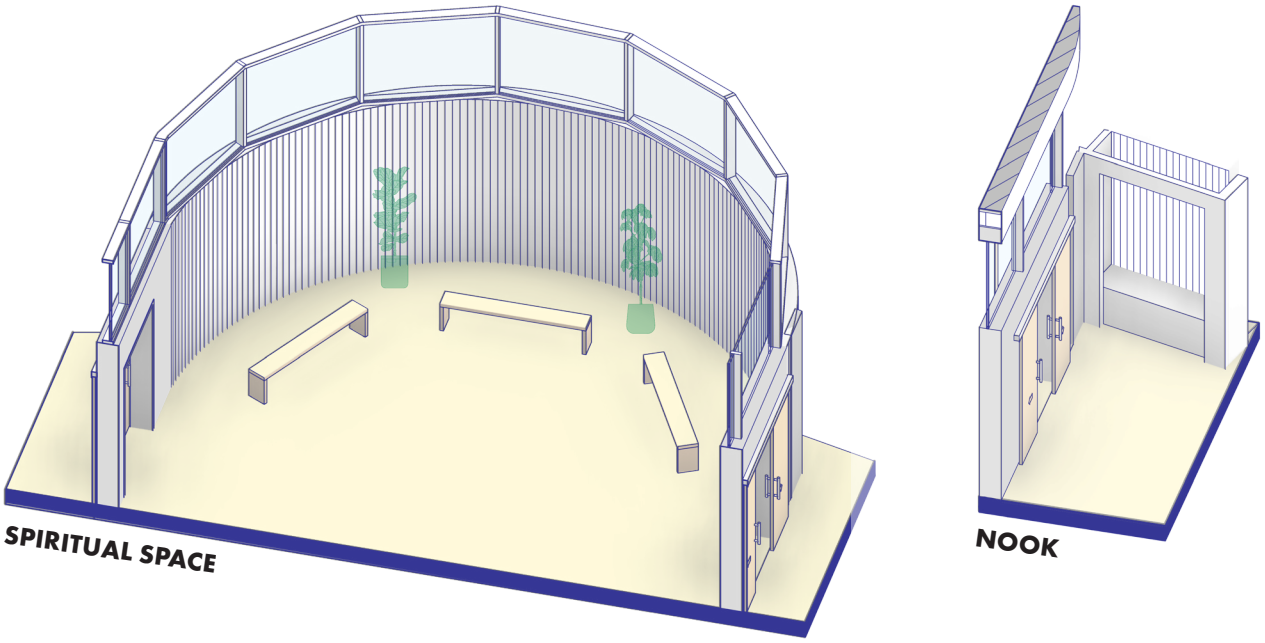
Located adjacent to the spiritual space, quiet rooms are private, soundproof spaces for reflection or moments of solitude. Minimally furnished, the quiet rooms face into the walking path and sensory garden, where nature and moving figures can be seen through glimpses between the wood privacy screen that lines the wall. The quiet rooms can also be used as additional counselling spaces, where conversations can be held privately in a calm space.



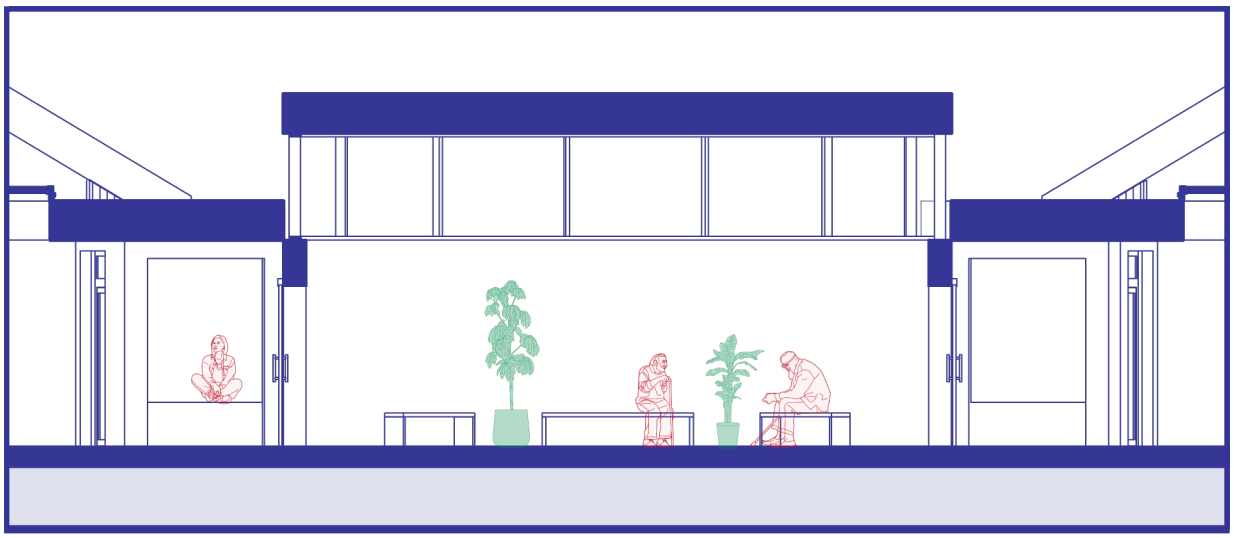



QUIET ROOM

## FIGURE 9.32 SPIRITUAL SPACE

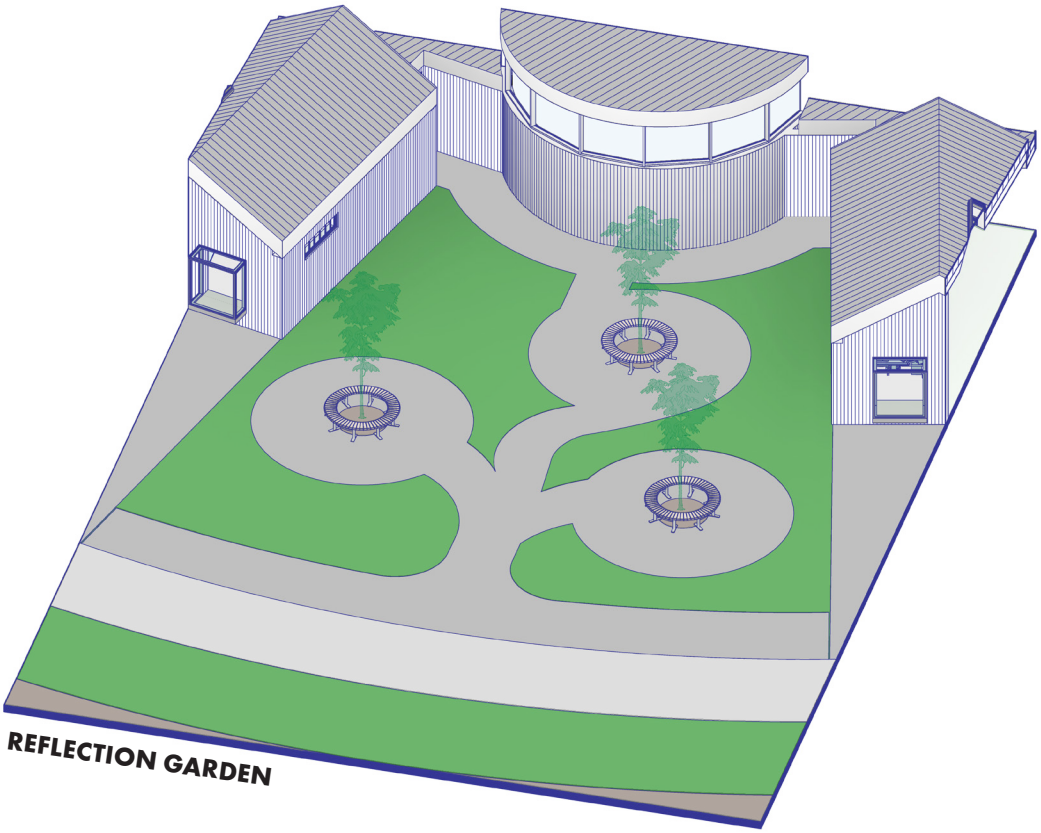



The spiritual space is designed to serve as a sanctuary for meditation, prayer, or reflection, for occupants of all faiths and belief systems. The spiritual space is located along the main axis of the building, acting as a vertex where both sides of the residential wing connect. The entrances to the space are flanked by nooks to offer waiting space for occupants. This calm and open space is minimally furnished with benches that can be rearranged to suit the needs of the hospice occupants, like for a wedding or ceremony. Natural light fills the space through the wall-to-wall windows located high on the wall, where views of only the sky can be seen.

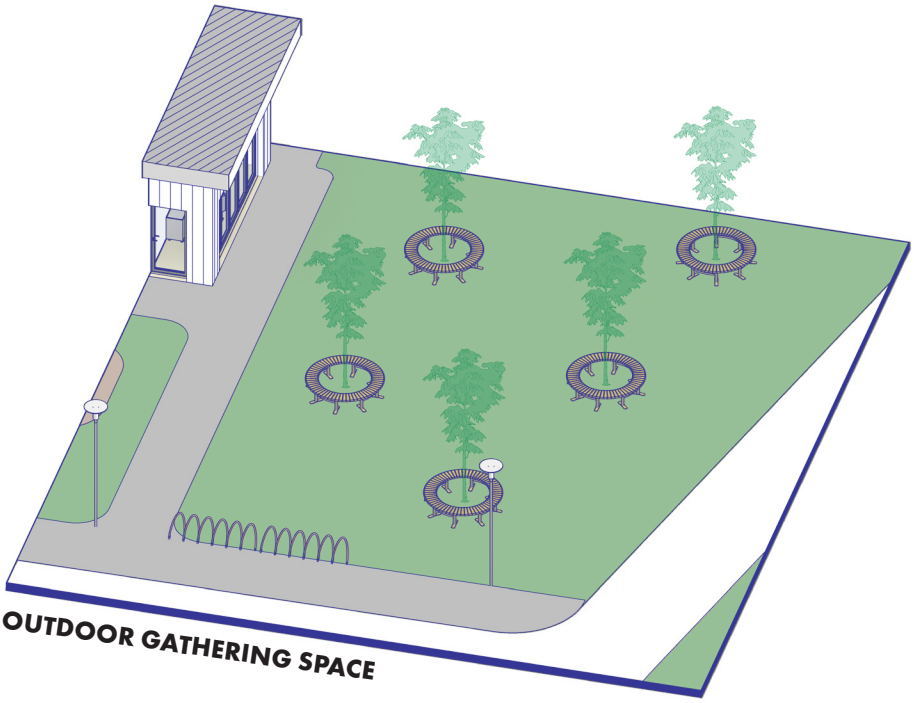


**SECTION 1:100**

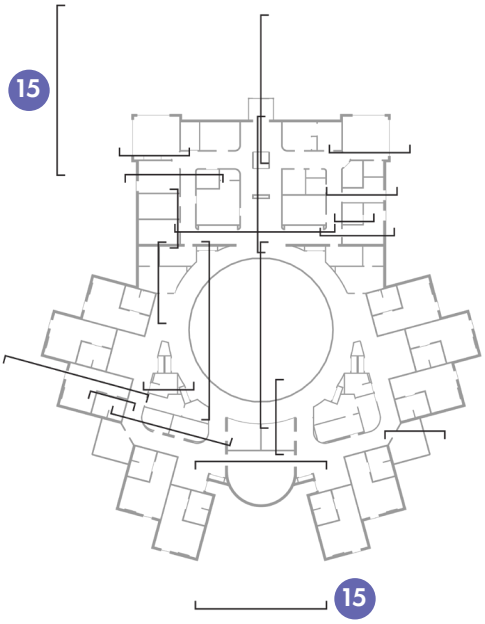
## FIGURE 9.33 OUTDOOR GATHERING SPACES

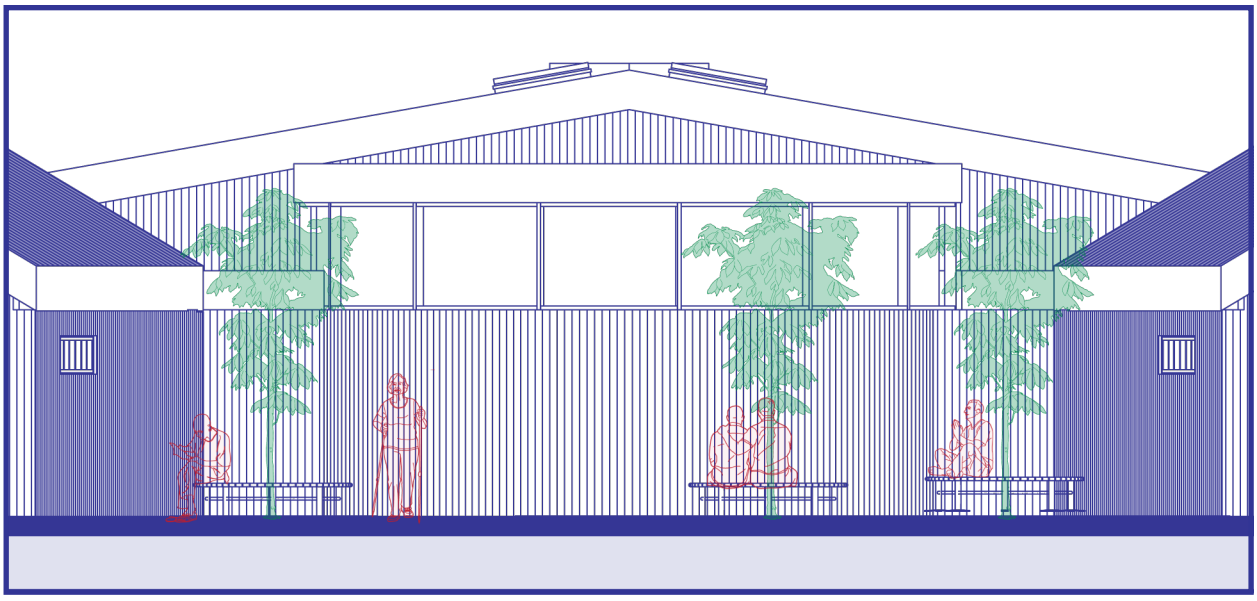


REFLECTION GARDEN



OUTDOOR GATHERING SPACE





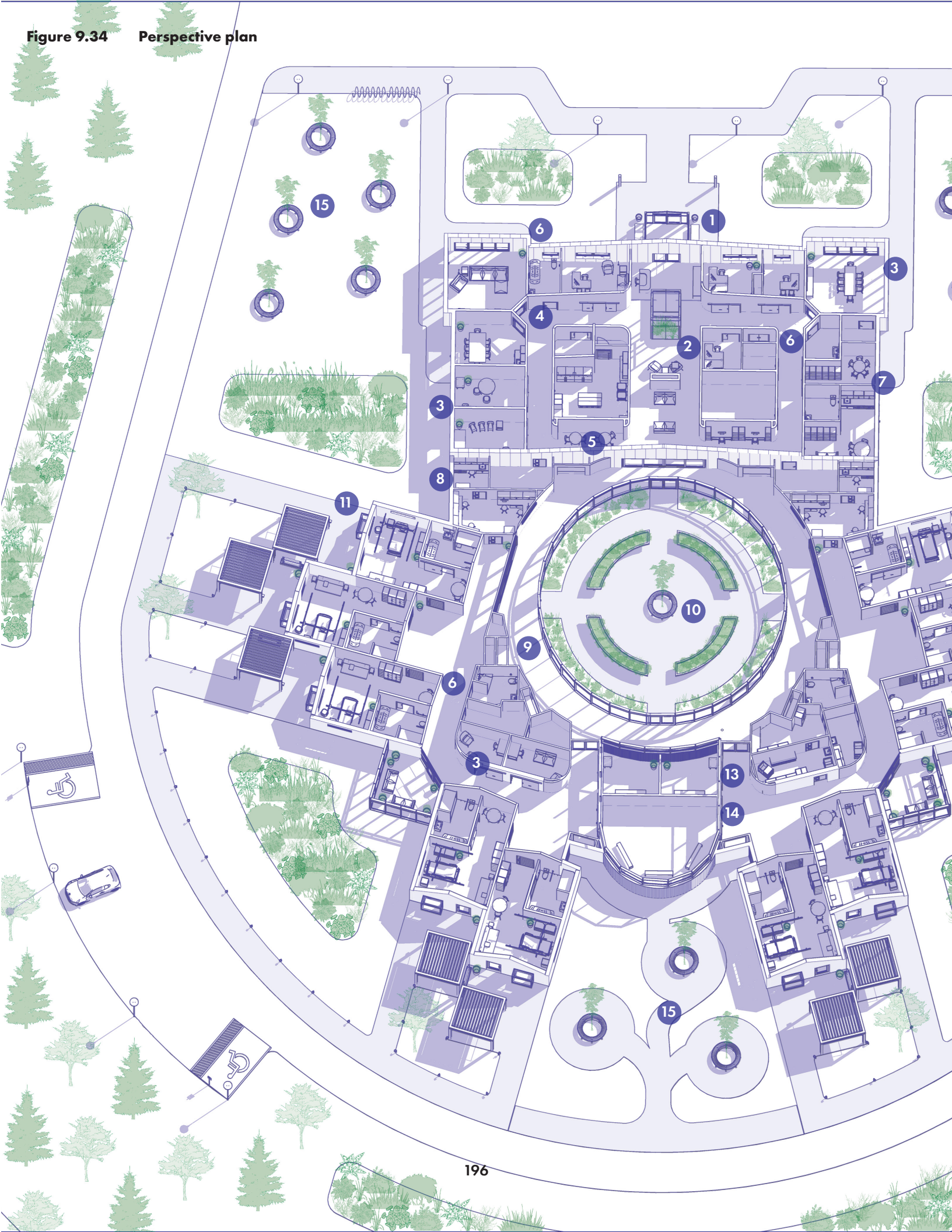
**SECTION 1:100**

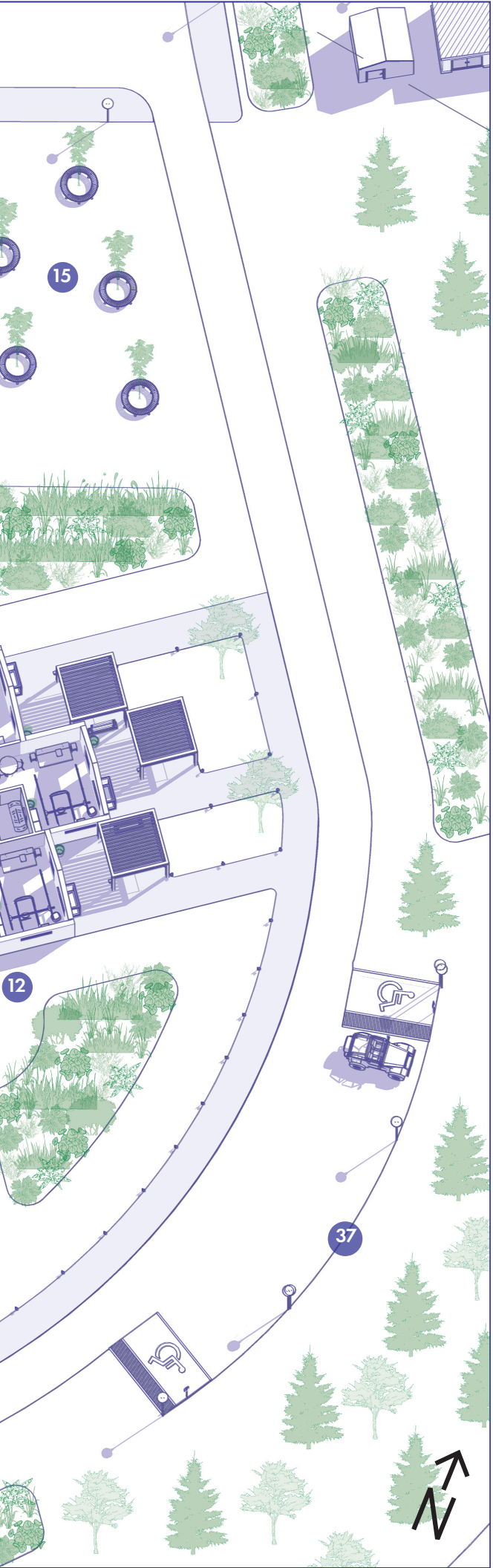
The gathering spaces on either side of the care center and the reflection garden behind the spiritual space are extensions of the indoor space, where occupants can immerse themselves in nature either in solitude or in community. Those looking for quiet reflection can spend time in the reflection garden whereas the front gathering spaces encourage social interaction.



**SECTION 1:100**

**Figure 9.34** **Perspective plan**






Each of the spaces in the kit of parts focuses on spaces that most directly shape each occupant's experience within the hospice. These key program areas are designed with the understanding that thoughtful, intentional design at the scale of the room can profoundly influence comfort, dignity, and connection.

1. Main entrance
2. Waiting spaces
3. Therapy rooms (group, offices, and art/music therapy)
4. Family gathering spaces (pantry/dining, living room)
5. Care center alcoves
6. Washrooms
7. Staff rooms
8. Nurse's station & med room
9. Residence Nooks
10. Sensory garden
11. Resident suite
12. Sunroom
13. Quiet rooms
14. Spiritual space
15. Outdoor gathering spaces (meditation garden, front gathering space)



**FIGURE 10.1 EXTERIOR VIEW OF DESIGN PROPOSAL**

# 10. CONCLUSION

Driven by the understanding of design as a human-centered discipline, this thesis presents a holistic design approach for hospice that incorporates evidence-based design to support the embodied experience of occupants. The reciprocal relationships between humans and their environment can be supported and nurtured to provide a sense of comfort through the smallest of details, like having a view of a tree out of one's window. Architects have the opportunity to shape these moments of connection and create spaces for meaningful interactions through thoughtful building and landscape design. Seeking to understand the nuanced needs of palliative patients, their loved ones, and care providers gives insight into how key spaces can be enhanced to better support them.

Through building a foundation of understanding the human experience at the end-of-life combined with evidence-based design research; a holistic design approach for hospices was established. Cataloging the existing diverse network of hospices in the province yielded great insight to varied design approaches, further enriched by case studies and field work interviews and tours to provide a first-hand experience in this context. The design proposal seeks to apply this holistic approach to explore possibilities for hospice and identify key design considerations and spaces that contribute to a better supported occupant experience at the end-of-life. All people deserve to have a comfortable and safe environment where they can live out the rest of their lives, knowing that the people they leave behind will have support to continue moving forward in a community that cares.

Community is fundamental to the establishment and sustenance of hospice residences. Within the space, communal spaces (mainly for visitors) create opportunities for engagement and compassion - communal dining, living spaces, gardens, reflective spaces - between all occupant groups. The creation of the space is driven by the community. There is a reciprocal relationship between hospices and their communities, where

hospices depend on community support to in return provide accessible, compassionate care to palliative patients and their families. Incorporating opportunities for community engagement through design can further strengthen this relationship, embedding the hospice in the community's identity.

Reflecting on the role of designers in spaces of care, field work interviews reveal the collaborative design approach needed for successful, high-quality design that meets the needs of the community in which the hospice is situated. As discussed, the current design standards and requirements governing hospice space are rather limited and serve as a minimum standard. While referencing other spaces of care can be a source of inspiration, to avoid the generic, institutional design it is important to understand what the needs and desires for the space are from the people who will be using it. One hospice director described their search for an architect that understood their vision of the space:

> *We really liked [them]...because [they] spoke to what we were trying to achieve [they] spoke to the feel of the space...[They] understood the vision...I think what made it such a successful partnership was [they were] really interested in understanding what the work was and what we were trying to create, and then [they] would build something around that, instead of coming in and saying I've got this building and I will just adapt it to what you're going to try to do.*[1]

To truly measure the success of a design, architects should embrace a *post-occupancy evaluation* process, where feedback is collected from occupants after they have spent some time in the space and have a sense of what elements are successful and areas for improvement. Reflecting on the design in this way not only gives insight to the architect about areas in need of further design development, but also improves their understanding of spatial needs for their next project. Such was the case with this architect-client relationship, where the architect continued to work with the hospice to develop spatial solutions for challenges identified

1 Hospice Care Provider, Fieldwork Interview – Hospice Waterloo Region, May 31, 2024.

through functional use of space. While post-occupancy evaluation is not an option for the conceptual design phase, the field work interviews in a sense provided similar-type feedback about the case study hospices in Waterloo region, which was then incorporated into the design approach – like having an open pantry space, or birdhouses outside of resident suite windows, incorporating lots of natural light, and ensuring acoustic privacy for sensitive conversations.

While the current research focuses on a provincial context, design considerations and the holistic approach could be further enriched by more in-depth architectural analysis of additional hospices, as well as expanding the scope of research to national perspective. The kit of parts acts as a basis for understanding the key spaces that contribute to specific occupant needs and experiences in hospice and could continue to be developed into a design guideline with more detailed spatial development, as well as exploring applications of the design approach through adaptive-reuse projects. Considering the exponentially growing network of hospices in Ontario, that still sits below the minimum standards for accessible palliative care, imagining possibilities for adaptive reuse hospices to be integrated into every neighbourhood, allowing people to spend their final days in a caring environment close to home.

Ultimately, this thesis demonstrates the importance of a compassionate, human-centered design approach, considerate of varied lived experiences and spatial needs of occupants. This approach can extend beyond hospice to inform other spaces of care, emphasizing the responsibility of architects to design with empathy, intention, and respect for the people their design serves.

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# APPENDIX

**FIELD WORK OVERVIEW:**

May 22, 2024 – Innisfree House
May 23, 2024 – Lisaard House
May 31, 2024 – Hospice Waterloo Region

Field work was conducted during my M3 term, where I was able to visit all three hospice residences in Waterloo Region. The aim of this research is to investigate how hospice residences in Ontario, particularly looking at regions with multiple residences – like Waterloo region, are designed to meet the nuanced needs of the communities they serve. By focusing on key functional program areas, circulation and adjacencies between spaces, and design details that make cultural and geographically specific connections to the community that the hospice residence serves, this study aims to propose best practices and design considerations for hospice residence design in Ontario. This research also aims to advocate for the role of designers in spaces of care, emphasizing the impact of design on quality of life for occupants and efficacy of care.

This study was approved by the Human Ethics Board at the University of Waterloo. Following a tour of each building, I sat with a group of care providers and discussed the following questions:

1. *What is your role in the hospice and what are the key spaces you interact with as part of your daily job duties?*
2. *What are the key functional program areas within hospice residences, and how do they contribute to the overall user experience for both staff and patients?*
3. *Particularly focusing on the environments that facilitate their work, how do staff members perceive the spatial organization of the hospice residence?*
4. *What atmospheric qualities - like light, colour, sound, material, or smell - stand out in the residence or are notably impactful on the resident and visitor experience?*
5. *Can you identify any challenges in the residence that impact either spatial functionality or experience? For example, not enough storage, too many steps between nurse's station and patient room, not enough natural light, etc.*