



PURPOSE **CASE**
BUILT **STUDY**

Marymount University Hospital and Hospice

This center applied patient-centric design and created a welcoming environment to offer high-quality and dignified care, demonstrating a model for hospices in the Republic of Ireland.

Executive Summary

Organization

Marymount University Hospital and Hospice

Location

Cork, Ireland

Project Type

New construction

Opening Date

2011

Project Area

12,000 square meters (129,167 square feet)

Project Cost

€57.7 million

The Atlantic Philanthropies Investment

€10 million (\$11.8 million)



Marymount University Hospital and Hospice is the sole provider of specialist palliative and elderly care in Cork, Ireland. It provides high-quality health care services for people with life-limiting illnesses, helping them to live with dignity in the context of their illnesses. Today, Marymount serves a population of approximately 600,000 people in County Cork.

Since its founding in 1870, Marymount was housed in a traditional brick Victorian building located in an urban area north of Cork City. By the 1990s, however, an aging population and a national increase in cancer patients escalated the demand for palliative care across Ireland, and the existing facility was limiting the organization's ability to fulfill its patient-centric mission. Following a 2001 government report mandating an increase in the number of palliative beds required per geographic area each hospital served, Marymount began the process of planning a new capital project.

Marymount's initial plan was to expand within its existing site. However, a decision was made to move all of its services to a new facility in a greenfield site on the edge of Cork City. With support from the Health Service Executive (HSE) of Ireland, the Friends of Marymount, and The Atlantic Philanthropies, Marymount opened its new 63-bed elderly and 44-bed palliative care facility in 2011.

The capital project has had a dramatic, positive impact on Marymount's ability to fulfill its core mission. The building allowed Marymount to double the size of its palliative care services. The project's focus on patient-centric design resulted in high-quality private rooms and public spaces as well as increased access to natural landscapes and daylight—transforming the health care experience for patients and family members. Furthermore, the building helped

to establish Marymount as a national leader in hospice design and attracted attention from hospice leaders in Europe and the United States.

At the same time, the capital project has also contributed to financial strain for Marymount. The organization's decision to abandon its initial, more modest expansion plan in favor of a new site and facility (a decision encouraged by Atlantic) significantly expanded the scope of the project. Marymount began operating the new facility with debt incurred due to a variety of factors: the rise and fall of the Celtic Tiger economy; decreased financial support from the HSE; changes in government service contracts that carried new financial risks; overruns in construction expenses; higher than anticipated costs for ongoing facility operation and maintenance; and increased staffing needs. This financial strain has been partially alleviated through Friends of Marymount contributions and continued fundraising, but the organization is still struggling to balance patient care with its staffing model and operating costs. While the building in many ways successfully achieved its intended design goals, these factors have created financial and operational pressures that are inhibiting Marymount from amplifying its organizational mission to the full extent desired through this capital project.

This case study is based on research conducted by MASS Design Group in May 2015. Funded by The Atlantic Philanthropies, this case illustrates how a capital project can support staff in providing patient-centered, dignified, and compassionate care. It also demonstrates the importance of aligning expanded facilities with an organization's operating model.

Purpose Built Series

Capital projects often bring lasting benefits to nonprofit organizations and the people they serve. Given this opportunity, foundations grant more than \$3 billion annually to construct or improve buildings in the United States alone.ⁱ Each capital project affects an organization's ability to achieve its mission—signaling its values, shaping interaction with its constituents, influencing its work processes and culture, and creating new financial realities. While many projects succeed in fulfilling their purpose, others fall short of their potential. In most instances, organizations fail to capture and share lessons learned that can improve practice.

To help funders and their nonprofit partners make the most of capital projects, The Atlantic Philanthropies and the S. D. Bechtel, Jr. Foundation commissioned *Purpose Built*—a multi-faceted study by MASS Design Group, a nonprofit architecture and research firm. In 2015 and 2016, MASS conducted interviews, reviewed literature, and examined a diverse set of completed projects around the world; each project was supported by one of the above funders.

The study generated a set of core principles as well as tools for those considering or conducting capital projects:



Introducing the Purpose Built Series is an overview of the study and its core principles.



Making Capital Projects Work more fully describes the *Purpose Built* principles, illustrating each with examples.



Planning for Impact is a practical, comprehensive tool for those initiating capital projects.



Charting Capital Results is a step-by-step guide for those evaluating completed projects.



Purpose Built Case Studies report on 15 projects to illustrate a range of intents, approaches, and outcomes.

See the full *Purpose Built* series online at www.massdesigngroup.org/purposebuilt.

ⁱ Foundation Center, *Foundation Maps* data based on grants made in the United States, 2006-2015.

“[This project] has changed my therapeutic relationship with people, because I now walk into their space—as opposed to them occupying a corner of mine. And that’s very powerful.”

—Clinician, Marymount University Hospital and Hospice



Above. Women take advantage of new day room space to meet with one another.
Cover. An exterior view of the Marymount University Hospital and Hospice.

Introduction

Marymount University Hospital and Hospice is a palliative and elderly care facility in the Republic of Ireland. Palliative care responds to physical, psychological, social, and spiritual needs for patients and their families at a time when a cure is no longer a medical expectation. Its goal is to provide the highest possible quality of life for both patients and families.¹ Founded by the Sisters of Charity, hospiceⁱⁱ care at Marymount was historically perceived as a “Home for the Incurables” where patients’ conditions had progressed to an advanced stage.

From 1870 until 2011, Marymount operated out of a traditional brick Victorianⁱⁱⁱ building on Wellington Road, adjacent to a convent in the urban area north of Cork City. The three-story building had one floor of hospice care, two floors of elderly care, and 24 beds in

ii “Hospice” or “hospice care” will be used interchangeably with “palliative care” in this case study.

iii “Victorian” refers to a period of architecture—constructed during the mid- to late 19th century—that is classified by its reference to Greek and Gothic architectural styles. Typically, Victorian architecture aimed to exhibit prestige and status through ornament and ecclesiastic motifs.

its inpatient unit. Today, Marymount is the sole provider of specialist palliative care in Cork County, extending services to the surrounding counties of Kerry, Waterford, Kilkenny, and Tipperary to serve a total population of approximately 600,000 people. The mission of the organization states, “In providing excellent care, we cherish the uniqueness and dignity of each person, showing compassion and respect. We strive for quality and integrity in all we do.”

A RISING NEED FOR MORE CAPACITY

Throughout the 20th century, vocations in the church decreased, health care provision transitioned to private facilities and government-supported service, and Ireland’s elderly population increased 70 percent from 1961 to 2011.² To respond to this increasing need, the Department for Health and Children established the National Advisory Committee in 1999 to examine palliative care in Ireland. This investigation resulted in the 2001 “Report of the National Advisory Committee of Palliative Care” (NAC Report). The NAC Report concluded that an aging population, the rising prevalence of chronic diseases, and a need to extend palliative care services to patients with illnesses other than cancer would together exacerbate Ireland’s existing shortage of palliative care beds over the coming decades. Following its publication, the report was adopted as government policy to inform the development and provision of palliative care in the Republic of Ireland. This response included

a series of recommendations, including increasing the required minimum number of palliative beds per area served.

Due to the limited space and aging infrastructure of its existing facility, Marymount was finding it increasingly difficult to achieve its mission, and these new government requirements provided more incentive to expand its scope. The new policy required Marymount to increase its number of beds in its palliative care inpatient unit to 44—nearly double the accommodations at the time—in order to serve the Cork County population. Years prior to the policy implementation, the physical capacity at Marymount had been inadequate to meet the needs of the area, and it frequently had waiting lists. One nurse recalled that waiting patients would often never be admitted to Marymount, either from being too sick to relocate or passing away by the time space became available.



Above. Marymount's original facility was a traditional brick Victorian building, built in 1870.

CHALLENGES TO PROVIDING QUALITY CARE

In addition to not meeting the demand for palliative care services in the region, the almost 150-year-old facility was challenging Marymount's desire for patients to be able to live full lives in the context of their illnesses. While patients and families reported that the staff members were resilient in maintaining dignified and compassionate care, the old building simply did not support the efforts or ability of the staff, and often hindered the quality of care that was possible.

One obstacle preventing Marymount from delivering the best quality care was the lack of privacy provided by the spatial layout. The facility utilized Nightingale wards^{iv}, large open rooms with multiple patient

iv Named after modern nursing pioneer Florence Nightingale, a Nightingale ward typically accommodates between 28 and 40 patients. The Nightingale ward was standard in hospital design from the late 19th century to the early 20th century.

beds, shared restroom facilities, and provisions for natural ventilation and lighting. The wards provided little privacy for those with deteriorating physical conditions and made it difficult for patients to have sensitive or personal conversations with staff or family members. One nurse recalled that “in the ward, you might pull the curtains and make sure you’re one-on-one with a patient, but others can [still] hear what you’re saying.” Another doctor commented that “sometimes the only privacy [that patients experienced] was because it was too noisy to overhear another family’s conversations.”

The shared bathrooms also created challenges for patients who might prefer discretion related to certain intimate issues, such as a malodorous condition. One nurse even suspected that the adjacency of the shared toilets to the wards likely caused frequent constipation among the patients, exposing them to even more severe pain and ailments along with psychological stress. Family members wanting to spend time with their dying relatives had to find places to sleep between patient beds and had few spaces to find respite on the campus. Similarly, many of Marymount's critical administrative and community care programs were cramped in small, overcrowded offices, which were not conducive to staff productivity and efficiency.

The design limits of the original facility made it difficult for Marymount to connect with the surrounding community and overcome its moniker as a “Home for the Incurables.” Nurses and community members reported that this perception resulted in some potential patients preferring to remain at home rather than be admitted to the building to receive treatment out of apprehension or fear of the place.

Project Mission

Since the Marymount building limited staff members' ability to provide dignified and comforting care, the board and management began to envision an infrastructure upgrade that would raise the quality of the facility to match and support the quality of its services. The former CEO of Marymount, Kevin Dwyer, summarized the need for the capital project, saying, “It was easy to fool ourselves that this is great, that we were doing a great job. But we knew that there was a much better service that we could be doing . . . The care was good, but there [was] no dignity in that. So that's what drove the dream.”

As the proposal developed, however, project leaders recognized further opportunity for the new building to achieve more than Marymount's immediate needs. By providing educational spaces, the building could encourage more interaction with local affiliates. In addition, Marymount had the potential to act as a model for future

hospices across the world as the first building constructed to meet the Republic of Ireland's new guidelines for palliative care.

Process

SHAPING THE PROJECT VISION

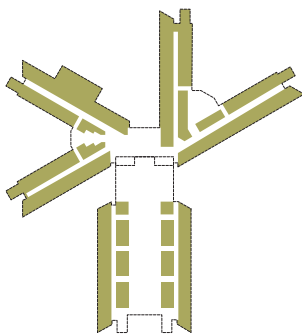
As early as 1997, Marymount began developing plans for a new capital project to meet its needs. In 2001, the Irish government committed to supporting the project through its Health Service Executive (HSE). Marymount formally established a project team that took responsibility for shaping the vision for the new facility. The team included three members from the staff (the CEO, the Consultant in palliative care, and the director of nursing), as well as representatives of the Sisters of Charity, the Friends of Marymount, and the HSE. The project team supplemented their knowledge and expertise by engaging the hospital's doctors, nurses, and support staff to solicit their thoughts and opinions regarding the design of the new building. As one project team member remembers, "We just brought groups together. Everybody got the opportunity to attend, [and we] asked them what they felt should happen. They came up with a lot of very good ideas."

By 2003, the project team had drafted a design brief and identified a site for the new building adjacent to the existing facility on Wellington Road. In this proposal, they planned to build a new purpose-built Specialist Palliative Care (SPC) facility and renovate their existing facility to house their growing elderly care services. The project was estimated to cost €35 million, and the HSE committed to paying for half the costs (€17.5 million).

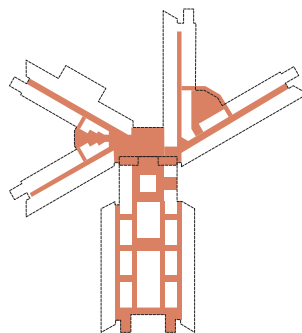
EXPANDING THE PROJECT VISION

As the project process unfolded, it became apparent that Marymount could set the standard for future hospices in the country. The government released Design Guidelines for Specialist Palliative Care Settings in response to the NAC Report's recommendations for palliative care services. According to one consultant, these guidelines fell short of fully providing dignified spaces, as they only required that 50 percent of patients be accommodated in single-patient rooms.³ As Marymount's new facility would be "the first hospice in the country [since the adoption of the NAC Report] to be built in collaboration with the [government]," the building could be leveraged to stand as a model of palliative care in the Republic of Ireland, and potentially influence the international palliative care community.⁴

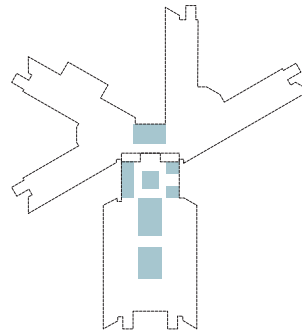
The local project team reached out to The Atlantic Philanthropies, which had been making grants in the Republic of Ireland since 1987, and had recently turned its attention to ensuring quality of life and care for the country's aging population. Atlantic decided to support Marymount with a grant in order to assist the Department of Health and Children with accelerating the implementation of the NAC Report and ensure that new facilities would be based on best practices. This grant would align Marymount's project proposal with current international best practices and serve as a template for future planning and development of SPC units and services.⁵ The grant team assembled an advisory group, comprised of leading international experts in various aspects of palliative care, to implement all aspects of the Irish national policy for palliative care as defined by the NAC report.⁶ This group created the "International Expert Advisory Group Report" in 2005, which informed the design brief for the hospital and intended to raise the bar that was set for hospice facilities by the government. These guidelines reflected an increased attention to dignity of the individual, recommending that Marymount's new facility, among



Private vs. Public



Circulation

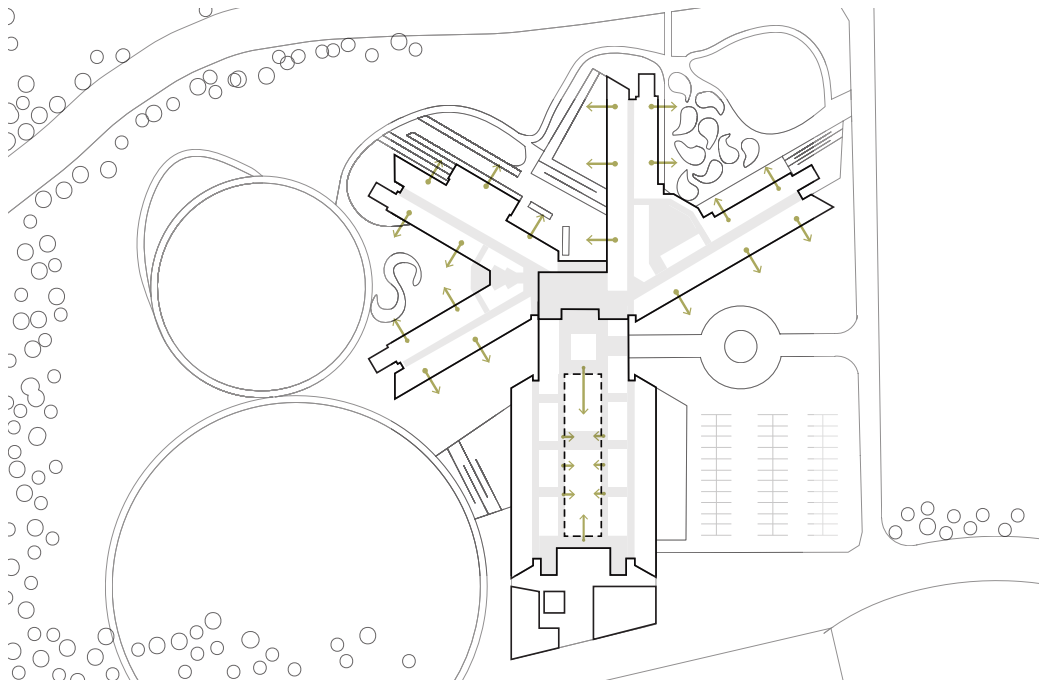


Atriums

Left. Private spaces are distributed along different axes in the building.

Middle. Circulation in the building leads to shared spaces at the nodes of the ward axes.

Right. Multi-story atriums help to bring and distribute natural light throughout the facility.



Left. The design of Marymount's new facility intended to maximize a connection to the outdoors with views from private spaces and internal atriums designed to bring daylight into the building.

Below. The site of Marymount's building, outside of Cork City, offers balconies that overlook agricultural fields and grazing livestock.



other things, provide all patients in palliative care settings with single rooms, private bathroom facilities, and direct outdoor access.

The HSE, Marymount’s primary capital project funder at the time, was reluctant to commit to the cost of a facility set to implement these high standards, knowing it would need to support other future hospices and hospitals across the country as well. The HSE pushed back on the recommendation to provide all single patient rooms, arguing that it would suffice to provide half this amount. During these discussions, Atlantic—which had developed a positive reputation in Ireland because of its continuing commitment to higher education—helped advocate on Marymount’s behalf for a commitment to the guidelines, eventually convincing the HSE to agree to adhere to the new standard.

In addition to the support for the advisory group, Atlantic expressed willingness to provide the capital project with a grant of €8 million. Soon after this initial agreement, Chuck Feeney, the founding chairman of Atlantic, visited Marymount for a tour. After seeing the existing facility and the proposed site for expansion adjacent to the convent, Feeney expressed concern that the site would limit the space, quality, and future growth of the facility. Feeney suggested that Marymount consider moving its services to a greenfield site^v. Knowing that this move would result in a larger project and a larger budget, Atlantic provided support to conduct a feasibility study of current and possible sites and offered to increase its grant by €2 million, contingent on Marymount moving to a new location.

Marymount decided to abandon its initial, more modest expansion plan in favor of a new site and facility . . . [which] would ultimately increase the original budget by about €23 million.

Although Dwyer recounts that Marymount was initially taken aback by the suggestion to relocate, the team agreed to undertake the feasibility study. The results indicated that the current site indeed would be unsuitable for a number of reasons, most notably, extensive excavation would be expensive and limit the ability of the hospital to function with minimal disruption, the elongated site would compromise efficient pathways among hospital programs, and the site could not accommodate necessary parking or other modes of transportation. Additionally, a financial analysis conducted by

v A greenfield site refers to a parcel of land that is previously undeveloped and which might be slated for commercial use or development.

McAvoy Associates at the height of the Celtic Tiger^{vi} period showed that the existing hospital and property could be sold for over €10 million. The analysis also revealed that with the HSE’s committed funding of €17.5 million, Atlantic’s total of €10 million of funding, and a strategy for attracting large gifts from the corporate sector, Marymount could build a new hospice and elderly care facility “for the same amount of local [fundraising]” raised by the local community, represented by the Friends of Marymount.

In the fall of 2004, with the information provided through the feasibility studies, Marymount decided to abandon its initial, more modest expansion plan in favor of a new site and facility. In addition to relocating the palliative care services, the hospital administrators decided to move elderly care to the new site as well. With the change in site, expanded project scope, the Expert Report from the advisory group, and influences from international hospice precedents, Marymount revised the design brief. The new goal for the building included a 44-bed inpatient unit for specialist palliative care and a 63-bed inpatient unit for elderly care.⁷ It also sought to include space for additional programs recommended in the Expert Report such as a day-care unit for outpatient care and spaces for bereavement and family support services, spiritual services, a pharmacy, education center, and administrative offices. This expanded project scope would ultimately increase the original budget by about €23 million (the budget grew from €35 million to €57.7 million over the course of the project).

DESIGNING FOR DIGNITY, COMPASSION, AND SUPPORT

The new hospital and hospice was designed to advance Marymount’s core values of dignity and compassion and to set a new standard of design quality for hospices throughout Ireland. In order to achieve this mission advancement, the project team prioritized patient-oriented design strategies that focused on each individual person and on supporting the care that he or she would receive both at Marymount as well as in its home-care settings. In the hospital and hospice, the design included large, comfortable single patient rooms with en suite bathrooms, a floor plan that maximized views and access to the exterior, spiritual and psychological daily care spaces (e.g., an oratory and space to host music and arts activities), and a “home-like” quality to building finishes.

Additionally, the project team incorporated design elements that would support staff and family care for patients in the hospital. They implemented technologies for staff members that would support interactions with patients (such as ceiling hoists in the patient rooms), centralized nursing stations at the axis of the patient wings, and

vi The “Celtic Tiger” refers to a period (from the mid-1990s to the mid-2000s) when the economy in Ireland experienced an economic boom. This period ended with the global recession in 2008.

added and expanded office spaces. For family members, space would be provided to accommodate pull-out beds in the wards themselves, and there would be a wing for “hoteling” family members. The building’s programming would include educational spaces to host conferences and events, allow teaching and learning opportunities for outside affiliates, and support community-based care providers. The design team additionally pursued sustainable technologies intended to reduce long-term operational costs and respond to growing global concerns regarding the environment. While the design would elevate the quality of care and care-provision overall, patient-centric design was prioritized over staff or organizational interests.

Guided by the new standards and the 140-page design brief, Scott Tallon Walker—in partnership with Jane Darbyshire Architects^{vii}—completed the design and construction documents for the new building in 2008. Based on these documents, the Quantity Surveyor (QS)^{viii} estimated the construction costs at €57.4 million.

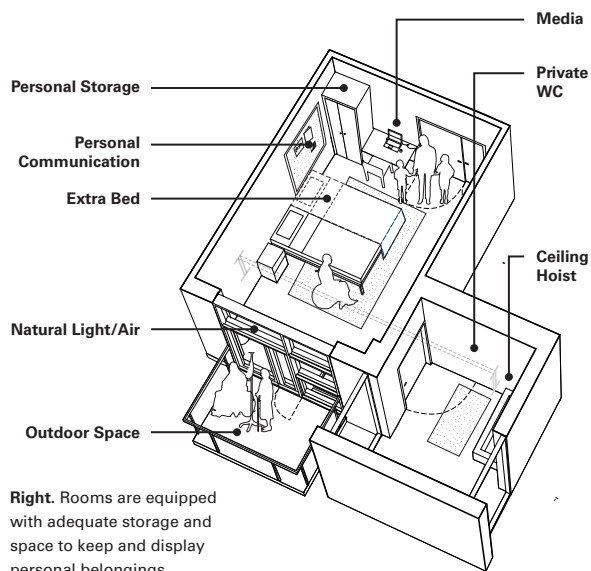
RESPONDING TO NEW GOVERNMENT CONTRACT REQUIREMENTS

The conditions and timing of the construction process for Marymount created challenges, some of which could be foreseen and others that could not be anticipated. For instance, Marymount was the first project subject to a new government procurement process established in 2007. The new form of contract was created in large part as a response to cost overruns of large public infrastructural projects from 2002 to 2005, for which the government assumed fiscal responsibility. The new contract shifted the burden of responsibility and the risk of cost overruns to the contractor, and since the hospital had partial government funding, the hospice project was subject to this process. Whereas an assumption for this type of contract is that a contractor might include a contingency to absorb unexpected risks, because of the recession, contractors were drastically cutting costs and underbidding projects in order to win jobs and stay in business.^{ix} The lowest bid, submitted by the international construction company Rohcon (now BAM Building), came in at €37.4 million—well below the original estimate by the QS. As one respondent noted, “the timing of this new contract couldn’t have been worse [for the project]”

vii *This practice is now known as Jane Darbyshire & David Kendall Ltd.*

viii *A quantity surveyor uses construction documents to develop a list of materials, labor, and equipment in order to calculate the cost necessary to complete a capital project. In the United States, this task is completed by a cost estimator or a cost engineer.*

ix *As evidence of the difficulty finding and keeping work at the time, out of the eight contractors who were short-listed for the project, five have since gone out of business due to the recession.*



Right. Rooms are equipped with adequate storage and space to keep and display personal belongings.

because of the 2008 recession.

According to one respondent, this context “all but ensured that a contentious relationship would develop [between Marymount and BAM Building].” The perspective of some project team members at Marymount was that BAM aimed to make back their losses from underbidding the project by submitting over 1,000 claims during the course of construction. From the contractor’s perspective, the risk structure forced the contractor to submit claims to rectify errors or else it would forgo compensation, even when the fault was not its own. Cost increases due to claims grew beyond contingency amounts allotted for the project.

ADJUSTING TO FINANCIAL SETBACKS

In addition to cost overruns during the construction phase, new national requirements for fire safety and standards for elderly facilities were imposed after the project was already well into construction. Although the design documents had previously been approved and construction was already underway, this complication required changes to the building before it could open, increasing project costs. In the end, the construction totaled €43.5 million including value added tax; this was approximately €6.1 million over the projected cost submitted by the construction company.

The 2008 recession also caused the value of the old facility north of Cork, which was to be sold to help pay for the new building, to depreciate steeply from its previous valuation between €10 and €12 million. By the time construction was underway, the value of the property was so low (approximately €2 million) that Marymount



Top. The staff members at Marymount report that the new facility has improved the nature of their interactions with the patients.

Center. Large central atriums are designed to connect the floors visually and to bring light into the center of the building.

Below. Patient rooms at Marymount are 25 square meters, with generous space for visitors. Here, a visitor takes advantage of the private balcony to appreciate the landscape.



decided not to sell the building, and instead leased the facility to a local college. Although the organization met its initial fundraising target for local community contributions via the Friends of Marymount, it only raised a little over €1 million from local businesses—€5 million less than anticipated. Additionally, in the years following the project’s inception, the HSE reduced the programmatic and staff funding that supported Marymount’s ongoing operating costs. These funding cuts continued after the building was opened.

Together, these factors placed Marymount in a vulnerable financial position—the organization took on significant debt, approximately €9 million, in addition to its responsibility to repay deferred value added tax to the government. As the financial concerns became clear, Marymount’s senior leadership and board decided to cut back on operational expenses and determined that they could not afford to open the entire facility. The building opened four months behind schedule, in September 2011 at half capacity, with only 22 of 44 palliative care beds, available for patients.^x

TRANSITIONING TO THE NEW SITE

Moving into the new health care building required careful planning and training in order to provide a safe and comfortable transition for Marymount patients. Prior to opening, the clinical staff members received orientation tours of the new building to familiarize themselves with their new workspaces and the locations of important supplies and equipment. Some non-clinical staff members, including cafeteria and building operations staff, additionally held “dummy runs” in the new facility. The day prior to relocating the patients, Marymount staff members volunteered to move equipment, stock cupboards, make beds, and clean surfaces in the new building on a day they were not originally scheduled to work.

Recognizing the delicate condition of Marymount’s patients, as well as the complexity of hospital operations, the transition of patients to Marymount was planned carefully and precisely. Called “Operation Swallow,” the plan was communicated frequently and staff members received a detailed brief that considered various aspects—from halting patient admission to hospice care one week prior to the move, to contingency plans for temporarily bifurcating services in the event that any patient would not be well enough to relocate. By all staff accounts, the move went extremely well, especially considering the complexity and potential dangers of the transition for patients.

However, the weeks after the move were not planned with the same degree of thoroughness, resulting in operational challenges that lasted several months. More complex systems were implemented; and even

^x *While the late opening has several causes, one respondent additionally attributed the delay to two hard winters that Ireland experienced in 2009 and 2010.*

though all nurses were trained prior to the move, some of them described initial challenges learning how to operate the new equipment, such as ceiling hoists, and locating items in storage. Even previously simple tasks like adjusting thermostats in patient rooms required training. Whereas the non-clinical staff had “dummy runs” in the new facility, the nurses had to adapt and learn the new facility while taking care of patients. This challenge in transition was aggravated by lingering construction issues, such as leaking water pipes and a malfunctioning incinerator. To help with the transition after the move, Marymount retained one member of the on-site project team, the clerk of works, for another year to help the facility’s staff members from the old site become acquainted with the new sustainable building systems.

Marymount did not operate at its full capacity until March 2015 when the additional 22 beds in the palliative care wards were opened. By this point, Marymount staff members had become familiar with the new facility, equipment, and layout; and scaling up operations went smoothly.

Impact

For Marymount Hospital and Hospice, moving to the new facility marked a significant change for the organization and its ability to enhance its physical and organizational capacity for quality care and uphold a model for the industry. This change has had significant impacts on the organization, its users—including patients, families, and staff—and the sector of palliative care.

IMPROVING EXPERIENCES FOR PATIENTS AND FAMILIES

The most dramatic, positive, and important impacts have been on Marymount’s patients and their families. With its additional patient rooms, the building allows the hospice to meet the palliative care needs of the community. Additionally, the facility’s design and equipment have radically improved the experience of care, and ultimately represent an incredible advancement of Marymount’s organizational mission. The design values articulated through the design brief drove the changed experience in the facility, leading to the envisioned “warm, welcoming, open, and bright environment.”⁸ Staff members are clear to articulate that while human capital is vital in encouraging and living out the mission, the building has been critical in supporting the staff to provide dignified care. As one physician articulated, “The building does so much to reinforce the view that you’re an important person, and that you matter.”

The individual patient rooms with en suite bathrooms have helped to create a sense of comfort and ownership over the space for patients. Staff members now have the privacy to conduct important and



Above. The two-story oratory features a wooden interior finish, stained glass clerestory, and skylight above.

sensitive conversations with patients, family members, and friends. The 25-square-meter patient rooms allow visitors to sit or stand comfortably, and pull-out beds accommodate family members who wish to stay the night by the patient's side. Patients with sensitive conditions are able to access the bathroom at their leisure, without the social stress of shared facilities. The rooms also incorporate design elements—such as adequate storage for personal items, refrigerators, and white boards where visitors can leave notes and messages of encouragement—that help patients personalize their space and experience independence and agency, even in the context of their illnesses. Even subtle features, like wood finishes and screens that patients can pull down to cover mirrors, have contributed to patients feeling comfortable and in control of their space. One clinician summarized the impacts on the patients:

Single room accommodation has transformed the therapeutic experience for patients and families. It has changed my therapeutic relationship with people, because I now walk into their space—as opposed to them occupying a corner of mine. And that's very powerful. It's like walking into somebody's apartment. And each person claims that space for themselves.

Orienting patient rooms on the exterior of a V-shaped ward maximizes views to the exterior landscaping as well as the amount of natural

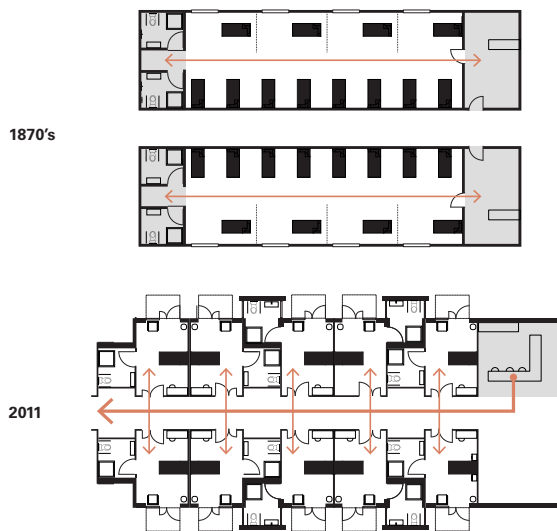
daylight received. Balconies attached to patient rooms and larger patios in the nodes between wards have also increased access to the outdoors, which has been shown to lead to better health outcomes.⁹

Through its qualities, characteristics, and programs, the building was designed to “support [patients] in their deficits, and not confront them unnecessarily with their deficits.” Long hallways have handrails and periodic cutouts with seating areas, providing patients with places to rest with dignity en route to their destination. One staff member noted that “in the old facility, these patients would have wound up on the floor.” Additionally, the larger facility has increased space to support day-care activities, art and music therapy spaces, as well as an inter-denominational oratory (as opposed to Catholic) to represent the changing religious demographics of Ireland.

Although the building and the patient rooms were largely successful from a holistic approach, some of the design choices have led to some unanticipated impacts. The greater independence granted to patients in the private rooms initially led to more falls as patients self-navigated the more expansive space between their beds and the bathroom. In addition, patients have had more difficulty engaging with a spiritual experience in the inter-faith oratory—which was originally designed to have a full glass wall but was “value engineered” due to cost constraints. For some, the design, which is modern and has little traditional religious ornamentation, feels secular or sterile. Nurses commented that patients with limited neck mobility are unable to see the stained glass located above eye-level, and are left to look at the “plain wooden box” walls.

INFLUENCING STAFF AND ORGANIZATIONAL CAPACITY

In moving from its previous location on Wellington Road to a new site, Marymount designed its facility to prioritize the experience of the patient in order to support its organizational mission; to some degree, this has compromised operational efficiency for its staff. While technological advances such as the ceiling hoists and wash facilities have helped nurses and staff members provide one-on-one care privately and with dignity, staff members have faced some difficulties in providing efficient care and supervision. Compared to the Nightingale wards in the previous facility, individual rooms have increased the distance between nursing stations and patient beds. Additionally, because of the larger site, travel distances among all of the hospital's programs have increased. During the design phase of the project, some nurses advocated for shorter walking distances between wards, but ultimately the design prioritized patient rooms with wide outdoor views. Nurses adapted to this change by purchasing more comfortable shoes and orthopedic socks and soles to help alleviate the strain of increased travel around the facility. Additionally, the transition from an open ward to private rooms limits the flexibility of the organization to adapt to increased patient



Above. The top floor plan shows the previous facility (built in the 1870s) with 12 patients per ward and two shared WCs. In this layout, nurse circulation is more simple and efficient. The plan above shows the current private room layout with en suite WCs.

loads or a decreased staff supply. For example, whereas a single nurse can instantaneously supervise an entire patient population in a Nightingale ward, the new facility requires a higher minimum staff-person-to-patient ratio in order to provide care.

The loss of organizational flexibility caused by the upgraded layout has created challenges for Marymount as the staff and board manage the debt incurred from the capital project and continued budget cuts from the HSE. This financial burden has been exacerbated by the high cost of maintaining the building. For example, the double-height window design, which was chosen to provide daylight for the facility, costs around €70,000 to clean annually. In addition, building systems, such as the CCTV system, ceiling hoists, and food waste macerator all require specialized maintenance contracts. Marymount continues to rely on local fundraising from the Friends of Marymount, who have already contributed over €24 million, to support its services and discharge the debt on the new facility. As of 2015, the organization was completing a strategic planning exercise to reduce operating costs without compromising its mission, use the new facility at its full capacity, and establish a foundation to identify new fundraising opportunities.

CONNECTING WITH THE LOCAL COMMUNITY

Though Marymount is working to build stronger links with the community in its new location, these impacts have been less significant than impacts on the patients and the organization. With

little development density surrounding the new facility's greenfield site, public integration with Marymount now requires deliberate effort. A number of Marymount's staff spoke of the organization's move as a loss to the community north of Cork. In the previous location, visitors and staff patronized the local restaurants, hotels, and shops, who in return felt pride in and affection for the hospice that had long been a part of their neighborhood. Despite the loss of organizational patronage at the previous site, Marymount currently leases the facility to Griffith College, whose presence can also drive local businesses with a new clientele, minimizing the downturn that came as a result of Marymount's move.

New pathways to community interaction have been opened due to Marymount's new design features and location. Whereas external groups and organizations were unlikely to interact with the hospital at its previous location on Wellington Road, they are now more likely to take advantage of the new facility's amenities such as conference rooms and other spaces for organizational meetings and functions. For example, the Friends of Marymount now have access to an office space where it can expand its educational capacity, and the change in location allows the building to accommodate a new cadre of volunteers. The project team additionally argued for the local municipality to extend a bus route to reach the building, so that staff and patients can easily and cheaply access the facility, even if they do not have a car. These events, along with the radically different building atmosphere, have helped to demystify the hospital and hospice within the local community.

ESTABLISHING A MODEL IN PALLIATIVE CARE

Through this project, Marymount has become recognized as a national leader in palliative care. After the building opened, staff persons from other hospices in Ireland as well as across Europe and the United States have visited the facility to learn from its design and ask about its implementation process. The educational and training spaces in the facility have allowed Marymount to host international conferences and have increased Marymount's ability to train clinicians in local schools and facilities in hospice and palliative care. Additionally, because of the creation of the Expert Report and the remarkable change in quality of care spaces, many believe that Marymount achieved its goal to raise the bar for hospice design. For example, because private rooms were implemented at Marymount, other hospices in Ireland will be able to demand the same from the HSE for their facilities as well. Many feel that without Marymount's example, this standard would never have been achieved. However, as of 2015 no new palliative care facilities had been constructed in Ireland, likely due to the recession. As such, the intended impact of Marymount as a model facility for the sector has yet to be fully realized.

Conclusion

The capital project has had dramatic and positive impact on Marymount's ability to fulfill its organizational mission of providing high-quality, dignified care for its patients; however, the project has also contributed to financial and operational challenges for the organization. The new building doubled Marymount's number of beds, enabling it to reach underserved members of the community with its inpatient palliative care services and shortening its wait list. Additionally, by focusing on patient-centric design through high-quality and spacious private rooms, beautiful shared public spaces, and increased access to natural landscapes and daylight, the new facility has transformed the health care experience for patients and family members—helping people to live full lives in the context of their illnesses. Many professionals in the sector, from across and beyond Europe, have visited and observed the building and its design process—helping to establish Marymount as a national leader with broader potential influence in hospice design.

A particularly unwelcome and enduring outcome has been the added financial burden of the new building. Marymount's decision to construct a higher-quality facility on a new site significantly expanded the original scope. Additionally, due to a variety of factors—including a collapse

of the economy, decreased financial support from the Health Service Executive, terms of new government contracts, overruns in construction, higher than anticipated ongoing costs, and an increased need for staffing—Marymount is operating with a significant amount of debt, and the Friends of Marymount has stepped in to provide additional fundraising support. Consequently, while the building has successfully achieved its patient-centric goals, it has created financial and operational pressures that are limiting Marymount's ability to fully amplify its mission and expand services, community outreach, and educational programming to the extent intended through this capital project.

Below. An exterior view of the Marymount University Hospital and Hospice.



Lessons from Marymount University Hospital and Hospice

Define donor support as more than construction funding.

Investment helps decision-makers raise their sights: Ambitious visions are generators for the most exceptional and memorable capital projects, and are instrumental in garnering the momentum and support needed to move projects forward. Conversely, an “unhealthy optimism” about the feasibility of a capital project can run the risk of compromising the long-term financial and operational health of an organization. Even when the mission and scope of a project are well aligned, sometimes hard-to-predict external factors can compound or contribute to the risk a grantee acquires in the course of a project.

In the case of Marymount University Hospital and Hospice, The Atlantic Philanthropies played a pivotal role in encouraging the grantee to take on a larger, more ambitious project at a new site, with the assumption that the expanded scope could be leveraged for greater impact. The original site would have limited Marymount’s capacity for future growth, and a feasibility study projected that the sale of the existing hospital and property would allow Marymount to take on the new project without increasing its goal for local fundraising. While this decision was strategic in many ways, in the end, it exposed the organization to greater risk as the scope and project budget increased to match this vision.

Both grantees and funders must understand and prepare for the risks associated with an expanded project vision. Marymount’s current financial vulnerability demonstrates the importance of understanding the liabilities of an evolving project scope, as well as the necessity of creating a generous project budget that considers all expenses associated with the building and includes an ample contingency to cover unexpected circumstances.

Funders can provide needed guidance: There are many ways foundations can support capital campaigns. They can be the first in the door and provide a seed grant that attracts other funders to come on board, or make the capstone grant needed to complete a campaign, or participate anywhere in between.

Capital investments, however, do not have to be directed only at building construction. On the front end, foundations can fund grantee research and preparation, which goes a long way in ensuring that the vision for the project aligns with the organization’s long-term goals and capacity. In the case of Marymount, The Atlantic Philanthropies supported an increased mission and scope for the capital project that would in turn increase the organization’s impact. Beyond opening day, foundations can stay involved with organizations and provide ongoing program, capacity building, or operating support.

While financial backing is perhaps the most obvious role that foundations play, they can also provide much needed guidance to grantee organizations. For instance, by insisting that project impact metrics be established early on in the process, foundations can encourage grantees to think critically about how they are defining success and tracking progress toward those benchmarks. Similarly, the due diligence process can be an important reality check that helps grantees identify opportunities for planning as well as gaps that need addressing.

Lessons from Marymount University Hospital and Hospice

Commit to planning to set the right scope.

An enhanced facility requires a new level of operations: From any project's onset, organizations must be realistic about what building upkeep and operations can cost. "Whole-life" building costs can come as a surprise to grantees undertaking a capital project for the first time. Even for grantees familiar with running a building, upgrading to a newer or larger facility can involve unexpected maintenance and operating costs, wrongly-calibrated projections, or other organizational requirements that must be supported through the budget. At minimum, planning should allow some financial room to adjust if initial projections are incorrect.

At Marymount, design decisions such as large, individual rooms with access to natural landscaping, generous amounts of glass, sustainable building systems, and advanced equipment helped fulfill the mission of the project. However, these design features resulted in significant implications for the ongoing costs of maintaining, operating, and staffing the facility. Marymount's experience underscores the importance of projecting these ongoing costs and working with the design and project team to understand the ramifications of design decisions to make sure they align with the organization's mission and operational capacity.

End Notes

1. “Report of the National Advisory Committee on Palliative Care.” 2001.
2. Central Statistics Office. “Census 2011 Profile – Older and Younger.” Stationery Office (Dublin, Ireland). 2011. <http://www.cso.ie/en/census/census2011reports/census2011profile2-olderandyounger/>.
3. Department of Health and Children. “Design Guidelines for Specialist Palliative Care Settings.” Dublin, Ireland. 2004. <http://health.gov.ie/wp-content/uploads/2014/03/Design-Guidelines-for-Specialist-Palliative-Care-Settings.pdf>, p. 26.
4. Grant Proposal from Marymount to The Atlantic Philanthropies. April 30, 2004.
5. “International Advisory Group Report for Marymount Hospice and The Atlantic Philanthropies.” 2005.
6. Ibid.
7. “Marymount University & Hospice.” Accessed January 24, 2017. www.marymount.ie
8. “Design Brief for New Hospice and Hospital Project at Ballinaspig More, Waterfall Road, Cork: Final Brief for Design Team.” St. Patrick’s Hospital (Cork) Ltd. July 5, 2006, p. 15.
9. Smith, Jerry. “Health and Nature: The Influence of Nature on Design of the Environment of Care.” The Center for Health Design. 2007. www.healthdesign.org/chd/research/health-and-nature-influence-nature-design-environment-care.

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