Clients' Perceptions of Value Drive Evaluation.

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A critical priority in human services today is accessing consumer feedback, as the need to optimise service delivery through client involvement increases. However it is difficult to find ways to do this that are both meaningful and achievable. This paper presents one way to effectively access consumer feedback; a major evaluation of service provision in which consumers/clients contributed to developing key content areas in the evaluation tool itself. In practice, this meant that the consumer/client perspective fundamentally drove the evaluation.

The paper has four main sections. These are: (i) outline of the purpose and drivers of the evaluation; (ii) description of the main project features; (iii) discussion of how the evaluation tool was developed and applied; and (iv) analysis of the project's results and challenges. Concluding remarks (v) highlight the significance and implications of this type of project for ongoing improvements in service delivery in human service organisations.

i. Purpose and Project Drivers

Purpose

The purpose of the project was to develop evaluation tools for residential care services within Baptist Community Services - NSW & ACT (BCS), based on what clients perceived to be of value in the service.

BCS is a major provider of quality aged and community care services in NSW and ACT. A section of BCS called LifeCare additionally provides a range of services which address needs associated with domestic violence, youth and adult homelessness, financial stress, relationship issues, and child care.

Project drivers

The project was driven by three main factors: the commitment of BCS to excellent service quality, the external environment in which BCS operates, and the need of BCS to grow and improve its approach to service delivery.

First, BCS' strong commitment to service quality entails continuous evaluation and improvement of its services. In 2007, BCS decided to introduce an organisational wide continuous improvement system, aimed at fostering evaluation and improvement processes; and embedding innovation even further into the culture and practice of the organisation. The Australian Business Excellence Framework (ABEF) (SAI Global, 2007) was chosen as the preferred framework to underpin

this planned continuous improvement process. The ABEF analytical framework distinguishes seven categories in which high performance is required to ensure organisational excellence and sustainable performance. These are: (1) leadership; (2) strategy and planning; (3) information and knowledge; (4) people; (5) customer and market focus; (6) process management, improvement and innovation; and (7) success and sustainability.

In category (5) - customer and market focus - the priority is to understand what the clients of an organisation need and want. The ABEF framework emphasises that finding ways to engage clients in providing feedback is crucial for organisational excellence. The desire to develop such a feedback system, which engaged BCS' clients and their relatives, became a significant driver for the project.

A second driver follows from the external environment in which BCS operates, which includes both other organisations and the general community. In the human services sector generally there is strong pressure from regulatory bodies for organisations to demonstrate that they have systems in place to obtain and use client feedback in service review, improvement and planning. In aged care more particularly, there is a proliferation of external accreditation and compliance systems with which organisations must conform in order to receive funding: for example, the Aged Accreditation Agency, Department of Health & Ageing, Aged Care Complaints Investigation Scheme, and the New South Wales Department of Ageing, Disability and Home Care. Most of these systems require evidence of consumer feedback and consultation. Moreover, it is expected that these processes extend beyond basic systems to include potential for internal and external benchmarking.

Additionally, there is increasingly an expectation in the general community that services are being regularly monitored and reviewed to ensure quality and continuous improvement, and that these reviews are based on evidence from a range of sources including clients and stakeholders (Consumer Focus Collaboration, 2002; Bastian, 1994; Aged Accreditation Agency, 2009).

The third main driver was that in addition to recognising the above imperatives, BCS' Board saw it as vital to the organisation's future growth and service development that it have more balanced information on which to make decisions and plan services, and made this project a priority in the organisation's business plan. Senior management were also cognisant of the need. More specifically, the view common to both the Board and senior management was BCS' success as an organisation required further information on services from clients' perspectives to combine with financial and other data to ensure BCS is performing well on a 'balanced scorecard' of relevant indicators.

From a review of the literature for this project it was apparent that client perception of value feedback for aged care services is not well researched. Rather, it tends to be a process which is conducted primarily to meet legislative or compliance requirements with its design essentially driven by service needs instead of the clients.

ii. Project Description and Key Project Steps

Description

The aim of the project was to create evaluation tools developed primarily from what clients, including relatives, perceived to be of value in care and service delivery. To add to their perspectives, the value perceptions of the care staff who provided the direct day to day care of clients was also sought.

The methodology chosen was essentially informed by *value chain mapping,* drawn from the manufacturing industry (Storer & Taylor, 2006; Simons, Francis, Bourlakis, & Fearne, 2003). Simply put the aim of this mapping process is to precisely identify where key elements of value are both created and lost in the business cycle, and to then take action accordingly by maximising value creation and reducing or changing elements that lose value.

Adapting this framework meant that the project sought to learn from clients and relatives what was of importance to them in the care process. That is, it first of all sought to identify where value is created for them, based on their own perception and experiences, and then to capture what was of greater or lesser value to them at each point, which is to say, the priorities of service delivery. This information was critical to developing the evaluation tools.

In rolling out the project there was a commitment to be transparent and to engage clients and staff, in order to demonstrate to all stakeholders in this process the value of client /consumer participation and service evaluation. Consequently, staff were kept informed of the project's progress through a creatively designed communication strategy, which included newsletters, posters and personal invitations. Survey results were shared with clients, relatives and staff through newsletters and information sessions at each facility. Additionally, clients and relatives were consulted regarding the suitability of draft 'Action Plans' and they also provided feedback on the project itself and how to it could be improved.

A crucial aspect of the project was that the project itself was continually evaluated on an ongoing basis through each of the critical points in its development. This commenced with an evaluation of the pilot evaluation, and continued throughout project rollout and the action plans. Feedback was sought from clients, regional teams and executive staff regarding the process of the project and the results it

produced. The information from these internal evaluations has been used to enhance this model.

Project steps

A planned methodology was developed using a structured, systematic approach based on the research methodology and the continuous improvement cycle - Plan, Do, Study, Act (Gleghorn & Headrick, 1996). The key steps in developing the client driven survey tool were as follows.

1. A previously completed service process mapping sequence was used to provide an initial framework for the tool, as this identified the key elements of aged care service provision (Locok, 2003). For example, it incorporated the stages and processes in caring for aged residents in homes, from entry to the home, including being welcomed, to assessing and delivering care and activities. The key service delivery elements of each stage of the care delivery process were then identified, so as to understand what actions contributed to service provision quality. For example, components of welcoming included such behaviour and responses as smiling, listening, giving information and answering questions. Later on in the process some of these words from this content were used to develop the survey statement sets.

2. A literature review was conducted to understand more about the concept and meaning of *client perception of value*: the components of value, how it has been used previously in evaluations, and how it can be operationalised. This review focused on the retail, marketing and health care sector, providing a range of definitions and highlighting that this is a relatively new area of research**.**

The definition of value that subsequently guided the project was the following:

> *Value reflects a fit between the features of product and services and consumers' expectations and perceptions*.

This definition was an amalgamation of key elements of value as understood from the literature review. In practice, it means that to measure value is to seek to capture how the client experiences service provision, and their view of the extent to which it meets their needs. The measurement of value is thus essentially experiential and personal in nature.

3. A smaller literature review of consumer participation models and their importance and relevance in the health care sector was completed.

4. Visits were made to two organisations outside the health sector considered to be leaders in client perception of value, with the aim of

identifying existing benchmarks in this area. These visits highlighted a range of critical success factors for projects, which included the need for a planned, multi dimensional and systematic approach. These organisations also emphasised the importance of measuring the clients' *experience* of systems, not just their satisfaction; that is their perception of receiving a product or service.

5. The questions for the focus groups and interviews were developed from a synthesis of the elements described in points 1-4 (Subramony et al, 2002). These were open-ended and exploratory in nature, and sought to understand and capture participants' experiences and perceptions of care in all its complexity.

6. The next step was planning and conducting focus groups with clients, relatives and direct care staff, in various geographic and socio-economic areas. Leading focus groups with an older, vulnerable population is challenging in a number of respects. One aspect of this is their physical and cognitive limitations and their expressed fear of being seen as too critical and too demanding of service providers. A common statement was, *I do not wish to cause any trouble*.

A further challenge was getting clients, relatives and staff to both identify and rank the aspects of service delivery that were of more or less importance. They were asked to think of aspects of service delivery that were of value to them, rather than of problem elements and/or areas of dissatisfaction. Ranking was difficult for them too, as it was a new concept and it was asking them to view care through a different lens. An additional challenge for the participants was being asked to unpack the elements of value in greater detail. For example, a client said, *I want good quality food* – the researchers needed to further explore what that meant in practice or what it *looked like for the client*.

7. A number of high care clients were interviewed; the questions used were similar to those used in the focus groups.

8. The data obtained from the focus groups and interviews was analysed in terms of repetitive themes and consistent areas that indicated points of value and the priorities given to this value (Krueger, 1988). This information created the foundation for what constitutes quality care from the clients' perspectives and informed the content of statement sets for the tool.

This analysis was further used to identify the key components of value for excellence in service provision as experienced by clients. Eight key components were identified in all; these were: (1) engaged staff who are caring and responsive to individual needs; (2) appropriate high quality clinical care; (3) sense of home, community and feeling safe; (4) choice and meaning in activities; (5) appreciating the individual – choice, spiritual life, respect, Christian values; (6) open two-way

communication; (7) user friendly systems and administration combined with effective operations; and (8) positive atmosphere and adaptive environment. These components of value provide a rich repository for future staff development, new service planning and facility assessment against drivers.

9. Subsequently statements sets were developed based on the above analysis and combined with the appropriate components of service mapping

10. The final tools were designed, with one for clients to complete and one for relatives. The questions used in the two tools were aligned, allowing for cross matching of responses.

III. Development and Implementation of Evaluation Tools

This section identifies examples of the key themes used in developing the tool, and then describes the rollout process.

Key Themes

It is beyond the scope of this paper to identify all the key themes drawn from the project that were reflected in the tool structure, content and style. However two examples will be provided. One theme expressed was the priority clients placed on being seen and cared for as individuals who have unique needs and a unique history: one size certainly does not fit all. Another theme was that even though clients are vulnerable and limited in their capacities they still see having choice as an imperative. These themes needed to be reflected throughout the tool, which was another of the many challenges in its design.

These two themes were applied to every section of the evaluation tool, including spiritual life, activities, meals, rooms, care, making a request, and general interactions during day to day life. The following are examples of questions used to illicit client perceptions on these themes in a selection of these areas:

In *care:*-
I feel my needs are important to staff
In spiritual life
The chaplain is available to listen to me if needed
In *activities*
There are a wide range of activities available to me
In *facilities*
My room is well designed to meet my needs

Structure of evaluation tool

The evaluation tool has 11 main sections, with 74 questions altogether. It also provides space for comments at the end of each section.

The survey was divided into the following sections, which were based on the initial mapping and some key aspects of service delivery as expressed by the clients. The sections were: welcome, assessing care, delivering care, spiritual life, meals, cleaning, laundry, activities, facility, client leaving and overall satisfaction. There was also an open ended question for clients/relatives to list 2-3 concerns or problems they had with the facility.

The options clients had to respond to each question were:

disagree	tend to disagree	neither agree nor disagree	tend to agree	agree

This response ranking allowed choice for the clients/relatives, but also placed some limits on the range of possible responses.

Presentation and Rollout of tool

(a) *Rollout methodology*

The rollout of the project across residential facilities was designed to engage staff, clients and relatives, both on the initial feedback day as well as later on in the process. The project was coordinated from head office using designated project staff, which worked to assist the project to be seen as independent from each facility.

(b) *Client organisation and consultation*

Criteria
Exclusion criteria were developed. These were physical illness that prevented participation, concentration deficits, and memory deficits, presence of dementia and language deficits.

Feedback Collection Day
Accessing and involving clients to be participants in the evaluation required planning and resourcefulness. Each facility chose a feedback day which was advertised well ahead using signs displayed throughout the facility. Reminders were sent around for clients to bring glasses and wear hearing aids. Designated private areas were set aside for survey completion, complete with food and resources to assist. These resources included surveys presented in very large print, display board, charts to explain the process, rulers to assist line flow and two

project staff. Consent was explained and obtained from each client. The process of working with older clients was time consuming.

(c) *Relatives Organisation and Consultation*

Criteria
The key contact person/next of kin was identified for every client and each of these relatives was issued a survey by mail.

Mailed out survey
The survey was sent to relatives with a reply paid envelope addressed to the project team. Relatives were deemed to have provided consent by completing and returning their survey and this was explained in survey instructions.

IV Results of the Evaluation

Project Outcomes

The project was conducted across all twenty one residential aged care facilities over seven months in 2008. A report was produced for each facility, each region and one report for residential care as a whole. This enabled BCS to internally benchmark all residential services: the first time it had been able to do so. It also enabled the organisation to identify systemic areas requiring improvement across residential care. The most significant themes to emerge from the results emphasised that clients and their relatives want more choice in the services provided and a much stronger role in the planning and evaluation of their care. Each facility was required to develop a local 'Action Plan' to address improvements and the systemic issues were addressed in the organisation wide, business plan.

Other aged care facilities have expressed interest in using the tools and BCS intends to form a benchmarking network for monitoring results. This would enable BCS to benchmark its results with similar facilities and further promote the importance of client feedback as a driver for continuous improvement.

Reflection on the research

One of the challenges faced during this project involved tension around how to best engage clients and what constituted research boundaries. Engaging this vulnerable population was primarily achieved by creating a 'social event', with personalised invitations and 'special' food and drink. Additionally, a number of clients were hearing and/or sight impaired and some had difficulties concentrating.

Research boundaries emerged as an issue during this project. A few examples are provided**.** One concerned the unclear boundary between assisting a client and 'leading' them in their responses to particular questions: how much effort is appropriate for the researcher to use to

encourage the participant before it could be perceived as ‘coercion’? Another one centred on the apparently prosaic issue of whether refreshments should be served before or after completing the survey. If they are served before this creates a positive atmosphere along with more freedom to discontinue the process, but there is potential for a ‘halo effect’, where client’s participation in a positive, social event influence their views about the care and services they receive as a whole. If refreshments are served after this creates an incentive to engage, but also in a way ‘coerces’ them to stay and engage.

V. Concluding Remarks

The evaluation of community services is increasingly required by growing demands from external agencies and the community for monitoring and assessment of services. However, service evaluation driven by client feedback also constitutes a critical means of improving services for organisations - such as BCS – which are committed to ongoing improvements in service quality in an ever challenging environment. The methodology developed here is one systematic method of undertaking such an evaluation, which uses a focus on clients’ perceptions of where the value is created in service delivery to not only identify problems, but also identify opportunities for enhancing service delivery at every key point. This method has application in many service areas beyond aged care.

Bibliography

Aged Care Accreditations Standards Agency Ltd. (2008) *Results and Processes Guide.* Aged Care Accreditations Standards Agency Ltd, Parramatta.

Aged Care Accreditations Standards Agency Ltd. (2007) *Audit Handbook.*Aged Care Accreditations Standards Agency Ltd, Parramatta.

Australasian Evaluation Society Lyneham ACT, *Guidelines for the Ethical Conduct of Evaluations.*

Bastian, H. (1994), *The Power of Sharing Knowledge*, UK Cochrane Centre.

Bloor, M., Frankland J., Thomas M. & Robson. K. (2001). *Focus Groups in Social Research,* Sage Publications, London.

Department of Trade and Industry (UK). *Value Mapping* – Fact Sheet

Gleghorn, G. D. & Headrick, L.A. (1996). The PDSA cycle at the core of learning, *Journal of Quality Improvement*, 22(3); 206-212.

IMC - Value Chain Management Services. *An Executive Guide – Innovate, Cooperate and Profit.*

Kreuger, R. (1988). *Focus Groups; a Practical Guide for Applied Research,* Sage Publications. London.

Letts, C., Ryan W. & Grossman, A. (1999) *High Performance Non-profit Organisations – Managing Upstream for Greater Impact*, John Wiley & Sons Inc.London.

Locock, L. (2003). Healthcare Redesign; Meaning, Origins & Applications. *Quality & Safety in Healthcare.* 12 .53-57.

Meade, C.M., Bursell, A.L., & Ketelsen, L. (2006). Effects of Nursing Rounds on Patient's Call Light Use, Satisfaction and Safety. *American Journal of Nursing.* 106 (9), 58-70.

National Health and Medical Research Council (Aust) Dec 2004, *A Model Framework for Consumer and Community Participation in Health and Medical Research.*

National Resource Centre for Consumer Participation in Health La Trobe University Vic., *The Evidence Supporting Consumer Participation in Health.*

Rubin, A. & Babbie, E. R. (2008). *Research Methods for Social Work*, (8th Ed) Thompson Brook/Cole, UK.

Sahin, B. & Tatar, M. (2006). Analysis of Factors Affecting Patient Satisfaction. *Disease Management and Health Outcomes*, 14 (3) 171-183.

SAI GLOBAL, (2007). *The Business Excellence Framework,* SAI Global, Sydney.

Sheth, J., Newman, B., & Gross, B. (1991). Why We Buy What We Buy; a Theory of Consumption Values, *Journal of Business Research*, 22, 159-170.

Simons D., Francis, M., Bourlakis, M. & Fearne.A. (2003). Identifying the Determinants of Value in the UK Red Meat industry, *Journal on Chain and Network Science, 3*,(2), 109-121.

Storer, C. & Taylor, D. (2006). Chain Mapping Tools for Analysis and Improvement of Inter-organisational Information Systems and Relationships, *Journal of Chain and Network Science*, 6, (2), 119-132.

Subramony, D., Lindsay, N., Middlebrook R. & Fosse, C. (2002). Using Focus Group Interviews' Performance Improvement, 41 (.8), *International Society for Performance Improvement.* 38 -45.

Zeithaml B.A. (1988). Consumer Perceptions of Price, Quality and Value: A Means End Model and Synthesis of Evidence. *Journal of Marketing*. 52 (7) 21-22.

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