“A plethora of job titles just serve to confuse our patients”

The burgeoning number of titles and roles for nurses and others in primary care may encourage choice and uphold the principles of skill mix, but can spell confusion for patients.

Imagine you are feeling unwell. You crawl out of bed and ring your surgery, probably because NHS Direct suggested you should.

There is the ringing tone followed by a minute of “muzak”, then you hear:

“You’d like an appointment for today, certainly, no problem. Would that be for the GP, GP registrar, practice nurse, nurse practitioner, assistant practitioner, community nurse, clinical nurse specialist, phlebotomist, level 2 healthcare assistant, level 3 healthcare assistant, or would you just like someone to read your aura?”

You groan. From feeling under the weather, you are now lurching towards the distinctly moribund.

“If it helps at all, one of our PNs and both the NP and ANP are prescribers, and if you think you need to be referred to hospital, I suggest you see the GP, GP registrar, NP or ANP, unless we are talking about tissue viability, in which case the PN is allowed to refer you on. Is that OK?”

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You make your decision, deeply relieved you are not an embarrassed teenager who’d plucked up the courage to call the surgery, someone whose first language is not English or a client with learning difficulties.

With so many primary care job titles out there, can patients deduce what level of service we are capable of providing from our name badges and what we wear?

In the 1970s, the annual addition of an extra stripe on our cap or epaulettes denoted level of seniority. Patients seemed to understand this. So, in our wisdom, what do we do now? We make it more difficult – the higher up the ladder we are, the more likely we are to dress like receptionists.

Are we sure that patients realise they no longer necessarily have to see a GP for family planning, or for asthma or diabetes reviews, because the nurse may have expertise? How can we convey the nature of our roles to patients with absolute clarity?

There are possible solutions, the first of which will be deeply controversial and unpalatable to anyone, like me, who is proud to be a nurse. It is to rebrand ourselves as some kind of generic health professional, distinct from a healthcare support worker. If this is, hopefully, a non-starter, we must start blowing our own trumpets instead of making the professional equivalent of a tentative squeak on a kazoo.

Critically appraise the websites of primary care providers. Are they up to date? Do they include the professional and educational qualifications of the nurses who work there, or just those of their employers? Do they clearly identify which members of staff are equipped to offer specific services? And is this information backed up with written material?

And if all else fails, there is always that reliable old chestnut: greet your patient, and say who you are and what you do. NT

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Nurses have come in for a lot of flak in the past few months. Some appalling care has been highlighted by the Care Quality Commission and the Health Service Ombudsman.

While there is no excuse for this, it is rare. The profession has understandably defended itself by pointing out that stretched staffing levels hardly help.

Working on a busy ward can be like spinning plates. No sooner have you responded to one patient’s request than you get another – and all the regular tasks still have to be done.

It is almost inevitable that the patients who shout loudest have their needs met first – and they are usually not the most vulnerable.

Intentional rounding may ease the pressure (see page 18). If each patient is visited every hour, the ones who shout are less likely to do so, the vulnerable get attention and observations can be done at the same time.

SPOTLIGHT

The right way rounding to ease ward life

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