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Title: Receptionists in intake in community health

Journal: Australian Health Review ISSN: 0156-5788

Year: 2011 Volume: 35 Issue: 2 Pages: 164-167

Abstract: Receptionists are employed as administrative assistants, but in Community Health Centres, especially rural ones, they are the first step in service delivery, the intake system. This has implications for the people seeking services and for receptionists. This paper looks at receptionist data from an intake study alongside relevant literature and makes findings relating to the occupational health and safety (OHS) of receptionists and for intake systems. What is known about the topic? Little attention has been given to the role of receptionists in health services. What is known suggests that receptionists would benefit from training related to mental illness and communications skills. It also indicates benefits from involving receptionists in system review and planning. What does this paper add? This paper identifies convergence between four sources of literature (receptionists in health, emotional labour, work and health (the Whitehall studies), and workplace learning) and the experience of receptionists in community health. What are the implications for practitioners? There is potential for managers to take into account the receptionist role as the first point in intake and service delivery. The OHS of receptionists can be protected by ensuring receptionists are resourced, supported in their role, and included in intake system development. The 'situated learning' used by reception could be supplemented by in house training. Attention to reception, the clients’ first point of contact, has the potential to improve the engagement of and outcomes for people seeking services.

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Abstract
The role of receptionists is as administrative assistants, but in rural Community Health Centres they are the first step in service delivery, the intake system. This has implications for the people seeking services and for receptionists. This paper looks at receptionist data from an intake study together with relevant literature and makes findings relating to the occupational health and safety (OH&S) of receptionists and for intake systems.

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What are the implications for practitioners? There is potential for managers to take into account the receptionist role as the first point in intake and service delivery. The OH&S of receptionists can be protected by ensuring receptionists are resourced, and supported in their role, and included in intake system development. The 'situated learning' used by reception could be supplemented by in house training. Attention to reception, the clients’ first point of contact, has the potential to improve the engagement of and outcomes for people seeking services.

Objectives
This paper examines issues relevant to receptionists in the intake process, and notes implications for community health practice, and directions for further research. Its goal is to articulate the findings of the study; the potential benefits of including receptionists in intake planning and revising their training and support needs.

Setting
During 2006-8 the author undertook a study of intake in a rural/coastal health network (1). The present paper explores the material collected from three receptionist informants and their member checks.

Two systems of intake were being used in the study area: a dedicated intake worker system and a rostered worker intake system. In both cases the difficulty for the receptionists was dealing with people who became frustrated when trying to access services.
Receptionists were usually the first point of contact for both phone and walk in enquiries. They made initial allocation decisions, and either referred people to a relevant phone line or other service, or collected people’s details and made appointments. Sometimes the people presenting or re-presenting were upset and might start to unburden themselves to the receptionist. Various clienteles, including early childhood, drug and alcohol and mental health clients could be seeking services.

Participants

The participating receptionists worked in community health centres undertaking administrative duties, phone and desk reception and staff management. Two had 20 years experience in community health. The other receptionist was relatively new to community health but had significant experience in other health settings.

One receptionist had three trainings in ‘dealing with difficult people’ over a twenty year period, the last being six years ago. These were ‘of limited use’ with one training being described as ‘useless’ and ‘patronising’. A second receptionist had a two day training in mental health alongside other receptionists and workers from non-government organisations five years ago and found this ‘excellent’. The third receptionist had undertaken an extensive communications skills course of her own initiative and this had been significantly helpful. This was the total relevant training received.

Methodology

Material for this study was drawn from the literature and a study of client intake in rural community health (1). In the original intake study themes were developed from exploratory discussions with informant interviews across the range of stakeholders (clients to senior management). The research interviews were unstructured but the same themes were raised with all respondents, who were also asked one overarching question: “What, from your point of view as (a receptionist), are the important features of a good intake system?”

The data was analysed manually using matrices of respondent categories and themes. For this paper the data was revisited in conjunction with relevant literature and themes identified from the receptionist interviews: lack of training, apologists for the system, emotional labour, importance of support, and allocation responsibility. All receptionists participated in member checks.

Findings

There are convergent findings from the literature and the informant interviews and these are presented together under four headings: clinical implications, emotional labour, skills and training, and control and support.
Clinical implications

Whilst the receptionists never took a clinical role they were the first point of contact. At that first contact they could influence whether a person became engaged, or to feel alienated by the service. The first contact had the potential to convey an impression to people as to whether they were welcome, whether they were going to be treated with respect, whether the agency was trustworthy and whether it would be helpful (2). Console et al have argued that every contact with an agency has the potential to influence clinical outcomes (3).

Emotional labour

Emotional labour occurs when workers manage their own emotions in order to provide a service (4). The receptionists needed to de-escalate crises when people were distressed, mentally ill or frustrated and they needed to subjugate their own feelings to achieve this (5).

“We’ve learnt to cope through experience. The thing is… I calm the person down that this is available and we understand you’re distressed.”

The receptionists expressed care and concern for the people they provided a service to. They were tuned to people’s feelings. Their emotional engagement included; concern for the clients’ well being, and balancing the need to make accurate allocation decisions and get accurate contact information against being intrusive or breaching confidentiality.

“You get a sense of what’s going on emotionally for a person, they’re sad or depressed or suicidal, or they’re going to blow up, you know you can feel it around them. You know what’s going to happen next.”

“I have some difficulties sitting there in a very public space where people can hear every little bit I say, and I’m very conscious of that because I do like to keep my work confidential. … and my training is to always repeat back… When they’re in a crisis they don’t want everyone to know …I feel for them in that situation and they’re not aware that people may be listening in.”

Emotional aspects of work are not considered in position advertisements, job descriptions or pay rates (6). Guy et al argue that our view of work is based on behavioural and task elements arising from the paradigm of industrial production, and needs to be updated to include service interactions. Feeling that their work made a difference, feeling supported and feeling part of a team were the identified protective factors for people doing emotional work (6).

Skills & Training

The role of receptionists could be complex and stressful. The process of seeking initial information could elicit the clients’ story, resonate with receptionists own life or demand an immediate response. Receptionists could be torn between competing demands; multiple phone lines, people at the counter, restrictions on what they could say. They drew on skill, experience, personal resourcefulness and even-temperedness to manage these situations (7, 8, 9).
“...by listening to what people are telling us. ...because they say, I need to speak to a Social Worker, then we've got to say, “Can you tell me a little bit...” to distinguish between Mental Health, D&A, sexual abuse, recent or non recent... I always like to ask the questions because what’s the point of having someone who’s in a trauma making the wrong telephone call?”

“I do find that when I’m on the phone with a client that’s called in, that I sometimes feel uncomfortable if I’m trying to identify if it’s a MHAL line (centralised intake for mental health) or just a straight intake. And sometimes I feel uncomfortable as to whether that's my role.”

Receptionists made the initial allocation decisions. These decisions could be difficult, and the interaction they involved could be important for the people who were seeking a service as well as making demands of the receptionist. There were no written protocols or decision trees for these decisions and they required careful questioning and skilful management of the conversation to elicit enough information without triggering the whole story.

’Situated learning’ (10) refers to the transfer of knowledge and skills in a workplace setting. It was the main form of training for the receptionists in relation to decisions about allocation and about managing emotional loads.

“... I did find it was hard to get good guidelines and that some people I asked had a certain impression that it was that category and that age group, and I'd ask someone else, ... slightly differently you know.”

Situated learning can be conservative and reproduce processes that are not ideal, not subject to quality reviews, nor reviewed by other staff or in the context of the wider system. There can be inconsistent transfer of knowledge depending on the individual (10).

Finding the balance between gathering enough accurate information without eliciting the person’s whole story was a skill developed over time. Receptionists balanced being helpful against becoming engaged. These skills were learned by modelling on experienced workers, coaching, plus gradually developing their own style.

“... listen to how we handle the calls and you’ll learn from that. I can’t teach you to do this job in a day or a week, it takes months and by listening to how we handle the different situations you’ll learn how to deal with things.”

It was uncommon for formal training to be offered in areas related to emotional demands. In the general practitioner setting receptionists training was found to eliminate ‘negative attitudes’ (9). Pyke and Butterill designed and delivered a training programme for mental health receptionists. This included information on mental illness, personal experiences shared by a mental health client, and skills to de-escalate situations. Receptionists in that study reported finding the training useful (including at 6 months), having a greater understanding of client’s needs and having become involved in protocol development (9).

Control, Support and the Effort –Reward balance

The Whitehall studies, identified three work circumstances that affect health, particularly heart disease, mental health and lower back pain. These factors were, the degree of control, the extent of support, and the effort-reward balance (11,12, 13).
The receptionists in this study dealt with the emotions of people attending the centres and their own responses to these. They often knew people were suffering but were unable to help and had concerns about whether people would be safe, and whether they would follow through on the enquiry. This imbalance between responsibility and control is an example of the lower degree of control common in lower grade positions and has implications for occupational health and safety (OH&S) (11, 12, 13). The degree of ‘control’ is understood in terms of the degree of authority over decisions and the use of skills, including the opportunity to develop skills.

“Availability of appointments. … there was a time when … we’ve had to cancel those sessions and we’ve had to do that (make those calls). Or when I have clients ring in then I’m not able to offer them something for some time. I feel discomfort from them. I’d like to be able to look after their needs. In an organisation it’s not always possible, but it’s upsetting when you know you’ve got a system there that’s set up to function in a certain way and it’s falling apart at that time.”

“Often people get upset when you tell them, and they become abusive because they can’t believe this. ‘I ring you and now you’re telling me I have to ring another number’ I actually apologise to them, when they react like that and I say ‘yes I know this is not a really great way to deal with it but it is what we have to do’.”

Receptionists bore the brunt of the shortcomings in intake systems without having direct involvement in their development or review. When client phone calls were not returned, appointments needed to be cancelled or were not available, or when contacts to one centre had to be redirected, it was the receptionists who managed the distress or frustration of the people affected. People in jobs characterised by low control had higher rates of sickness, absence, mental illness, heart disease and lower back pain. Policy implications of this, said the Whitehall authors, include involvement in decision making, and redesigning practices to enable employees to have greater control (12).

The emotional labour literature (6), the Whitehall studies (11,12,13) and the receptionist literature (5,8, 9) all identified support as important. The receptionist literature recommended receptionists be provided with debriefing, peer support, and supervision. (8,9). The Whitehall studies identified the need for both management and collegial support, and the inclusion of ‘clear and consistent information’ as supportive (11). Policy implications included ‘mutual support between colleagues’ and skills development (11,12, 13).

“When it becomes distressing …we just talk to each other…”

The support or lack of support from the clinical staff was significant for receptionists, with support being highly valued. Feeling supported was found to reduce OH&S risks (6,12).

High effort was not in itself stressful, stress was found to arise in the absence of reward, hence, ‘effort – reward balance’. The Whitehall studies found that reward could be by way of esteem,
career development or remuneration (12). They found workers needed to be respected, supported, involved in the design of work processes, able to use their skills and to receive training, and be adequately rewarded in terms of opportunities, esteem and remuneration. The findings led to policy recommendations; ‘involvement in decision making’, ‘mutual support between colleagues’, and ‘improving rewards’ including praise, development and pay (11, 12, 13).

Discussion

Research with a larger number of participants would be required to establish whether the present indicative findings can be validated. If action research methods were used the initiatives that could be explored would include: training, support, and validation.

Formal training could be directed at communications skills training and training in mental health issues. These areas of training have been shown to improve performance as well as OH&S. Since Health Services typically employ staff with expertise in both communication skills and mental health it is likely these trainings could be provided in-house at little expense.

Important support strategies to put in place for receptionists would be; ensuring there is back-up available from clinical staff, access to debriefing after incidents, and access to supervision. These would involve a change of commitment to reception and re-organisation of existing resources. Indications from the literature are they would improve OH&S risk.

Validation or valuing, could occur through including reception staff in the review and development of intake systems. More input would give them greater control over the system they represent and signal inclusion in the team. This too would cost little and, based on both the emotional labour (4,6) and Whitehall literature 11, 12, 13) offer OH&S protection.

In précis, indications are that receptionists could be better supported to do the best job possible, that this would involve little cost, would protect their OH&S status and contribute to improved service delivery.
References

1. Rural Community Health Intake Study; client intake for counselling in rural community health. Institute for Rural Clinical Services and Teaching; 2008 Available at: (accessed July 2009). Detail removed for review purposes


