



Continuous improvement and innovation in clinical supervision for supervisors in aged and non-acute health care settings.



Workshop 1: Effective Supervision (Contextual Practice)

Workshop 2: Interpersonal communication skills

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These workshops will support supervisors / educators in maintaining a program of continuous improvement and innovation in clinical supervision. It will assist in the clinical management of students undertaking Certificate III, IV and Diploma Health courses in aged and non-acute health care settings.

Objectives of the workshops

- To recognise, value and better support clinical supervisors.
- To equip health professionals meet current and emerging demands of the health care sector
- To educate clinical supervisors about the minimum standards of skills and knowledge required before a student commences a placement
- To provide an overview of the placement including the objectives and theoretical components
- To support clinical supervisors with the provision of training including undertaking assessment and giving feedback
- To support clinical supervisors develop educational knowledge about training methods including role modelling and mentoring
- To act as a conduit between TAFE and the health service to ensure that students and clinical supervisors are supported throughout the duration of the student placement.

The content of these workshops has been adapted from the original content of: *The super guide: a handbook for supervising allied health professionals*, Health Education and Training Institute (HETI), 2012, Sydney and TAFE NSW resources: *Communicate And Work Effectively in Health HLTHIR301B*, *Apply reflective practice, critical thinking and analysis in Health HLTEN508B*, *Provide mentoring support to colleagues CHCORG627B*.

	Core Supervision Skills
Workshop 1	Effective Supervision (Contextual practice)
Workshop 2	Interpersonal communication skills
Workshop 3	The Adult Learner
Workshop 4	Effective feedback
Workshop 5	Clinical teaching & learning
Workshop 6	Managing Performance



Workshop 1: Effective Supervision (Contextual Practice)

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Workshop 1: Effective Supervision (Contextual Practice)

The purpose of clinical supervision

The purpose of clinical supervision is to ensure:



Clinical supervision is considered a vital part of modern, effective health care systems (Milne 2007). Providing effective clinical supervisory support to health professionals enhances quality, safety and productivity and improves competence and confidence in clinical practice (Country Health SA 2009; Smith & Pilling 2008; The Chartered Society of Physiotherapy 2005).

Effective Supervision facilitates:

- acquisition of skills and knowledge
- reflective practice
- development of professionalism
- confidence and competence in clinical practice
- professional growth and development

Functions of supervision

Kadushin's model of supervision outlined three functions; educational, supportive and administrative (1976). These functions have been further defined by Proctor (1987) as formative, restorative and normative, describing them in terms of an interactive framework for clinical supervision, suggesting that all three functions should be overlapping and flexible (Driscoll 2007).

Educational (Formative)

- Educational development of each worker in a manner that enhances their full potential.
- Providing knowledge and skills
- Developing self-awareness
- Reflecting on practice
- Integrating theory into practice
- Facilitating professional reasoning



Supportive (Restorative)

- The maintenance of harmonious working relationships with a focus on morale and job satisfaction.
- Dealing with job-related stress
- Sustaining worker morale
- Developing of a sense of professional self-worth.

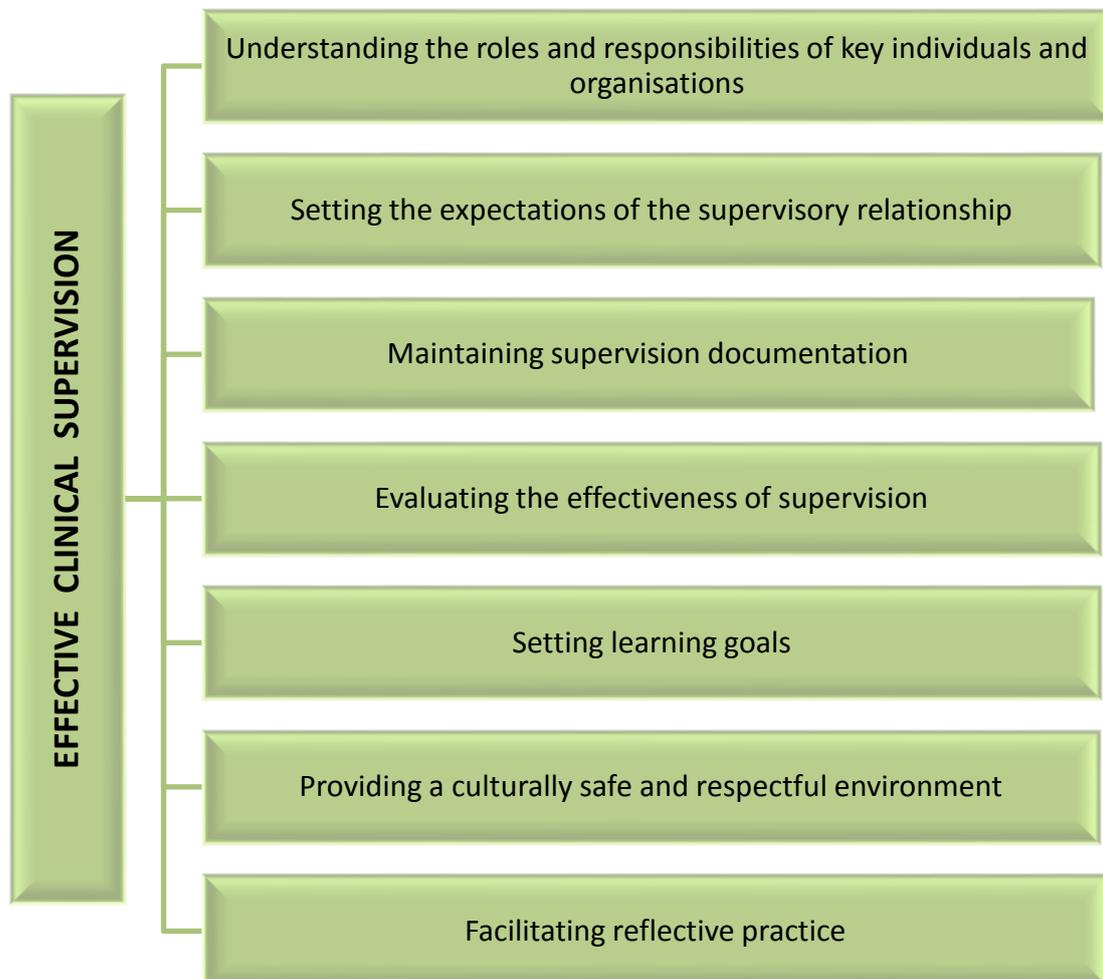
Administrative (Normative)

- The promotion and maintenance of good standards of work, including ethical practice, accountability measures and adhering to policies of administration.
- Clarification of roles and responsibilities
- Work load management
- Review and assessment of work
- Addressing organisation and practice issues.

(NSCCAHS 2009, p.4)

Facilitating clinical supervision

The components that contribute to effective clinical supervision include:



Methods of supervision

Supervision may occur in the following ways:

- On a day-to-day basis
- Structured one-to-one sessions
- In a group environment
- Peer-to-peer

Day-to-day supervision

This is conducted where the student has access to their supervisor in “real time” to facilitate the delivery of patient care. Also known as “informal” supervision and the supervisor may also provide physical or “hands on” assistance if required to build clinician confidence and to support the delivery of safe patient care.

One-to-one structured supervision

This is conducted regularly, as determined by local supervision policies or professional practice requirements. The supervision session time should be prioritised by both the supervisee and the supervisor. Supervision should be conducted in an appropriate environment that facilitates patient care/case discussion, reflective practice, and the setting and monitoring of learning goals and objectives.

Group supervision

The purpose of group supervision is to provide a forum for facilitated open discussion and learning from each other’s experiences. This may include clinical case discussions, topics of interest, interprofessional collaboration and team work. Group supervision is led by a clinical supervisor and can be conducted face to face or via the use of online technology, particularly for rural, remote or sole practising clinicians.

- Do some planning prior to establishing a supervision group, to ensure it is the most appropriate/feasible form of supervision and will meet the needs of the health clinicians requiring supervision
- Carefully consider the composition of the group and selection of staff to be supervised. Important considerations include how many supervisees are in the group, as well as the skills, experience and individual attributes of the supervisees.
- Developing a clear supervision contract that is agreed to and signed by all is essential. This includes the frequency of meetings, participants, model of supervision, roles, expectations, review and evaluation processes and confidentiality.
- It is important that there is clarity about how feedback will be given to individuals in the group and that a culture of learning and self-reflection is fostered amongst participants.
- Group dynamics need to be managed.
- Managing time equitably and ensuring that the needs of each participant are met should be constantly monitored.



Peer supervision

This is usually conducted between two or more experienced health professionals as a method of consultation, problem solving, reflective practice and clinical decision making. It provides a forum for sharing of knowledge and experience and is used to complement more formal avenues of supervision.

For supervision to be effective, it is recommended as a minimum that day-to-day supervision is provided in conjunction with one-to-one structured supervision sessions at a frequency relative to the supervised professional's experience in the clinical area and years of practice.

- Whilst peer supervision is often considered a less “formal” process, it still requires a clear purpose and structure. Contracts and/or agreements are important and should address goals, expectations of participants, how the process will work and any “ground rules”.
- Groups may include staff that have had supervision training, but members share the responsibility for convening and facilitating sessions, with members often taking turns in being the supervisor and supervisee.
- It often works well with staff of similar training and experience that share values but hold a range of experiences.
- It can be a valuable adjunct to formal supervision. It is also a consideration when addressing the needs of experienced clinicians or clinicians in rural settings.
- It can involve a mix of case discussions, theoretical discussions, role plays or case based learning.
- It is important that there is clarity about how feedback will be given to individuals in the group and that a culture of learning and self-reflection is fostered among participants.
- Like all supervision, peer supervision requires regular review to ensure it is meeting participants' needs.

(SES & HIS 2011, p.5)

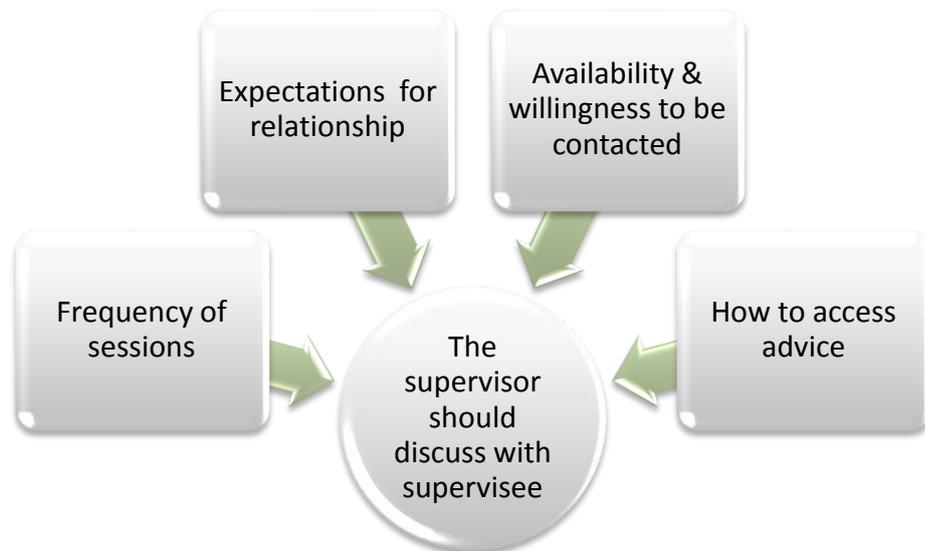
Setting expectations

When establishing a relationship between a supervisee and supervisor, it is important to ensure from the very beginning that clear boundaries are set and both parties have clear expectations of the process.

Staff that are new to a department or clinical area need a comprehensive orientation. An effective way to set expectations from the very beginning is to discuss:

- perceived strengths of both parties
- current concerns or fears
- areas the supervisee would like to develop
- how the supervisee learns best (recognition of different learning styles)
- what level of support the supervisee currently feels they require
- what the supervisee expects from the supervisory relationship
- what has worked/not worked for the supervisee in supervision in the past





This will assist both parties to manage potential issues or concerns as they arise because a point of reference regarding expectations has been established. It is important that the supervisor does not perceive or project to others that supervision is a burden. Supervision is an opportunity to support the development of staff and ensure the delivery of high quality patient care. Supervisors should ensure the staff they are supervising feel genuinely supported and that their role as a supervisor is taken seriously.

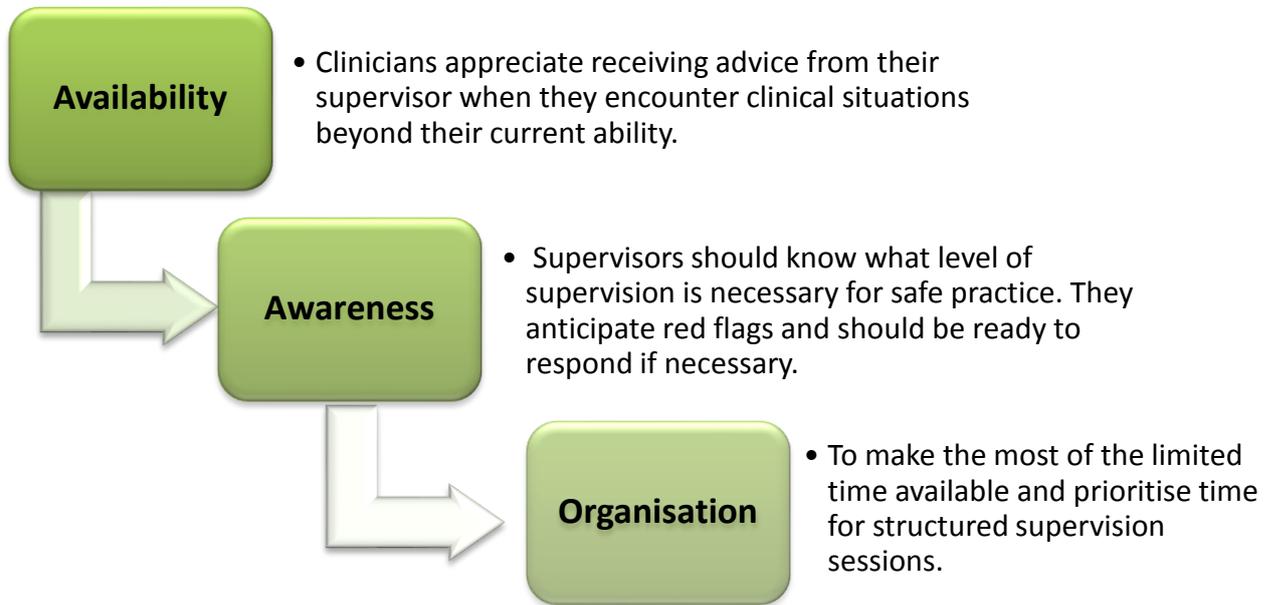
What makes an effective clinical supervisor?

Many health supervisors report that they simply do not have the time to actively supervise staff in the way that they would like. This is a real problem with no easy solutions. However, even small changes in how supervisors organise their clinical duties can make big differences to the effectiveness of supervision.

Time spent actively supervising health professionals are rewarded in two ways. The first is that active supervision improves staff performance, which saves time and enhances patient care. The second is that supervisors who increase their involvement with staff tend to report higher levels of job satisfaction, as playing a leading role in the development of health professionals is personally rewarding. It builds better team interactions and contributes to self-esteem for all involved. In order to provide high quality supervision, there are a number of skills which supervisors should ensure they actively focus on developing.



Supervisory skills



Personal skills

Empathy: Do you remember what it was like to be a more junior clinician? A good supervisor uses insight and understanding to support supervisees.

Respect: Showing respect for clinicians and others promotes positive working relationships. This should occur regardless of individual differences and levels of experience.

Clarity of expectations: A common problem for clinicians is uncertainty about what their supervisor thinks or wants. Clear expectations and honest feedback from supervisors is highly valued.

Confidentiality: Staff are more open and honest about errors or lack of capability if they can discuss these matters in confidence with their supervisor.

A motivating and positive attitude: Most people respond best to encouragement, and feedback is more effective if framed in constructive terms.

Ability to reflect on practice: A supervisor who is able to reflect on their own practice provides a valuable role model for supervisees.

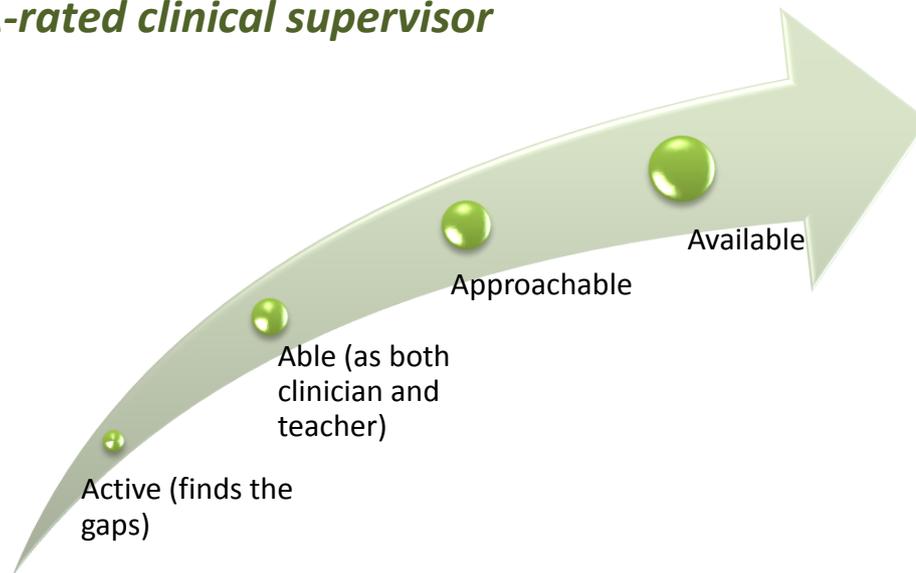
Willingness to allow staff members to grow, be independent and make some mistakes without fear of blame: While the aim of supervision is to minimise risk to patients and build confident and competent professionals, everyone makes mistakes. All supervisors were junior clinicians once and should acknowledge that some of the most important lessons learned were from making mistakes and putting plans into action to prevent them from happening again.

Clinical skills: The modelling of good clinical skills is one of the most effective ways that supervisors help their staff. The clinical skills of supervisors should be up-to-date and evidence-based.



Teaching skills: In order to be an effective teacher it is important to invest in your own professional development to enhance teaching skills.

The A-rated clinical supervisor



A key concept: hands-on, hands-off

An effective supervisor knows when to give staff direction and when to give them freedom of action. To move the staff member from consciously incompetent to consciously competent, the supervisor must actively calibrate the level of support provided.

The concept of “hands-on, hands-off” supervision was originally developed for the training of junior doctors, but can also apply to allied health professionals. Iedema et al. (2008) put forward a model of clinical supervision that recognises the need for support and independence. It was found that supervisees value supervisory support of two kinds:

“Hands-on” supervision — when the supervisor is directly involved in monitoring or helping the supervised clinician as he/she performs tasks.

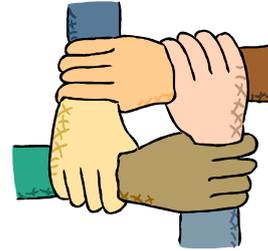
“Hands-off” supervision — when the supervisor trusts the supervised clinician to act independently, leaving space for the supervisee to deploy emerging skills and test growing clinical abilities. However, “hands-off” supervision is not the absence of supervision!

In general, staff need more hands-on supervision when tasks are new and increasing amounts of hands-off supervision as they progress and increase their skills, confidence and competence. Staff members also value an intermediate zone that allows them to shift back and forth between monitored (hands-on) and independent (hands-off) practice.



“Hands-on” supervision

- Guidance on interventions that require further skills development
- Specific skills training sessions
- Seeing patients with supervisor
- Discussing mistakes
- Opportunities to discuss patient management.



“Hands-off” supervision

- Identifying crucial supervision moments
- Allowing room to develop independence
- Feeling trusted
- Providing opportunities for de-briefing and discussion.

From a supervisor’s point of view, both hands-on and hands-off supervision are active processes, requiring the exercise of judgment. To work out how much hands-on and hands-off supervision your staff member needs, it may be helpful to ask yourself: *How far along the trajectory of development is the staff member? When is it time to intervene?*

Contextual Practice – the Certificate III Health Worker

The Certificate III Health Worker (Aged Care & Health Services Assistance) is expected to work within this defined scope of practice document for the duration of their course.

General Expectations throughout the course:

- All work is to be conducted under the direction of the RN or EN
- Provide nursing care in accordance with ethical considerations and legal requirements
- Demonstrate safe practice and contribute to the provision of a safe environment
- Implement the principles of the ‘no-lift’ policy
- Demonstrate effective communication skills when interacting with individuals requiring care, their significant others and colleagues
- Identify the psycho-social, physical, cultural and spiritual needs of the individual
- Contribute to the development / maintenance of individual nursing care plans
- Recognise, report and record changes in an individual’s health status
- Assist in assessing the individual’s potential to contribute to his/her own activities of daily living
- Participate in the promotion of a healthy life style for individuals under their care
- Participate effectively in a multidisciplinary team
- Maintain confidentiality in regard to clinical records and interactions with residents



Procedures that MAY be undertaken during work placement:

Admission procedure:

- Completion of the admission, discharge & transfer procedures of a resident as directed
- Patient and allergy identification
- Safe keeping and documentation of jewelry and valuables
- Physical assessment (overall appearance of resident)
- Documentation of clothing and other belongings (e.g. TV, photo frames etc.)

Clinical skills:

- Bed making – unoccupied and occupied
- Care of hearing aids, spectacles
- Client transfer
- Positioning & skin care
- Hand washing
- Resident feeding
- Bed sponge and showering
- Shaving, grooming, dressing of resident
- Weighing a resident - scales, chairs
- Slide sheets and mobility aids
- Basic Life Support using one & two operators
- Temperature, pulse and respiration
- Blood pressure
- Measuring and monitoring of blood glucose levels
- Urinalysis – routine
- Collection of specimens
- Deep breathing & coughing exercises (under instruction from physio or RN / EN)
- Active and passive exercises (only under instruction of physio, RN / EN)
- Assist the registered nurse with minor procedures as directed

Reporting and documentation:

- Verbal reporting / Handover reports during and end of shift
- Report writing
- Patient care plan
- Completion of patient charts
- ACFI
- Hazard and incident reporting and documentation
- Inspection and recording of urine, faeces, vomitus, sputum and reporting as necessary



Workplace risk assessment:

- Environmental hazard assessment
- Staff health issues
- Risk assessment of resident (manual handling, falls)
- Cleaning/tidying all areas
- Meal supervision-preparation of resident and environment
- Identify emergency situations and respond appropriately (e.g. fire, bomb, cardiac arrest)

Manual Handling / Transfer Techniques:

- Assist residents to ambulate
- Application of splints
- Use of manual handling aids (e.g. slings / slide sheets / pat slide)
- Bed to chair / trolley
- Use of mechanical lifters / aids (2 staff members at all times)
- Assisting with mobility frames / tripod
- Use of crutches, canes, walking frames
- Care and safe use of wheelchairs
- Use of bed / trolley accessories (e.g. trapeze / bed cradle / bed rails)

Basic Nursing Care:

- Bed making (open, closed, prevention of foot drop)
- Full / partial sponging in bed
- Showering a resident
- Oral care
- Eye toilet
- Care of prosthetic devices (e.g. spectacles/ dentures/hearing aids/ artificial limb)
- Simple ear cleansing
- Care of hair, teeth, nails (excluding nail cutting)
- Facial shave and hair washing
- Pressure area risk assessment and care, including use of aids
- Continence management
- Urinary catheter care
- Giving and removal of bedpan/urinal
- Application and care of uridome
- Penile / perineal hygiene
- Feeding a patient without dysphagia
- Promoting sleep and rest
- Care of the resident when giving - vomit bowl, sputum mugs.
- General bandaging (excluding new amputations)
- Report pain and ensure intervention when appropriate e.g. prior to exercise



Infection control

- Standard Precautions
- Principles and prevention of cross contamination
- Hand washing
- Use PPE
- Determine sterility of items
- Disposal of sharps
- Disposal of contaminated waste
- Cleansing and sanitising – bed unit, bed pans, urinals, bowls, sputum mugs

Death & dying

- Specific religious/ cultural beliefs
- Care and support of dying and their significant others
- Care of the body after death

Wound Care Management

- Simple dressing - Aseptic (clean field wound concept) technique
- Observation and reporting status of wound

Oxygen Therapy

- Care and observation of patient receiving oxygen therapy
- Safety, use and identification of medical gas cylinders

Collection of Specimens

- Urine (excluding urinary catheters)
- Faeces
- Vomitus
- Sputum

Bandaging

- Re-application of arm sling

Procedures that MAY NOT be undertaken during work placement:

Legal aspects:

- Witness consent forms
- Provide information on resident condition to:
Ambulance officers or Police, Relatives, Ministers of Religion / Media representatives
- Accept verbal or telephone orders
- Transcribe medical orders to charts, books and forms etc.



Respiratory:

- Percussion and vibration
- Insertion of an oro / naso pharyngeal airway
- Initiation of oxygen therapy
- Deep suctioning of the trachea through a tracheostomy tube
- Use of spacers, puffers, nebulisers

Intravenous:

- Check or manage blood, blood products or IV fluids
- Venepuncture / Cannulation or Remove IV cannulas

Miscellaneous:

- Provide sole escort for any client
- Apply infra-red ray therapy

Medication Administration:

- Administering medication or checking medications

GI Tract:

- Regulate suction on an IG tube
- Care of a nasogastric tube / PEG tube

Urinary:

- Perform bladder irrigation or change solutions
- Perform catheter specimen of urine
- Change indwelling catheter drainage bags

Eyes & ENT:

- Syringe an ear
- Take throat swab

Wound Care:

- Perform wound irrigations
- Dress or redress burns
- Probe or pack wounds

Cardiovascular:

- Measure patient for TED stockings

(NSW TAFE Commission)



Workshop 2: Interpersonal communication skills

It is important that you develop your communication skills and consider it a priority to review and revise them continuously to address organisation standards.

The word *communicate* is often used in conversation, for example, ‘She or he is a great communicator’ or ‘we just can’t communicate’. Usually, when we talk about someone being a ‘good communicator’, we mean they have good communication skills and use them effectively. When people say they are ‘not communicating’, they usually mean they are not communicating effectively (not getting the right message across) or are not feeling comfortable about their interaction with someone.

Personal skills in communication

The word *communication* can be broadly defined as *the sending or receiving of messages containing meaning*. The message usually contains thoughts, ideas, opinions, feelings and information. Communication can be: verbal (spoken) or non-verbal (e.g. body language) or written. (NSW Department of Education & Training 2007)

Interpersonal refers to *an interaction between two people or between people in a small group*.

We can then join these two definitions together and define *interpersonal communication* as being:

Verbal and/or non-verbal interaction between two people or in a small group that involves sending and receiving messages with meaning.

Good communication skills are a bit like physical exercise. Even the most unfit among us can improve our physical abilities with some learning and practice. People with effective communication skills tend to do well in life—that is, in both employment and in relationships. Good communication skills don’t just happen and effective communicators are aware of the skills they use and work at improving those skills; they work at becoming fitter communicators.

Communication can be divided into two broad types:

- verbal
- non-verbal

Verbal communication involves all the messages that are sent using words.

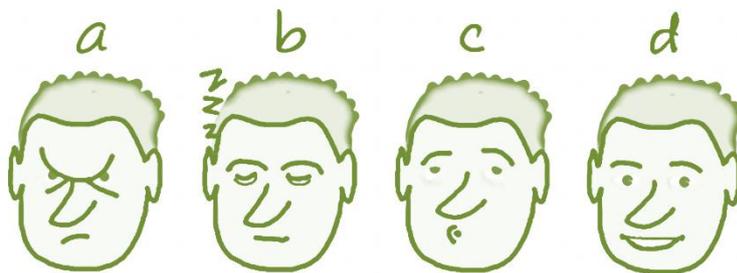
Non-verbal communication refers to all those messages that are not expressed in words. Non-verbal communication is sometimes called ‘body language’. Sign language is also an example of non-verbal communication.



Communicating verbally (with words) is important when we are trying to give someone information, for example, our address. We call the verbal part of a message the *content*. The content of a message usually relates to our thoughts and ideas about a particular issue, or it might refer to the information we provide to someone. Words, however, only convey part of the message. If we want to assess how someone feels about what they are saying we look to the non-verbal cues such as the tone of the voice. It is often the ability to read non-verbal cues accurately and confidently that makes or breaks an interpersonal communication.

Non-verbal cues

Who would you rather deal with?



You probably chose figure (d). You did this because you made a decision by considering non-verbal communication (in this case, the open smile) or body language. Studies have shown that approximately 75% of our message is non-verbal so we must be as careful of our body language as of the words that we use. (NSW Department of Education & Training 2007)

Visual cues



Which one of these faces would a client find easiest to communicate with?

The face that is turned away offers no visual cues to support an imperfectly heard voice.

The face with hands over the mouth offers only limited expressive information and no possibility of speech reading.

The heavily bearded face is also difficult to “read”.

A face that is open, directly visible, and offers normal (not exaggerated) lip movement makes communication easiest for clients.



Barriers to effective communication

We all communicate on a daily basis, often with lots of different people and in different situations. The amount of communicating we do and the fact that we do it with lots of different people can make communication complicated and many of us create barriers in interpersonal communications.

We may wrongly believe that communication is easy, so when we come across problems in communication we give up or blame the other person. This is because we don't know the nature of the problem and how to deal with it.

A common barrier to effective communication is when someone starts to tell a story and the listener jumps in and starts talking about when a similar thing happened to them or they change the subject totally. This is very frustrating for the person wanting to share and a great way to kill a meaningful conversation and, if it keeps happening, a good friendship.

Another great barrier to effective communication is when the listener tries to solve the talker's problems. This is usually done from a place of caring and concern, but as most people just want someone to listen to them, it can prevent them from sharing what they want to share. Also, besides being disrespectful (most people have the skills and insight to solve their own problems), we tend to give advice before the other person has finished telling us their problem. Again, we are not listening to what someone is saying!

Listening

Cues to poor listening are:

- poor eye contact
- looking elsewhere
- asking irrelevant questions
- a closed posture (or they even turned away from you)
- a bored or uninterested tone of voice
- they kept on interrupting you
- they diverted the conversation to themselves
- they allowed themselves to be interrupted by someone or something else

All these behaviours send the message, 'I'm not interested'. When we receive this message, we tend to feel uncomfortable, boring, uninteresting and, if we are feeling vulnerable, we can feel devalued and worthless. Showing that we are genuinely interested in a person and their story is, therefore, the first step in communicating effectively in our industry.

(NSW Department of Education & Training 2007)



The way to show we are attending to what someone is telling us is to use our non-verbal behaviour appropriately. We need to show people that we are physically and emotionally prepared to listen to them.

How to show someone you're listening

- Remove physical barriers.
- Be on the same eye level as your client. When interviewing clients, try to sit close and not to sit behind a large desk. This barrier can convey the message that you are a distant 'authority figure' as well as making it more difficult to hear and see you).
- Be aware of personal space and face the client.
- Use eye contact in a culturally appropriate way. In Australia, eye contact is perhaps the most powerful way of demonstrating that we are listening and interested in what someone is saying. To facilitate good eye contact, you should make sure you are sitting on similar chairs that help you to be at the same eye level as your client. However, you should be aware of different cultural protocols and use eye contact appropriately—as different cultures have different values attached to eye contact. For example, in western cultures it is usually considered appropriate to look someone in the eye when you are speaking to them. People can even be viewed as dishonest if they don't look you in the eye. This is not the same for all cultures. In some cultures, for example in Aboriginal cultures, it is thought a mark of respect to look down or away if you are speaking to someone in authority. When listening to someone make sure that you use the right amount of eye contact, taking into account their culture and their understanding of your culture.
- Maintain an open, relaxed body posture.
- Communicate with warmth and empathy.
- Use silence positively. If there is a moment of silence when someone is telling us a problem, we may become uneasy and want to fill it up with words. We often think this is the moment to give advice or solve the problem for the client. One of the important things we need to learn in order to be a good listener is to cope with these uneasy feelings when there is silence. We need to allow the other person silent time to reflect and collect their thoughts, and often they come up with their own solutions!
- Don't rush the client. People are often upset, anxious or distressed in some way when they have come to us for help and are trying to discuss a problem. They may never have spoken about it before and not have a clear way of expressing what they need or what the issue is. The best thing we can do for them is give them time. If we rush them, this will only escalate the distress. This takes tolerance, and awareness that we need to set aside time for this to happen.
- For clients who do not have English as their first language, the presence of someone with better English skills is recommended.



- Email and SMS have become preferred methods of communication for many people. Check and respond to messages on a daily basis.
- When you are having difficulty in making yourself understood you should re-phrase the sentence not just repeat it at a louder level.

(NSW Department of Education & Training 2007)

Using questions

Another way of letting someone know we are listening to them is to ask them questions. By asking questions we can clarify what they are saying and find out more about their story.

Tips for asking questions

- Only ask questions that will help move the client forward.
- Avoid asking questions because you feel at a loss and asking a question gives you a way out.
- Avoid questions that satisfy curiosity but have little or no relevance to the issues at hand.
- Too much questioning can make the client feel they are being interrogated.
- Too little questioning can imply a lack of interest or concern.
- Avoid questions that ask for trivial information which does not relate to the client's immediate concerns.

Types of questions

There are two broad types of questions: open and closed.

Open questions

Open questions encourage the exploration of thoughts and feelings as they ask the talker to describe something in their own words. Open questions are great to use when you want the other person to expand on the topic or issue they are talking about.

Open questions are useful to find out about a problem, for example, 'What seems to be the problem?'

Closed questions

Closed questions usually lead to a specific answer and often narrow down communications. They usually begin with: (Is ... ?, Are ... ?, Have ... ?, Has ... ?, Do ... ?, Did ... ?, Does ... ?, Can ... ?)

They require either a yes or no answer or a short factual comment. Closed questions don't encourage clients to talk further. They are useful, however, if you want a specific answer, e.g., 'Are you on medication?', 'Do you experience dizziness or loss of balance?' 'Do you hear ringing or other noises in your ears?'



The use of closed questions in a directive way to 'sell' a product or a course of action (e.g., 'Would you like to pay by cheque or credit card?') is a forced choice question designed to close a sale and is not appropriate in a clinical environment.

Using language to build positive relationships

Words are a powerful tool. Using the right words can help you to build strong, long-lasting client relationships. Inclusive language uses words such as 'we' and 'our' to identify you and the client, or the organisation and the client as having the same goals or objectives. Remember too that using a person's name is an important part of building positive relationships.

Speaking

One easy way to improve your communication skills is to make sure your voice sounds interesting when you are speaking. Some people have developed the habit of talking in such a way that their voices sound flat. They put very little expression into their speech and tend to sound unhappy even if they're not. You will find it helpful if you can be cheerful and positive. If you put your personality into your voice it can become a wonderful tool and very effective.

Voice quality is very important when dealing with clients who have hearing difficulties. You must speak clearly and slowly enough to allow one word to be differentiated from the next. You should take care to maintain a reasonable level of speech and in particular not to drop your voice at the end of a sentence.

Take care to give the client every opportunity to seek additional information by pausing or asking 'Have I explained that adequately?' at intervals while you are giving complex instructions.

Expressing empathy

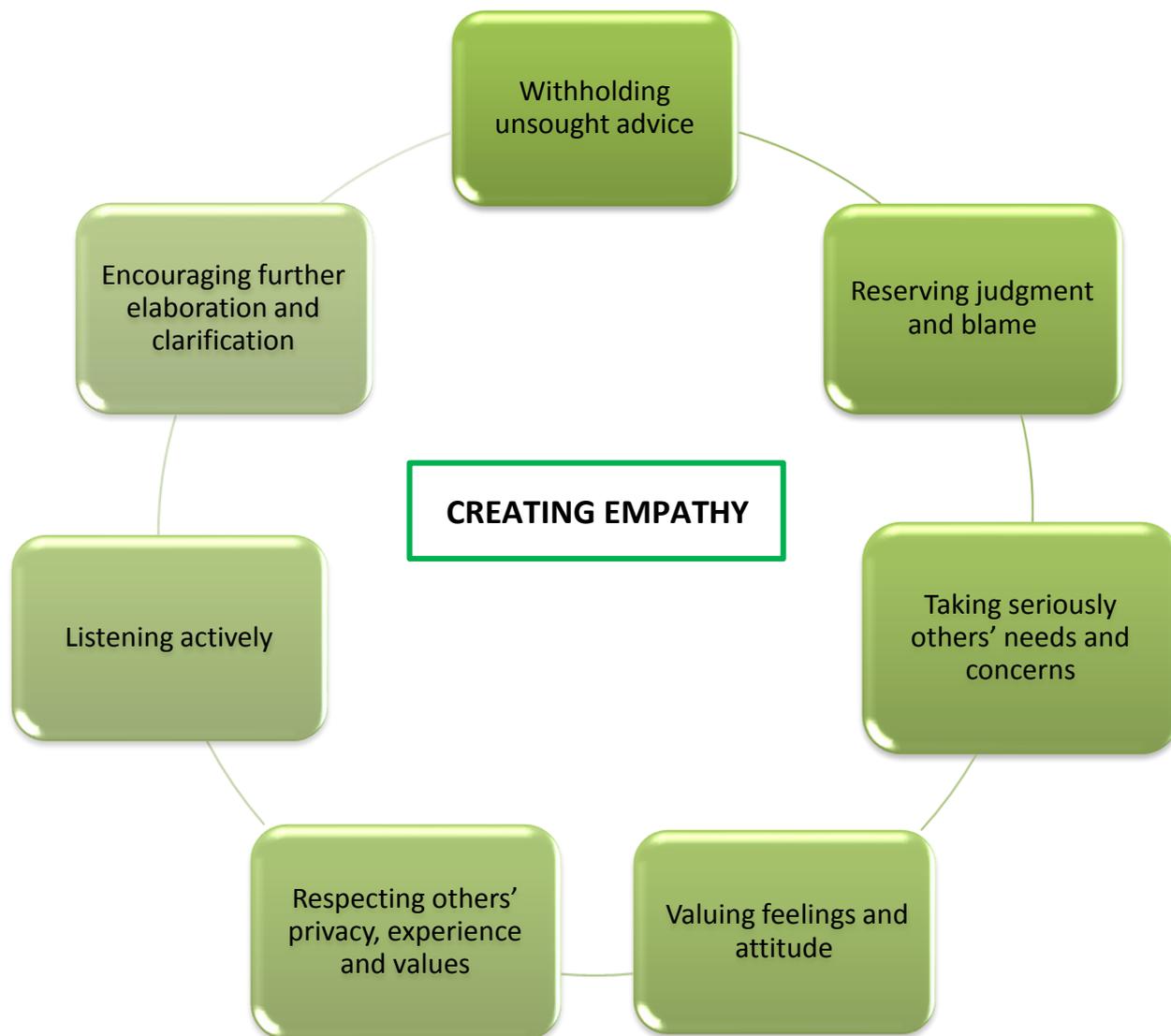
Empathy is sensing another's feelings and attitudes as if we are experiencing them ourselves. It is our willingness to enter into another's world and be able to communicate to that person our sensitivity to them.

Simply asking if a client found parking easily shows some empathy for their situation.

Remember that it is easy to feel empathy for someone with a similar world view. The challenge is to feel empathy when someone thinks in a very different way.

(NSW Department of Education & Training 2007)





Recognise individual and cultural differences

These days, the term ‘culture’ is closely related to the term ‘community’. Culture includes the values and common behaviour of a group. Culture is what defines or describes one community in contrast to what defines or describes other communities.

Sometimes people equate ‘culture’ with ethnic and/or religious background. While these elements are important in people’s identity, so are many other elements. Elements include ethnic background, age, and sexual preference.

Being part of one culture doesn’t stop you from being part of another. Someone whose mother is of one culture and whose father is of another might relate to both communities and cultures. Some people in such situations might feel a stronger affiliation with one culture than another.



Workplace culture

These days all workplace positions include communication roles, even if they are only part of someone's job description.

The way people communicate at work will depend on many different things, including the:

- workplace culture
- various cultures and norms of the staff, clients and customers
- specific audience/s and/or participants in each communication
- purposes of each communication
- amount of detail and complexity that needs to be shared
- time available for each communication

Each workplace has its own culture, values and standards of behaviour that are considered normal and appropriate. Sometimes these things are formal. They might be structured into a work policy or mission statement. At other times, they are informal norms and expectations.

Some common elements of workplace cultures are:

- type and standard of dress
- standard of language and level of politeness
- level of commitment
- family friendliness, for example, whether people who need time off to care for sick children are frowned upon or supported
- level of commitment to the customer

(NSW Department of Education & Training 2007)

The importance of attitude

Not surprisingly, a positive, respectful attitude is one of the most helpful aids to communication. If we genuinely have good will and respect toward someone, we are much more likely to find appropriate and effective strategies for communicating with them. Respect and attitude are precursors for good listening – and everyone wants to be listened to.

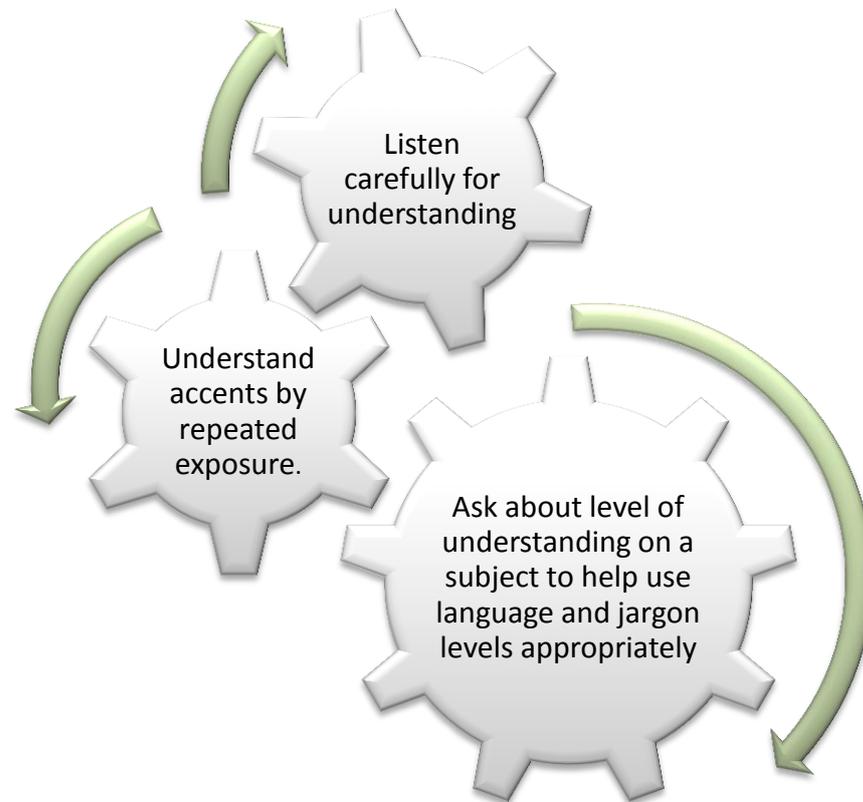
Respect and a positive attitude are important factors in communicating with everybody – those from our own culture/s and those from other cultures.

Misunderstandings

Misunderstandings can occur easily. They are even more likely when we converse with someone whose first language and culture are different to ours. In such cases we need to be open-minded and patient. And we may need to clarify things more often to ensure we are accurately receiving the message.



Strategies to overcome misunderstandings:



Interpersonal communication with colleagues

Your interpersonal communication needs to be carried out in a manner that enhances a client-centred approach to hearing health care consistent with organisation standards. Your ability to quickly or carefully consider a situation so that you can work out what action to take, and the probable consequences of your action, is useful because you may often be in this situation.

Your attitude towards clients and how you deal with their situation are important parts of your role. People react to anxiety and hearing loss in different ways and some may appear aggressive while others may be very anxious. It is important to maintain a calm approach at all times and to show sympathy to those who are in need of support.

Experience shows that listening to people rather than telling them what to do is the best approach. This way you are more likely to gain their cooperation and the problem can be dealt with more quickly. It is important that you maintain a professional manner by being courteous and attentive to clients at all times.

By presenting a positive image to colleagues, you are creating the best possible setting for clear communication to occur. When you communicate clearly with each person you deal with you will give them the attention they feel they deserve. When you communicate clearly with all of them you are actually removing barriers before they appear.



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