Alberta College of Speech-Language Pathologists and Audiologists

Hear. Speak. Connect.

Patient Relations eCourse

Self-Assessment Checklists

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Communication Skills

Patient relationships are the most important factor in building trust. Trust is built on transparency, openness and communication. Studies show that patients often feel intimated when visiting a speech-language pathologist or audiologist because they do not get clear or consistent information and are unclear about why and what procedures they must endure.

Use this short checklist to assess your communication skills with patients.

1. Do you take the time to explain the agenda for each patient's visit?
2. Do you feel rushed within each appointment?
3. Do you explain each procedure to the patient carefully and ensure you are understood?
4. Do you get informed consent before doing any work on the patient?
5. Do you obtain consent prior to touching the patient?
6. Do you ask the patient if he/she has any questions or concerns?
7. Do you avoid inappropriate comments, remarks or jokes?
8. Do you treat each patient as an individual?
9. Do you speak directly to the patient, in a relaxed, non-judgmental and supportive manner?
10. Do you carefully observe the patient's expressions and non-verbal language to ensure understanding and to detect any discomfort or pain?
11. Do you adjust your language to deal with children, seniors and individuals from other cultural backgrounds?
12. Are you mindful of, and adjust to, hearing difficulties, language barriers, cultural and religious values?
13. Do you apologize quickly and sincerely to the patient when appropriate?
14. Is your language and approach sensitive to the patient's feelings?
15. Is your communication with patients non-judgmental and non-threatening?
16. Do you talk less and listen more, allowing your patients to respond at their own pace?
17. Are you sensitive to any inconsistencies and discrepancies in the information your patients provide you?
18. At the end of the appointment, do you explain to each patient anything they must do and discuss plans for their next appointment?
19. Do you provide patients with information that they can take home with them?
20. Do you enter into the patient's chart/record, any significant information about the patient that will facilitate better communication in subsequent visits?

Listening Skills

Active listening is a very important part of a speech-language pathologist's and audiologist's communication skills. Effective listening enables the collection of accurate and correct information, as well as being able to respond and communicate to the patient when providing health care services.

Use this Listening Checklist to assess yourself as to how good a listener you are. Use the results to work on improving your listening skills.

1. Are you consciously aware of your listening strategy in every conversation?
2. Do you get impatient in a conversation and finish the speaker's sentences?
3. Do you create and keep eye contact when you are listening?
4. If the patient is long-winded or boring, do you stop listening?
5. When you are unable to commit your full attention, do you let the patient know that you are distracted?
6. Do you listen more than you talk?
7. Do you ask for clarification when required in your conversations?
8. When someone is speaking to you, do you generally focus on paying full attention to them?
9. Do you make an effort to demonstrate your interest in the conversation through your body language?
10. Do you work on improving your listening skills?
11. Are you willing to change your opinions and beliefs after hearing someone else's thoughts and experiences?
12. Do you look as if you are listening in personal meetings (lean forward, keep eye contact)?
13. Can you tune out distractions when listening?
14. Do you pay full attention to what the patient is saying, or do you partially listen while preparing mentally a response or follow-up question?
15. Do you value what other people say, even if you don't agree with them?
16. When listening, do you pay attention to the patient's non-verbal cues such as body language and facial expressions?
17. Do you work on developing an ability to remember important facts?
18. When in a conference or phone conversation, do you make notes about the most important details?
19. Do you repeat the essential details of a conversation back to the patient to confirm that you have understood him/her correctly?
20. Do you make an effort to show interest in what the patient is saying?

Boundary Crossing Signs

Boundary crossings occur when the behaviour of a regulated member deviates from the accepted boundaries of a therapeutic relationship.

How do you know when you have crossed a boundary? Use the following checklist to assess if you have crossed a boundary with a particular patient. If yes, then you may need to take appropriate actions to reset those boundaries or else transfer the patient to another health care professional.

Do you:

1. Spend time with the patient beyond the scheduled appointments or normal office hours?
2. Provide the patient with your personal contact information?
3. Communicate and interact with the patient after hours using texts, e-mails or social media?
3. Share or disclose personal information about yourself to the patient?
4. Swap patient assignments to allow more time to be with a particular patient?
5. Provide less thorough care for other patients to allow more time for a particular patient?
6. Act or feel possessive about the patient?
7. Provide a different and better standard of care to that particular patient than to the rest?
8. Keep secrets with the patient and not share this information with the rest of the team?
9. Respond defensively or guardedly when questioned about interactions with the patient?
10. Record and report selectively rather than provide complete record keeping and reporting?
11. Make exceptions to office rules and protocols for the patient?
12. Exchange more than small appreciation gifts with the patient?
13. Deny the patient is a patient?
14. Deny you have crossed a boundary from a therapeutic relationship to a non-therapeutic relationship?

Sexual Misconduct

Sexual misconduct is defined as any incident or repeated incidents of objectionable or unwelcome conduct, behaviour or remarks of a sexual nature by a regulated member towards a patient that the regulated member knows, or ought to reasonably know, will cause offense or humiliation to the patient, or adversely affect the patient's health and well-being.

How often do you engage in the following activities when providing services to your patients?

1. Making sexually demeaning gestures or expressions?
2. Leering and staring, particularly at the patient's intimate areas?
3. Making sexually suggestive remarks, innuendos and jokes?
4. Giggling or laughing at sexual comments that cause awkwardness or embarrassment?
5. Making lewd or suggestive comments, inquiries or jokes about a person's sexual habits, appearance or sexual attractiveness?
6. Making verbal threats that have sexual overtones?
7. Making sexual flirtations, advances or propositions?
8. Making an implied or express promise of reward for complying with a sexual oriented request?
9. Making a threat of reprisal if the patient does not comply with a sexually oriented request?
10. Inappropriate physical contact such as touching, patting, pinching or punching?
11. Making persistent unwanted contact such as standing close or brushing up against a patient unnecessarily?
12. Using procedural techniques that may involve touching in an intimate area such as placing items on a patient's chest?
13. Hugging, kissing or touching the patient without getting their permission first?
14. Displaying sexually offensive or derogatory material in the work area?
15. Asking inappropriate or unnecessary questions about sexual health, habits or activities when compiling a health history?
16. Texting or emailing sexually oriented messages, comments or images to patients?
17. Requesting or coercing patients to respond to sexual texts or e-mails?
18. Participating in sexually-oriented communications with patients on social media?

Any one of these activities may be grounds for a sexual misconduct complaint.

Sexual Abuse

Sexual abuse is defined by the *Health Professions Act* as the threatened, attempted or actual conduct of a regulated member towards a patient that is of a sexual nature.

Have you, or do you engage in the following activities when providing health care services?

1. Threaten, attempt or have actual sexual intercourse with a patient?
2. Threaten, attempt or have actual genital to genital contact with a patient?
3. Threaten, attempt or have actual genital to anal contact with a patient?
4. Threaten, attempt or have actual oral to genital contact with a patient?
5. Threaten, attempt or have actual oral to anal contact with a patient?
6. Threaten, attempt or engage in actual self-masturbation in the presence of a patient?
7. Threaten, attempt or actually masturbate a patient?
8. Encourage a patient to masturbate in front of you?
9. Threaten, attempt or actually sexually touch a patient's genitals, anus, breasts or buttocks?

EXCEPTIONS:

Conduct, behaviour or remarks are NOT of a sexual nature if appropriate to the professional services provided such as a health assessment or medical examination.

It is NOT sexual abuse if the regulated member engages in consensual sexual acts with a patient who is:

- The regulated member's spouse
- The regulated member's adult interdependent partner
- An individual who had an ongoing pre-existing sexual relationship with the regulated member prior to the date when the SLP or audiologist first had a professional interaction with the individual.

Response to Disclosure

What should a speech-language pathologist or audiologist say and do if a patient discloses that they have experienced sexual abuse or sexual misconduct in the past? Communicating to the survivor that they have been heard and believed is critical! The practitioner's immediate verbal and non-verbal responses to disclosure can have a significant impact on the patient.

Here is what you should do:

1. **Accept the information**. Individuals need to know that you have heard them and accepted the information. If you do not respond appropriately, it may be interpreted as a lack of interest. This may deter them from mentioning it again. They also may stop seeing you, or even worse, avoid all health care services.

2. **Express empathy and caring**. Survivors want to know that you care about them. Simple statements of empathy and concern can convey both compassion and interest.

3. **Clarify confidentiality**. Confidentiality is a vital concern for many survivors. Therefore, it is important that you confirm the degree of confidentiality that you can extend.

4. **Acknowledge the prevalence of abuse**. Understandably, many survivors feel isolated and alone in their experience. Having you demonstrate awareness about the prevalence and long-term effects of sexual abuse normalizes the experience for survivors and may reduce their sense of shame.

5. **Validate the disclosure**. You must validate the courage that it took to disclose this traumatic experience. Let the person know that you believe what they have told you. Failure to validate the individual's experience, silence or judgmental comments can be shaming and contribute to reticence to disclose in the future.

6. **Address time limitations**. It is important that the time constraints are communicated in such a way that will not leave survivors feeling dismissed or that they have done something wrong by disclosing. Consult with the individual and book another, longer appointment.

7. **Offer reassurance**. You should reassure survivors that you applaud the courage it took to talk about past abuse. Tell them that the information that has been shared will be useful to you in providing appropriate health care.

8. **Collaborate to develop an immediate plan for self-care**. Some survivors have unsettled feelings or flashbacks of their abuse as an immediate after-effect of disclosure. You should caution individuals who have just disclosed to be prepared for these feelings. You should work with the individual to make sure a specific self-care plan and supports are in place.

9. **Recognize that action is not always required**. You need to recognize that a survivor may simply want you to have the information. They may not necessarily expect you to do anything about it except to be present with them in the moment. But ask to be sure.

10. **Ask whether this is the patient's first disclosure**. This can help you learn what supports the survivors already have and what they may still need.

Here is what you should NOT do:

1. **Convey pity**. “Oh, you poor thing”.
2. **Offer simplistic advice**. “Look on the bright side.” “Get over it.” “Don’t dwell on the past.”
3. **Overstate or dwell on the negative**. “Something like that can ruin your whole life.”
4. **Smile**. A neutral or concerned expression is more appropriate.
5. **Touch**. Do not touch without permission even if you intend it as a soothing gesture.
6. **Interrupt**. Let the individual finish speaking.
7. **Minimize or ignore** the experience of abuse or decision to disclose. “How bad could it be?” “What’s that got to do with your hearing (or speech) problems?”
8. **Ask intrusive questions**. Do not ask questions about the abuse that are not pertinent to the examination, procedure or treatment.
9. **Disclose** your own history of abuse.
10. **Give the impression that you know everything** there is to know about abuse.

If you think that you have inadvertently responded to the disclosure in an inappropriate way, or if the patient’s non-verbal feedback suggests a negative reaction to your initial responses, you should immediately clarify the intended message and check with the survivor for further reaction.

Source: *Handbook on Sensitive Practice for Health Care Practitioners*. Public Health Agency of Canada (2008).

Trauma-Informed Practice Principles

By consciously applying these principles of trauma-informed practice, the SLP and audiologist can not only enhance the therapeutic relationship with the survivor, but will also prevent re-traumatizing the patient. Many survivors have indicated how interactions with health care practitioners have left them feeling violated and re-traumatized.

Principle 1: Respect

Conveying respect for another involves seeing the "other" as a particular individual, with unique beliefs, values, needs and history. Survivors often feel diminished as human beings and may be sensitive to any hint of disrespect. Many survivors say that being accepted and heard by a practitioner helped them to feel respected.

Principle 2: Taking time

Time pressures are a reality to today's healthcare system. Being hurried often results in survivors feeling depersonalized and devalued. For some, being rushed or treated like an object diminishes their sense of safety and undermines any care that follows. Feeling genuinely heard and valued is healing in itself.

Principle 3: Rapport

While rapport is essential to every therapeutic relationship, it is an absolute necessity to facilitate safety for survivors. Practitioners who are warm and compassionate facilitate good rapport and subsequent feeling of safety. Good rapport also facilitates clear communication and engenders cooperation.

Principle 4: Sharing information

Being told what to expect on an ongoing basis helped many survivors allay their fear and anxiety and often prevented them from being triggered by unanticipated events. Having a running commentary on what you are doing does not require any additional time, is a great tool for patient education, and can be tremendously reassuring to the survivor.

Principle 5: Sharing control

Sharing control of what happens in the interactions enable the survivors to be active participants in their own care, rather than passive recipients of treatment. The process of ascertaining informed consent is a vital part of sharing control, as well as a legal responsibility. Informing, consulting and offering choices are all part of seeking consent and sharing control.

Principle 6: Respecting boundaries

For many survivors, healing from abuse involves establishing or re-establishing personal boundaries and learning healthy and effective boundary maintenance strategies. By demonstrating respect for and sensitivity to personal boundaries, the practitioner models healthy boundaries and reinforces the patient's worth and right to personal autonomy.

Principle 7: Fostering mutual learning

Many survivors need encouragement to become full, active participants in their own health care. As practitioners learn about the health effects of interpersonal violence and about working effectively with survivors, the best teachers may be the survivors themselves.

Principle 8: Understanding non-linear healing

Healing and recovery from sexual abuse is not a linear process. As a result, the degree to which a survivor is able to tolerate or participate in treatment may vary from one health care encounter to the next. Therefore, practitioners must check in with their patients throughout each encounter and adjust the behavior accordingly.

Principle 9: Demonstrating awareness and knowledge of interpersonal violence

Many survivors look for indications of a practitioner's awareness of issues of interpersonal violence. Incorporating these principles of trauma-informed practice into daily practice indicates that an SLP or audiologist is aware of the issues and is able to deal with the special needs of survivors.

Source: *Handbook on Sensitive Practice for Health Care Practitioners*. Public Health Agency of Canada (2008).