Clinical recommendations for using DIALOG in an inpatient setting

This document provides recommendations and best practice guidance that aims to standardise the use of DIALOG(+) in an inpatient setting.

This has been developed by Healthy London Partnership in conjunction with clinical and transformation leads in London Mental Health Trusts as well as those with lived experience.

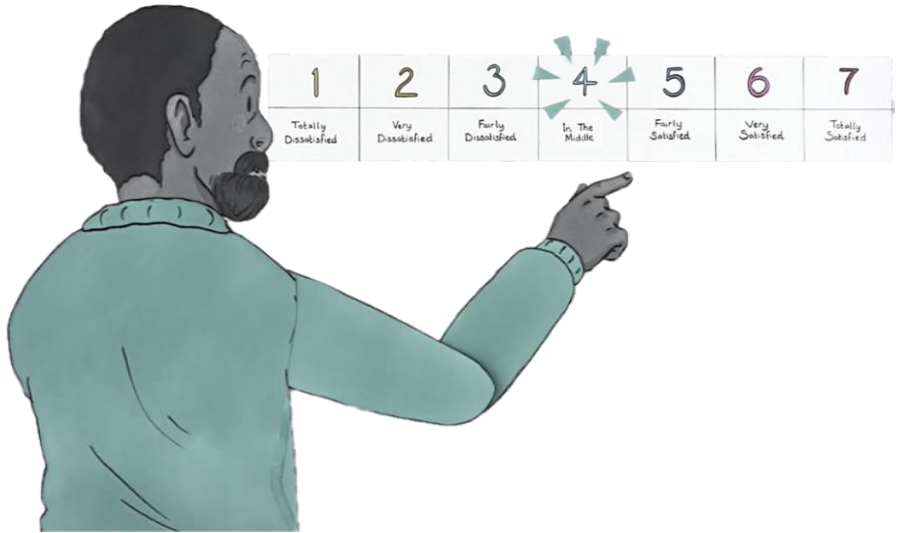
See appendix for full list of contributors.

Healthy London Partnership

Introduction and purpose

DIALOG(+) can be used in a variety of different contexts both as a Patient Reported Outcome and Experience Measure (i.e. DIALOG) as well as a care planning intervention (i.e. DIALOG+).

This document provides recommendations and best practice guidance that aims to standardise the use of DIALOG(+) for an inpatient setting.



01 Background and context

> **It is about forging that relationship via DIALOG+; it is about letting people know what that entails.**
>
> **Lived experience expert, ELFT**

Policy background

The Community MH Framework for Adults and Older Adults aims to ensure that people with serious mental illness are supported by a **single care plan** that is **co-produced and personalised-** taking into account **all of their needs** and is **accessible to all involved** in the person's care.

The framework states that the care plan will include:

Timescales for review, which should be discussed and agreed with the person and those involved in their care at the outset.

Shift away from risk assessments and ineffective predictive approaches to safety planning and "positive risk taking", with staff supported by managers and to do so under progressive, partnership clinical governance arrangements.

Focus on improved outcomes and will deliver place-based integrated mental health care to people whatever their level of need

What is the challenge that we are trying to respond to?

Current care planning is often **dependent on the setting or service rather than the service user -** this is the case for an inpatient care plan.

This can cause several consequences…

Information may be lost from inpatient to community setting as some elements may lie outside my care and safety plan.

Does not effectively capture the things that matter most to the individual, rather the service that they are using.

Current care plans may not capture all information that is relevant to service user with different complexity of needs.

Does not always involve and include all healthcare professionals that are involved in someone's care - it does not follow their whole care journey.

Can lead to more than one care plan which can be detrimental to the service user and may open up critique from CQC inspections.

Why is this important to inpatient?

We want to….

Develop **one comprehensive care plan** that will **follow the service user throughout their care journey**, helping a healthcare professional and a service user **come together to understand what matters most to them** and **how they achieve it through a meaningful conversation.**

People love to tell you how you feel, or how you should be feeling…

DIALOG is an opportunity for you to think and reflect and note what you think and feel and experience

Lived Experience Expert, ELFT

The care plan needs to **follow the person across services** to enable….

Empower the service user to shape their own recovery

Improve the conversation between the healthcare professional and the service user

Minimise fragmented care for the patient

Guidance resource

We are developing a clinical recommendations document on using DIALOG in an inpatient setting. This document will provide guidance on the do's and don'ts' of using it in this setting.

Our guidance is driven by ongoing work to simplify care planning in an inpatient setting…

1 patient, 1 care plan; The care plan to follow the person across services and offers continuity of care planning across settings (e.g. inpatient and community) thereby potentially improving the conversation between staff and patient and minimising fragmented care for the patient.

Develop **one comprehensive care plan** that will replace the existing nursing inpatient care plan and will **incorporate additional inpatient specific domains and DIALOG principles**.

…as well as adding context around existing DIALOG(+) initiatives and plans in this service domain:

Additions to DIALOG + care plan

- Add an **inpatient care plan form hyperlink** added to the DIALOG + form near the top.
- **Add additional fields** not captured in existing DIALOG + care plan (see below).

Develop an inpatient care plan editable letter

- Similar to existing letter that includes **DIALOG + care plan AND the new fields incorporated** in a single document

The document will include additional considerations; for the Mental Health Act and Mental Capacity Act, leave arrangements, visit arrangements, nursing observations among others.

02 How can DIALOG be meaningful for everyone in the inpatient setting?

> This is about empowerment, this conversation is being driven by the service user, it is about them so they can formulate a plan so they can achieve whatever hopes, dreams and goals they have.
>
> Lived experience expert, CNWL

Does the person understand the question?

- For DIALOG(+) to be carried out, it is important at first to determine whether the service user can understand the questions being asked, rather than formally assessing capacity.
- DIALOG domains provide an insight into the service user's subjective experience, which by definition means if the question is understood, then the answer is relevant. At its core, DIALOG(+) is a PROM/PREM and a care planning tool grounded in solution focused therapy.
- Therefore, deciding when and how to perform DIALOG is similar to, but not the same as determining whether a person's mental capacity is diminished, for example, as a result of SMI (e.g. schizophrenia or bipolar disorder), learning disabilities, or brain damage.

DIALOG should be carried out in a time-specific and question-specific way – for example, a person may be able to make a judgement on where they would like to be, such as at home, but may not fully understand the questions they are being asked and so aren't in a position to accurately represent themselves.

Choosing when and how…

A person may be unable to have a meaningful response to DIALOG questions for a brief period of time but regain the ability to do so, e.g. when suffering from Delirium.

EXAMPLE

It is not appropriate to complete DIALOG with a person that is experiencing delirium because it is not an immediate planning tool. If they have an existing DIALOG you may see if there are parts that need adapting – asking questions that are relevant at the time however you will not need to do the whole rating for care planning purposes.

It is important to note that **this is not an exclusion made on a discriminatory basis but one of fairness to ensure that DIALOG is used as a tool that is meaningful to that person** – this is important to ensure that it remains a valid and useful tool and is not abused or used without any purpose.

Hence time- and question-specificity is important to bear in mind when choosing when to perform DIALOG (i.e. avoiding periods of agitation or confusion). In this way, DIALOG represents an iterative, ongoing process.

What is the experience of being an inpatient?

Building service user autonomy and a sense of self-empowerment is a critical facet of the inpatient experience. There are several tools which equip inpatient teams for this; among them are a **solution-focused** approach and standardising support in the **first five minutes**.

Our conversations with service users have unearthed common themes in the experience of inpatient services, which provide corresponding opportunities to fine-tune the delivery of DIALOG(+) as well as showing where it can best support patients.

"People need to feel confident to leave, and their carers involved, otherwise it won't work, they'll become ill again."

HARNESSING STRENGTHS

"You are always trying to negotiating your freedom... I know myself if I forge a good relationship with someone on the ward, it seems to ease the passage."

BUILDING RELATIONSHIPS

"DIALOG conversation can be done on an inpatient ward and carried through with them into the community so they are working on their life choices."

HARNESSING STRENGTHS

"There isn't always that opportunity for some service users to have a DIALOG discussion because staff are often busy."

LOSS OF POWER & AUTONOMY

"You always have a feeling that you have to wait, it enforces that feeling you are not important that– your issue is not important but you might be quite desperate."

IMPORTANCE OF CONVERSATION

Solution focused therapy is a future focused, goal-directed approach to solving peoples everyday problems.

The focus is on the service user's **health** rather than the problem, on **strengths** rather than weaknesses or deficits, and on **skills, resources and coping abilities** to help reach future goals.

Service user's describe what they wanted to happen in their lives (solutions)…

…and how they will use personal resources to solve their problems.

Service users are encouraged to believe that positive changes are always possible, and are encouraged to increase the frequency of current useful behaviours.

For more information on what SFT is click here >

How can DIALOG support this?

DIALOG+ can help facilitate a person-centred approach by supporting meaningful conversations between service users and the healthcare professional about what aspects of their lives are important to them.

By using the DIALOG questions it can help focus the conversation between the service user and the healthcare professional to understand what matters most to them.

DIALOG + uses a solution-focused approach to understand what is important to them, look forward and explore the solutions and strengths a person has to achieve their goals.

For more information on how SFT works click here >

DIALOG+ and solution focused therapy

- Below is an example of the types of questions that can be asked by using the DIALOG+ four-step approach
- DIALOG + can aid a solutions-focused conversation to take useful steps to support a person's recovery journey.

Step 1: Understanding

The service user is encouraged to explore positive and negative aspects of the situation. The healthcare professional may want to explore a persons typical daily routine.

"Can you tell me more about the distressing voices you've been hearing?"

"Your satisfaction with your relationship is 3. What makes your situation better than a 2 or a 1?"

Step 2: Looking forward

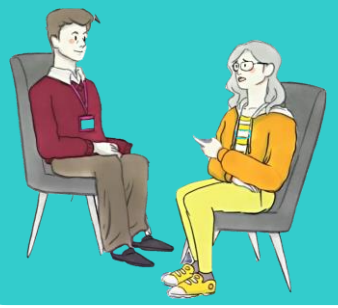
The service user is encouraged to move away from a description of the problem towards the desired alternative scenarios.

"It can take time to adapt to new medication, especially when you are experiencing side effects. What would be the first sign that you were adjusting to it?"

Step 3: Exploring options

The service user is asked to consider the practical actions that might help make a change.

"We've talked about what needs to change in order for you to feel safe. What is the first thing you can do to ensure your own safety?"



Step 4: Agreeing actions

Appropriate actions are agreed upon. You may want to support the service user to consider achievable actions that can be reviewed in other sessions.

"Of all the options we've discussed, are there some in particular that you are leaning towards?"

'Building a mutual relationship'

Conversations with lived experience practitioners have highlighted that patients sometimes struggle to feel heard when discussing medication or safety with inpatient staff; the four-step DIALOG+ process should take this backdrop into consideration.

Making a difference in the first 5 minutes

- Service users recognise that healthcare professionals working within an inpatient care setting are often working at time capacity, but emphasise the benefits of small behavioural changes which have an exponential impact on service user understanding and a sense of being heard and valued.
- Particularly important is the **first 5 minutes** following a service user's introduction to DIALOG(+) – the process of service user empowerment can be drastically improved by helping them to understand what DIALOG is and how they can complete it.

DIALOG(+) should be completed together (i.e. healthcare professional and service user) but it may be appropriate to introduce DIALOG and return to it to go through when more appropriate. In doing so, service users have outlined particularly helpful approaches:

- ✓ Part of the process is about helping someone to feel empowered or have the confidence to complete the DIALOG questions; remember to promote a feeling of self-belief.
- ✓ Reduce the use of jargon and explain DIALOG in 'plain English' to create a sense of shared understanding.
- ✓ Treat service users as an equal, removing a sense of 'them and us'.
- ✓ Convey that DIALOG is an opportunity to think and reflect, noting what you think, feel and experience – not to have ones experiences dictated.
- ✓ Provide anecdotal evidence to illustrate the benefit – 'tell a story', for service users, DIALOG is a way to bring direction and hope.

You may want to consider asking staff to say their '5-minute DIALOG pitch' as part of a creative way of delivering training – this can help staff understand the benefits of DIALOG and what matters most to that person.

"I am busy right now but this is important and I will come back to it – we will work through your care plan together."

In spite of time capacity constraints, service users would benefit from clear signalling in the **'first 5 minutes'** of DIALOG being introduced.

03 How can DIALOG be applied to the inpatient setting?

Often service users don’t get heard, this tool can help them discuss the things that they want to- the things that are important to them.

Lived experience expert, ELFT

Analytical framework

DIALOG scores provides a set of PROM / PREM scores.

The inpatient setting offers one of the best opportunities to demonstrate change in outcomes and experiences.

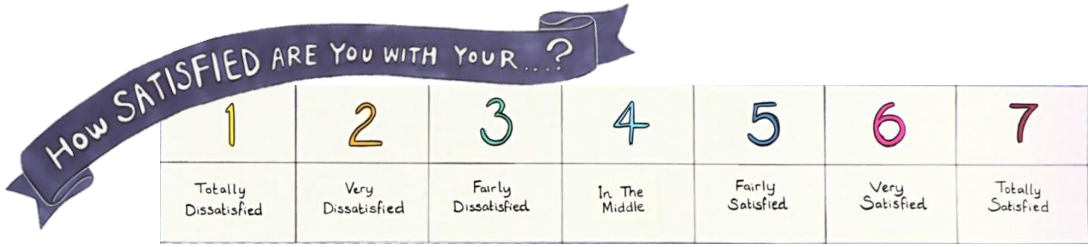
When should DIALOG be captured when using as an outcome measure?

Episode start: At the start of a new treatment episode; for acute treatment it should be carried out within 48 hours – within community settings (e.g. within the first or second meeting).

Review: Every 4 weeks for acute treatment- inpatient and crisis team. No longer than 6 months for community services and outpatient.

Episode end: At the end of treatment episode – discharge from a team, service or provider.

The quality of the data will be improved when paired scores are collected – analysis and interpretation of the data will be more meaningful



Missing scores

- **Mean scores** can be calculated even when one item (of the 11 scales) is missing (that item is then ignored when calculating the mean).
- Yet, **when more than one item is missing, mean scores may be substantially affected.** Unrepresentative and incomplete data prevents comparisons and limits the utility of feedback.

Paired data is critical to measure change. For data to be meaningful DIALOG scores need to be complete and collected at critical timepoints.

Paired data is when two sets of DIALOG scales have been recorded for a person – for example at new treatment episode (T1) and end of treatment episode, or at review (T2) and can be displayed graphically. Paired data may represent admission to discharge, admission to review or review to discharge and (rarely) review to review.

When should a rating be attained?

DIALOG is a person-centred and patient-rated scale that measures **Patient Reported Outcome** (PRO measure or PROM) as well as a measure of **Patient Experience** (Patient Reported Experience measure). DIALOG can be used as an outcome measure and a care planning tool in inpatient and other settings.

Using DIALOG as an outcome measure – important considerations for analysing the data:

- How DIALOG is going to be used is an important consideration to ensure that when it is used as an outcome measure, DIALOG keeps its integrity and value as a tool.
- Using DIALOG across both community and inpatient settings, across numerous geographies, organisations and staff groups can introduce new challenges when several people or partner organisations are completing the DIALOG form with the same person.

Timelines & IT considerations

- Inpatients following a single care plan through multiple service timelines presents issues around the collection and labelling of data points.

DIALOG Timelines

- When a service user is accessing multiple services it is important to consider the number and regularity of DIALOG scores completed.
- If these are carried out by the same service provider, it is advisable that the exit / discharge DIALOG from the previous service might serve the purpose of the entry / admission DIALOG for the new service or vice versa.
- For example, admission DIALOG scores for the new service can serve the purpose of discharge DIALOG scores for the previous service.
- Considerations must be made around how this is logged to enable the measurement and tracking of interventions within inpatient.

Inpatient Setting

- Inpatient settings generally entail more disruption for service users than in the community, therefore more sittings are needed to complete DIALOG meaning that scores will often be taken over time.
- Clear thinking is needed about iterative filling out of the editable document and how this can properly represent the service user at a given point in time.

System Adaptations

- IT adaptations should be considered to consider care planning, in order to support the DIALOG process and the above elements.

Leave arrangements

One key aim of DIALOG(+) across all contexts is to achieve true and meaningful co-production within care planning. For the inpatient setting, leave arrangements should be considered as part of this conversation. Service users have highlighted the need for:

- Clear signposting of relevant processes / rules
- Access to decision-makers and understanding of decisions
- Patient-led conversations around leave; emphasising the benefits

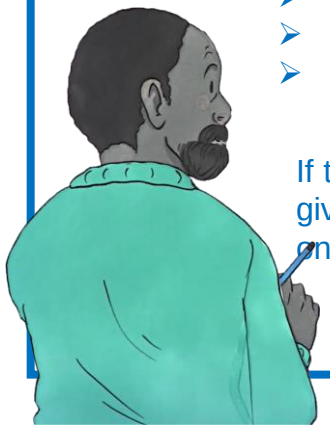
This dovetails into an important aspect of DIALOG(+) within inpatient, which is to properly articulate how freedom of movement and capacity play a role in recovery and return to the community.

Mental Capacity

If a person's mental capacity is diminished, for example, as a result of SMI (e.g. schizophrenia or bipolar disorder), learning disabilities or brain damage then they may not be able to interact with the DIALOG(+) process.

Someone with relevant impairments is thought to be unable to make a decision if they cannot:

- Understand information about the decision
- Remember that information
- Use that information to make a decision
- Communicate their decision by talking, using sign language or any other means



If this is the case, then the person may not understand or may not give a meaningful answer. It would be unfair to make a judgement on a persons needs if they have misjudged or misunderstood it.

See appendix for further details around relevant legislation (i.e. Mental Health Act 1983; Mental Health Capacity Act 2005).

Visit arrangements

Similarly, visit arrangements were highlighted as an aspect of the inpatient setting which requires consideration when applying DIALOG+:

- Care plans should set basic, reasonable constraints (e.g. times, rules, locations) to visit arrangements as well as support for all parties to sustain arrangements going forward.
- Integrated care plans should consider the pre-arrangements necessary to ensure the safety of visitor, service user, and service provider are protected equally; security of facilities and all parties is therefore a relevant consideration.
- The service user's visit arrangements should support ongoing recovery and transition to the community, and therefore must connect with wider risk assessments.

Existing visit arrangements provide a platform for post-discharge support for service users; London Trusts already provide guidance for visitors to assist this support.

Pandemic Considerations

- The Covid-19 pandemic and related restrictions have imposed certain limitations / demands on care planning.
- For example, ELFT introduced an interim and subsequent methodologies for Mental Health Act Monitoring Visits as guided by the CQC.
- Service users have highlighted the important of leave and visit arrangements being provided for as part of the care planning arrangement in the event that further restrictions are introduced.

Staff training

To enable effective execution of DIALOG(+) in an inpatient setting, further staff training could support relevant culture change as well as the shift from risk assessments to safety planning, as addressed in the NHSE/I CPA Position Statement:

Co-production:

- Positive steps can be made to move towards a patient-led culture in which DIALOG(+) captures the patients own descriptions and understanding of their mental health.
- Further training around co-production and patient-led approaches would enhance the DIALOG+ conversation, on an incremental level.

CPA Principle 3 **"High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community** to ensure efficiency and minimise the administrative burden on all staff, as well as improve care."

Risk assessments and safety:

- A comprehensive inpatient care plan incorporating DIALOG(+) should deliver 'safety planning' that is built into overall personalised care planning as opposed to a risk assessment sitting divorced from care planning. This would involve:
  1. Co-produced risk management strategies that sit within the DIALOG(+) 'safety' domain, focusing on risk management.
  2. Further safety measures relevant to delivering safe care within the inpatient setting being covered in additional sections within the inpatient care plan e.g. nursing observations, mental health legislation (though outside the DIALOG(+) care plan).
- Together they produce a single comprehensive and personalised safety plan.

"A much more accessible, responsive and flexible system with personalised and highly responsive care planning with safety planning in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their carer(s) and family members." 5 CPA Principle

Service User Insights

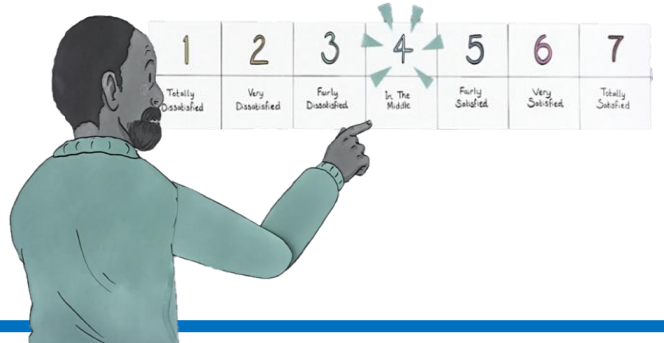
Our discussions highlighted potential areas for value-add across inpatient wards:

- Specific programmes offered for staff to adopt 'DIALOG champion' roles, offering a specific touchpoint for service users to ask questions about the process.
- Training for staff to enable patient-centric conversations around medication.
- Face-to-face DIALOG(+) sessions with Q&A sessions; CNWL have launched a programme on applications which incorporates role play.

"One of the key tenets of the trauma-informed approach is compassion. It means stepping into someone else's shoes, meeting them on a level playing field. It all sounds easy, but there's certainly some training and learning there for DIALOG to take on, that compassionate tone, some people have compassion fatigue."

"Things need to be joined-up, DIALOG in isolation won't work; for it to be successful it needs to reach out to the other services required and other people important in their journey."

"People need to feel confident to leave [inpatient], and have their carers involved, otherwise it won't work, they'll become ill again."



Nursing observations

- In the past, the CQC has criticised inpatient wards for maintaining separate nursing care plans alongside the DIALOG+ care plan.
- CQC recognised that DIALOG+ did not cover some of the aspects of care that nurses needed to understand, such as how frequently they would be checking in on the patient and other issues. This disparity can create unnecessary complexity for service users.

- DIALOG+ provides a system of care planning which is advantageous in an inpatient setting; when dissatisfaction levels are at their highest (i.e. when a service user is in crisis) there is an opportunity to stocktake along the 11 mental health domains.
- Nursing observations are critical to ensuring the inpatient setting is maintained in a way which is additive to the mediating of this level of dissatisfaction.
- Integrated care plans should account for nursing observations by detailing the frequency, nature and ownership of nursing care for specific service users.
- They should provide a timeline for how such observations will support recovery and subsequent transition into the community, and how specific observations will be tracked and recorded for the duration of the inpatient stay.

Forensic services

Forensic Services present **a series of differences** to usual context in which DIALOG(+) is carried out, our conversations have explored a variety of these:

- Adaptations to DIALOG(+) concerning leave arrangements simplified by the inherent nature of the forensic setting.
- Where service users report ambiguity around leave and visit arrangements in normal inpatient wards, they are naturally alleviated in forensic environments.
- Visiting arrangements are reported as being less clear, and would benefit from offering information groups, so prospective visitors were kept abreast of the latest processes and details.

West London – QMUL DIALOG+ pilots are taking place in Lea (Male Medium Secure), Parkland (Women's Enhance Secure) and Solaris (Male Low Secure)

A Appendix

Trauma informed DIALOG

What are the principles?

Safety - It is important that the patient and staff feel psychically and psychologically safe

Trustworthy and transparency – The trust between the healthcare professional and the service user starts with openness and transparency

Peer support – People with lived experience integrated into support for the patient is seen as an integral part of service delivery

Collaboration – Collaboration between staff, patients and service users will contribute to better decision making and better support for one another

Empowerment – Patients and staff strengths are recognised, built on and validated - and creates the belief in resilience and the ability to heal from trauma.

Humility and Responsiveness – Biases, stereotypes and historical trauma are also addressed (this includes biases and stereotypes related to gender, race, sex, ethnicity, sexual orientation and geography).

VCSE organisations provided tangible tips to make DIALOG more trauma informed:

Cultural competency

Cultural training for staff to give a better understanding and awareness of trauma within different ethnic groups. SU's are more likely to feel comfortable with healthcare workers if they feel understood.

Data input and analysis that is integrated with culturally competent training so that:

- healthcare professionals can engage well in culturally competent conversations
- the software used within public healthcare can allow those conversations to be defined and processed better

Mental health legislation

Further details regarding legislation relevant to considerations around mental capacity are included below:

Mental Health Act 1983

- The Mental Health Act is a law that guides the compulsory treatment and care of people with mental health problems.
- If you are very unwell, you might be kept in hospital under section, or allowed to leave hospital under a community treatment order.
- You have the right to free and confidential support from an independent mental health advocate (IMHA) if you are under section.
- The nearest relative of someone under section also has particular powers under the act.
- Ask a member of staff if have any questions, concerns or complaints about your section.
- If you disagree with your section or want it to end, you can appeal.
- Voluntary patients have chosen to be in hospital. They are also known as informal patients.

Mental Capacity Act 2005

- The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.
- It covers decisions about day-to-day things as well as serious life-changing decisions like whether to move into a care home or have major surgery.
- Examples of people who may lack mental capacity include those with dementia, a severe learning disability, a brain injury, a mental health illness, a stroke, unconsciousness caused by an anaesthetic or sudden accident.
- Someone can lack mental capacity to make some decisions (for example, to decide on complex financial issues) but still have the mental capacity to make other decisions (for example, to decide what items to buy at the local shop).
- The MCA says assume a person has the mental capacity to make a decision themselves, unless it's proved otherwise.

Involving carers

Our exploratory conversations have extended to those with lived experience of both the inpatient setting as well as caring for those using services.

Throughout our conversations we came across several consistent themes:

Trust

Carers of inpatients often feel undermined by a lack of trust which staff have in them; this can be made worse by the suspicions of service users which result from being in crisis.

Access

Whilst carers can not always have physical or communicative access to service users, there is a lack of support provided to understand why, or to mitigate resultant anxieties.

Partnership

Carers often have deep experience in the specific presentations of a service user, and are frustrated when they cannot contribute their expertise to the delivery of care.

Support

Given their critical importance to many inpatients, carers represent a key stakeholder for service user recovery but often feel unsupported by the system in terms of their own wellbeing.

Carer Involvement

Consider the following when interacting with carers:

1. Approach carer conversations with patience and as much information as possible; where limited, give carers visibility over the relevant processes.
2. Provide opportunities for carers to contribute to the delivery of care, whether in-person or from an advisory perspective, with an emphasis on partnership building.
3. Treat carers like adjacent service users; consider their ongoing time capacity to support service users in their recovery journey.
4. Engage carers in the return to community process for inpatients, communicating leave and visit arrangements to them and building the foundation for a sustainable discharge.

Though in some scenarios, involving carers in DIALOG would not be appropriate:

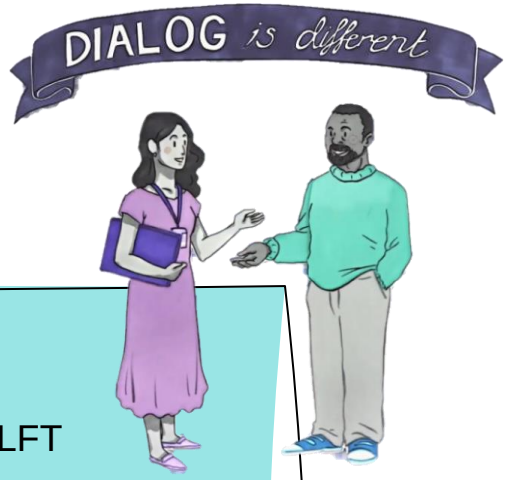
This is an example where DIALOG would not be an appropriate tool as a patient-reported outcome measure (PROM) or patient reported experience measure (PREM).

Using a carer as a proxy for the person's DIALOG scores is not an appropriate way to determine a person's satisfaction score. The carer may want to use their own DIALOG to find solutions to their own concerns.

Acknowledgements & contributions

We would like to give thanks to everyone that contributed to this document and acknowledge their valuable input and advice.

This document has been signed off by Clinical Leads across London including the London DIALOG Working Group and the London Older Adult Working Group Clinical and Technical Leads.



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