Assessing contentment and distress

DisDAT is a tool designed specifically to determine levels of contentment and distress in people unable to communicate verbally. Emma Cooper describes its use with a man who had a learning disability and advanced dementia.

This article focuses on the Disability Distress Assessment Tool, also known as the DisDAT. The DisDAT is designed to recognise signs of contentment and distress in clients who have little or no verbal communication due to disability or illness. It assesses facial signs, appearance, habits, mannerisms and other non-verbal indicators of contentment, and contrasts these cues with the signs the client exhibits when distressed.

I used the DisDAT to assess a client who had a learning disability and end-stage dementia. His mental health had deteriorated to the extent that he had lost all verbal communication. His eyesight had diminished and he had little controlled movement, relying on staff for all aspects of his care. His physical health was very poor, and he often cried out and appeared distressed.

Because of the deterioration in his condition, the manager at the placement felt that assessment and documentation was important to ensure all staff caring for this man, including agency and new staff members, recognised non-verbal signs indicating that he might be in pain or distressed. The DisDAT was considered appropriate as the client was unable to contribute and this assessment tool relies on other people’s skilled observations of the client. The DisDAT was used alongside an ‘as needed’ protocol for pain relief, which provided staff with clear information about indicators suggesting that the client may be distressed or in pain.

Clear guidance

The DisDAT has clear guidance on how and when it should be used, and contact details should the person using it need further advice. It includes a clinical decision distress checklist to help identify the cause of a client’s distress. Harrison (2001) explains that physical symptoms and a person’s emotions are closely connected. The checklist gives possible medical reasons for a client’s distress, but these are only suggestions. Smith and Buckwater (2005) argue that at any time there may be more than one problem causing a client’s distress.

Once distress has been identified, investigation by relevant professionals should be undertaken to establish the exact cause. Suitable intervention should then be carried out.

The ideal method for assessing any type of discomfort is self-report (Pollard 2007), but this is not possible when the client has lost verbal communication and cognitive ability. Therefore the DisDAT assessment centres on observations made of the client. Vlaskamp (2005) explains that observations are a vital part of assessment for this client group.

The DisDAT is comprehensive in terms of non-verbal communication used to assess the client. When considering non-verbal communication, Silverman...
et al (2005) discuss posture, body movements, facial expression, eye behaviour and vocal cues. All these are included in the DisDAT, with additional focus on jaw movement, and further observations that include pulse rate, breathing, sleeping, appetite and eating patterns. Gleeson and Timmins (2004) explain that touch is an essential part of non-verbal communication with this vulnerable client group. This is covered in the DisDAT by considering how a client responds to touch and how comfortable the person is with having someone near him or her.

Facial expressions

The DisDAT provides the assessor with a wide choice of words to circle in an attempt to describe how the client is feeling. Chambers (2003) says that people with limited speech can become expert at expressing themselves through gestures and facial expression. These facial expressions offer vital information about how a client may be feeling (Davies et al 2004).

Davies and Evans (2001) explain that familiarity and a good understanding of the client is beneficial when assessing a person with non-verbal communication, but Regnard et al (2007) discovered when developing the DisDAT that the length of time a person had worked with a client does not affect the amount of distress cues reported.

In the case described here, I had known the client only for a very short time and so the assessment was completed with the guidance of the client’s keyworker. The assessment is simple to do but the keyworker spoke English as a second language. This proved a barrier because he did not fully understand many of the descriptive words used. It also highlighted the fact that this assessment relies on an understanding of English. Many nurses and carers working in the UK speak English as a second language and Sale (2002) explains that it is vital for nurses to be able to read, write and speak the language of the patient to a high standard. Assessors who have only basic English may find this assessment difficult to complete, but Regnard et al (2007) state that most carers have found the DisDAT straightforward to use and useful in the workplace.

The DisDAT can be completed by anyone who works closely with the client, but it is important to remember that the data collected on the monitoring sheets must be analysed by a professional with the knowledge to interpret the information correctly. If necessary, an intervention can then be made to reduce the client’s distress. Hodges (2003) suggests that should a psychological problem be identified through assessment then referral for counselling can be made, if considered suitable and viable for the client.

It is considered good practice to work in a person-centred way and Carnaby (2002) explains that the client should be at the heart of the assessment and as involved as possible. DisDAT is focused totally on the client. However, the client’s contribution is minimal and Vlaskamp (2005) suggests that this can affect the validity and reliability of the assessment.

Signs open to interpretation

Regnard et al (2007) discovered when developing the DisDAT that different carers recognised a different range in the distress signs of the client, thereby showing that the assessment is open to the interpretation of the assessor. The reliability and validity of the DisDAT is not yet known, and Whelton (2005) explains that there needs to be further testing to establish whether it is effective. Regnard et al (2007) explain that the tool was piloted successfully in the development stages.

The client in this situation was unable to give consent for the assessment to take place, the Nursing and Midwifery Council (NMC) (2008) states: ‘You must be aware of legislation regarding mental capacity, ensuring that people who lack capacity remain at the
centre of decision making and are fully safeguarded.’ This would also apply to the process of assessment. The Mental Capacity Act stresses this point by saying that any decisions made on behalf of another person regarding treatment must be in the best interests of that person.

**Monitoring sheets**

The DisDAT has been designed with a front sheet that includes a summary of the data collected in the monitoring sheets, which provides the reader with ‘at a glance’ information about the client. The front page also includes essential information needed to identify the client including name, date of birth, gender and NHS number. There is space for the assessor(s) to sign and record the date the assessment was completed. This is in accordance with NMC guidelines for record-keeping (2005). Dimond (2005) explains that accurate records must be kept as part of the duty of care owed to the patient.

There are three additional, optional monitoring sheets available with the DisDAT. The first records the sign of distress and measures the degree to which it is affecting the client’s day. When filled in regularly it provides a clear indication of whether there is a problem. On completing this sheet I was able to recognise a pattern in the client’s distress as each morning the distress cue was dominating the day, whereas in the afternoon no signs of distress were noted.

Another monitoring sheet measures the frequency and duration of the distress cue. Sturmey (1996) explains that noting the frequency of a behaviour at different times of the day can help identify the stimuli that might increase or decrease the behaviour.

The third monitoring sheet provides a functional analysis of the situation and requires more information than the other two sheets regarding the context of the distress. A functionalist approach examines what purpose the behaviour serves to the individual rather than looking at the actual behaviour itself (Sturmey 1996). A disadvantage with all three of these monitoring sheets is that none provides a space for the person completing it to sign their name, which, as discussed, is a requirement of the NMC.

Due to the nature of the disability of the man being assessed, his distress cues could be perceived as precognitive. Identifying the meaning of precognitive behaviour and responding to it correctly can help the client to develop a language of non-verbal cues (Hodges 2003).

In conclusion, the DisDAT enables comprehensive assessment when caring for a client with limited communication. In this situation it proved invaluable when used alongside a protocol for pain relief and allowed staff working with the client to see ‘at a glance’ signs the client may be distressed or in pain. It also provided essential information about the client’s non-verbal signs of contentment and distress for new and agency staff. It is straightforward to complete, providing the assessor has a good understanding of English.

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**References**


