

## Distress Assessment Tool

Client's name:

DoB:

Gender:

Unit/ward:

NHS No:

Your name:

Date completed:

Names of others who helped complete this form:

**DisDAT is**

**Intended** to help identify distress cues in people who because of cognitive impairment or physical illness have severely limited communication.

**Designed** to describe a person's usual content cues, thus enabling distress cues to be identified more clearly.

**NOT a scoring tool.** It documents what many staff have done instinctively for many years thus providing a record against which subtle changes can be compared. This information can be transferred with the client or patient to any environment.

**Only the first step.** Once distress has been identified the usual clinical decisions have to be made by professionals.

**Meant to help you and your client or patient.** It gives you more confidence in the observation skills you already have which in turn will help you improve the care of your client or patient.

**INSTRUCTIONS FOR USING DisDAT ARE ON THE BACK PAGE****SUMMARY OF SIGNS AND BEHAVIOURS****Appearance when CONTENT**

Face:

Eyes:

Tongue/jaw

Skin

**Appearance when DISTRESSED**

Face

Eyes

Tongue/jaw

Skin

**Vocal signs when CONTENT**

Sounds

Speech

**Vocal signs when DISTRESSED**

Sounds

Speech

**Habits and mannerisms when CONTENT**

Habits

Mannerisms

Comfortable distance

**Habits and mannerisms when DISTRESSED**

Habits

Mannerisms

Comfortable distance

**Posture & observations when CONTENT**

Posture

Observations

**Posture & observations when DISTRESSED**

Posture

Observations

**Known triggers of distress** (write here any actions or situations that usually cause or worsen distress)

# Disability

## Distress Assessment Tool



Please take some time to think about and observe your client's appearance and behaviours when they are both content and distressed, and describe these cues in the spaces given. We have listed words in each section to help you to describe your client or patient. You can circle the word or words that best describe the signs and behaviours when your client or patient is content and when they are distressed. Document the cues in each category and, if possible, give a fuller description in the spaces given. Your descriptions will provide you with a clearer picture of your client's 'language' of distress.

### COMMUNICATION LEVEL \*

- This person is unable to show likes or dislikes  Level 0
- This person is able to show that they like or don't like something  Level 1
- This person is able to show that they want more, or have had enough of something  Level 2
- This person is able to show anticipation for their like or dislike of something  Level 3
- This person is able to communicate detail, qualify, specify and/or indicate opinions  Level 4

\* This is adapted from the Kidderminster Curriculum for Children and Adults with Profound Multiple Learning Difficulty (Jones, 1994, National Portage Association).

### FACIAL SIGNS

#### Appearance

Information / instructions	Appearance when content	Appearance when distressed
<b>Ring</b> the words that best describe the facial appearance	Passive    Laugh    Smile    Frown Grimace            Startled    Frightened Other:	Passive    Laugh    Smile    Frown Grimace            Startled    Frightened Other:

#### Jaw movement

Information / instructions	Movement when content	Movement when distressed
<b>Ring</b> the words that best describe the jaw movement	Relaxed            Drooping            Grinding Biting              Rigid Other:	Relaxed            Drooping            Grinding Biting              Rigid Other:

#### Appearance of eyes

Information / instructions	Appearance when content	Appearance when distressed
<b>Ring</b> the words that best describe the appearance	Good eye contact            Little eye contact Avoiding eye contact            Closed eyes Staring            Sleepy eyes 'Smiling'            Winking            Vacant Tears            Dilated pupils Other:	Good eye contact            Little eye contact Avoiding eye contact            Closed eyes Staring            Sleepy eyes 'Smiling'            Winking            Vacant Tears            Dilated pupils Other:

### SKIN APPEARANCE

Information / instructions	Appearance when content	Appearance when distressed
<b>Ring</b> the words that best describe the appearance	Normal            Pale            Flushed Sweaty            Clammy Other:	Normal            Pale            Flushed Sweaty            Clammy Other:

**VOCAL SOUNDS** (NB. The sounds that a person makes are not always linked to their feelings)

Information / instructions	Sounds when content	Sounds when distressed
<p><b>Ring</b> the words that best describe the sounds</p> <p>Write down commonly used sounds (write it as it sounds; 'tizz', 'eeiow', 'tetetetete'):</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p><b>Volume:</b> high medium low</p> <p><b>Pitch:</b> high medium low</p> <p><b>Duration:</b> short intermittent long</p> <p><b>Description of sound / vocalisation:</b> Cry out Wail Scream laugh</p> <p>Groan / moan shout Gurgle</p> <p>Other:</p>	<p><b>Volume:</b> high medium low</p> <p><b>Pitch:</b> high medium low</p> <p><b>Duration:</b> short intermittent long</p> <p><b>Description of sound / vocalisation:</b> Cry out Wail Scream laugh</p> <p>Groan / moan shout Gurgle</p> <p>Other:</p>

**SPEECH**

Information / instructions	Words when content	Words when distressed
<p>Write down commonly used words and phrases. If no words are spoken, write NONE</p>		
<p><b>Ring</b> the words which best describe the speech</p>	<p>Clear Stutters Slurred Unclear</p> <p>Muttering Fast Slow</p> <p>Loud Soft Whisper</p> <p>Other:</p>	<p>Clear Stutters Slurred Unclear</p> <p>Muttering Fast Slow</p> <p>Loud Soft Whisper</p> <p>Other:</p>

**HABITS & MANNERISMS**

Information / instructions	Habits and mannerisms when content	Habits and mannerisms when distressed
<p>Write down the habits or mannerisms, eg. "Rocks when sitting"</p>		
<p>Write down any special comforters, possessions or toys this person prefers.</p>		
<p>Please <b>Ring</b> the statements which best describe how comfortable this person is with other people being physically close by</p>	<p>Close with strangers</p> <p>Close only if known</p> <p>No one allowed close</p> <p>Withdraws if touched</p>	<p>Close with strangers</p> <p>Close only if known</p> <p>No one allowed close</p> <p>Withdraws if touched</p>

**BODY POSTURE**

Information / instructions	Posture when content	Posture when distressed
<p><b>Ring</b> the words that best describe how this person sits and stands.</p>	<p>Normal Rigid Floppy</p> <p>Jerky Slumped Restless</p> <p>Tense Still Able to adjust position</p> <p>Leans to side Poor head control</p> <p>Way of walking: Normal / Abnormal</p> <p>Other:</p>	<p>Normal Rigid Floppy</p> <p>Jerky Slumped Restless</p> <p>Tense Still Able to adjust position</p> <p>Leans to side Poor head control</p> <p>Way of walking: Normal / Abnormal</p> <p>Other:</p>

**BODY OBSERVATIONS**

Information / instructions	Observations when content	Observations when distressed
<p>Describe the pulse, breathing, sleep, appetite and usual eating pattern, eg. eats very quickly, takes a long time with main course, eats puddings quickly, "picky".</p>	<p>Pulse:</p> <p>Breathing:</p> <p>Sleep:</p> <p>Appetite:</p> <p>Eating pattern:</p>	<p>Pulse:</p> <p>Breathing:</p> <p>Sleep:</p> <p>Appetite:</p> <p>Eating pattern:</p>

## When to use DisDAT

### **When the team believes the client is NOT distressed**

The use of DisDAT is optional, but it can be used as a

- baseline assessment document
- transfer document for other teams

### **When the team believes the client IS distressed**

If DisDAT has already been completed it can be used to compare the present signs and behaviours with previous observations documented on DisDAT. It then serves as a baseline to monitor change.

If DisDAT has not been completed:

- a) When the client is well known DisDAT can be used to document previous content signs and behaviours and compare these with the current observations
- b) When the client or the distress is new to the team, DisDAT can be used to document the present signs and behaviours to act as a baseline to monitor change.

## How to use DisDAT

1. **Observe the client** when content and when distressed- document this on the inside pages. *Anyone* who cares for the patient can do this.
2. **Observe the context** in which distress is occurring.
3. **Use the clinical decision distress checklist** on this page to assess the possible cause.
4. **Treat or manage** the likeliest cause of the distress.
5. **The monitoring sheet** is a separate sheet, which may help if you want to see how the distress changes over time.
6. **The goal** is a reduction in the number or severity of distress signs and behaviours.

## Remember

- Most information comes from the whole team in partnership with the family.
- The assessment form need not be completed all at once and may take a period of time.
- Reassessment is essential as the needs of the client or patient may change due to improvement or deterioration.
- Distress can be emotional, physical or psychological. What is a minor issue for one person can be major to another.
- If signs are recognised early then suitable interventions can be put in place to avoid a crisis.

## Clinical decision distress checklist

Use this to help decide the cause of the distress

### Is the new sign or behaviour?

- Repeated rapidly?  
*Consider* pleuritic pain (in time with breathing)  
*Consider* colic (comes and goes every few minutes)  
*Consider*: repetitive movement due to boredom or fear.
- Associated with breathing?  
*Consider*: infection, COPD, pleural effusion, tumour
- Worsened or precipitated by movement?  
*Consider*: movement-related pains
- Related to eating?  
*Consider*: food refusal through illness, fear or depression  
*Consider*: food refusal because of swallowing problems  
*Consider*: upper GI problems (oral hygiene, peptic ulcer, dyspepsia) or abdominal problems.
- Related to a specific situation?  
*Consider*: frightening or painful situations.
- Associated with vomiting?  
*Consider*: causes of nausea and vomiting.
- Associated with elimination (urine or faecal)?  
*Consider*: urinary problems (infection, retention)  
*Consider*: GI problems (diarrhoea, constipation)
- Present in a normally comfortable position or situation?  
*Consider*: anxiety, depression, pains at rest (eg. colic, neuralgia), infection, nausea.

If you require any help or further information regarding DisDAT please contact:

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Northgate & Prudhoe NHS Trust Palliative  
Care Team  
and St. Oswald's Hospice

## Further reading

Regnard C, Matthews D, Gibson L, Clarke C, Watson B. Difficulties in identifying distress and its causes in people with severe communication problems. *International Journal of Palliative Nursing*, 2003, 9(3): 173-6.

**Distress may be hidden,  
but it is never silent**