

Abbey Pain Scale
For measurement of pain in patients who cannot verbalise.

Name and designation of person completing the scale:

Date:Time:

How to use scale: While observing the patient, score questions 1 to 6

Q1. Vocalisation

eg. whimpering, groaning, crying

Absent 0 Mild 1 Moderate 2 Severe 3

Q1

Q2. Facial expression

eg: looking tense, frowning grimacing, looking frightened

Absent 0 Mild 1 Moderate 2 Severe 3

Q2

Q3. Change in body language

eg: fidgeting, rocking, guarding part of body, withdrawn

Absent 0 Mild 1 Moderate 2 Severe 3

Q3

Q4. Behavioural Change

eg: increased confusion, refusing to eat, alteration in usual patterns

Absent 0 Mild 1 Moderate 2 Severe 3

Q4

Q5. Physiological change

eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor

Absent 0 Mild 1 Moderate 2 Severe 3

Q5

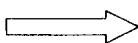
Q6. Physical changes

eg: skin tears, pressure areas, arthritis, contractures, previous injuries.

Absent 0 Mild 1 Moderate 2 Severe 3

Q6

Add scores for 1 - 6 and record here



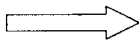
Total Pain Score

Now tick the box that matches the Total Pain Score



0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe
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Finally, tick the box which matches the type of pain



Chronic	Acute	Acute on Chronic
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ABBEY PAIN ASSESSMENT SCALE (FOLLOW ON ASSESSMENT)

DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME
VOCALISATION										
eg. whimpering, groaning, crying <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>										
FACIAL EXPRESSION										
eg: looking tense, frowning grimacing, looking frightened <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>										
CHANGE IN BODY LANGUAGE										
eg: fidgeting, rocking, guarding part of body, withdrawn <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>										
BEHAVIOURAL CHANGE										
eg: increased confusion, refusing to eat, alteration in usual patterns <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>										
PHYSIOLOGICAL CHANGES										
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>										
PHYSICAL CHANGES										
eg: skin tears, pressure areas, arthritis, contractures, previous injuries <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>										
Total score =										
Signature of person completing score										
0-2	3-7			8-13			14 +			
NO PAIN	MILD PAIN			MODERATE PAIN			SEVERE			

The Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

The Abbey pain scale does not differentiate between distress and pain, therefore measuring the effectiveness of pain relieving interventions is essential.

The pain scale should be used as a **movement based assessment**, therefore observe the patient while they are being moved, during pressure area care, while showering etc.

A second evaluation should be conducted **1 hour after** any intervention taken. If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate.

Complete the scale hourly until the patient scores mild pain then 4 hourly for 24 hours treating pain if it recurs.

If the pain/distress persists, undertake a comprehensive assessment of all facets of the patients care and monitor closely over 24 hours including further intervention undertaken.

If there is no improvement during that time notify the doctor/pain team of the pain scores and actions taken.