Abbey Pain Scale

Name of resident

For measurement of pain in people with dementia who cannot verbalise

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

Name/designation of person completing the scale

Date Time

Latest pain relief given was at hours

Q1 Vocalisation

eg. whimpering, groaning, crying

Absent 0 Mild 1 Moderate 2 Severe 3

Q2 Facial expression

eg. looking tense, frowning, grimacing, looking frightened

Absent 0 Mild 1 Moderate 2 Severe 3

Q3 Change in body language

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 rocking, guarding part of body, withdrawn

Absent 0 Mild 1 Moderate 2 Severe 3

Q4 Behavioural change

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

Absent 0 Mild 1 Moderate 2 Severe 3

Q5 Physiological change

eg. temperature, pulse or blood pressure outside of normal limits, perspiring

Absent 0 Mild 1 Moderate 2 Severe 3

Q6 Physical changes

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

Absent 0 Mild 1 Moderate 2 Severe 3

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

Finally, tick the box that matches the type of pain	Chronic	Acute	Acute on chronic

Funded by the JH & JD Medical Research Foundation 1998-2002

The Abbey Pain Scale

Rationale

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

The Abbey Pain Scale is best used as part of an overall pain management plan.

Assessment

The Scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential and should be ongoing throughout admission.

NHS Grampian Acute Pain Intranet Guidance recommends the Abbey Pain Scale be used as a movement-based assessment.

The staff member recording the scale should therefore observe the patient while they are being assisted to move or mobilising eg during assistance with personal care, pressure area care, coughing and deep breathing etc.

The staff member should complete the pain scale immediately following providing assistance to the patient and record the results in the patient's notes.

The staff member should include the time the pain scale was completed, the score, the staff member's signature and action(if any) taken in response to the results of the assessment, eg discussion with medical staff/members of the MDT/family members and pain medication or other therapies considered.

A second evaluation should be conducted one hour after any intervention taken in response to the first assessment, to determine the effectiveness of any pain-relieving intervention.

If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate.

Complete the pain scale hourly, until the patient appears comfortable, then four-hourly for 24 hours, treating pain if it recurs. Record all the pain-relieving interventions undertaken.

If pain/distress persists, a comprehensive assessment should be completed that includes discussions with family members and carers.

Please utilise all information available including the 'Getting To Know Me' document.