CGA Toolkit Plus www.cgakit.com

Resources for the Comprehensive Geriatric Assessment based Proactive and Personalised Primary Care of the Elderly

Abbey Pain Scale

Purpose : Assessment of pain in patients who are unable to clearly articulate their needs.

Admin time : Variable

User Friendly : High

Administered by : GP or nurse

Content : The original initial Abbey Pain Scale assessment is performed by a proxy-rater who observes the subject and evaluates the presence of eight pain-related behaviours from 0 to 3 representing increasing presence of the behaviour.
Recommendations and chart for follow on assessments are included in the CGA Toolkit Plus revision.

Author : Abbey, J et al, 1998 - 2002

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L: Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002
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https://www.cgakit.com/m-5-abbey-pain-scale

Abbey Pain Scale

Name of resident: .....

Name and designation of person completing the scale: .....

Date: .....**Time:** .....

Latest pain relief given was.....**at** .....**hrs.**

Q1. **Vocalisation**
eg. whimpering, groaning, crying **Q1** ☐
Absent 0 *Mild 1* *Moderate 2* *Severe 3*

Q2. **Facial expression**
eg: looking tense, frowning grimacing, looking frightened **Q2** ☐
Absent 0 *Mild 1* *Moderate 2* *Severe 3*

Q3. **Change in body language**
eg: fidgeting, rocking, guarding part of body, withdrawn **Q3** ☐
Absent 0 *Mild 1* *Moderate 2* *Severe 3*

Q4. **Behavioural Change**
eg: increased confusion, refusing to eat, alteration in usual patterns **Q4** ☐
Absent 0 *Mild 1* *Moderate 2* *Severe 3*

Q5. **Physiological change**
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor **Q5** ☐
Absent 0 *Mild 1* *Moderate 2* *Severe 3*

Q6. **Physical changes**
eg: skin tears, pressure areas, arthritis, contractures, previous injuries. **Q6** ☐
Absent 0 *Mild 1* *Moderate 2* *Severe 3*

Total pain score ☐

0 – 2 No pain	3 – 7 Mild	8 – 13 Moderate	14+ Severe

Chronic	Acute	Acute on Chronic

Notes :

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CHANGE IN BODY LANGUAGE eg: fidgeting, rocking, guarding part of body, withdrawn *Absent 0 Mild 1 Moderate 2 Severe 3*										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

Notes :

Abbey Pain Scale

Recommended use

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

The Scale does not differentiate between distress and pain, and is recommended for use as a movement-based assessment.
The staff recording the scale should therefore observe the patient while they are being moved, eg during pressure area care, while showering etc.
Complete the scale immediately following the procedure and record the results on the Abbey Pain Scale chart.
Include a brief reference to action taken (if any) in response to results of the assessment, eg pain medication or other therapies.

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.
Record the results on the Abbey Pain Scale follow on assessment chart.
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, undertake a comprehensive assessment of all facets of patient's care and monitor closely over a 24-hour period, including any further interventions undertaken.

If there is no improvement during that time, notify the medical practitioner of the pain scores and the action/s taken.