ALL WALES
PAIN ASSESSMENT

NHS Wales v2.5 (04/10/2024)

ADDRESSOGRAPH

- Pain scores should be recorded on the electronic system but if unavailable, paper format can be used
- ALL patients must have a pain assessment on admission (on movement) and further evaluation as indicated overleaf
- Indicate the pain assessment tool being used and ensure it is appropriate for this patient's level of communication (guidance overleaf)
- Once the patient has been assessed, using the guidance overleaf, transcribe the pain score in to the Equivalent Categorical Pain Scale below (NONE, MILD, MODERATE, SEVERE)
- If an action is documented, the pain score must be re-evaluated at an appropriate interval (guidance on frequency overleaf)

Hospital & Ward	**Date & Time**	**Pain assessment tool used:**	**Pain Score**	**Equivalent Categorical Pain Scale (see overleaf)**				**Action/comments**	**Signature & Designation**
				NONE	MILD	MODERATE	SEVERE		
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							
		Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
		0-10							
		PainAD							
		Abbey							

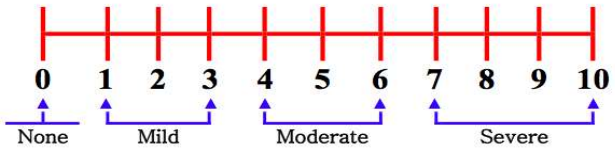
All Wales Pain Assessment Pain Tool Guidance

Is your patient able to verbalise their pain? If **Yes**, use the Categorical Scale (NONE, MILD, MODERATE, SEVERE) **OR** Numerical Pain scale (0-10) as **typically used in your clinical area**. **Use one tool only**. If UNABLE to verbalise pain**,** use PainAD **OR** Adapted Abbey. If necessary, convert the score into the Categorical Scale (NONE, MILD, MODERATE, SEVERE) and record overleaf. All pain scored MUST be assessed on **movement / patient activity.**

CATEGORICAL SCALE

0	1	2	3
NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN

NUMERICAL SCALE



Numerical Rating Scale	Equivalent Categorical Scale
0	NO PAIN
1-3	MILD PAIN
4-6	MODERATE PAIN
7-10	SEVERE PAIN

PAINAD SCALE

PAINAD	0	1	2
Breathing (Independent of vocalization)	Normal	Occasional laboured breathing. Short period of hyperventilation	Noisy laboured breathing. Long period of hyperventilation. Cheyne-stokes respirations
Negative Vocalisation	None	Occasional moan or groan / low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying
Facial Expression	Smiling or inexpressive	Sad, Frightened, Frown	Facial grimacing
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or punching away. Striking out
Consolable	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure

PainAD Scale Total Score:	Equivalent Categorical Scale
0	NO PAIN
1-3	MILD PAIN
4-6	MODERATE PAIN
7-10	SEVERE PAIN

Score guidance for each category: (0, 1 or 2) when screening for pain related behaviours during activity (MAX=10)

ADAPTED ABBEY SCALE

Vocalisation (score 0-3)	Whimpering, groaning, crying
Facial Expression (score 0-3)	Grimacing, frowning, looking tense, looking frightened
Change in Body Language (score 0-3)	Fidgeting, rocking, guarding part of body, withdrawn
Behavioural Change (score 0-3)	Alterations in usual patterns, increased confusion, refusing to eat
Physiological Change (score 0-3)	Temperature, rapid pulse, blood pressure outside normal limits
Physical Changes (score 0-3)	Skin tears, pressure areas, arthritis, contractures

Adapted Abbey Pain Scale Total score:	Equivalent Categorical Scale
0-2	NO PAIN
3-7	MILD PAIN
8-13	MODERATE PAIN
14+	SEVERE PAIN

Acknowledgment:
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Score guidance for each category: Absent = 0, Mild = 1, Moderate =2, Severe=3 (MAX=18)

Discuss with family / carers how the person usually reacts to pain (past and present). Ask about their usual behaviour patterns. Check any getting to know you forms such as "This is Me", "Reach Out to Me", DIS-DAT for individual pain behaviours. Record any particular pain behaviours in the sections above.

FREQUENCY OF PAIN ASSESSMENT AND ANALGESIA ADMINISTRATION

NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN
Reassess 12-hourly as per NEWS observations	Give step 1 analgesia Reassess 4-hourly	Give step 2 analgesia Reassess after 30-60 minutes Ongoing assessment minimum 4-hourly	**Give step 3 analgesia** **Reassess after 30 and 60 minutes** **Ongoing assessment minimum 4-hourly**

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