

Abbey Pain Scale

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 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
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**

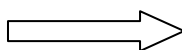
Q3. Change in body language
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3 **Q3**

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**

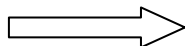
Q6. Physical changes
eg skin tears, pressure areas, arthritis, contractures,
previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3 **Q6**

Add scores for 1 - 6 and record here



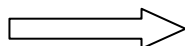
Total Pain Score

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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