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eg fidgeting, rocking, guarding part of body, withdrawn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

Finally, tick the box which matches the type of pain ⇒

Chronic	Acute	Acute on Chronic

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