Appendix 5: 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 releif given was: _____ at _____ hours

Q1. Vocalisation
eg. whipering, 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 fidgeting, rocking, guarding part of body, withdrawn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**

☐ **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**

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

Modified Abbey Pain Scale (Follow on assessment form)

	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. whipering, 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CHANGE IN BODY eg: fidgeting, rocking, guarding part of body, withdrawn Absent - 0 Mild - 1 Moderate - 2 Severe - 3										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 patternsg 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										

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, for example, patients with dementia, cognition or communication issues. The scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

The Australian Pain Society recommends the pain scale should be used as a movement-based assessment. Therefore observe the patient while they are being moved, during pressure area care, while showering, etc. Complete the scale immediately following the procedure and record the results on the Abbey Pain tool chart.

A second evaluation should be conducted 1 hour after any intervention taken. If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate. Complete the scale hourly until the patient scores mild pain then 4 hourly for 24 hours treating pain if it recurs.

If the pain/distress persists, undertake a comprehensive assessment of all facets of the patients care and monitor closely over 24 hours including further intervention undertaken.

If there is no improvement in that time, then it is essential to notify the GP of ongoing pain scores and actions taken.

Modified from Hywel Dda University Health Board NHS 2013; Wales, UK