

Affix Patient Label here or record

NAME:

NHS NO:

HOSP NO:



D.O.B: / / MALE FEMALE

ABBEY PAIN SCALE TOOL (for measurement of pain in people with dementia, delirium or cannot verbalise)

WARD:.....CONS:.....

Pain should be assessed with routine observations and post analgesia

Date													
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 Fidgeting, rocking, guarding part of body, withdrawn Absent= 0 Mild= 1 Moderate= 2 Severe =3													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 change 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 Pain Score													
Have you escalated? Yes / No / N/A													
Initials													

	Total Pain Score (enter number shown in brackets on NEWS observation chart)	0-2 No pain (0)	3-7 Mild (1)	8-13 Moderate (2)	14+ Severe (3)	
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