

Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

Behavior	0	1	2	Score
Breathing Independent of vocalization	Normal	- Occasional labored breathing - Short period of hyperventilation	- Noisy labored breathing - Long period of hyperventilation - Cheyne-Stokes respirations	
Negative vocalization	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 pushing away - Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract, or reassure	
TOTAL SCORE				

(Warden et al., 2003)

Scoring:

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

Source:

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *J Am Med Dir Assoc.* 2003;4(1):9-15.