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NOPPAIN

(Non-Communicative Patient's Pain Assessment Instrument)
ACTIVITY CHART CHECK LIST

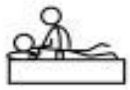
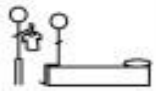
LABEL

Name of Evaluator: _____

Title: _____ Signature: _____

Date: _____ Time: _____

DIRECTIONS: Nursing assistant should complete at least 5 minutes of daily care activities for the resident while observing for pain behaviors. This form should be completed immediately following care activities

		Did you do this? Check Yes or No	Did you see pain when you did this? Check Yes or No
(a) Put resident in bed OR saw resident lying down		☐ YES ☐ NO	☐ YES ☐ NO
(b) Turned resident in bed		☐ YES ☐ NO	☐ YES ☐ NO
(c) Transferred resident (bed to chair, chair to bed, standing or wheelchair to toilet		☐ YES ☐ NO	☐ YES ☐ NO
(d) Sat resident up (bed or chair) OR saw resident sitting		☐ YES ☐ NO	☐ YES ☐ NO
(e) Dressed resident		☐ YES ☐ NO	☐ YES ☐ NO
(f) Fed resident		☐ YES ☐ NO	☐ YES ☐ NO
(g) Helped resident stand OR saw resident stand		☐ YES ☐ NO	☐ YES ☐ NO
(h) Helped resident walk OR saw resident walk		☐ YES ☐ NO	☐ YES ☐ NO
(i) Bathed resident OR gave resident sponge bath		☐ YES ☐ NO	☐ YES ☐ NO

REMEMBER: Make sure to **ASK THE PATIENT** if he/she is in pain!

Pain Response/Responsibility (What did you see and hear?)

Pain Words?
"That hurts!" "Ouch!" "Cursing" "Stop that!"

☐ YES ☐ NO

How intense were the pain words?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Pain Faces?
grimaces winces furrowed brow

☐ YES ☐ NO

How intense were the pain faces?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Bracing?
rigidity holding guarding (especially during movement)

☐ YES ☐ NO

How intense was the bracing?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Pain Noises?
moans groans grunts cries gasps sighs

☐ YES ☐ NO

How intense were the pain noises?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Rubbing?
massaging affected area

☐ YES ☐ NO

How intense was the rubbing?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Restlessness?
frequent shifting rocking inability to stay still

☐ YES ☐ NO

How intense was the restlessness?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Locate Problem Areas

Please "X" the site of any pain
Please "O" the site of any skin problems

FRONT BACK

Snow AL, O'Malley K, Kunik M, Cody M, Bruera E, Beck C, Ashton C. Developed with support from the U.S. Veterans Affairs Health Services Research & Development Service and the National Institute of Mental Health. For more information, contact Dr. Snow at asnow@bcm.tmc.edu. *(This document may be reproduced*

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(Non-Communicative Patient's Pain Assessment Instrument)

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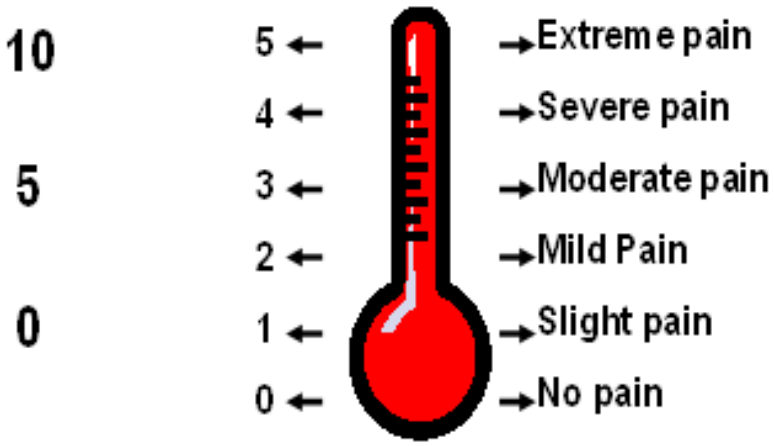
Name of Evaluator: _____

Title: _____ Signature: _____

Date: _____ Time: _____

PAIN THERMOMETER SCALE

Rate the Resident's pain at the highest level you observed during care.
(circle your answer)



From: Snow, A.L.; O'Malley, K; Kunik, M; Cody, M.; Bruera, E.; Beck, C.; Ashton, C. (2004). A Nursing Assistant-Administered Pain Assessment Instrument for Use in Dementia. Dement Geriatr Cogn Disor. 17:240-246.

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