

# NOPPAIN

(Non-Communicative Patient's Pain Assessment Instrument)

LABEL

## ACTIVITY CHART CHECK LIST

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

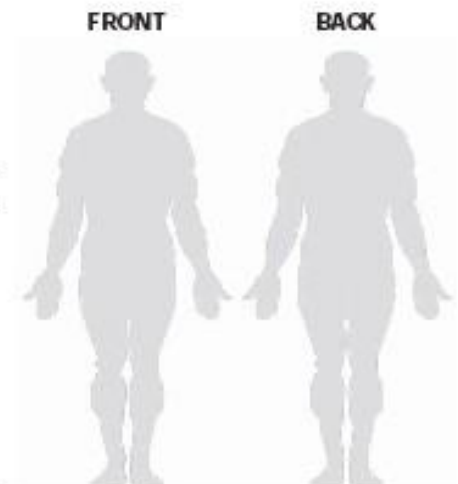
		Did you do this? Check Yes/No	Did you see pain when you did this? Check Yes/No		Did you do this? Check Yes/No	Did you see pain when you did this? Check Yes/No
(a) Put resident in bed OR saw resident lying down		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(f) Fed resident		<input type="checkbox"/> YES <input type="checkbox"/> NO
(b) Turned resident in bed		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(g) Helped resident stand OR saw resident stand		<input type="checkbox"/> YES <input type="checkbox"/> NO
(c) Transferred resident (bed to chair, chair to bed, standing or wheelchair to toilet)		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(h) Helped resident walk OR saw resident walk		<input type="checkbox"/> YES <input type="checkbox"/> NO
(d) Sat resident up (bed or chair) OR saw resident sitting		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(i) Bathed resident OR gave resident sponge bath		<input type="checkbox"/> YES <input type="checkbox"/> NO
(e) Dressed resident		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>REMEMBER: Make sure to ASK THE PATIENT if he/she is in pain!</b>		

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

### Locate Problem Areas

<b>Pain Words?</b> "That hurts" "Ouch!" "Cursing" "Stop that!"  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense were the pain words? 0 1 2 3 4 5 Lowest Possible Intensity Highest Possible Intensity	<b>Pain Faces?</b> -grimaces -wincing -furrowed brow  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense was the pain faces? 0 1 2 3 4 5 Lowest Possible Intensity Highest Possible Intensity	<b>Bracing?</b> -rigidity -holding -guarding (especially during movement)  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense was the bracing? 0 1 2 3 4 5 Lowest Possible Intensity Highest Possible Intensity
<b>Pain Noises?</b> -moans -groans -grunts -cries -gasps -sighs  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense were the pain noises? 0 1 2 3 4 5 Lowest Possible Intensity Highest Possible Intensity	<b>Rubbing?</b> -massaging affected area  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense was the rubbing? 0 1 2 3 4 5 Lowest Possible Intensity Highest Possible Intensity	<b>Restlessness?</b> -frequent shifting -rocking -inability to stay still  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense was the restlessness? 0 1 2 3 4 5 Lowest Possible Intensity Highest Possible Intensity

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



Snow AL, O'Malley K, Kurik 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](mailto:asnow@bcm.tmc.edu). (This document may be reproduced

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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.*