

NOPPAIN

(Non-Communicative Patient's Pain Assessment Instrument)
Activity Chart Check List

Name of Evaluator _____

Name of Resident: _____

Date: _____

Time: _____

DIRECTIONS: Nursing assistant should complete at least 5 minutes of daily care activities for the resident while observing for pain behaviors. Both pages of 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		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		<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			

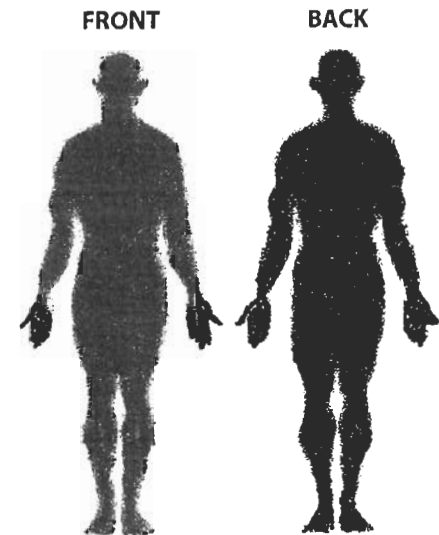
ASK THE PATIENT: Are you in pain? yes no
ASK THE PATIENT: Do you hurt? yes no

Pain Response (What did you see and hear during care?)

Locate Problem Areas

Pain Words? • "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	Pain Faces? • grimaces • wincing • furrowed brow <input type="checkbox"/> YES <input type="checkbox"/> 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) <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
Pain Noises? • 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	Rubbing? • 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	Restlessness? • 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



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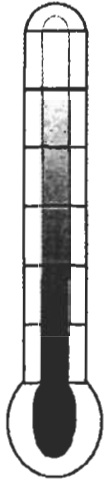
Name of Evaluator _____

Name of Resident: _____

Date: _____

Time: _____

Rate the resident's pain at the highest level you saw it at during care. **(circle your answer)**



Pain is almost unbearable

Very bad pain

Quite bad pain

Moderate pain

Little pain

No pain
