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
(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

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?)

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

NOPPAIN

(Non-Communicative Patient's Pain Assessment Instrument

Activity Chart Check List

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