AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
Pressure Injury Assessment and Documentation
(Pressure Injury Numbering from Nursing Services Basic Injury Assessment)
Use one form per pressure injury described.

Section 1. Client Information (Completed by DSHS or AAA Staff, RN, and/or Contractor)

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
<th>DATE OF BIRTH</th>
<th>CLIENT ACES ID</th>
<th>CLIENT PROVIDER ONE ID</th>
</tr>
</thead>
</table>

Pressure Injury Description

1. PRESSURE INJURY NUMBER
   From form 13-780 (pictorial diagram)

2. LOCATION DESCRIPTION

3. PRESSURE INJURY CLASSIFICATION
   Staging (check one):
   □ 1 □ 2 □ 3 □ 4
   or (check one of the following):
   □ Unstageable:
   □ Suspected deep tissue injury reason:

4. MEASUREMENT OF WOUND
   Length: cm Width: cm Depth (visual estimate): cm

5. TUNNELING
   □ No □ Yes. If yes, describe:

6. UNDERMINING
   □ No □ Yes. If yes, describe:

6. A. WOUND EXUDATE: (% SATURATION OF DRESSING)
   □ None: (0%)
   □ Moderate: (26-75% Saturation of Dressing)
   □ Minimal: (<25% Saturation of Dressing)
   □ Heavy: (>75% Saturation of Dressing)

   B.
   □ Serous: (Thin, Watery, Clear)
   □ Purulent: (Thin or Thick, Opaque, Tan/Yellow)
   □ Sanguineous: (Bloody)
   □ Serosanguineous: (Thin Watery, Pale Red/Pink)

7. WOUND BED
   □ Granulation □ Slough □ Necrotic
   Comments:

8. ODOR
   □ No □ Yes. If yes, describe:

9. PAIN SCALE
   NO PAIN □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 WORST PAIN IMAGINABLE

10. SURROUNDING SKIN
    □ Erythema □ Edema □ Warm □ Induration (hard) □ Other:
    Comments:

Pressure Injury Documentation, Pages of

RN SIGNATURE DATE PRINTED RN NAME

11. RN POST PRESSURE INJURY ASSESSMENT RECOMMENDATIONS TO DSHS CASE MANAGER (INCLUDING TREATMENT AND/OR RECOMMENDATIONS FOR HCP FOLLOW-UP, ADDITIONAL TREATMENT OR CARE NEEDS AND/OR RECOMMENDED CHANGES TO SERVICE PLAN)