|  | 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.** | | | | | | DATE OF SERVICE | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CASE MANAGER NAME | |
| RN NAME | |
| **Section 1. Client Information (Completed by DSHS or AAA Staff, RN, and/or Contractor)** | | | | | | | | |
| CLIENT NAME | | | DATE OF BIRTH | | | CLIENT ACES ID | | CLIENT PROVIDER ONE ID |
| **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: | | | | UNDERMINING  No  Yes. If yes, describe: | | | | |
| 6. A. Wound Exudate: (% saturation of dressing)  None: (0%)  Minimal: (<25% Saturation of Dressing)  Moderate: (26-75% Saturation of Dressing)  Heavy: (>75% Saturation of Dressing) | | | | | | | | |
| B.  Serous: (Thin, Watery, Clear)  Sanguineous: (Bloody)  Purulent: (Thin or Thick, Opaque, Tan/Yellow) 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 | | | | | | | | |