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EDMUND G. BROWN, JR.
Governor

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AFL 15-03
(Supersedes AFL 10-01)

TO: Acute Psychiatric Hospitals
General Acute Care Hospitals
Special Hospitals

SUBJECT: Clarification for Reporting of Healthcare Acquired Pressure Ulcers

AUTHORITY: Health and Safety Code (HSC) section 1279.1

This All Facilities Letter (AFL) clarifies the reporting requirements for hospitals regarding suspected deep tissue injuries and healthcare acquired pressure ulcers. This AFL supersedes previous guidance communicated in AFL 10-01.

Pursuant to HSC section 1279.1(a), general acute care hospitals, acute psychiatric hospitals, and special hospitals must report an adverse event to the California Department of Public Health (CDPH) no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Further, HSC section 1279.1(c) requires the facility to inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

The term “adverse event” includes any one of 28 specified events. HSC section 1279.1(b)(4)(F) states that an “adverse event” includes a Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

According to the National Pressure Ulcer Advisory Panel (NPUAP), there are four stages or categories of pressure ulcers, Stage 1 through Stage 4. Two additional categories or stages are defined as “Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown,” and “Suspected Deep Tissue Injury – Depth unknown.”

Unstageable/unclassified is indicated by full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are

removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Stage 3 or 4. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.

A suspected deep tissue injury is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed, and the wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

CDPH recommends the careful documentation of skin conditions and instances of suspected deep tissue injuries or unstageable/unclassified wound conditions in the patient’s medical record. If the unstageable ulcer or suspected deep tissue injury progresses and is classified as a Stage 3 or 4 pressure ulcer, it becomes an adverse event reportable to CDPH.

For additional information regarding prevention and treatment as well as the full list of pressure ulcer stages/categories, refer to the NPUAP webpage at:

<http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/>

If you have any questions concerning this letter, please contact your respective District Office.

Sincerely,

Original signed by Jean Iacino

Jean Iacino
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