



# CD OUTBREAK INVESTIGATION SUB-ACUTE HEALTH CARE FACILITY



INITIAL REPORT: \_\_\_\_\_ DATE \_\_\_\_\_  FINAL REPORT: \_\_\_\_\_ DATE \_\_\_\_\_

<b>Facility Name</b>		<b>Census Tract</b>	<b>Outbreak Number</b>	
			YR	No.
<b>Facility Address - number, street</b>		<b>Facility City</b>		<b>Facility Zip Code</b>
				<b>Health District</b>
<b>Facility Telephone</b>		<b>Facility Contact Person</b>		<b>Facility Contact Person Telephone</b>

**Disease:**  Norovirus  Influenza  Scabies  Unknown Gastrointestinal  Unk. Respiratory  Unk. Rash  Other: \_\_\_\_\_

<b>Facility Type</b> <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Psychiatric Care Facility <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Intermediate Care Facility <input type="checkbox"/> Other: _____	<b>Facility Population</b> (on date first case identified)  Total # of Patients/Residents: _____  Total # of Direct Care Staff: _____	<b>Number of:</b>		Patients	Staff
		a. Clinical Cases (symptomatic only)			
		b. Laboratory Confirmed Cases			
		c. Total Cases (sum of clinical and lab confirmed)			
<b>Reported By</b>		<b>Reporting Source Title</b>		<b>Reporting Source Telephone</b>	
				<b>Report Date</b>	

**ADDITIONAL BACKGROUND (OPTIONAL) or INVESTIGATION SUMMARY AND CONCLUSIONS**

**CLINICAL DESCRIPTION**

<b>Date of First Case</b>	<b>Date of Last Case</b>	<b>Date Most New Cases Identified</b>	<b>Check all predominant symptoms among the patients that apply</b> (please only include new or worsening symptoms):																			
<b>Severity of Disease</b> (attributable to outbreak)  # Requiring Clinic/Doctor Visit _____ # Requiring Hospitalization _____ # Deaths _____	<b>Age Distribution</b>		<u>General</u>	<u>Respiratory</u>	<u>Gastrointestinal</u>	<u>Skin</u>																
	<u>AGE</u>	<u># CASES</u>	<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Itch																
	<1	_____	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> New or worsened cough	<input type="checkbox"/> Nausea	<input type="checkbox"/> Rash																
	1-4	_____	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Vomiting	<u>Other</u>																
	5-19	_____	<input type="checkbox"/> Headache	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> _____																
20-49	_____		<input type="checkbox"/> Increased sputum	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> _____																	
50-65	_____	<b>Has treatment been given to cases? If yes, please describe below.</b>																				
66-74	_____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%; text-align: center;"><u>Recipient</u></td> <td style="width: 15%; text-align: center;"><u>Treatment(s)</u></td> <td style="width: 15%; text-align: center;"><u># Treated</u></td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes: Patients / Residents</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes: Staff</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes: Visitors</td> <td>_____</td> <td>_____</td> </tr> </table>					<u>Recipient</u>	<u>Treatment(s)</u>	<u># Treated</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Patients / Residents	_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Staff	_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Visitors	_____	_____	
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75+	_____	<b>Has prophylaxis been given to non-cases? If yes, please describe below.</b>																				
<b>Is there any obvious clustering of cases among the following categories? Please check all that apply.</b> <input type="checkbox"/> Patient acuity <input type="checkbox"/> Demographic variables <input type="checkbox"/> Patient location <input type="checkbox"/> Procedures <input type="checkbox"/> Shared staff <input type="checkbox"/> Medications <input type="checkbox"/> Other: Specify _____ Please describe any observed clustering: _____ _____			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%; text-align: center;"><u>Recipient</u></td> <td style="width: 15%; text-align: center;"><u>Treatment(s)</u></td> <td style="width: 15%; text-align: center;"><u># Treated</u></td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes: Patients / Residents</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes: Staff</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes: Visitors</td> <td>_____</td> <td>_____</td> </tr> </table>					<u>Recipient</u>	<u>Treatment(s)</u>	<u># Treated</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Patients / Residents	_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Staff	_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Visitors	_____	_____
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**INFLUENZA OUTBREAKS ONLY - VACCINATION**

Total # of people vaccinated against influenza ≥14 days before the outbreak began: Patients \_\_\_\_\_ Staff \_\_\_\_\_

Total # of people offered catch-up Influenza vaccination after the outbreak began: Patients \_\_\_\_\_ Staff \_\_\_\_\_

Total # of people vaccinated against *S. pneumoniae* (pneumococcal disease) ≥14 days before the outbreak began: Patients \_\_\_\_\_

**LABORATORY DESCRIPTION**

Were specimens sent to a laboratory for testing?  No  Yes If yes, please complete this section.

SPECIMENS			Type of Test	RESULTS		Name of Laboratory
Type	Number of Patients	Dates Collected		Number Positive	Organism	

**INFLUENZA CASES ONLY- RESULTS FOR LAB-CONFIRMED**

Influenza A <input type="checkbox"/> (H3) <input type="checkbox"/> (2009H1N1) <input type="checkbox"/> (A Unknown)	<input type="checkbox"/> Positive (# positive cases: ____)	<input type="checkbox"/> Negative (# negative cases: ____)
Influenza B <input type="checkbox"/> (Yamagata) <input type="checkbox"/> (Victoria) <input type="checkbox"/> (B Unknown)	<input type="checkbox"/> Positive (# positive cases: ____)	<input type="checkbox"/> Negative (# negative cases: ____)
Influenza type undetermined	<input type="checkbox"/> Positive (# positive cases: ____)	<input type="checkbox"/> Negative (# negative cases: ____)

**ACTIONS AND RECOMMENDATIONS (if applicable)**

Action/Recommendation	Action/Recommendation Made by District Health Office	Action Implemented by Facility
Reminded facility to report outbreak to Los Angeles County Department of Public Health and Health Facilities Inspection Division	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Suggested facility review its relevant policies and procedures with staff	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Followed Los Angeles County/California/CDC guidelines for environment and organism	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Patient cohorting	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Staff cohorting	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Contact / Respiratory precautions	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Enhanced environmental cleaning	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Begin or increase use of hand hygiene messages	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Begin or increase use of respiratory / cough etiquette messages	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
Facility closed to new admissions	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date closed _____ <input type="checkbox"/> Date reopened _____
Notification regarding outbreak made to: <input type="checkbox"/> Staff <input type="checkbox"/> Patients <input type="checkbox"/> Visitors <input type="checkbox"/> Community	<input type="checkbox"/> Date _____	<input type="checkbox"/> Date _____
In-service by: <input type="checkbox"/> PHN Topic: _____ <input type="checkbox"/> Date _____ <input type="checkbox"/> Date _____ <input type="checkbox"/> Facility Staff Topic: _____ <input type="checkbox"/> Date _____ <input type="checkbox"/> Date _____		
Field visit by PHN:	<input type="checkbox"/> Date _____ <input type="checkbox"/> Date _____ <input type="checkbox"/> Date _____ <input type="checkbox"/> Date _____	

Investigator name (print) and title	Investigator signature	Date	Telephone number
Nurse Supervisor name (print) and title	Nurse Supervisor signature	Date	
Area Medical Director name (print)	Area Medical Director signature	Date	

<b>ACD USE ONLY - ACD Reviewer Name (print)</b>	ACD Reviewer Signature	Date
<input type="checkbox"/> Closed – OK to report	<input type="checkbox"/> Closed – False OB, Do not report	<input type="checkbox"/> Closed – Other _____