



CD OUTBREAK INVESTIGATION SUB-ACUTE HEALTH CARE FACILITY



INITIAL REPORT _____ DATE _____ FINAL REPORT _____ DATE _____

1. Facility Name		2. Census Tract	3. Outbreak Code													
			YR	No.												
4. Facility Address - number, street		5. Facility City		6. Facility Zip Code												
				7. Health District												
8. Facility Telephone		9. Facility Contact Person		10. Facility Contact Person Telephone												
11. Disease																
<input type="checkbox"/> Scabies <input type="checkbox"/> Norovirus <input type="checkbox"/> Influenza <input type="checkbox"/> Unknown Gastrointestinal <input type="checkbox"/> Unknown Respiratory <input type="checkbox"/> Unknown Rash <input type="checkbox"/> Other: _____																
12. Facility Type		13. Facility Population (on date first case identified)		14. Number of:												
<input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Psychiatric Care Facility <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Other: _____ <input type="checkbox"/> Intermediate Care Facility		Total Number of Patients/Residents: _____ Total Number of Direct Care Staff: _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 25%;">Patients</th> <th style="width: 25%;">Staff</th> </tr> </thead> <tbody> <tr> <td>a. Clinical Cases (symptomatic only)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>b. Laboratory Confirmed Cases</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>c. Total Cases (sum of clinical and laboratory confirmed)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Patients	Staff	a. Clinical Cases (symptomatic only)	_____	_____	b. Laboratory Confirmed Cases	_____	_____	c. Total Cases (sum of clinical and laboratory confirmed)	_____	_____
	Patients	Staff														
a. Clinical Cases (symptomatic only)	_____	_____														
b. Laboratory Confirmed Cases	_____	_____														
c. Total Cases (sum of clinical and laboratory confirmed)	_____	_____														
15. Reported By		16. Reporting Source Title	17. Reporting Source Telephone	18. Report Date												

ADDITIONAL BACKGROUND (OPTIONAL)

CLINICAL DESCRIPTION

19. Date of First Case	20. Date of Last Case	21. Date Most New Cases Identified	22. Check all predominant symptoms among the patients that apply (please only include new or worsening symptoms):																			
			<u>General</u>	<u>Respiratory</u>	<u>Gastrointestinal</u>	<u>Other</u>																
23. Severity (attributable to outbreak)			<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> _____																
# Requiring Clinic or Doctor Visit _____ # Requiring Hospitalization _____ # Deaths _____			<input type="checkbox"/> Muscle pain	<input type="checkbox"/> New or worsened cough	<input type="checkbox"/> Nausea	<input type="checkbox"/> _____																
24. Age Distribution			<input type="checkbox"/> Chest pain	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Vomiting	<input type="checkbox"/> _____																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">AGE</th> <th style="width: 30%;"># CASES</th> </tr> </thead> <tbody> <tr><td><1</td><td style="text-align: center;">_____</td></tr> <tr><td>1-4</td><td style="text-align: center;">_____</td></tr> <tr><td>5-19</td><td style="text-align: center;">_____</td></tr> <tr><td>20-49</td><td style="text-align: center;">_____</td></tr> <tr><td>50-65</td><td style="text-align: center;">_____</td></tr> <tr><td>66-74</td><td style="text-align: center;">_____</td></tr> <tr><td>75+</td><td style="text-align: center;">_____</td></tr> </tbody> </table>			AGE	# CASES	<1	_____	1-4	_____	5-19	_____	20-49	_____	50-65	_____	66-74	_____	75+	_____	<input type="checkbox"/> Headache	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> _____
AGE	# CASES																					
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1-4	_____																					
5-19	_____																					
20-49	_____																					
50-65	_____																					
66-74	_____																					
75+	_____																					
			<u>Skin</u>	<input type="checkbox"/> Increased sputum	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> _____																
			<input type="checkbox"/> Itch			<input type="checkbox"/> _____																
			<input type="checkbox"/> Rash			<input type="checkbox"/> _____																
25. Is there any obvious clustering of cases among the following categories? Please check all that apply.			26. Has treatment been given to cases? If yes, please describe below.			Number Treated																
<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 border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%;">Recipient</th> <th style="width: 40%;">Treatment(s)</th> <th style="width: 30%;"></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes:</td> <td>Patients / Residents</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes:</td> <td>Staff</td> <td style="text-align: center;">_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes:</td> <td>Visitors</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>				Recipient	Treatment(s)		<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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			27. Has prophylaxis been given to non-cases? If yes, please describe below.			Number Treated																
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<input type="checkbox"/> No	<input type="checkbox"/> Yes:	Visitors	_____																			

LABORATORY DESCRIPTION

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

SPECIMENS			28d. Type of Test	RESULTS		28g. Name of Laboratory
28a. Type	28b. Number of Patients	28c. Dates Collected		28e. Number Positive	28f. Organism	

INVESTIGATION SUMMARY AND CONCLUSIONS

ACTIONS AND RECOMMENDATIONS (if applicable)

29. 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"/> Facility Staff Topic: _____	<input type="checkbox"/> Date _____ <input type="checkbox"/> Date _____	<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 _____	

30. Investigator name (print) and title	31. Investigator signature	32. Date	33. Telephone number
34. Nurse Supervisor name (print) and title	35. Nurse Supervisor signature	36. Date	
37. Area Medical Director name (print)	38. Area Medical Director signature	39. Date	

ACD USE ONLY		
40. ACD Reviewer Name (print)	41. ACD Reviewer Signature	42. Date
<input type="checkbox"/> Closed – OK to report	<input type="checkbox"/> Closed – False OB, Do not report	<input type="checkbox"/> Closed – Other _____