

OUTBREAK INVESTIGATION GENERAL ACUTE CARE HOSPITAL



Outbreak/Situation	
YR	NO
<input type="checkbox"/> Outbreak	<input type="checkbox"/> Situation
Report to CDPH	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of Final Report:	

1. Facility Name:		2. Reported by (Full name and title):		3. Date/time reported: AM/PM	
4. Facility Address:			5. City:		6. Zip Code:
7. Facility Contact Person (include backup person):				8. Telephone:	
9. Cell:		10. Email:		11. Date/time ACDC investigation started: AM/PM	

I. Outbreak Description

12. Number of cases identified at time of reporting: ____			13. Date outbreak/situation recognized by facility:				
14. a. Number of deaths:			b. Deaths attributed to the organism? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inconclusive				
15. Above baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No			16. Number of population at risk:				
17. Number of:		18. Cases received treatment of or dependent of (provide number of cases)			19. Sex Distribution	20. Age Distribution	
	Patients	Staff	<input type="checkbox"/> Catheter: _____ <input type="checkbox"/> Surgery: _____ <input type="checkbox"/> Central line: _____ <input type="checkbox"/> Transplant: _____ <input type="checkbox"/> Chemotherapy: _____ <input type="checkbox"/> Respiratory therapy: _____ <input type="checkbox"/> Dialysis: _____ <input type="checkbox"/> Ventilator: _____ <input type="checkbox"/> Endoscopy: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Immunocompromised: _____			<input type="checkbox"/> Male: _____ <input type="checkbox"/> Female: _____	<input type="checkbox"/> < 1 <input type="checkbox"/> 1 - 18 <input type="checkbox"/> 19 - 50 <input type="checkbox"/> 51 - 65 <input type="checkbox"/> 66 - 74 <input type="checkbox"/> ≥ 75
Infected/ Symptomatic	a.	b.					
Colonized/ Asymptomatic	c.	d.					
Total	e.	f.					
21. Facility type:		22. Unit type:		23. Organism:		24. Infection type:	
<input type="checkbox"/> General acute care hospital <input type="checkbox"/> Pediatric hospital <input type="checkbox"/> Long-term acute care hospital <input type="checkbox"/> Other:		<input type="checkbox"/> ICU <input type="checkbox"/> Step-down <input type="checkbox"/> Med surgical <input type="checkbox"/> Sub-acute <input type="checkbox"/> Multiple units <input type="checkbox"/> Surgery <input type="checkbox"/> NICU <input type="checkbox"/> Telemetry <input type="checkbox"/> Neuro <input type="checkbox"/> Transplant <input type="checkbox"/> Oncology <input type="checkbox"/> Other: <input type="checkbox"/> Psych		<input type="checkbox"/> Acinetobacter <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> Aspergillus <input type="checkbox"/> MSSA <input type="checkbox"/> Unknown gastroenteritis <input type="checkbox"/> CRE <input type="checkbox"/> Mold <input type="checkbox"/> Unknown rash <input type="checkbox"/> C. difficile <input type="checkbox"/> Norovirus <input type="checkbox"/> Other: <input type="checkbox"/> E. coli <input type="checkbox"/> Pseudomonas <input type="checkbox"/> Influenza <input type="checkbox"/> RSV <input type="checkbox"/> Legionella <input type="checkbox"/> Scabies		<input type="checkbox"/> Bloodstream <input type="checkbox"/> Urinary tract <input type="checkbox"/> CNS <input type="checkbox"/> Other: <input type="checkbox"/> Eye <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin/soft tissue <input type="checkbox"/> Surgical Site	
25. Organism an MDRO? <input type="checkbox"/> Yes <input type="checkbox"/> No				26. Procedure related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possibly, but more analysis required			
27. Case definition (include outbreak duration):							

II. Laboratory

28. Patient Test				
Specimen source:	Method of testing:	Number (+):	Number tested:	Organism:
a.	b.	c.	d.	e.
f.	g.	h.	i.	j.
k.	l.	m.	n.	o.
29. a. Was environmental testing done? <input type="checkbox"/> Yes <input type="checkbox"/> No, skip to 30				
		b. If yes, date collected:		c. Tested by:
Sample type (e.g. water, air, surface swab)		Test type:	Total collected:	Number positive:
d.		e.	f.	g.
h.		i.	j.	k.
30. a. Was molecular testing done? <input type="checkbox"/> Yes <input type="checkbox"/> No, skip 31 <input type="checkbox"/> NA, skip to 31				
c. Type of test: <input type="checkbox"/> PCR <input type="checkbox"/> PFGE <input type="checkbox"/> WGS <input type="checkbox"/> Other:		b. If yes, date tested:		
d. Tested by:		e. Were strains related?		
		<input type="checkbox"/> Isolates Identical <input type="checkbox"/> Isolates Related <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Related		

III. Investigation

31. a. Did ACDC staff conduct a site investigation? <input type="checkbox"/> Yes, provide date(s): _____, _____, _____ <input type="checkbox"/> No, skip to 29				
b. Joint visit(s) with: <input type="checkbox"/> EH <input type="checkbox"/> PHL <input type="checkbox"/> HFID <input type="checkbox"/> CDPH <input type="checkbox"/> Other: _____ <input type="checkbox"/> None				
c. Why was a site investigation performed?				
<input type="checkbox"/> Severity of disease		<input type="checkbox"/> Disease agent unknown		<input type="checkbox"/> Continued transmission
<input type="checkbox"/> Deaths		<input type="checkbox"/> Unknown source of transmission		<input type="checkbox"/> Other: _____
32. Did ACDC receive reports from other agency's site visit?				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
33. Were any procedures observed? (e.g. medical device reprocessing, dressing change, wound care)				
<input type="checkbox"/> Yes <input type="checkbox"/> No, skip to 30				
34. Notes from infection control assessments and deficiencies observed:				
35. Did ACDC consult with external agencies? <input type="checkbox"/> CDC <input type="checkbox"/> CDPH <input type="checkbox"/> DWP <input type="checkbox"/> Manufacturer <input type="checkbox"/> FDA <input type="checkbox"/> Other:				

IV. Control Measures

36. Control measures initiated by healthcare facility prior to ACDC investigation

- Patient cohorting Special precautions Begin/increased use of hand hygiene Other:
 Staff cohorting Staff education Begin/increased use of respiratory/cough etiquette
 Closed to new admission Prophylaxis Enhanced environmental cleaning None

37. Recommendations	ACDC Recommendations	Action Implemented by Facility	NA
a. Isolation precautions	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
b. Enhanced healthcare worker education and training	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
c. Enhanced environmental cleaning	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
d. Patient cohorting	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
e. Staff cohorting	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
f. Family/visitor education	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
g. Continue control measures implemented prior to notification	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
h. Surveillance Testing (admission cultures, point prevalence, high risk contacts)	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
i. Other:	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>
j. Other:	<input type="checkbox"/> Date:	<input type="checkbox"/> Date:	<input type="checkbox"/>

38. a. Was post exposure procedure patient notification conducted? Yes No, skip to 35 b. If Yes, number of patient(s) notified: _____
 c. Date range: _____ to _____ d. Method of patient notification: _____

39. a. Were outbreak notification letters posted at the hospital? Yes No NA If, yes Date: _____ b. Locations: _____

40. a. Were healthcare workers informed of the outbreak? Yes No, skip to 38 b. If yes, how: _____

41. Was surveillance testing(s) obtained? Yes No, skip to 36

a. First surveillance tests:	b. Date collection first started:	e.	Number collected	Number positive	i. Second surveillance tests:	m. Date collection first started:	p.	Number collected	Number positive
<input type="checkbox"/> Patients <input type="checkbox"/> Staff		Patients:	f.	g.	<input type="checkbox"/> Patients <input type="checkbox"/> Staff		Patients:	q.	r.
		Staff:	h.	i.			Staff:	s.	t.
c. Type of test:		Total:	j.	k.	n. Type of test:		Total:	u.	v.
d. Type of specimen collected:					o. Type of specimen collected:				

42. Were any units closed: a. To new admissions? Yes No b. To new transfers? Yes No c. Date unit closed: _____ d. Date unit reopened: _____ e. Were the closures: Voluntary ACDC Recommendation

43. Was a case-control study done? Yes No If Yes, by provide the file pathway: _____

V. Investigation Summary and Conclusions

44. Main hypothesis: _____

45. Alternative explanations for the observed increase in incidence: _____

46. Outbreak summary/notes: _____

47. Potential exposures: Central line Improper cleaning Improper PPE Procedure related Person to person
 Improper hand hygiene Improper reprocessing Intubation Medical device Other:

48. Potential source: Water HCW Food Medication Injection Other environmental source:

49. Investigator name: _____ 50. Title: _____ 51. Telephone number: _____

52. Signature: _____ 53. Date of final report: _____ 54. Date closed in OB log: _____

55. Attachments: Final Line List Epi Curve Letter/ Investigation Summary (if applicable) Other:

56. Date and time when active investigation closed: _____ 57. Date and time closure email sent to facility: _____ : AM/PM