Reset Form

Acute Communicable Disease Control
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Los Angeles, CA 90012
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213-482-4856 (facsimile)
www.publichealth.lacounty.gov/acd

CD OUTBREAK INVESTIGATION
SUB-ACUTE HEALTH CARE FACILITY

☐ **INITIAL REPORT:** _____ DATE ☐ **FINAL REPORT:** _____ DATE

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

Disease: ☐ Norovirus ☐ Unk. GI ☐ Scabies ☐ Unk. Rash ☐ Influenza ☐ RSV ☐ Other Respiratory ☐ Other: _____

Facility Type
☐ Skilled Nursing Facility ☐ Psychiatric Care Facility
☐ Dialysis Center ☐ Intermediate Care Facility
☐ Other: _____

Facility Population *(on date first case identified)*
Total # of Patients/Residents: _____
Total # of Direct Care Staff: _____

Number of:	Patients	Staff
a. Clinical Cases (symptomatic only)		
b. Laboratory Confirmed Cases		
c. Total Cases (sum of clinical and lab confirmed)		

Reported By	**Reporting Source Title**	**Reporting Source Telephone**	**Report Date**

ADDITIONAL BACKGROUND (OPTIONAL) or INVESTIGATION SUMMARY AND CONCLUSIONS

CLINICAL DESCRIPTION

Date of First Case	**Date of Last Case**	**Date Most New Cases Identified**

Severity of Disease (attributable to outbreak)

	Patient	Staff
# Requiring Clinic or Doctor Visit		
# Requiring Hospitalization		
# Deaths		

Age Distribution

AGE	Patient # CASES	Staff # CASES
<1		
1-4		
5-19		
20-49		
50-65		
66-74		
75+		

Check all predominant symptoms among the patients that apply *(please only include new or worsening symptoms):*

General	Respiratory	Gastrointestinal	Skin
☐ Fever	☐ Shortness of breath	☐ Stomach pain	☐ Itch
☐ Muscle pain	☐ New or worsened cough	☐ Nausea	☐ Rash
☐ Chest pain	☐ Sore throat	☐ Vomiting	Other
☐ Headache	☐ Runny nose	☐ Diarrhea	☐ _____
	☐ Increased sputum	☐ Bloody stools	☐ _____

Has treatment been given to cases? If yes, please describe below.

	Recipient	Treatment(s)	# Treated
☐ No ☐ Yes:	Patients / Residents		
☐ No ☐ Yes:	Staff		
☐ No ☐ Yes:	Visitors		

Has prophylaxis been given to non-cases? If yes, please describe below.

	Recipient	Treatment(s)	# Treated
☐ No ☐ Yes:	Patients / Residents		
☐ No ☐ Yes:	Staff		
☐ No ☐ Yes:	Visitor		

Is there any obvious clustering of cases among the following categories? Please check all that apply.

☐ Patient acuity ☐ Demographic variables
☐ Patient location ☐ Procedures
☐ Shared staff ☐ Medications
☐ Other: Specify _____

Please describe any observed clustering: _____

FOR INFLUENZA OUTBREAKS ONLY - VACCINATION

Total # of people **vaccinated against influenza** ≥14 days before the outbreak began:
Patient _____ Staff _____

Total # of people **offered catch-up Influenza vaccination** after the outbreak began:
Patient _____ Staff _____

Total # **vaccinated against S. pneumonia** ≥14 days before the outbreak began:
Patients ____

Facility Name: _____ Outbreak Number: _____

LABORATORY DESCRIPTION

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

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

INFLUENZA CASES ONLY- RESULTS FOR LAB-CONFIRMED

Influenza A ☐ (H3) ☐ (2009H1N1) ☐ (A Unknown)	☐ Positive (# positive cases: ____)	☐ Negative (# negative cases: ___)
Influenza B ☐ (Yamagata) ☐ (Victoria) ☐ (B Unknown)	☐ Positive (# positive cases: ____)	☐ Negative (# negative cases: ___)
Influenza type undetermined	☐ Positive (# positive cases: ____)	☐ 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	☐ Date _____	☐ Date _____
Suggested facility review its relevant policies and procedures with staff	☐ Date _____	☐ Date _____
Followed Los Angeles County/California/CDC guidelines for environment and organism	☐ Date _____	☐ Date _____
Patient cohorting	☐ Date _____	☐ Date _____
Staff cohorting	☐ Date _____	☐ Date _____
Contact / Respiratory precautions	☐ Date _____	☐ Date _____
Enhanced environmental cleaning	☐ Date _____	☐ Date _____
Begin or increase use of hand hygiene messages	☐ Date _____	☐ Date _____
Begin or increase use of respiratory / cough etiquette messages	☐ Date _____	☐ Date _____
Facility closed to new admissions	☐ Date _____	☐ Date closed _____ ☐ Date reopened _____
Notification regarding outbreak made to: ☐ Staff ☐ Patients ☐ Visitors ☐ Community	☐ Date _____	☐ Date _____
In-service by: ☐ PHN Topic: _____ ☐ Facility Staff Topic: _____	☐ Date _____ ☐ Date _____	☐ Date _____
Field visit by PHN:	☐ Date _____ ☐ Date _____ ☐ Date _____ ☐ 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	
ACD USE ONLY - ACD Reviewer Name (print)	ACD Reviewer Signature	Date	
☐ **Closed – OK to report**	☐ **Closed – False OB, Do not report**	☐ **Closed – Other** _____	