Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

The Respiratory Outbreak Summary Form was created to help nursing homes and other LTC providers summarize the findings, actions and outcomes of an outbreak investigation and response. Completing this outbreak form will provide LTC facilities and other public health partners with a record of a facility's outbreak experience and highlight areas for outbreak prevention and response.

Instructions for each section of the form are described below. This form should be filled out by the designated infection preventionist with support from other clinicians in your facility (e.g., front-line nursing staff, physicians or other practitioners, consultant pharmacist, laboratory).

A LTC facility can use this form for internal documentation and dissemination of outbreak response activities. Facilities are encouraged to share this information with the appropriate public health authority by contacting the local health department. Should a facility decide to share this form with the local/state public health officials, please include facility contact information at the bottom of the form.

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LTC Respiratory Surveillance Outbreak Summary

Section 1: Facility Information

Health Dept. Contact Name and Phone Number: A LTC facility should have contact information (name or division, phone number) for the local and/or state health department for outbreak guidance and reporting purposes. Enter the health dept. contact information your facility used to request support during an outbreak.

Date First Notified Local Health Dept: Record the date you first contacted local or state public health during this outbreak at your facility.

Total # of residents at facility: Document the total number of residents in the facility at the time of the outbreak.

Total # of employees: Document the total number of staff working in the facility at the time of the outbreak. Staff includes all healthcare personnel (e.g., nurses, providers, consultants, therapists, food services, environmental services) whether employed, contracted or volunteer.

Summary Form Status: Information in the summary form may be completed over the course of the outbreak. Record the dates your facility started collecting information on the form and completed the outbreak summary report.

Section 2: Influenza Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received the Flu Vaccine within the past year.

Total # of staff vaccinated: Record the total number of staff that received the Flu Vaccine within the past year.

Section 3:Pneumococcal Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received at least one dose of the Pneumococcal Vaccine (either polysaccharide or conjugate).

Section 4: Case Definition

Provide a description of the criteria used to determine whether a resident should be considered a case in this outbreak. The description can include: signs/symptoms, presence of positive diagnostic tests, location within facility, and the timeframe during which individuals may have been involved in the outbreak (e.g., within the past 4 weeks).

Example: A Respiratory illness case includes any resident with the following symptoms: cough, shortness of breath, sputum production and fever residing on Units 2E or 2W, with onset of symptoms between Jan 15th and Feb 1st with or without a sputum specimen positive for Streptococcus pneumoniae.

Section 5: Outbreak Period Information

Outbreak start: (Date of symptom onset of first case): Record the date the first person developed signs/symptoms (e.g., fever, cough, shortness of breath) consistent with the outbreak illness.

Average length of illness: Estimate the average number of days it takes for signs/symptoms to resolve, based on clinical course among residents/staff affected by the outbreak illness.

Outbreak end: (Symptom resolution date of last case): Record the date the last person recovered from the outbreak illness and became symptom free for 24 hours.

Total # of Cases: Document the number of residents and staff (if applicable) who were identified as having the outbreak illness.

Section 6: Staff Information

Were any ill staff delivering resident care? Check yes or no.

- If yes, try to estimate the number of ill staff involved in resident care based on date when a staff member reported symptoms compared with the date when/if staff member was excused from work.

Did any staff seek medical attention for an acute respiratory infection at any time during the outbreak? Check yes or no.

- If yes, try to estimate the number of staff that sought medical attention based on self-report.

If available, indicate if ill staff received care at an emergency department (ED). Check yes or no and estimate number of staff.

If available, indicate if ill staff was hospitalized as a result of the outbreak illness. Check yes or no and estimate number of staff.

Section 7: Diagnostic and Laboratory Tests

Chest x-ray: Fill in the box (yes or no) indicating whether or not residents and staff had an x-ray done as a part of the diagnosis of the outbreak illness. If yes, please record the # of individuals who received chest x-ray and the # of x-rays that had abnormal findings consistent with the outbreak illness.

List all bacterial (e.g., *S. pneumoniae, Mycoplasma*); viral (e.g., Influenza, RSV) organisms that were identified through laboratory testing; Use the space provided by "Other" to specify if a parasite or non-infectious cause of respiratory illness was identified.

Diagnostic testing results: In the table, each row corresponds to an organism identified during the outbreak. Use the column to specify the type of testing used to identify each organism (either microbiologic culture, PCR (also known as nucleic acid amplification) or specify if a different diagnostic test was used (e.g., Legionella urinary antigen). For each test type, document the total number of residents and staff that received laboratory confirmation by that test.

Section 8: If Influenza Identified During Outbreak:

Antiviral Treatment: Fill in the box (yes or no) indicating whether or not antiviral treatment was offered. If antiviral treatment was offered, please record the total number of residents and staff that received treatment.

Antiviral Prophylaxis Offered: Fill in the box (yes or no) indicating whether or not antiviral prophylaxis was offered to any additional residents, staff or family members at risk for infection due to the outbreak. If antiviral prophylaxis was offered, please record the total number of residents and staff that received prophylaxis.

Section 9: Resident Outcome

Hospitalizations: During the outbreak, fill in the box (yes or no) indicating whether or not hospitalization was required for any residents. If yes, please record how many residents were hospitalized.

Deaths: During the outbreak, fill in the box (yes or no) indicating whether or not any residents died. If yes, please record how many residents died during the outbreak period (deaths should be recorded even if unable to determine if outbreak illness was the cause).

Section 10: Facility Outbreak Control Interventions

In this section, check if any of the infection control strategies listed were implemented at your facility in response to the outbreak. If a practice or policy change was implemented during the outbreak that is not listed (e.g., new cleaning/disinfecting products used, change to employee sick leave policy), specify in the space provided by "Other". For each strategy, record the date the change was implemented (if available).

Section 11: # of New Cases Per Day

Please fill in the chart with the number of new cases that are residents and staff per day. Once each day is complete, add the number of new cases of residents and staff and place the sum in total column for that corresponding day.

In the space provided under the chart, record the date which corresponds to Day 1 on the outbreak period (i.e., date of outbreak start).

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Facility Licensed by State: Fill in the box (yes or no) indicating whether or not the facility is licensed by the state.

Facility Certified by CMS: Fill in the box (yes or no) indicating whether or not the facility is certified by the Center for Medicare and Medicaid Services (CMS).

Facility Type: Check that box that best describes the type of care the facility provides: Nursing home, Intermediate Care Facility, Assisted living Facility or Other (specify).

# of Licensed Beds: Document the total number of licensed beds at the facility.

# of staff employees: Document the total number of facility employed staff working in the facility at the time of the outbreak.

# of contract employees: Document the total number of contract/consulting providers working in the facility at the time of the outbreak.

LTC Respiratory Surveillance Outbreak Summary

1. Facility Information

Health Dept. Contact Name:________________________________ Health Dept. Contact Phone Number:________________________
Health Dept. Fax Number:__________________________________ Date First Notified Local Health Dept.:___/___/____
Total # of residents at facility: _______________________________ Total # of employees (staff and contract personnel): _____________
Summary Form Status: Date initiated:___/___/______ Date completed:___/___/____

2. Influenza Vaccination Status		3. Pneumococcal Vaccination Status
Total # of residents vaccinated:	Total # of staff vaccinated:	Total # of residents vaccinated:

4. Symptomatic Case Definition

Summarize the definition of a symptomatic case during the outbreak, including symptoms, time range and location (if appropriate) within facility:

5. Outbreak Period Information

Outbreak start: (Date of symptom onset of first case):___/___/_____
Average length of illness:___________ days
Outbreak end: (Symptom resolution date of last case):___/___/_____

Total # of Cases
Residents: Staff:

6. Staff Information

Were any ill staff delivering resident care at the beginning of the outbreak? ☐ Yes ☐ No If yes, how many:____
Did any ill staff seek outside medical care at the beginning or during the outbreak? ☐ Yes ☐ No If yes, how many:____
ED Visit: ☐ Yes ☐ No If yes, how many:____ Hospitalization: ☐ Yes ☐ No If yes, how many:____

7. Diagnostic and Laboratory Tests

Chest x-ray: ☐ Yes ☐ No	# performed:	# abnormal:

Which organisms were identified through laboratory testing:
Bacterial: Specify_____________________ **Viral**: Specify_____________________ **Other**: Specify___________________________

Total # of Laboratory Confirmed Cases	Culture	PCR	Other Diagnostic Tests: Specify ________________________
Organism 1 ________________________________	Residents:____ Staff:____	Residents:___ Staff:___	Residents:____ Staff:____
Organism 2 ________________________________	Residents:____ Staff:____	Residents:___ Staff:___	Residents:____ Staff:____
Organism 3 ________________________________	Residents:____ Staff:____	Residents:___ Staff:___	Residents:____ Staff:____

8. If Influenza Identified During Outbreak:

Antiviral **treatment** offered: ☐ Yes ☐ No
If yes, indicate total # : Residents______ Staff________

Antiviral **prophylaxis** offered: ☐ Yes ☐ No
If yes, indicate total # : Residents______ Staff_______

9. Resident Outcome

Hospitalizations: ☐ Yes ☐ No If yes, how many:_____
Deaths: ☐ Yes ☐ No If yes, how many:_____

10. Facility Outbreak Control Measures

☐ Educated on hand hygiene practices: Date:__________
☐ Implemented transmission-based precautions: Date__________
☐ Dedicate staff to care for only affected residents: Date: _________
☐ Suspend activities on affected unit: Date: __________
☐ Notified family/visitors about outbreak: If yes, Date: __________
☐ Other: ____

☐ Monitored appropriate HH and PPE use by staff: Date:_________
☐ Cohorted ill residents within unit/building: Date: __________
☐ Placed ill staff on furlough: Date: __________
☐ Restricted new admissions to affected unit: Date: __________
☐ Educated family/visitors about outbreak: If yes, Date: _________
☐ Other: ____

11. # of New Cases Per Day

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Residents														
Staff														
Total														

Indicate Date of Day 1: _____/_____/_________ **List units/floors involved in the outbreak:**________________________________

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Facility Licensed by State: ☐ Yes ☐ No Facility ID: ___________________________
Facility Certified by CMS: ☐ Yes ☐ No Facility Type: ☐ Nursing home ☐ Assisted living ☐ Other (specify): ________________
# of Licensed Beds: ___________ # of staff employees: ___________ # of contract employees: ___________