Long-Term Care (LTC)
Acute Gastroenteritis Outbreak Summary

Instructions for the Long-Term Care (LTC) Acute Gastroenteritis Outbreak Summary Form

The Acute Gastroenteritis 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 Acute Gastroenteritis 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 Health Department: 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: 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 gastroenteritis case includes any resident with the following symptoms: nausea, vomiting, abdominal pain, or diarrhea, residing on Units 2E or 2W, with onset of symptoms between Jan 15 and Feb 1 with or without a stool specimen positive for norovirus.

Section 3: Outbreak Period Information

Outbreak Start (Date of symptom onset of first case): Record the date the first person developed signs/symptoms (e.g., nausea, vomiting, diarrhea) 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 4: 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.

Were any ill staff responsible for handling food at the start of the outbreak? Check yes or no.

- If yes, try to estimate the number of ill staff who handled food at the beginning or during the outbreak based on date when a food-handling 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 gastroenteritis infection at any time during the outbreak? Check yes or no.

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

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

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

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Section 5: Laboratory Tests

List all bacterial (e.g., *C. difficile, Salmonella, Campylobacter*); viral (e.g., *Rotavirus, Norovirus*) organisms that were identified through laboratory testing; use the space provided by "Other" to specify whether a parasite or non-infectious cause of gastroenteritis 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 whether a different diagnostic test was used (e.g., C. diff toxin)). For each test type, document the total number of residents and staff that received laboratory confirmation by that test.

Section 6: Resident Outcome

Hospitalizations: During the outbreak, check 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, check 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 whether outbreak illness was the cause).

Section 7: Facility Outbreak Control Interventions

In this section, check whether 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 8: # of New Cases Per Day

Please fill in the chart with the number of new cases of 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 that corresponds to Day 1 on the outbreak period (i.e., date of outbreak start).

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

Facility Certified by CMS: Check the box (yes or no) indicating whether or not the facility is certified by the Centers for Medicare & Medicaid Services (CMS).

Facility Type: Check the 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 Acute Gastroenteritis Outbreak Summary

1. Facility Information

Health Dept. Contact Name: ____________________________ Health Dept. Contact Phone Number: ____________________
Health Dept. Fax Number: _____________________________ Date First Notified Health Dept.: ___/___/____
Total # of Residents at facility: ____ Total # of Employees (staff and contract personnel):
Summary Form Status: Date initiated: ___/___/____ Date completed: ___/___/____

2. Case Definition

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

3. Outbreak Period Information

Outbreak Start (Date of symptom onset of first case): ___/___/____
Average Length of Illness: ____
Outbreak End (Symptom resolution date of last case): ___/___/____

Total # of Cases
Residents: ____ Staff: ____

4. Staff Information

Were any ill staff delivering resident care at the beginning or during the outbreak? ☐ Yes ☐ No If yes, how many: ____
Were any of the ill staff responsible for handling food at the beginning or during 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: ____

5. Laboratory Tests

Which organisms were identified through laboratory testing?
Bacterial: Specify____________________ **Viral:** Specify____________________ **Other:** Specify_________________________

Diagnostic testing results	**Microbiology Culture**	**PCR**	**Other Test:** 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: ____

6. Resident Outcome

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

7. Facility Outbreak Control Measures (Check if control measure used and provide date of implementation)

☐Educated on hand hygiene (HH) practices: Date: ___/___/____
☐Implemented Transmission-Based Precautions: Date: ___/___/____
☐Dedicated staff to care for only affected residents: Date: ___/___/___
☐Suspended activities on affected unit: Date: ___/___/____
☐Notified family/visitors about outbreak: 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: Date: ___/___/____
☐Other: ____

8. # 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 outbreaks:____**

If faxing to your local Public Health Department, please complete the following information:

Facility Name: ______________________________ **City, State:** ________________________________ **County:** _____________________________
Contact Person: ____________________________ **Phone:** ____________________________________ **Email:** ________________________________

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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 Employed Staff: ______ # of Contract/Consultant providers: ______