

Attachment C

NOTE: The revised Gastroenteritis Outbreak Summary Form entitled “ Outbreak Summary for GASTROENTERITIS at a LONG-TERM CARE FACILITY” is attached on the following 3 pages.

Completion of this form will substitute for a narrative final report unless otherwise indicated with DHMH’s Division of Outbreak Investigation (DOOI) Division.

Please contact DOOI at 410-767-6677 if you have any questions about completing this form.

Thank you.

**Epidemiology and Disease Control Program
Division of Outbreak Investigation**

Outbreak Summary for GASTROENTERITIS at a LONG-TERM CARE FACILITY

Facility Name _____
Illness _____

DHMH Outbreak # _____
County _____
Date of Final Report _____

I. INTRODUCTION:

Date outbreak reported to LHD _____
Who reported outbreak to LHD _____
Who at LHD conducted the investigation _____
Date infection control recommendations were given to facility by LHD _____
Date LHD reported outbreak to DHMH _____
Primary contact for outbreak at DHMH (Name & phone #) _____

II. BACKGROUND:

Total number of residents at facility _____
Total number of staff at facility _____
Type of long-term care facility (i.e. nursing home, assisted living, etc.) _____

III. CLINICAL RESULTS:

RESIDENTS:

cases (TOTAL) _____
lab-confirmed _____
of hospital admissions _____
of ER visits related to this outbreak only _____
of deaths related to outbreak _____

STAFF:

cases (TOTAL) _____
lab-confirmed _____
of hospital admissions _____
of ER visits related to this outbreak only _____
of deaths related to outbreak _____

Onset date range for entire facility, i.e. residents and staff (first to last) _____
Onset date range for residents only (first to last) _____
Onset date range for staff only (first to last) _____
-Include an epi curve

Duration of symptoms for cases (range = shortest to longest, & median) _____

Was the outbreak limited to one floor or wing? (circle one) YES NO
If YES, please list floor/wing # and/or name _____

Symptom frequency for cases:

Residents:

Symptom	Number with Symptom
Diarrhea	
Vomiting	
Abdominal Cramps	
Nausea	
Fever	
Bloody Stool	
Muscle Aches	
Headache	
Chills	

Staff:

Symptom	Number with Symptom
Diarrhea	
Vomiting	
Abdominal Cramps	
Nausea	
Fever	
Bloody Stool	
Muscle Aches	
Headache	
Chills	

If symptom frequency is unavailable, please list predominant symptoms of this outbreak.

IV. LABORATORY RESULTS:

Kit used	Stools tested for the following agents:	Number collected	Number positive	Agent identified
Enteric				
Miscellaneous				
Viral				
Other				

Was PFGE testing done? YES NO
 If so, did stools match? YES NO

V. DISCUSSION:

Please list the lab-confirmed etiology of the outbreak _____

Is the above etiologic agent consistent with the observed course of this outbreak?
 YES NO UNKNOWN

If an etiology was not lab-confirmed, please provide a “suspect” etiology of the outbreak (i.e. What do **you** think it is? Please base this answer on the available epidemiological evidence collected in this investigation.).

How do you think the outbreak was initiated (i.e. do you think a staff person introduced the agent to the facility)?

Did the outbreak appear to be spread via (a) person-to-person route or (b) foodborne? (circle one)
 (NOTE: If foodborne, please fill out the appropriate “foodborne outbreak” forms (i.e. CDC “Fork & Spoon”))

Was there any evidence that there was a breakdown in infection control at the facility that caused the outbreak?

YES

NO

UNKNOWN

If YES, please explain briefly _____

Was infection control improved at the conclusion of the outbreak?

YES

NO

UNKNOWN

If NO, please explain briefly _____

Was an environmental analysis performed?

YES

NO

Date: _____

Results of the environmental analysis _____

What recommendations were issued at the beginning and conclusion of the outbreak investigation?

Please note any other pertinent information.

CC LIST

Please send a copy of the final report to the implicated entity (Director of Nursing, Infection Control Practitioner, etc.).