

**Office of Infectious Disease Epidemiology and Outbreak Response**

**Division of Outbreak Investigation**

**Outbreak Summary Report: RESPIRATORY ILLNESSES at a HEALTHCARE FACILITY**

DHMH Outbreak # \_\_\_\_\_

Facility Name \_\_\_\_\_ County \_\_\_\_\_

Circle facility type: Nursing home Assisted Living Other: \_\_\_\_\_

Illness \_\_\_\_\_ Date of Final Report \_\_\_\_\_

(NOTE: If there are several types of illnesses (e.g. pneumonia, ILI, etc.), please indicate the most prevalent illness in this outbreak—see DHMH Guidelines for definitions.)

**I. INTRODUCTION:**

Date outbreak reported to LHD \_\_\_\_\_

Who reported outbreak to LHD \_\_\_\_\_

Name of facility's IP \_\_\_\_\_ Has the IP taken a training course? Y N

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 \_\_\_\_\_

**II. BACKGROUND:**

Total number of residents at facility \_\_\_\_\_

If outbreak was in one unit, number of residents in that unit \_\_\_\_\_

Total number of staff at facility \_\_\_\_\_

If outbreak was in one unit, number of staff in that unit \_\_\_\_\_

Influenza vaccination coverage rate among residents \_\_\_\_\_ (express as a fraction or %)

Pneumococcal vaccination coverage rate among residents \_\_\_\_\_ (express as a fraction or %)

Influenza vaccination rate among staff \_\_\_\_\_ (express as a fraction or %)

**III. CLINICAL RESULTS:**

**RESIDENTS:**

# of cases (TOTAL\*) \_\_\_\_\_

# with lab-confirmed influenza \_\_\_\_\_

# with ILI \_\_\_\_\_

# with pneumonia \_\_\_\_\_

# of hospital admissions \_\_\_\_\_

# of ER visits \_\_\_\_\_

# of deaths related to outbreak \_\_\_\_\_

\*Total = number with ILI, influenza, or pneumonia.

**STAFF:**

# of cases (TOTAL\*) \_\_\_\_\_

# with lab-confirmed influenza \_\_\_\_\_

# with ILI \_\_\_\_\_

# with pneumonia \_\_\_\_\_

# of hospital admissions \_\_\_\_\_

# of ER visits \_\_\_\_\_

# 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) \_\_\_\_\_

*-Please attach an epi curve*

Duration of symptoms for cases: shortest: \_\_\_\_\_ longest: \_\_\_\_\_ median: \_\_\_\_\_

Was the outbreak limited to one floor or wing? YES NO  
 If YES, please list floor/wing # and/or name \_\_\_\_\_

Were antivirals (e.g. oseltamivir) given as part of this outbreak? YES NO  
 If YES, please list which antiviral(s) \_\_\_\_\_  
 Which categories of individuals received antivirals? (circle)  
 Residents with lab confirmed influenza Residents with ILI or other respiratory illness  
 All well residents Some well residents  
 Ill staff Well staff  
 Other: \_\_\_\_\_  
 Duration of antiviral prophylaxis: \_\_\_\_\_

**Symptom frequency for cases:**

**Residents:**

Symptom	Number with Symptom
Fever	
Cough	
Sore Throat	
Runny Nose	
Congestion – Nasal	
Congestion - Chest	
Shortness of breath	
Muscle Aches	
Vomiting	
Diarrhea	

**Staff:**

Symptom	Number with Symptom
Fever	
Cough	
Sore Throat	
Runny Nose	
Congestion – Nasal	
Congestion - Chest	
Shortness of breath	
Muscle Aches	
Vomiting	
Diarrhea	

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

**IV. RADIOLOGY AND LABORATORY RESULTS:**

	Number performed	Number positive
Chest X-ray (CXR)		

Please provide any notes relating to findings of any positive CXRs \_\_\_\_\_  
 \_\_\_\_\_

Test	Number Collected	Number Positive	Agent identified
PCR for influenza (Viral throat or NP swab)			
Rapid influenza test			
Bacterial sputum culture			
Legionella urine antigen			
Legionella culture			
Blood culture			
Other _____			

**V. CONCLUSION(S):** (Please complete *either* #1a or #1b, *and* #2-6)

1a. 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

1b. If an etiology was not lab-confirmed, the etiology of the outbreak is believed to be:

\_\_\_\_\_

Briefly, the evidence for this conclusion includes: \_\_\_\_\_

\_\_\_\_\_

2. How do you think the outbreak was initiated?

\_\_\_\_\_

3. Please describe changes (if any) in infection control practices at the conclusion of the outbreak.

\_\_\_\_\_

\_\_\_\_\_

4. Was a site visit done? YES NO Date: \_\_\_\_\_

Observations made during the visit:

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were admissions to the facility restricted? YES NO

Entire facility Dates restricted: \_\_\_\_\_ to \_\_\_\_\_

Unit: \_\_\_\_\_ Dates restricted: \_\_\_\_\_ to \_\_\_\_\_ Unit: \_\_\_\_\_ Dates restricted: \_\_\_\_\_ to \_\_\_\_\_

Unit: \_\_\_\_\_ Dates restricted: \_\_\_\_\_ to \_\_\_\_\_ Unit: \_\_\_\_\_ Dates restricted: \_\_\_\_\_ to \_\_\_\_\_

6. Please note any other pertinent information.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CC LIST

\_\_\_\_\_

\_\_\_\_\_

LTCF Official: \_\_\_\_\_ Date Sent: \_\_/\_\_/\_\_\_\_