Long-Term Care (LTC) Acute Gastroenteritis Surveillance Line List

Instructions for the Long-Term Care (LTC) Acute Gastroenteritis Surveillance Line List

The Acute Gastroenteritis Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected gastroenteritis cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness.

Each row represents an individual resident or staff member who may have been affected by the outbreak illness (i.e., case). The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results, and outcomes. While this template was developed to help with data collection for common gastroenteritis outbreaks, the data fields can be modified to reflect the needs of the individual facility during other outbreaks.

Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

LTC Acute Gastroenteritis Surveillance Line List

Instruction Sheet for Completion of the Long-Term Care (LTC) Acute Gastroenteritis Surveillance Line List

Section A: Case Demographics

In the space provided per column, fill in each line with name, age, and gender of each person affected by the current outbreak at your facility. Please differentiate residents (R) from staff (S).
*Staff includes all healthcare personnel (e.g., nurses, physicians and other providers, therapists, food services, environmental services) whether employed, contracted, consulting, or volunteer.

For residents only: Short-stay (S) residents are often admitted directly from hospitals, require skilled nursing or rehabilitation care, and are expected to have a length of stay less than 100 days. Long-stay (L) residents are admitted to receive residential care or nursing support and are expected to have a length of stay that is 100 days or more. Indicate the stay type for each resident in this column.

Section B: Case Location

For residents only: Indicate the building (Bldg), unit, or floor where the resident is located and the room and bed number for each resident being monitored for outbreak illness. *Answers may vary by facility due to differences in the names of resident care locations.

For staff only: For each staff member listed, indicate the floor, unit, or location where that staff member had been primarily working at the time of illness onset. Fill in the box (Y or N) indicating whether that monitored or ill staff member was responsible for handling food at the beginning or during the outbreak period.

Section C: Signs and Symptoms (s/s)

Symptom onset date: Record the date (month/day) each person developed or reported signs/symptoms (e.g., abdominal cramps, diarrhea, vomiting) consistent with the outbreak illness.

Symptoms: Fill in the box (Y or N) indicating whether or not a resident or staff member experienced each of the signs/symptoms listed within this section (abdominal pain or tenderness; diarrhea; vomiting).

Additional documented s/s (*select all codes that apply*): In the space provided, record the code that corresponds to any additional s/s the resident or staff member experienced. If a resident or staff member experienced a s/s that is not listed, please use the space provided by "other" to specify the s/s.
N – nausea, F – fever, B – blood in stool, LA – loss of appetite, O – other: specify_____

Section D: Diagnostics

Type of specimen collected: (e.g., stool, blood): In the space provided, record the type of specimen collected for laboratory testing. If the type of specimen collected is not listed, please use the space provided by "other" to specify the specimen type.
S – stool, B – blood, O – other: specify_____

Date of collection: Record the date (month/day) of specimen collection.

Type of test ordered (*select all codes that apply*): In the space provided, record the code that corresponds to whether a diagnostic laboratory test was performed for each individual. If no test was performed, indicate "zero." If the laboratory test used to identify the pathogen is not listed, please use the space provided by "Other" to specify the type of test ordered.
0 – No test performed, 1 – Culture, 2 – Polymerase Chain Reaction (PCR), also called nucleic acid amplification testing (includes multiplex PCR tests for several organisms using a single specimen), 3 – Other: specify_____

Pathogen Detected (*select all codes that apply*): In the space provided, record the code that corresponds to the bacterial and/or viral organisms that were identified through laboratory testing. If the test performed was negative, indicate "zero." If a pathogen not listed was identified through laboratory testing, please use the space provided by "Other" to specify the organism.
0 – Negative results; Bacterial: 1 – *Salmonella*, 2 – *Campylobacter*, 3 – *Clostridium difficile,* 4 – *Shigella;* Viral: 5 – Norovirus, 6 – Rotavirus, 7 – Other: Specify_____

Section E: Outcome During Outbreak

Symptom Resolution Date: Record the date that each person recovered from the outbreak illness and was symptom free for 24 hours.

Hospitalized: Fill in the box (Y or N) indicating whether or not hospitalization was required for a resident or staff member during the outbreak period. *Note: The outbreak period is the time from the date of symptom onset for the first case to date of symptom resolution for the last case.*

Died: Fill in the box (Y or N) indicating whether or not a resident or staff member expired during the outbreak period.

Case (C) or Not a case (leave blank): Based on the clinical criteria and laboratory findings collected during the outbreak investigation, record whether or not each resident or staff member meets the case definition (C) or is not a case (leave space blank).

LTC Acute Gastroenteritis Surveillance Line List

Date: ___/___/____

This worksheet was created to help nursing homes and other LTC facilities detect, characterize, and investigate a possible outbreak of acute gastroenteritis.

	A. Case Demographics					B. Case Location				C. Signs and Symptoms (s/s)					D. Diagnostics				E. Outcome During Outbreak[A]			
	Name	Age	Gender (M/F)	Resident (R) or Staff (S)	Residents Only: Short stay (S) or Long stay (L)	Residents Only: Bldg/Floor/Unit	Residents Only: Room/Bed	Staff Only: Primary assignment (floor or location)	Staff Only: Food handler (Y/N)	Symptom onset date: (mm/dd)	Abdominal pain or tenderness (Y/N)	Diarrhea (Y/N)	Vomiting (Y/N)	Additional documented s/s (*select all codes that apply*) N – nausea, F – fever, B – blood in stool, LA – loss of appetite, O – other: Specify_____	Type of specimen collected (*select all codes that apply*) S – stool, B – blood, O – other: Specify_____	Date of collection: (mm/dd)	Type of test ordered (*select all codes that apply*) 0 – No test performed, 1 – Culture, 2 – PCR, 3 – Other: Specify_____	Pathogen detected (*select all codes that apply*) 0 – Negative results Bacterial: 1 – *Salmonella*, 2 – *Campy*, 3 – *C. difficile*, 4 - *Shigella* Viral: 5 – Norovirus, 6 – Rotavirus 7 – Other: Specify_____	Symptom resolution date: (mm/dd)	Hospitalized (Y/N)	Died (Y/N)	Case (C) or Not a case (leave blank)
1.																						
2.																						
3.																						
4.																						
5.																						
6.																						
7.																						
8.																						
9.																						
10.																						

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

Facility Name: _____ **City, State:** _____ **County:** _____

Contact Person: _____ **Phone:** _____ **Email:** _____

[A] Note: Outbreak period defined as date of first case to resolution of last case.

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.

Contents **Page Number**

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.

LTC Acute Gastroenteritis Surveillance Outbreak Summary

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).

For HD Use Only

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:** _____

For HD Use Only

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: _____