



GASTROENTERITIS CONTROL MEASURES REPORT

OUTBREAK # _____ FACILITY NAME _____

CORPORATION NAME _____

Completed by: _____ Date: ____/____/____ County: _____

FACILITY POPULATION QUESTIONS

- _____ Total number of residents in the facility during the outbreak.
_____ Total number of employees (not including staff from "temp" agencies) during the outbreak.
_____ Total number of temporary staff hired during this outbreak (enter 0 if temporary staff were not used).
_____ Total number of patient care staff during the outbreak.

FACILITY QUESTIONS *(please include dates)*

Y ? N NA

- A ☐ ☐ ☐ ☐ Is the facility Medicare certified?
B ☐ ☐ ☐ ☐ Is the facility Medicaid certified?
C ☐ ☐ ☐ ☐ Is the facility owned by a corporation?
D ☐ ☐ ☐ ☐ Does the facility have written procedures for contact isolation of patients?
E _____ When were facility control measures first implemented? ____/____/____
F _____ When were control measures lifted and typical procedures resumed? ____/____/____
G _____ What type of facility is it? *(check all that apply)*
☐ Skilled nursing ☐ Residential Care ☐ Assisted Living ☐ Adult Foster Care ☐ Memory Care

CONTROL MEASURES FOR RESIDENTS & PATIENTS *(please include Start and End dates)*

Y ? N NA

- H ☐ ☐ ☐ ☐ Were admission discontinued until the outbreak was over? *If yes, what date were the admissions discontinued?* ____/____/____ *and resumed?* ____/____/____
I ☐ ☐ ☐ ☐ Were sick patients confined to their rooms until they were symptom free for 48 hours or more? *If yes, when were patients confined?* ____/____/____ *through* ____/____/____
J ☐ ☐ ☐ ☐ Were group activities discontinued until the outbreak was over? ____/____/____ *through* ____/____/____
K ☐ ☐ ☐ ☐ Were ward transfers discontinued during the outbreak? ____/____/____ *through* ____/____/____
L ☐ ☐ ☐ ☐ Were visitors restricted during the outbreak? ____/____/____ *through* ____/____/____
M ☐ ☐ ☐ ☐ Was patient care equipment dedicated to a single sick patient, or shared among similarly sick patients?
N ☐ ☐ ☐ ☐ Were patients with vomiting or diarrhea put on contact precautions? ____/____/____ *through* ____/____/____
O ☐ ☐ ☐ ☐ Were patients with vomiting or diarrhea moved to private rooms or to rooms with other patients with vomiting or diarrhea (cohorting)? ____/____/____ *through* ____/____/____

CONTROL MEASURES FOR STAFF *(please include Start and End dates)*

Y ? N NA

- P ☐ ☐ ☐ ☐ Are sinks, soap and paper towels within or just outside each residents room?
Q ☐ ☐ ☐ ☐ Were the same staff-to-resident assignments maintained throughout the outbreak (cohort nursing)?
R ☐ ☐ ☐ ☐ Do employees have paid sick leave? *If yes, (check only one box)* ☐ all permanent staff or ☐ some permanent staff
S ☐ ☐ ☐ ☐ Were there any employees with vomiting or diarrhea restricted from work until symptom-free for 48 hours?
Number of restricted employees: _____
T _____ What did patient caregivers use while caring for a patient with vomiting or diarrhea *(choose one)*?
☐ gloves only ☐ gloves & gown both ☐ gloves, gown & mask ☐ no equipment
U _____ What preparation(s) were used to clean up fecal and vomit accidents *(choose all that apply)*?
☐ Bleach & water ☐ Other: _____
V ☐ ☐ ☐ ☐ Were non-essential staff excluded from outbreak units? ____/____/____ *through* ____/____/____
W ☐ ☐ ☐ ☐ Was staff education on the cause of the outbreak and control measures? When? ____/____/____