GASTROENTERITIS CONTROL MEASURES REPORT

OUTBREAK # __________________ FACILITY NAME __________________

CORPORATION NAME ________________________

Completed by: ____________________________ Date: _______/_____/_____

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, 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?
T Number of restricted employees:___________
□ 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? ___/___/____