Long Term Care Facility Influenza Outbreak Report Form

For influenza outbreaks in Pennsylvania (Pa.) long-term care facilities (LTCFs), 2023-2024 Influenza Season

Initial Outbreak Information: Instructions for Long-term Care Facilities

When a new outbreak is identified, please complete and submit Initial Outbreak Information (page 1) within one workday (typed preferred).

When submitting the Initial Outbreak Information, the Final Outbreak Information (page 2) can be left blank. Please do not wait until the outbreak is over to submit the Initial Outbreak Information page.

IMPORTANT DEFINITIONS	
Influenza-like-illness (ILI)	Fever (≥100°F) **plus** new cough or sore throat
LTCF Influenza Outbreak	One resident with laboratory-confirmed influenza plus at least one additional resident with ILI **OR** Two or more residents with ILI within 72 hours of each other
LTCF Outbreak is "over"	When no new cases have occurred for 14 days. Day 0 is date of last positive test or (if no testing performed) first day of illness onset for last symptomatic resident.

CDC interim guidelines for Influenza Outbreak Management in Long-Term Care Facilities: http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

FACILITY INFORMATION

Facility name: _____ County Allegheny County

Address (street, city, state, zip): _____

Name of reporter: _____ Title: _____

Phone: _____ Fax: _____

Email: _____

Type of facility (check all that apply)

☐ Skilled nursing ☐ Rehabilitation ☐ Assisted living ☐ Personal care home

☐ Other (explain): _____

License Numbers: Pa. Dept. of Health _____ Pa. Dept. of Human Services _____

INITIAL OUTBREAK INFORMATION AT TIME OF INITIAL REPORT

Date **initial outbreak information** completed: _____

Dates of symptom onset: First case: _____ Most recent case: _____

Current number of **residents** in facility: _____ Current number of **staff** in facility: _____

Number of residents with symptom(s)*: _____ **Number of staff** with symptom(s)*: _____

Number of residents hospitalized*: _____ Number of staff hospitalized*: _____

Number of resident deaths**: _____ Number of staff deaths**: _____

Where do residents with symptom(s) reside? ☐ Single unit ☐ Multiple units

Where do staff with symptom(s) work? ☐ Single unit ☐ Multiple units

Facility identifies any shortage(s) of: antivirals ☐ Yes ☐ No **OR** influenza vaccine ☐ Yes ■ No

*Symptoms including fever, cough, sore throat, pneumonia, regardless of testing or results

**Record only hospitalizations and deaths related to influenza

LABORATORY TESTING AT TIME OF INITIAL REPORT

Influenza type: ☐ A ☐ B ☐ Both A&B ☐ Unknown ☐ Other (explain:): _____

Number of residents tested: _____ Number of **staff tested**: _____

Number of residents with positive tests: _____ Number of staff with **positive** tests: _____

DOH USE ONLY: INVESTIGATOR AND OUTBREAK INFO

Investigator Name _____ DOH office/jurisdiction _____

Phone _____ Fax _____ Email _____

How was outbreak reported to DOH?

☐ Review of NEDSS

☐ Notification by licensing agency (e.g., QA/nursing care facilities)

☐ Notification by facility/provider

☐ Other (explain):

Date and time of outbreak notification Date: _____ at _____ ☐ AM ☐ PM

Will specimens be sent to BOL for testing? ☐ Yes ☐ No BOL FI # (if assigned): _____

Long Term Care Facility Influenza Outbreak Report Form (page 2)

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Final Outbreak Information: Instructions for Long-term Care Facilities

Please submit this form after the outbreak is over, (14 days have passed since the last positive test or date last symptomatic resident became ill). Typed forms are preferred.

When submitting the Final Outbreak Information, you do not need to update the Initial Outbreak Information (page 1). Please enter the final outbreak totals on page 2 below and submit page 1 with page 2.

FACILITY INFORMATION

Facility name: _____ County Beaver County

FINAL OUTBREAK INFORMATION AT TIME OF FINAL REPORT

Date **final** form completed: _____

Dates of symptom onset: First case: _____ Most recent case: _____

Current number of **residents** in facility: _____ Current number of **staff** in facility: _____

Number of residents with symptom(s)*: _____ **Number of staff** with symptom(s)*: _____

Number of residents hospitalized*: _____ Number of staff hospitalized*: _____

Number of resident deaths**: _____ Number of staff deaths**: _____

Where do residents with symptom(s) reside? ☐ Single unit ☐ Multiple units

Where do staff with symptom(s) work? ☐ Single unit ☐ Multiple units

Outbreak line listing submitted with outbreak ☐ Yes ☐ No

*Symptoms including fever, cough, sore throat, pneumonia, regardless of testing or results

**Record only hospitalizations and deaths related to influenza

LABORATORY TESTING AT TIME OF FINAL REPORT

Influenza type: ☐ A ☐ B ☐ Both A& B ☐ Unknown ☐ Other (explain): _____

Number of residents tested: _____ Number of **staff tested**: _____

Number of residents with positive tests: _____ Number of staff with **positive** tests: _____

ANTIVIRAL PROPHYLAXIS OF WELL BUT EXPOSED RESIDENTS/STAFF

Was prophylaxis given to **residents**?

☐ Yes, residents in the entire facility
☐ Yes, residents in selected units only
☐ Yes, roommates of ill residents only
☐ No prophylaxis of residents
☐ Other (explain): _____

Was prophylaxis given to **staff**?

☐ Yes, staff in the entire facility
☐ Yes, unvaccinated staff only
☐ No prophylaxis of staff
☐ Other (explain): _____

INFLUENZA VACCINATION DURING CURRENT SEASON

Number* of residents vaccinated: _____ Number* of staff vaccinated: _____

Type of vaccine used:
☐ Traditional quadrivalent
☐ High-dose quadrivalent
☐ Cell-based Quadrivalent
☐ Other (explain): _____

*Number vaccinated should not exceed the current number of residents or staff.

DOH USE ONLY: FINAL OUTBREAK INFO

PA NEDSS Investigation ID(s): ☐ No reports found in NEDSS inbox or NOFUN

PA NEDSS Outbreak ID: _____