

## Investigation of GAS outbreak in LTCF, Illinois – 2015 Resident Record Extraction Form

Person Completing Form \_\_\_\_\_

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

### A. Resident Background

1. Sex:  Male  Female

2. Age: \_\_\_\_\_

3. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Room History since [DATE]:

| Room Number | Unit | Dates | Type  | Acuity  |
|-------------|------|-------|---|---|
| a.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |
| b.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |
| c.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |
| d.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |
| e.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |
| f.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |
| g.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |
| g.          |      |       | <input type="checkbox"/> Private<br><input type="checkbox"/> Double | <input type="checkbox"/> Short Term<br><input type="checkbox"/> Long Term |

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

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5a. Does/did the patient have a roommate with GAS infection or colonization?  Yes  No  Unknown (If no or unknown, skip to 6)

| (I)nfected or (C)olonized Roommate | Date of positive culture result | Site of Culture | Dates of Shared Rooms |             |
|------------------------------------|---------------------------------|-----------------|-----------------------|-------------|
|                                    |                                 |                 | From                  | To          |
| b.                                 | ___/___/___                     |                 | ___/___/___           | ___/___/___ |
| c.                                 | ___/___/___                     |                 | ___/___/___           | ___/___/___ |
| d.                                 | ___/___/___                     |                 | ___/___/___           | ___/___/___ |
| e.                                 | ___/___/___                     |                 | ___/___/___           | ___/___/___ |

6. Total length of stay at time of chart review (mark only one):  ≤ 1 week  1-3 weeks  4-8 weeks  ≥ 8 weeks

7a. Is resident currently living?  Yes  No If deceased, date of death  
 \_\_\_/\_\_\_/\_\_\_

7b. If resident died, death was:  Related to GAS infection  Possibly related to GAS infection  Not related  
 Not applicable

8a. Resident's primary physician? \_\_\_\_\_

8b. Was this patient admitted to this facility from home?  Yes  No

8c. Was this patient discharged from this facility to home?  Yes  No  Still in facility at time of chart review

9. List admission and discharge information since [5/1/2015].

| Facility | Admission Date       | Discharge Date       | Diagnosis |
|----------|----------------------|----------------------|-----------|
| a.       | ___/___/___<br>_____ | ___/___/___<br>_____ |           |
| b.       | ___/___/___<br>_____ | ___/___/___<br>_____ |           |
| c.       | ___/___/___<br>_____ | ___/___/___<br>_____ |           |
| d.       | ___/___/___<br>_____ | ___/___/___<br>_____ |           |
| e.       | ___/___/___<br>_____ | ___/___/___<br>_____ |           |

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**B. Medical History**

10a. Original date of admission to this facility: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

10b. Facility patient admitted from? \_\_\_\_\_

Patient admitted from home

10c. Primary diagnosis (reason for admission to facility):  
\_\_\_\_\_

11. Which medical condition(s) does the resident have? (*mark ALL that apply*):

- Diabetes       CHF/history of MI       Peripheral Vascular Disease       Stroke       Asthma/COPD  
 Hypertension       Chronic Leg Edema       Recent Herpes Zoster       Dialysis  
 Renal insufficiency       Dementia       Cancer (specify type) \_\_\_\_\_  
 Vent dependence       None       Other: \_\_\_\_\_

12. Weight: \_\_\_\_\_ lbs or kg (*circle unit of measure*)

12b. Height: \_\_\_\_\_

13a. Has the patient had a surgical procedure since [5/1/2015]?     Yes     No

| Procedure | Date               | Incision Site |
|-----------|--------------------|---------------|
|           | ____ / ____ / ____ |               |
|           | ____ / ____ / ____ |               |
|           | ____ / ____ / ____ |               |
|           | ____ / ____ / ____ |               |
|           | ____ / ____ / ____ |               |

14b. Surgical skin wounds present since [5/1/2015] (*mark ALL that apply*):

- PICC line                       Tracheostomy                       PEG/PEJ site       Colostomy site  
 AV fistula or graft       Suprapubic catheter       Hemodialysis catheter       None  
 Surgical wound: \_\_\_\_\_  
 Other: \_\_\_\_\_

15. Type of IV access present at time of positive GAS culture     None     Not applicable

|                  |                        |                                 |
|------------------|------------------------|---------------------------------|
| 18a. Access Type | 18b. Date of Insertion | 18c. Person Inserting (e.g. RN) |
|------------------|------------------------|---------------------------------|

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|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |

16a. Since [5/1/2015], did the resident have non-surgical skin breakdown?  Yes  No *(If no, skip to 17)*

16b. Non-surgical skin breakdown since [5/1/2015] *(mark ALL that apply)*:

- Sacrum  Ischium  Trochanter  Heel  Shoulder  Occipital  Lat. Malleolus  
 Med. Malleolus  Elbow  Ear  Coccyx  Toe  Other: \_\_\_\_\_

17. Products used for wound care (surgical and nonsurgical):

- Versafoam  Granufoam  Prisma Wound  Matrix  Mepilex  Accuzyme  
 Ethyzyme  DuoDerm  Biotane Foam  None  Other: \_\_\_\_\_

18a. Was a clinical diagnosis of cellulitis made since [5/1/2015]?  Yes  No *(If no, skip to 19)*

| Location | Surgical Site  | Date of Onset               | Treated with Antibiotics                                 |
|----------|--|-----------------------------|--|
| b.       | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____ / ____ / ____<br>_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c.       | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____ / ____ / ____<br>_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d.       | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____ / ____ / ____<br>_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

19. **Since** [5/1/2015] new, nonsurgical breakdown *(mark ALL that apply)*:  None  Not applicable

- Sacrum  Ischium  Trochanter  Heel  Shoulder  Occipital  
 Lat. Malleolus  Med. Malleolus  Elbow  Ear  Coccyx  
 Toe  Other: \_\_\_\_\_

20. Surgical procedures **since** [5/1/2015] *(mark ALL that apply)*:  None  Not applicable

- PICC line insertion  Tracheostomy site  PEG/PEJ site

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- Colostomy site                       Suprapubic catheter     Hemodialysis catheter  
 AV fistula or graft             Surgical incision: \_\_\_\_\_  
 Debridement                       Other: \_\_\_\_\_

21a. Was a new clinical diagnosis of cellulitis made **since** [5/1/2015]?  Yes     No     Not applicable (*If no or not applicable, skip to 22*)

| Location | Surgical Site  | Date of Onset               | Treated with Antibiotics                                 |
|----------|--|-----------------------------|--|
| 21b.     | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____ / ____ / ____<br>_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21c.     | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____ / ____ / ____<br>_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21d.     | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____ / ____ / ____<br>_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

22a. Does/Did the resident receive negative pressure wound therapy via a vacuum-assisted closure device?

- Yes     No

23b. If yes, date of initiation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

24b. Stop date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ or

- still in place at time of discharge from facility or at time of chart review

23. Since [5/1/2015], did the resident have any of the following signs or symptoms? (*mark ALL that apply*)

|      |   | Date of onset (dd/mm/yy) |  |
|------|---|--------------------------|--|
| 24a. | <input type="checkbox"/> Fever ( $\geq 100.5^{\circ}\text{F}$ ) | ____ / ____ / ____       | Max temp recorded:   |
| 24b. | <input type="checkbox"/> Sore throat                            | ____ / ____ / ____       |  |
| 24c. | <input type="checkbox"/> Cough                                  | ____ / ____ / ____       | Productive? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24d. | <input type="checkbox"/> Purulent discharge from wound          | ____ / ____ / ____       | Site:  |

**C. Resident Baseline Status**                      (*Can get further information from nursing*)

24. Which appliances does the resident use (*mark ALL that apply*):



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32d.  Positive for other Strep species    32e. List type \_\_\_\_\_

33a. Did resident have other cultures positive for GAS since [5/1/2015]     Yes     No (*if No skip to 35*)

33b. Culture #1    33c. Date obtained \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

33d. Site:  Skin/Wound: \_\_\_\_\_     Blood     Lung     Sputum  
 Other \_\_\_\_\_

33e. Culture #2    33f. Date obtained \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

33g. Site:  Skin/Wound: \_\_\_\_\_     Blood     Lung   

Sputum

Other \_\_\_\_\_