

Candida auris – infection prevention and control guidance for healthcare workers

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Introduction

Candida auris (*C. auris*) is an uncommon fungus that can cause serious blood stream infections and other invasive type infections in people in hospitals and those in aged residential care facilities. It mainly affects people who have multiple medical problems, have invasive medical devices and who have received previous antifungal therapy.

Most patients affected by *C. auris* are colonised. Colonisation is persistent and is difficult to eradicate. A minority will also develop infection. Infections caused by *C. auris* are no different to other types of *Candida* however it is more difficult to treat, can be difficult to identify, can spread rapidly to others and is often multidrug resistant.

C. auris can spread via direct contact through patient care and indirectly through contact with contaminated objects and the environment. It can colonise people/patients for several months and survive in the environment for weeks. It is not always easy to remove with healthcare cleaning products.

This guidance document has been developed using international guidance and resources to help healthcare facilities develop their own policies and procedures based on their environment when providing patient care.

This is a living document and as such updates and changes may occur as new information becomes available.

Risk assessment

Follow your local policy for screening and identifying patients at risk for *C. auris* with particular attention to

- Received healthcare in an overseas hospital in the last 12 months
- Transferred from other health facilities in which known cases have been identified.

Liaise with your Infectious Disease team or Clinical Microbiologist regarding specimen collection and laboratory requesting processes.

Standard and transmission-based precaution

All staff should follow [standard and Contact precautions](#) when providing care for patients.

These include

- Hand hygiene – Good hand hygiene practice is key in reducing transmission of *C. auris*. Follow good hand hygiene practices using alcohol-based hand sanitiser (preferred method) and follow 5 moments of hand hygiene. If hands visibly soiled, wash with soap and water, dry thoroughly and then use alcohol-based hand rub.

Use of Personal Protective Equipment (PPE)

- Long sleeve gown
- Gloves for all contact with patient or patient's environment.

Ensure adequate supplies of PPE are available outside of patient room and good adherence to donning and doffing including waste management and adherence to hand hygiene.

Patient placement and signage

Patients should be nursed in a single room that has a dedicated en-suite bathroom.

Signage should be visible to all those entering room indicating use of contact precautions and to don the appropriate PPE.

As with other multi-drug resistant organisms, patients should be seen last on ward rounds and other service needs, dependent on patient's condition and need.

C. auris – Colonised patient care

Strategies to prevent infection in patients colonised with *C. auris* include:

- Skin decontamination with chlorhexidine washes/wipes.
- Removal of venous cannulas if signs of infection.
- Adherence to central and peripheral catheter care bundles, urinary catheter care and care of tracheostomy sites.
- Aseptic technique for wound care – discharging wounds should be secured with impermeable dressing. Waste should be discarded into clinical waste bag as per hospital policy.
- Care should be taken when managing or changing urinary catheters or other drainage systems.

Patient equipment

Use disposable or patient dedicated equipment and avoid moving wheeled equipment in and out of the room. If needed for wound care, leave a trolley in the patient's room and take the required equipment into the room.

All equipment (e.g. mobility aids, monitoring equipment) should be cleaned in accordance with the manufacturer's instructions). Particular attention should be paid to cleaning reusable equipment including the wheels on any equipment in patient's room)

If equipment must be shared, it must be thoroughly cleaned and disinfected before use on another patient.

Movement to other clinics and departments

Limit patient movement wherever possible. If a patient needs diagnostic testing that cannot be performed in the patient's room, then department must be aware of the patient's condition to enable thorough cleaning and disinfection of any equipment or surfaces that the patient may have had contact with. Ideally, if patient's condition allows, they should be seen last on list. Patients requiring rehabilitation in hospital gym should be the last patient of the day to enable through cleaning and disinfection of equipment used. (Note: wheelchairs and patient trolleys if needed for transporting patients must have cleaning regimes that include cleaning of the wheels to prevent further spread throughout facility).

Cleaning and disinfection

C. auris can persist in the environment for several weeks therefore is important to increase cleaning regimes focussing on high touch surfaces such as light switches, patient call bell, toilet flusher, faucets (taps), bedside table and locker. Room should be cleaned last in ward settings.

Floor cleaning- mop heads should be changed and bucket cleaned after floor cleaning in patient's room completed.

Cleaning staff should be briefed on PPE requirements and the importance of the need to change all PPE used after contact with the environment.

Cleaning needs to be done before disinfection to remove gross soiling. Products can be a 2 in 1 (clean and disinfect) and must be certified as effective against C. auris.

Sodium Hypochlorite (1000ppm) available chlorine, or peracetic acid solution (2000 ppm) is suitable for use. Quaternary ammonium compounds ("quats") are not as effective against C. auris. The CDC have a comprehensive [list](#) of registered chemicals and products.

Note: this list is not New Zealand based however may provide some guidance for suitable products available in New Zealand through IPC services and procurement. As with all cleaning products adherence to the manufacturer's guidance on use, dwell time and personal protective equipment must be adhered to.

Discharge cleaning

On discharge of patient, a terminal clean should be undertaken as per local hospital IPC guidelines including

- all horizontal surfaces
- all patient care equipment
- all items that may have come into contact with the patient or staff hands
- the walls.

Privacy curtains should be changed and laundered if they are not disposable. Consideration should be given to discarding less expensive items that are difficult to decontaminate.

Facilities that use non-touch disinfecting equipment (electro-static, hydrogen peroxide vapourisation or UV) can be used after the initial cleaning with a detergent has been performed.

Dispose of any unused items (eg wound dressing packs, boxes of tissues, unopened non-perishable food items).

Waste management

- Infectious clinical and controlled waste should be disposed as per hospital/healthcare facility IPC guidance.
- Ensure regular emptying of waste to avoid over-filled bins.

Linen and laundry

Linen should be handled as per local hospital IPC guidance.

Transferring patient to another facility

If the patient is ready for discharge to another healthcare facility, communication to that facility is essential including IPC team. Ensure that clear information both verbally and written has been provided.

Ensure that notification on the patient's health record is complete and any electronic warning system updated.

Communicability of C. auris

People who have had an infection or are colonised with C. auris are considered to be colonised indefinitely at this time and must always remain in contact precautions for all hospital admissions. Further research is required before clearance criteria can be determined.

Patient discharge

On discharge of patient, information on C. auris colonisation should be included in patient discharge summary and information to patient provided.

If the case is diagnosed following direct transfer from an overseas hospital, please ensure your IPC team informs the overseas hospital and copies this communication to the local public health service team (PHS). (The PHS will forward this to the Ministry of Health who will decide whether or not to inform the other country's National IHR Focal Point or not).

Management of deceased patients

Standard Precautions should be followed including the appropriate PPE.

Screening/outbreaks

Contacts of identified cases are those who were in the same bay or room longer than 24 hours within a 28-day period prior to the first isolation of *C. auris*.

All contacts should be screened for *C. auris* colonisation. Newly identified cases should be isolated and managed as above. Hospital should refer to local outbreak policies on managing contacts.

Additional resources

Centres for Disease Control and Prevention (CDC)

Infection Prevention and Control for *C. auris*

<https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html>

Public Health England (PHE)

Guidance for the laboratory investigation, management and infection prevention and control for cases of *C. auris* August 2017 v2.0

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/637685/Updated_Candida_auris_Guidance_v2.pdf

The characteristics, diagnosis and management of *C. auris*

<https://www.gov.uk/government/collections/candida-auris>