Candida auris Readiness Toolkit

Materials for Health Care Facilities

Published: August 2023

Updated: May 2025

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Prevention and Readiness for *Candida auris* and Other Novel and Targeted Multidrug-Resistant Organisms

Whether your facility has been impacted by *Candida auris* or is hearing about it through the news or through public health or academic publications, *C. auris* clinical infections and colonized cases have increased across Pennsylvania. Health care facilities should be prepared to prevent transmission and manage cases of *C. auris*.

Prevention aims to minimize the impact of infectious organisms, such as *C. auris* and all other novel and targeted multidrug-resistant organisms (MDROs). Prevention works at all stages of transmission, ranging from before an infectious organism is identified in a region, to endemicity. Impactful prevention strategies of focus for facilities include education, infection prevention and control (IPC) measures, surveillance and screening, and communication. Table 1 contains a brief summary of the impact of each prevention strategy.

Table 1. Summary of the prevention strategies and their impact

Prevention Strategies	Impact of Prevention Strategies
Education	Education can increase health care personnel and facility administration engagement and adherence to recommended prevention interventions.
IPC	Core IPC practices are designed to reduce pathogen transmission and infections among patients and residents. Good adherence to these practices is predicted to limit transmission of all novel and targeted MDROs.
Surveillance and Screening	Clinical infections only represent a small fraction of MDRO cases. Colonized individuals can be a source of transmission to others within the health care setting, particularly when their colonization status is unknown and recommended IPC interventions are not applied. Combining colonization screening with adherence to core IPC practices will have a larger impact on limiting MDRO transmission.
Communication	Effective communication of patient/resident MDRO status increases the likelihood that appropriate IPC actions will be implemented continuously through transitions of care. This decreases the likelihood of MDROs spreading to others.

Focusing on these preventive elements keeps health care facilities in a state of readiness to combat *C. auris* and other novel and targeted MDROs. Facilities can continue this state of readiness through performing regular IPC audits and ensuring health care personnel stay up to date on targeted and novel MDRO education.

The MDRO Prevention Team has created this readiness toolkit to facilitate discussion, provide background for MDRO-specific infection prevention practices, and enhance the infection prevention assessment experience. With these prevention strategies your facility can feel prepared to handle any MDRO.

Definitions of Common Terms

Colonization: an organism can be found in or on the body, but it is not causing any symptoms or disease

Clinical infection: invasion of an infectious agent (i.e., micro-, or macro-organism) in the body

Infection prevention and control: practice of responding to or stopping the spread of infections in health care settings. Core elements of infection control include (but are not limited to) hand hygiene, use of personal protective equipment, use of standard and transmission-based precautions, following respiratory hygiene/cough etiquette, cleaning and disinfecting the environment appropriately, and following safe injection practices.

MDRO: multidrug-resistant organism. These are microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent (e.g., methicillin-resistant *Staphylococcus aureus* (MRSA)), Vancomycin-resistant enterococci (VRE)), these pathogens are frequently resistant to several available antimicrobial agents.

Outbreak: an increase, often sudden, in the number of cases of a disease above what is normally expected in a limited geographic area (e.g., health care facility)

Prevention: actions aimed at eradicating, eliminating, or minimizing the impact of disease and disability

Transmission: the spread of infectious agents. This could occur through contact, sprays, splashes, inhalation, and sharps injuries.

Candida auris Overview

Background

Candida auris is an emerging fungus of global concern that is often multidrug-resistant, can be misidentified in the laboratory, and has caused outbreaks in health care settings.
C. auris has caused clinical and colonization cases. A clinical case occurs when there is a positive *C. auris* specimen collected for the purpose of diagnosing or treating disease in the normal course of care. A colonization case occurs when there is a positive *C. auris* specimen collected for the purpose of screening or surveillance; colonization cases are identified in people without associated symptoms. Both clinical infection and colonization cases can lead to transmission of *C. auris*. A colonized person may later develop clinical infection.

Risk of clinical infection or colonization is increased in persons with long lengths of stay in high-risk long-term care settings, serious underlying medical conditions, long-term use of broad-spectrum antimicrobial agents, chronic or indwelling medical devices, and in persons undergoing invasive procedures. Invasive *C. auris* infections have been associated with bloodstream, respiratory and urinary tract infections. Many patients infected with *C. auris* have other serious illnesses. These pre-existing conditions likely contribute to the high mortality that has been associated with *C. auris*.

Epidemiology of *C. auris*

Since *C. auris* was first identified in the United States in 2016, the number of cases has continued to increase annually with 4,514 new clinical cases reported in the U.S. in 2023.The first case of *C. auris* in Pennsylvania was reported in March 2020. As of February 2025, 569 cases of *C. auris* have been identified. To stay informed on the changing *C. auris* epidemiology sign up for the PA HAN alerts and check the PA Department of Health's *C. auris* dashboard.

Transmission of *C. auris*

C. auris is transmitted through direct person-to-person contact or through contact with contaminated health care personnel hands or contaminated surfaces. *C. auris* has been demonstrated to survive on a range of surface types, including dry, moist, and plastic surfaces, with organisms being viable for weeks. Persons can transmit *C. auris* whether they are infected or colonized.

Vulnerable Populations

C. auris can cause serious infections in vulnerable patients. Vulnerable patients include residents of nursing homes or long-term care facilities who have high-risk factors. High-risk factors can include medical conditions that compromise the host's immune system but might

also include indwelling medical devices, mechanical ventilation, tracheostomy, wounds, residents who are bed bound, or persons who are on broad-spectrum antibiotics or antifungals.

Laboratory Diagnosis

C. auris has been misidentified as several different organisms when using traditional phenotypic methods for yeast identification, although accuracy of testing has improved in the last several years. CDC provides resources laboratorians can use to identify possibilities for misidentification, available here. The information is based on current knowledge of *C. auris*. The appearance and color of *C. auris* colonies in culture may aid in species identification but cannot be used solely for identification. Definitive ways to identify *C. auris* include the use of matrix-assisted laser desorption/ionization time-of-flight mass spectrometry (MALDI-TOF MS), molecular testing based on whole genome or targeted DNA sequencing, and real-time PCR. Health care facilities are encouraged to report suspected or confirmed cases of *C. auris* to state or local public health authorities. Health care facilities may screen patients for *C. auris* after an initial case is identified or may choose to screen for *C. auris* colonization using a proactive approach upon admission or at predetermined intervals. Isolates suspected to be *C. auris* can be sent to the PA Bureau of Laboratories (BOL) for identification. This testing is performed free of charge and will require coordination through the Department of Health, Bureau of Epidemiology, Division of Healthcare Associated Infection Prevention. Specimens can include cultures of blood, body fluids, and other body sites. Screening swabs tested at public health laboratories are collected from the axilla and groin using a BD ESwab™.

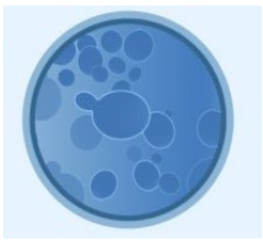
Prevention

Prevention for *C. auris* is multifactorial and encompasses core IPC practices, identifying infection prevention and control gaps to improve practice, education, screening and surveillance, and communication. The following pages within this document will provide valuable resources that discuss IPC measures to prepare for *C. auris*.

C. auris Overview Handout

The *C. auris* Overview Handout, on the subsequent page, is a one-page resource intended for infection preventionists, or it can be shared as a handout for health care facility personnel. This resource provides an overview of what this organism is, the epidemiology in PA, how it is diagnosed, who is at risk, how it is transmitted, and IPC practices to assist in preventing transmission.

C. auris Overview Handout



What is *C. auris?*

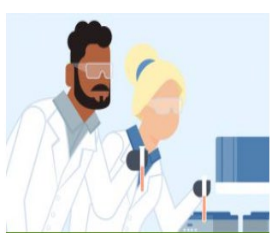
- Multidrug-resistant yeast, first identified in 2016

Why is *C. auris* a problem?

- Causes serious infection
- Often resistant to multiple antifungal drugs commonly used to treat *Candida* infections
- Can cause outbreaks in health care facilities

Is *C. auris* in Pennsylvania?

- Yes! Cases of *C. auris* have been identified across the regions of PA and continue to increase
- Clinical and colonized cases of *C. auris* have been identified in acute care hospitals, long-term acute care settings, and ventilator-capable skilled nursing facilities
- As of February 2025, 569 cases, both colonized and clinical, have been identified



How is *C. auris* diagnosed?

- Diagnosis is done by culture of blood, body fluids, or body site. It can be difficult to diagnose as it may be misidentified in labs without specific technology
- Colonization: positive identification of *C. auris* in people without symptoms, in a specimen that was collected for screening purposes
- Clinical Infection: positive *C. auris* specimen that was collected for the purpose of diagnosing or treating disease

Who is at risk for *C. auris?*

- Residents of nursing homes or long-term care facilities who have high-risk medical conditions
- Patients/residents with indwelling medical devices, ventilation, or are on broad-spectrum antibiotics/antifungals

How is *C. auris* spread?

- Contact transmission: in health care settings, *C. auris* can be spread by hands of health care workers and through contact with contaminated objects or surfaces

How can *C. auris* be prevented?

- Instituting infection prevention and control practices like hand hygiene, transmission-based precautions, and environmental cleaning with List P products
- Identify infection prevention and control gaps to improve practices
- Provide education to health care personnel
- Screen high-risk patients
- Communicate with transferring facilities for clinical infection or colonization with *C. auris*
- Partner with the PA Department of Health MDRO Prevention Program to ensure you are ready!

Hand Hygiene

Overview

Hand Hygiene (HH) can be defined as cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e., alcohol-based hand sanitizer foam or gel), or through surgical hand antisepsis.

Performing HH decreases the spread of organisms by reducing the amount of germs on the hands. It also reduces the risk of health care provider colonization or infection caused by infectious organisms acquired from residents.

The two methods discussed in this toolkit are alcohol-based hand rub (ABHR) and washing with soap and water. ABHR is the preferred and most effective product for reducing the number of germs on the hands of health care providers. Unless hands are visibly soiled, ABHR is preferred in most clinical situations. Washing hands with soap and water is essential after care of residents with infectious diarrhea, when hands are visibly soiled, before eating, and after using the restroom.

Health Care Personnel Should Use HH for the Following Clinical Indications:

- Before patient contact
- Before donning gloves
- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
- After touching a patient or the patient's immediate environment
- After risk of contact with blood, body fluids, or contaminated surfaces
- After doffing gloves

Health Care Facilities Should:

- Require health care personnel to perform hand hygiene in accordance with CDC or the World Health Organization's recommendations
- Ensure health care personnel perform hand hygiene with soap and water when hands are visibly soiled
- Ensure supplies necessary for adherence to hand hygiene are readily accessible in all areas where care is being delivered

Visual Aid

A visual for critical moments of HH is provided by the PA Department of Health below and describes seven key moments of hand hygiene within the health care setting.

Summary

In summary hand hygiene, when performed correctly and consistently, is an effective method for preventing transmission of *C. auris* within the health care setting.

MAKE YOUR INTENTION PREVENTION

Clean Hands Stop the Spread

Before Donning

After Doffing

Hand hygiene is critical during these key times

Before Patient Contact

After Patient Contact

Before Aseptic Procedure

After Body Fluid Exposure Risk

After Touching Patient Surroundings

1-877-PA-HEALTH
(1-877-724-3258)

Healthcare Professionals (pa.gov)

Updated 4/7/25

Transmission-Based Precautions: Contact Precautions

Background

Transmission-Based Precautions (TBP) are used in addition to standard precautions to reduce transmission of highly transmissible or epidemiologically important pathogens like *C. auris*. *C. auris* can be transmitted from person-to-person via contact with contaminated hands or from contact with contaminated environments. One method of TBP for prevention of *C. auris* transmission is known as contact precautions.

Contact Precautions in Acute Care Settings

Contact precautions are used on all colonized or clinically infected cases of *C. auris.*

Contact Precautions in Skilled Nursing Facilities

Contact precautions are an outdated method of TBP for colonized or infected cases of *C. auris* in skilled nursing facilities (SNFs). The CDC recommends using Enhanced Barrier Precautions (EBP) for residents throughout their stay in SNFs. EBP is currently not recommended for acute care hospitals, long-term acute care hospitals, or assisted living facilities. EBP is the least restrictive TBP for residents, as it does not restrict residents to their rooms, allows them to participate in group activities, and provides a higher quality of life within the SNF. Contact precautions for residents colonized or clinically infected with *C. auris* would apply if the resident has acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained, or for a limited period during a suspected or confirmed MDRO outbreak investigation.

Contact Precaution Requirements

Contact precautions are a set of practices used to prevent transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient's environment. A single patient room is preferred for patients who require contact precautions. When a single room is not available, consultation with infection control is helpful to assess the various risks associated with other placement options (i.e., cohorting, keeping the patient with an existing roommate). In multi-person rooms, ≥3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients. Health care personnel caring for patients on contact precautions should wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning of gown and gloves upon room entry, removal before exiting the patient room, and performance of HH prior to donning gloves and immediately upon exiting, are all done to contain pathogens.

Other recommendations for patients on contact precautions include using disposable or dedicated care equipment (e.g., blood pressure cuffs). If common use of equipment for

multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.

Contact Precautions and Cleaning and Disinfecting

Cleaning and disinfection of contact precaution areas are a priority. Contact precaution areas should be cleaned and disinfected frequently (e.g., at least daily or prior to use by another patient if in outpatient setting) focusing on frequently touched surfaces and equipment in the immediate vicinity of the patient.

Contact Precautions Signage

Identifying an area of contact precautions is important as it clearly sets the expectations for entering the room. Signage for identifying contact precautions can include hand hygiene, gown/glove use, utilization of dedicated or disposable equipment and cleaning of reusable equipment. An example of TBP signage can be seen in Figure 1.

Summary

In summary, initiation of TBP reduces transmission of *C. auri*s. Contact precautions should be utilized for colonized and clinical *C. auris* cases in the acute care setting. Additional details on TBP for *C. auris* in acute care settings can be found in Table 2.

Figure 1: Contact Precaution Signage Example. The full version is available on the CDC website.

Table 2. Transmission-Based Precautions for *Candida auris* in Acute Care Hospitals

Standard Precautions	Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. These practices include: - Hand hygiene - Use personal protective equipment (PPE) whenever there is an expectation of possible exposure to infectious material - Follow respiratory hygiene/cough etiquette principles - Ensure appropriate patient placement - Properly handle and clean/disinfect patient care equipment - Clean and disinfect the environment appropriately - Handle textiles and laundry carefully - Follow safe injection practices
What are TBP?	In addition to standard precautions, TBP are used for patients with documented or suspected infection or colonization with highly transmissible epidemiologically important organisms. Examples of TBP include contact, droplet, and airborne precautions.
What type of TBP are used for *C. auris* in the Acute Care setting?	Contact precautions. *C. auris* can be transmitted from person-to-person or from contaminated environments. Using contact precautions assists in preventing *C. auris* transmission.
What type of PPE is used for contact precautions?	Use PPE appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room should be done to contain pathogens.
What are room placement options for a *C. auris* patient on contact precautions?	Ensure appropriate patient placement in a single patient space or room if available. If a single room is not available, patients with *C. auris,* or the same MDRO can be cohorted.

What precautions should be taken when transporting a patient on contact precautions?	Limit transport and movement of patients outside of the room to medically necessary purposes. When transport or movement is necessary, cover or contain the infected or colonized areas of the patient's body. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients. Don clean PPE to handle the patient at the transport location.
What should be done with reusable medical equipment when used on *C. auris* patients/residents?	Use disposable or dedicated patient/resident-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient/resident with List P products.
How to identify a patient on contact precautions	Use TBP signage that clearly sets the expectations for contact precautions. This could include, but is not limited to, hand hygiene, proper PPE, and use of dedicated equipment.

Transmission-Based Precautions: Enhanced Barrier Precautions

EBP Background

Residents in skilled nursing facilities (SNFs) are disproportionately affected by MDRO infections. SNFs have been implicated in regional outbreaks of MDROs that are classified as urgent threats by CDC, including *C. auris*. Pathogen transmission in SNFs occurs, in part, via health care personnel, who may transiently carry and spread MDROs on their hands or clothing during resident care activities. CDC has developed a TBP approach called Enhanced Barrier Precautions (EBP). EBP are designed to reduce transmission of MDROs in SNFs.

EBP Personal Protective Equipment

EBP involves the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those who are at-risk of MDRO acquisition (i.e., residents with wounds or indwelling medical devices). High-contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use, and wound care.

EBP vs. Contact Precautions

EBP should be used when contact precautions do not otherwise apply, per the facilities' policies and procedures. Residents are not restricted to their rooms or limited from participation in group activities; unlike contact precautions, EBP are less restrictive. EBP are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed the resident at higher risk.

EBP Implementation

EBP is recommended as a best practice by CDC and PA Department of Health, and is now required by the Centers for Medicare and Medicaid Services (CMS) for nursing homes per QSO-24-08-NH.

Implementing EBP in SNFs comes with challenges. Effective use of EBP requires staff training in the proper use of personal protective equipment (PPE) and protocols related to EBP. It also requires that PPE and hand hygiene supplies are available at the point of care. Standard precautions still apply to care of all residents.

Although the use of EBP can take additional effort, planning, and resources, the approach offers a balance of protection and quality of life for residents clinically infected or colonized with an MDRO and at-risk residents. Preventing the spread of MDROs may help to manage long term PPE use and personnel time by limiting the number of residents who require specialized medical care or treatment. EBP should be implemented facility-wide during high-

contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.

EBP Signage

Identifying an area of EBP is important as it clearly sets the expectations for resident care. Signage for identifying EBP should include hand hygiene and gown and glove use for high-contact resident care activities. An example of EBP signage can be seen in Figure 2.

EBP Frequently Asked Questions

For further information and answers to frequently asked questions on EBP please visit cdc.gov – Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes.

Summary

EBP should be used by SNFs, when contact precautions do not otherwise apply, for high-contact resident care activities. EBP should be implemented facility wide for infection or colonization with an MDRO or for a wound or indwelling medical device, even if a resident is not known to be infected or colonized with an MDRO. EBP should be used across the whole facility for residents who meet the above criteria. Additional details on TBP for *C. auris* in SNFs can be found in Table 3.

Figure 2: EBP Signage Example. Find the full version on the CDC website.

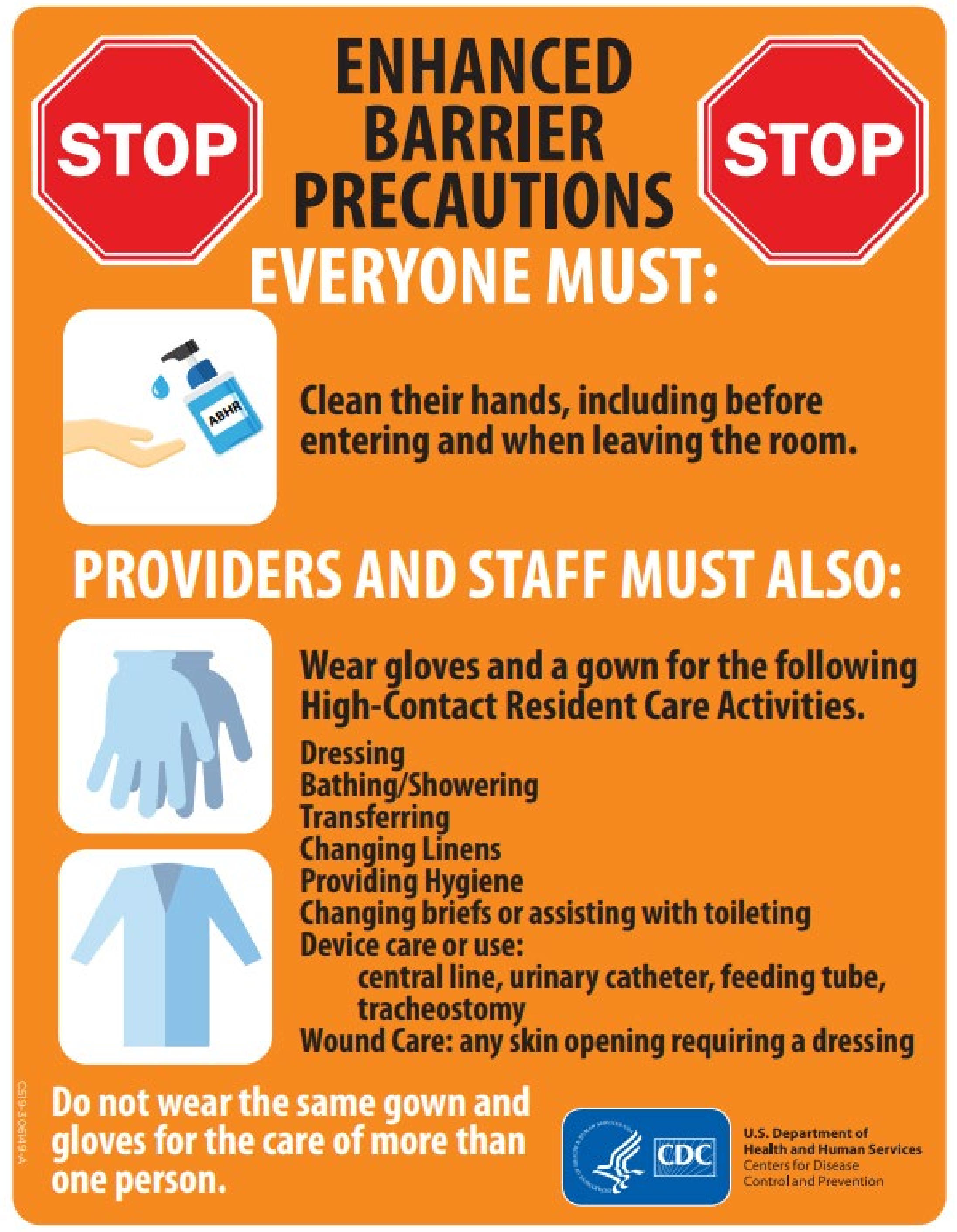


Table 3. Transmission-Based Precautions for *Candida auris* in Skilled Nursing Facilities

Standard Precautions	Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. These practices include: - Hand hygiene - Use PPE whenever there is an expectation of possible exposure to infectious material - Follow respiratory hygiene/cough etiquette principles - Ensure appropriate patient placement - Properly handle and clean/disinfect patient care equipment - Clean and disinfect the environment appropriately - Handle textiles and laundry carefully - Follow safe injection practices
What are TBP?	In addition to standard precautions, TBP are used for residents with documented or suspected infection or colonization with highly transmissible epidemiologically important organisms. Examples of TBP include contact, droplet, and airborne precautions.
What type of TBP are used for *C. auris* in SNFs?	Enhanced Barrier Precautions (EBP) are a best practice to be used in cases of *C. auris* colonization or infection. Contact precautions may be used if the resident is experiencing acute diarrhea, draining wounds or other sites of secretions or excretions that are unable to be covered or contained or for a limited period during a suspected or confirmed MDRO outbreak investigation.
What type of PPE is used for EBP?	EBP involves the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with *C. auris*, other MDROs, as well as those who are at-risk of MDRO acquisition (i.e., wounds or indwelling medical devices). High-contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use, and wound care.
What are room placement options for a *C. auris* patient on EBP?	Residents may share a room with other residents, however, facilities with capacity to offer single-person room or create roommate pairs based on MDRO colonization may choose to do so.

What should be done with re-useable medical equipment when used on *C. auris* residents?	Use disposable or dedicated resident-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple residents is unavoidable, clean and disinfect such equipment before use on another resident with List P products.
How to identify a resident on EBP?	Use TBP signage that clearly sets the expectations for EBP. This could include, but is not limited to, hand hygiene, proper PPE, examples of high-contact care activities for PPE use, and use of dedicated equipment.

Environmental Cleaning and Disinfection

Background

C. auris can persist on surfaces in health care environments for a prolonged period. It has been cultured from multiple locations in resident rooms, including both high-touch surfaces, such as bedside tables and bedrails, and surfaces farther away from the resident, such as windowsills.*C. auris* has also been identified on mobile or reusable equipment that is shared between residents, such as glucometers, temperature probes, blood pressure cuffs, ultrasound machines, nursing carts, and crash carts.

Cleaning and Disinfecting Frequency

For residents with *C. auris,* perform thorough routine (at least daily) and terminal cleaning and disinfection of rooms and other areas where residents receive care (e.g., radiology, physical therapy) using an appropriate disinfectant. Clean and disinfect shared, reusable equipment (e.g., ventilators, physical therapy equipment) after each use.

Reusable Equipment

All health care personnel providing patient care should be trained on which mobile and reusable equipment they are responsible for cleaning and how to clean the equipment properly. Numerous CDC and health department investigations have found that health care personnel are often unclear on who is responsible for cleaning mobile or reusable equipment and how it should be cleaned. Because equipment moves from room to room, often several times per day, in the case of vital signs monitors and glucometers, mobile or reusable equipment is likely an important source of *C. auris* spread. Label cleaned and disinfected equipment as such and store it in a designated clean area away from dirty equipment.

Product Disinfectant Time

Follow all manufacturer's directions for use of surface disinfectants and apply the product, ensuring the surface stays wet for the correct contact time. Some products with fungicidal claims may not be effective against *C. auris*, and accumulating data indicate that products consisting of only quaternary ammonium compounds (QACs) are NOT effective.

Products with Environmental Protection Agency (EPA)-Registered Claims for *C. auris* (List P)

CDC recommends using an EPA-registered hospital-grade disinfectant effective against *C. auris*. See EPA's List P for a current list of EPA-approved products for *C. auris.* It is important to follow all manufacturer's directions for use, including applying the product for the correct contact time.

Process for Identifying EPA-Registered Products Effective Against *C. auris* using the EPA Website

Overview

Disinfectant products will have a registration number listed in either a primary registration format or a supplemental distributor product format. You can use this number to determine whether EPA expects a given product to effectively kill *C. auris*. For more information on how to choose an effective EPA-registered disinfectant product, you can watch a short training available on the TRAIN PA Website, course ID 1102420.

Primary Registration Number

The primary registration format is a product's registration number in **two parts** (i.e., **1234-12)**.

Supplemental Distributor Product Number

A supplemental distributor product has the same chemical composition and efficacy as primary products but may have a different brand or product name. For these, the product's registration number is in **three parts** (i.e., **1234-12-123**). The first **two parts** of the registration number reflect the primary registration, while the **third part** identifies the distributor's EPA company number.

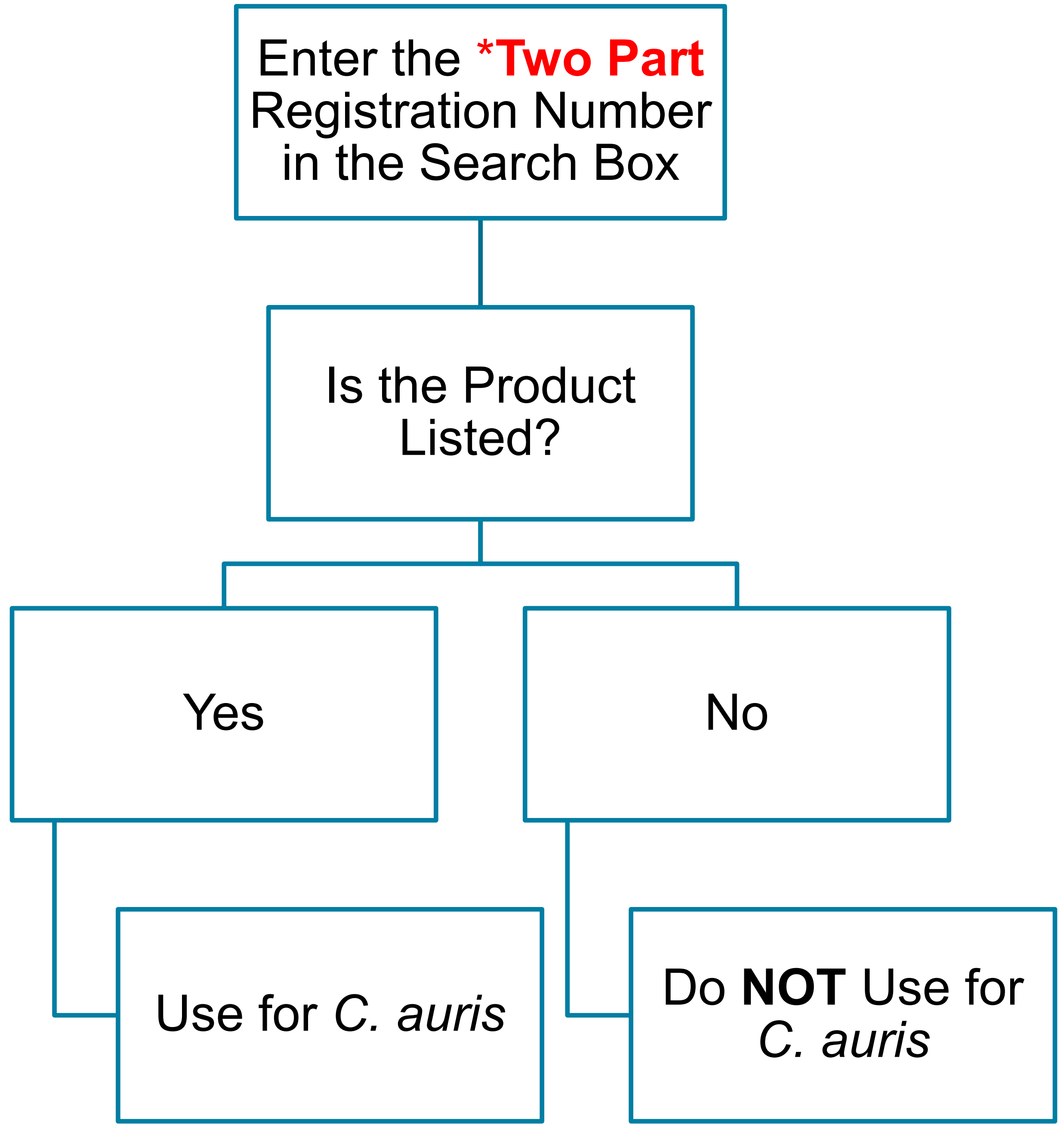
Using the Registration Number on the EPA Website

Use the first **two parts** of the product registration number when searching List P on the EPA website. If the first **two parts** of the registration number are on List P, the product is qualified for use against *C. auris*. Go to the EPA Website and follow Figure 3 for assistance in identifying EPA-registered products effective against *C. auris*.

Summary

In summary, cleaning and disinfecting plays an important role in the prevention of *C. auris*. List P disinfectant products should be utilized in the health care facility to effectively kill *C. auris.*

Figure 3: Process for Identifying EPA-Registered Products Effective Against *C. auris*



Colonization Screening

Background

C. auris has been found in noninvasive body sites and can colonize a person without causing an active infection. These sites include skin, urine, external ear canal, wounds, and respiratory specimens.

Colonization of *C. auris* can persist for several months after active infection has resolved. We do not know the maximum amount of time that a patient can be colonized.

Colonization Screening

Testing for *C. auris* colonization screening is available through BOL . This testing requires coordination with the Division of Healthcare Associated Infection Prevention of the PA Department of Health. This testing comes at no cost to the facility.

Colonized persons with *C. auris* can be a source of transmission to others within the health care setting, particularly when colonization status is unknown and, as a result, recommended IPC interventions are not applied. Combining colonization screening with good adherence to core IPC practices will have a larger impact on limiting transmission of *C. auris*. Colonization screening for *C. auris* can occur in response to a newly identified *C. auris* case or performed as a prevention effort for high-risk individuals or units, upon admission or at predetermined frequencies.

Screening for *C. auris* colonization is performed using a composite swab of the patient's bilateral axilla and groin. Data suggest these sites are the most common and consistent sites of *C. auris* colonization. Although patients have been colonized with *C. auris* in the nose, mouth, external ear canals, urine, wounds, and rectum, these sites are usually less sensitive for colonization screening.

For more information on *C. auris* colonization screening practices and information for patients, please visit the Healthcare Facility Toolkit for Response to *Candida auris* and *C. auris* Specimen Collection Guidance and Supply Order Form.

Infection Control Practices for *C. auris* Colonization

When screening identifies a patient with *C. auris* colonization, use the same infection control precautions as for patients with *C. auris* infection. While awaiting screening results, health care facilities should consider placing patients at highest risk of *C. auris* colonization on appropriate empiric transmission-based precautions.

Summary

C. auris colonization screening is a prevention tool which can identify potential silent spread of *C. auris* within a health care facility. Identifying colonized *C. auris* cases allows facilities to put proper IPC practices in place to stop transmission.

Infection Control Assessment

An Infection Control Assessment (ICA) is used to systematically assess a health care facility's IPC practices and guide quality improvement activities (i.e., by addressing identified gaps). The ICA uses specific CDC Infection Control Assessment and Response (ICAR) tools. This assessment is intended to help assess IPC practices in acute care, long-term care, and outpatient settings.

Prior to the onsite ICA, a facility may be asked to independently complete the demographics section of the CDC ICAR tool. This will help members of the prevention team in understanding the facility's background. The demographics sections are facility type specific:

Demographics – Acute Care [PDF – 6 pages]
Demographics – Long-Term Care [PDF – 6 pages]
Demographics – Outpatient/Ambulatory Care [PDF – 5 pages]

CDC ICAR tools utilized during the onsite ICA will generally include four modules. A brief description of the four CDC ICAR modules is highlighted below with a generalized overview of the contents.

Training, Audits, Feedback [PDF – 5 pages]

This tool assesses areas where trainings, auditing and feedback are performed by the facility. Assessing trainings include who is involved, how often trainings are conducted, how knowledge is assessed, and how records are maintained. The audit portion of the assessment includes the type of audit, practice of audits, who conducts the audit, what areas are audited, and the number of observations included. Feedback in this assessment refers to how feedback about adherence to recommended practices are provided to health care personnel (HCP) and how they are shared within the facility.

Hand Hygiene [PDF – 7 pages]

This tool assists in reviewing HH practices and policies and guides HH observations. The form identifies the facility's preferred method for HH, when HCP are expected to clean their hands, the process for ensuring HH supplies are available and restocked, how patients and visitors clean their hands, and observational audit forms for the MDRO prevention team to complete during a site visit.

Transmission-Based Precautions (TBP) [PDF – 30 pages]

This tool reviews the facility's TBP practices and policies and guides TBP implementation. The form assists in identifying the facility's different types of TBP, how to identify residents who need TBP, signage, who initiates TBP, actions for TBP, patient placement during TBP, and discontinuation process of TBP.

Environmental Services (EVS) [PDF – 18 pages]

The EVS tool reviews the facility's practices and policies and provides a tool for EVS observations. The CDC ICAR encompasses sections related to the daily cleaning process, type of cleaning and disinfection products, frequency of cleaning, minimum cleaning times, and the responsibility of cleaning reusable equipment. Observation tools highlight the cleaning product, the product's use, and contact time, mixing and dilution of products if applicable, EVS cleaning carts use and storage, cleaning processes, and use of cleaning equipment (i.e., mops and rags).

Summary

These CDC ICAR tools are not only useful for audits with the MDRO Prevention Team but can be utilized by your own facility to conduct audits at any scheduled frequency. Use of these tools assists in identifying and mitigating infection control gaps and assists health care personnel with maintaining a state of readiness and preparedness in prevention efforts. More information on the CDC ICAR tools can be found through the CDC website Infection Control Assessment Tools | HAI | CDC.