Quick reference guide for healthcare staff

Candida auris infection prevention and control principles for healthcare facilities (HCF)

This guide provides staff with information regarding infection prevention and control (IPC) principles for management of patients in a healthcare setting who are either colonised or infected with *C.auris* or are known/suspected to be a contact of *C.auris*.

These principles may also apply to other care settings/providers including residential care facilities (RCF) and South Australian Ambulance Service (SAAS).

Refer to local policies and guidelines for specific advice and instructions.

For further detail refer to the Australasian Society for Infectious Diseases (ASID) Diagnosis, management and prevention Candida auris in hospitals: position statement and other helpful reference guides including screening and infection control guideline documents which have been created by Health Victoria and Queensland Health.

Also refer to state and local policies (see related information and resources on page 8) and Flowchart 1: Infection Prevention and Control (IPC) *C.auris* risk assessment and management for patients presenting to a healthcare/residential facility.

Background

C.auris is a multi-drug-resistant fungus (yeast) that can cause serious infections. Infections caused by *C.auris* are difficult to treat and are associated with increased mortality and high health care costs.

C.auris was first recognised in 2009 in Japan where it was isolated from a sample taken from a patient with a localised ear infection. Subsequently there has been emergence of the organism as a human pathogen in many countries including Australia.

A person may carry *C.auris* in or on their body or on medical devices (such as feeding tubes, intravenous catheters, urinary catheters or central lines) and not have any symptoms (this is called colonisation).

People can also become very sick from *C.auris* infection. Infections can include bloodstream infections, as well as infections affecting other parts of the body such as bones (osteomyelitis), ear (otitis media), brain lining (meningitis), heart lining (pericarditis), urinary tract infections or wound infections. The signs and symptoms a person who has a *C.auris* infection might experience depends on the site of the infection.

Persons who test positive for *C. auris (*either via culture methods or PCR testing) with an infection or colonisation are considered to be colonised indefinitely.

In 2021, *C.auris* became a notifiable condition in South Australia under the *South Australian Public Health Act 2011*.

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HCF governance and *C.auris* management plan

As part of an effective IPC program as per the Australian Commission on Safety and Quality HealthCare (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards, HCFs should have an effective IPC *C.auris* management plan that includes:

- management of a known case where transmission has not occurred in the facility, and/or
- managing an outbreak or a case that that has been identified after being admitted.

An outbreak is the occurrence of more cases of disease than expected in a given area or among a specific group of people, over a particular period of time.

This can include:

- two or more confirmed cases of genetically closely related *C.auris*, **OR**
- an isolate from an environmental source and a closely related isolate from a confirmed *C.auris* case suggestive of acquisition from the environment, with a plausible epidemiological link and without an alternative explanation.

To minimise *C.auris* transmission risk and to promote patient safety, HCFs should implement recommended IPC practices including:

> appropriate governance and management including a designated responsible lead

> instigation of an outbreak management team if an outbreak is suspected

> an IPC program and Outbreak Action Plan including standard and transmission-based precautions (TBP), environmental controls/cleaning and effective antimicrobial stewardship

> education for HCF staff on how to respond to cases of *C.auris*.

> systems for effective patient screening, including a process to screen and identify patients at high risk for *C.auris* carriage on admission

> systems to detect *C.auris* clusters or outbreaks including:

  - access to a laboratory that can provide accurate testing and timely results
  - clinicians who can review *C.auris* cases to identify the likely source of acquisition and any need for further patient screening
  - a *C.auris* alert system to ensure standard and TBP are implemented for each admission.

The routes of transmission of *C.auris*

C.auris can be spread:

> directly from person to person, including by contact/touch e.g. via contaminated hands

> indirectly via contaminated environmental reservoirs/surfaces or shared equipment.

Note: Infection is the result of a complex interrelationship between a host, and an infectious agent and people vary in their response to exposure to an infectious agent.

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Patient placement and precautions

- standard and TBP (contact) are required including hand hygiene, personal protective equipment, aseptic technique, dedicated patient equipment where possible, environmental cleaning and disinfection etc.
- patients with *C.auris* are to be managed in a single room with a dedicated ensuite or dedicated shower/toilet. If this is not possible, a bedpan or dedicated commode is required. Also refer to the SA Health Bed Management Toolkit for infectious diseases and multi-resistant organisms for guidance when prioritising single rooms.
- patients with *C.auris* can be cohorted if needed as per a local risk assessment and medical advice regarding clades/strains.
- Consider scheduling patients undergoing procedures at the end of the day's list or alternatively allow sufficient time for appropriate cleaning and disinfection between patients.
- movement of a patient with *C.auris* should be limited if possible, however, *C.auris* colonisation or infection should not be a barrier to clinically required inter/intra hospital or RCF transfers.
- If a patient with *C.auris* is discharged or transferred to another facility, ensure the receiving facilities healthcare team, patient transport/ambulance service, and/or treating medical practitioner is notified prior to transfer, and an IPC management plan discussed including the need for a risk assessment and the implementation of TBP.
- A patient's *C.auris* status must not interfere with the provision of appropriate, high-quality care. No person in South Australia should be refused admission to any HCF or RCF or have their health care compromised solely due to being colonised or infected with *C.auris*.
- For further details, refer to the Healthcare: infection prevention and control (IPC) webpage.

Staff allocation

All staff (including nursing, medical, allied health and cleaning staff) must strictly adhere to standard and TBPs – including hand hygiene and personal protective equipment (PPE).

The staff caring for the patient should:

- be educated and have heightened awareness of *C.auris* risk and management
- ensure multidisciplinary staff are compliant with TBPs, including correct donning/doffing of PPE, hand hygiene and cleaning/disinfection of shared patient care equipment between uses, e.g. stethoscopes

Based on a local risk assessment (including patient and location factors) to limit the risk of *C. auris* transmission, HCFs may consider allocating a dedicated nurse or carer to a patient with *C.auris.*

Minimise the number of number of healthcare/residential care staff having contact with the patient. Consider allocating a dedicated "staff buddy" to;

- assist with patient care if required
- relieve during breaks

Where possible and part of a local risk assessment and capacity, staff assisting the allocated staff member and providing direct care to the patient should ideally not be allocated to the care of patients with transmission risk factors. This can include patient with open wounds, indwelling urinary catheters, or invasive medical devices. However, where this is not possible, ensure that both staff members are competent and compliant with recommended IPC measures including use of hand hygiene, PPE and environmental contamination.

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Patients at higher risk of *C.auris* acquisition may include people who:

- have underlying immunocompromise or chronic disease (e.g. diabetes, lung disease, renal failure, cardiovascular disease, malignancy)
- are being treated with broad-spectrum antibiotics or antifungals
- have invasive medical devices or invasive procedures
- are intensive care patients, pre-term neonates and elderly patients
- require assistance from healthcare personnel for the activities of daily living
- have draining wounds that are difficult to cover or control
- have cognitive impairment that affects their personal/hand hygiene

Antimicrobial stewardship actions

- Optimising antifungal use is an important component of addressing *C.auris* transmission and infection risk in an institution.
- Antibiotic prescribing for both the patient with *C. auris*, and other patients in the HCF should be reviewed and assessed for appropriateness.
- Hospitals contributing to the National Antimicrobial Utilisation Surveillance Program (NAUSP) can review antimicrobial utilisation rates for their facility and benchmark against other similar hospitals.

Staff, volunteer and patient education

All clinical and non-clinical staff, volunteers and patients are to be provided with IPC and *C.auris* education as indicated.

Provide guidance to the patient with *C.auris* to:

- regularly wash their hands with soap and water or use an alcohol-based hand rub, including when leaving their room if relevant
- use allocated toilet facilities (e.g. ensuite) or assist with continence management
- clean hands on entry to communal areas if accessing these
- read the SA Health Candida auris patient and visitor information sheet and ask questions if unsure.

It is important to maintain patient's ability to access social and rehabilitation opportunities for their healthcare. If use of communal areas is clinically required, IPC precautions should be tailored to the situation to minimise the risk of transmission e.g., dedicated equipment for rehabilitation where possible, continence management, covering wounds, clean clothes before entering communal areas where possible, etc.

Environmental and medical equipment cleaning

The environment and medical equipment can play a significant role in transmission and *C.auris* may be present on surfaces in the patient environment for up to 2 weeks, so it is important to undertake cleaning and disinfection of environmental surfaces, fixtures, fittings and equipment.

A Therapeutic Goods Administration (TGA) listed or registered detergent and sporicidal disinfectant product (e.g. bleach) or products with TGA claims to be effective against *C.auris* is recommended and manufacturer's instructions should be followed, including cleaning methods, correct amounts, dilutions, concentrations, contact time and as indicated, effectiveness against

biofilms. For more information refer to the SA Health SA Health Environmental hygiene in healthcare webpage.

Daily cleaning of medical equipment is essential.

Where possible, medical equipment should be disposable or dedicated to the individual patient and not shared with other patients. If equipment is unable to be dedicated as single patient use it must be cleaned and disinfected after each use – refer to local policies and procedures.

Linen management

Standard laundry practices apply as per AS 4146:2024 Laundry Practice.

Standard and transmission-based precautions apply as per local risk assessment including the placing of a linen skip/trolley in the patient's room for exclusive use.

Waste management

Standard waste management practices apply as per standard and transmission-based precautions and as per local risk assessment.

C.auris screening

Identification of patients who may be recommended for *C.auris* screening is as per current guidelines and risk assessment. Patients being screened may require isolation based on the reason for screening prior to results being available. E.g. known contacts of *C auris*.

Patients who should be considered for screening includes those who:

- are close contacts* of *C. auris* patients
- have had a possible/known exposure to an environment where there is a known risk of *C. auris* (e.g. local, interstate or international healthcare setting)
- have had a healthcare encounter (minimum of an overnight stay) in an overseas healthcare institution in the previous 12 months
- as per discharge communication or handover the patient has been in a known. transmission risk area (an area or distinct geographical area or ward in which local transmission has occurred).

*A close contact is any person who has resided for at least 24 hours in a shared room / environment with a person colonised with *C. auris*.

Isolation of close contacts can be ceased after three consecutive negative screens taken at least 24 hours apart. Isolation of all other persons undergoing screening can be ceased after a single negative screen.

In the absence of three negative *C.auris* screens, contact alerts should remain in place for a minimum of 5 years.

In facilities where there is an epidemiological link to a patient with *C.auris*, screening should include screening of identified ward/area contacts. E.g transmission risk area.

Point-prevalence screening of an entire ward/area or facility may be required to assess the extent of transmission and to identify all colonised patients.

Repeated screening of currently hospitalised patients (e.g. weekly screening) should be considered if further cases are identified despite other measures.

Bilateral axilla and inguinal region (groin) swabs can be taken as a combined swab and should be taken as a minimum. Colonisation with *C.auris* may be variable across the body.

Swabs of other sites can be considered if clinically indicated, such as throat, wounds, indwelling medical device entry sites, drainage fluid, endotracheal secretions, and urine in catheterised patients.

Note: Routine screening of healthcare workers and the environment is not generally recommended. Also refer to local policies and procedures.

Monitoring and auditing of IPC strategies

Facilities must monitor and record audit results and IPC strategies including hand hygiene, TBP adherence, PPE donning / doffing technique, environmental and equipment cleaning and address gaps as required.

Refer to SA Health: Preventing and Controlling Infections Standard suite of audit tools located on the Healthcare: infection prevention and control (IPC) web page.

An outbreak action plan must be developed and maintained by HCFs when there has been *C.auris* transmission.

Appendix A is a checklist to ensure specific IPC measures for care of patients with *C.auris* are in place.

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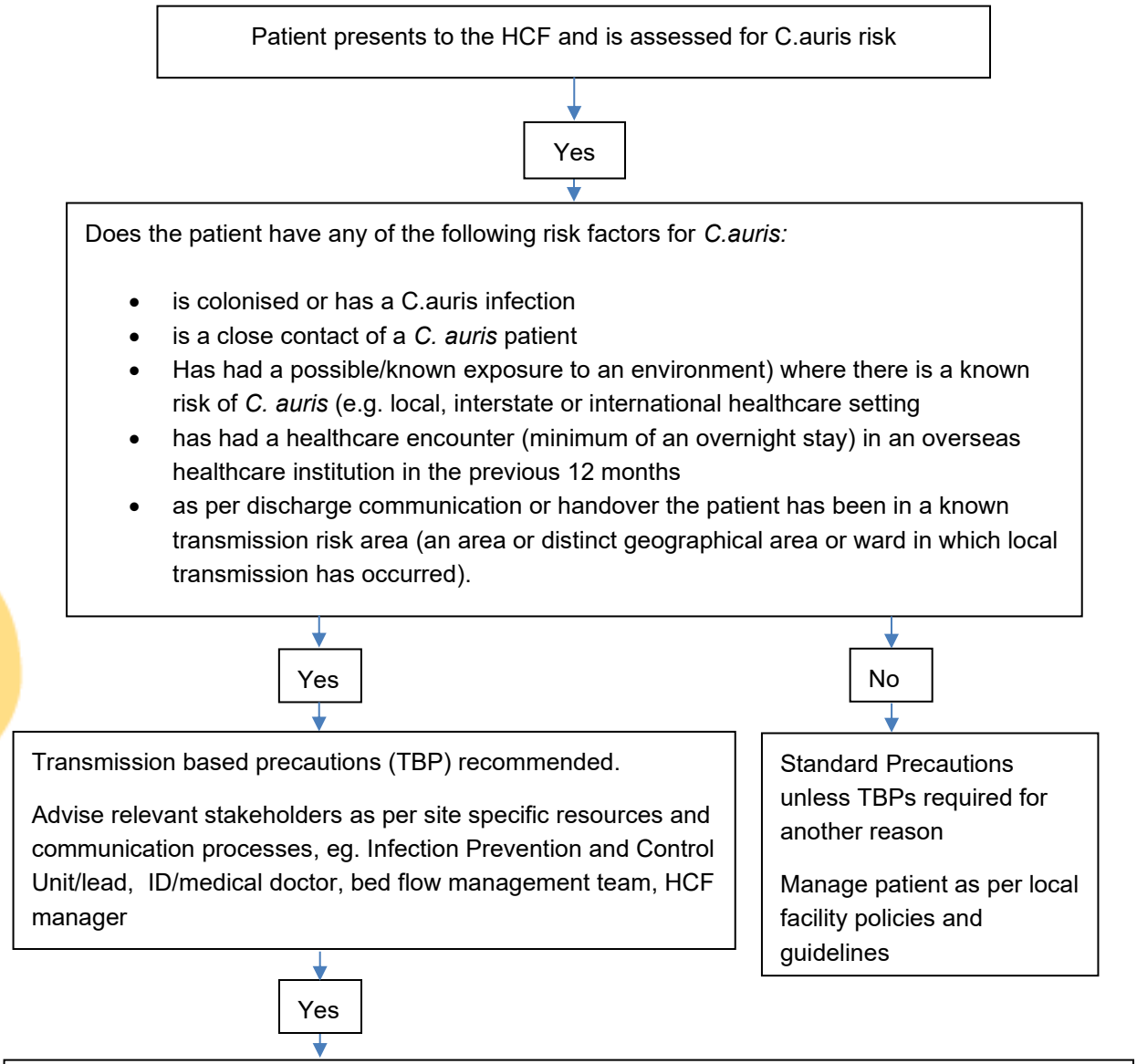
Flowchart 1: Infection Prevention and Control (IPC) *C.auris* risk assessment and management for patients presenting to a healthcare facility.



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Further information and resources:

- Australasian Society for Infectious Diseases (ASID) Diagnosis, management and prevention Candida auris in hospitals: position statement
- Australian Commission on Safety and Quality in Healthcare (ACSQHC) Candida auris webpage
- ACSQHC Australian Guidelines for the Prevention and Control of Infection in Healthcare
- SA Health Bed management toolkit for infectious diseases and multi-resistant organisms
- SA Health Candida auris - including symptoms, treatment and prevention webpage
- SA Health Multidrug-resistant organisms (MRO) webpage
- SA Health Environmental hygiene in Healthcare webpage
- SA Health Healthcare: infection prevention and control (IPC) web page
- SA Health Prevention and controlling healthcare associated infection audit tools
- Victoria Health: Victorian guideline on Candida auris for health services
- Also refer to local guidelines and policies.

Appendix

Appendix A – Example of an Infection Prevention and Control Checklist for care and management of a patient with *C.auris* in a healthcare facility.

For more information

Infection Control Service
Communicable Disease Control Branch
Telephone: 1300 232 272
www.sahealth.sa.gov.au/infectionprevention

Official

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SA Health

Appendix A: Example of an Infection Prevention and Control Checklist for the management of a patient with *Candida auris (C.auris)* in a healthcare facility

Instructions:	This checklist is an example of a quality insurance tool to be completed by the nurse/staff member/carer looking after the patient with *C.auris*. "No" responses are to be discussed, and risk assessed with the shift coordinator/team leader/manager. Frequency of completing the checklist may differ in clinical settings – refer to local policy and procedures.	
1	Does the facility have a guideline/protocol regarding the management and care of patients with multi-resistant organisms, including *C.auris*?	Yes / No
2	Have all staff involved with the care of the patient received specific education regarding the management and care of patients with *C.auris*?	Yes / No
	• Is this training compulsory?	Yes / No
	• How often is training provided? _____	
	• Do staff have access to written information pertaining to *C.auris*?	Yes / No
3	Have patients and family members received specific consumer education regarding *C.auris*?	Yes / No
4	Does the patient with *C.auris* have a single room with their own ensuite?	Yes / No
	• **If No**, is the patient with *C.auris* assigned a dedicated bathroom?	Yes / No
5	Is the patient with *C.auris* always toileted in their own bathroom or have a dedicated commode in their room?	Yes / No
	• **If No**, is the patient with *C.auris* assigned a dedicated toilet?	Yes / No
	• **If No**, is the toilet used by the patient with *C.auris* outside their own room cleaned and disinfected immediately after use?	Yes / No
6	Is there an alert mechanism (for example signage displayed at the entrance to the room) to alert staff that contact precautions are required for the management and care of patients with *C.auris*, including hand hygiene?	Yes / No
7	Is there personal protective equipment (PPE), including gowns/aprons and gloves that are easily accessible for staff to wear and hand hygiene facilities (i.e soap and water and/or alcohol-based hand gel) when attending to close personal care of patients with *C.auris* ?	Yes / No
8	Do all staff use gowns/aprons and gloves for all close personal care (for example toileting) of patients with *C.auris*?	Yes / No
9	Do rooms of patients with *C.auris* receive a full clean and disinfection daily?	Yes / No
10	Are the following areas of the rooms of patients with *C.auris* cleaned and disinfected daily, including?	Yes / No
	• Bathrooms/toilets/commode chair	Yes / No
	• Frequently touched surfaces (i.e. door handles, light switches, sinks, bed rails)	Yes / No
	• Equipment/furniture in the immediate vicinity of the patient	Yes / No
11	Is a TGA detergent and sporicidal disinfectant product or products with claims to be effective against *C.auris* used to disinfect environmental surfaces in rooms of patients with *C.auris* ?	Yes / No
	• **If No**, what alternative method for cleaning/disinfection is used? _____	

12	Is all equipment (for example commode chair, lifting machine, frames) used for patients with *C.auris* dedicated to their use?	Yes / No
	• List shared equipment: _____	
	• Are these items cleaned and disinfected after use/prior to use on another patient?	Yes / No
13	Is shared equipment used by patients/residents with *C.auris* in group activities cleaned and disinfected prior to use by other patients?	Yes / No / N/A
14	Are other healthcare or residential care facilities advised of a patients *C.auris* status prior to being transferred to a different site?	Yes / No
	• If Yes, is a template letter of transfer used to document all necessary information?	Yes / No