PICNet
PROVINCIAL INFECTION CONTROL NETWORK OF BRITISH COLUMBIA
A program of the Provincial Health Services Authority

Interim Infection Prevention and Control Guidance for *Candida auris* (*C. auris*) in Health Care Settings

Revised: June 16, 2025

Revision 2.0 — updated from July 3, 2024, Interim Infection Prevention and Control Guidance for Candida auris (C. auris) for Health Care Settings.

Contents

Guideline Approval

Approval From	Date
Provincial Infection Prevention and Control Steering Committee	May 23, 2025

Document Version

Document Version	Summary of Major Changes

Jun 16, 2025	• Expanded information on *C. auris* background.
	• Addition of the following sections:
	  ○ Land Acknowledgement
	  ○ Purpose
	  ○ Admission screening
	  ○ Transmission events and outbreak
	• Expanded recommendations under Contact Management and Exposure and Contact Management sections.
	• Updated resources and references.

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Land Acknowledgement

PICNet wishes to acknowledge with gratitude that we work and live on the traditional, ancestral and unceded territories of many B.C. First Nations who have cared and nurtured this land for all time. PICNet's office in Vancouver is located on the traditional land of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) Nations. We also acknowledge that there are other Indigenous people that live on these lands that originate from their own respective territories outside of these lands, the Chartered Communities of the Métis Nation B.C., and Inuit.

Purpose

The purpose of this guidance is to provide updated recommendations on infection prevention and control (IPC) measures for management of *Candida auris* (*C. auris*) in health care settings. This includes acute care, urgent and primary care centres, and long-term care settings. The following recommendations have been revised from PICNet's July 2023 Interim Infection Prevention and Control Guidance for *C. auris* for Health Care Settings, to align with Public Health Agency of Canada's (PHAC) Candida auris Infection Prevention and Control in Canadian Healthcare Settings - Canada.ca (updated December 23, 2024). PHAC guidance expands on recommendations for management of *C. auris* and additional recommendations for transmission events and outbreaks.[1]

The term 'patient' in this guideline refers to persons receiving care in health care settings and includes clients and residents.

Introduction

Background

C. auris is an emerging multi-drug resistant fungus that has caused increasing numbers of health care facility outbreaks in multiple countries.[1–5] *C. auris* can be resistant to one or three main available classes of antifungal treatments (e.g., azoles such as fluconazole, polyenes such as amphotericin B, and echinocandins. Patients are at risk of acquiring *C. auris* if they have been hospitalized in other countries or have been in a health care facility experiencing transmission events/outbreaks.[1]

C. auris poses significant challenges in health care settings and includes the following[1–7]:

- Limited treatment options due to resistance to common antifungal agents.
- Associated with invasive infections that can have high mortality (>40%). Infections with significant morbidity and mortality are more likely to occur in patients with pre-disposing risk factors such as having central venous catheters or other invasive lines/devices, receiving intensive care, treatment with broad-spectrum antibiotics or antifungals, and being immune compromised.
- Environmental transmission risk due to persistence on environmental surfaces and fomites (e.g., medical equipment, linens), ability to form biofilms, and resistance to some common hospital-grade disinfectants, such as quaternary ammonium compounds.
- Detection challenges due to the following:
    - Persistence on skin and mucous membranes of people who are colonized with it, and yet they can remain asymptomatic.
    - Ability to form biofilms and penetrate within hair follicles and deep skin layers.
    - Difficulty in identifying *C. auris* using conventional laboratory methods. Specialized diagnostic procedures are needed to enhance timely detection.
- Transmission from patients or the environment can potentially cause prolonged outbreaks that can be disruptive and challenging to manage and control.

Therefore, awareness of *C. auris* and the recommended measures to recognize and prevent transmission are needed to address this emerging concern within health care settings.

Transmission

C. auris is spread in health care settings through direct contact with a patient colonized or infected with it or via in-direct contact with their environment or fomites (e.g., medical equipment/devices, linen) that are contaminated with *C. auris*.

Clinical presentation

C. auris infection is associated with a wide range of clinical presentations, with asymptomatic colonization to nonspecific symptoms that vary depending on the location and severity of infection. It can cause invasive

infections with significant morbidity and mortality, particularly among hospitalized patients who are immunocompromised or receiving intensive care.[5,7]

For more information on clinical presentation and complications refer to information for health care providers from Public Health Agency of Canada (PHAC) and US Centres for Disease Control (CDC).

Infection prevention and control recommendations in health-care settings

Admission Screening

As recommended by PHAC, health authorities should consider active targeted screening for *C. auris* as a key measure for early detection and surveillance to prevent transmission, especially given the recent, rising global trends of the microorganism, coupled by its treatment resistance, environmental persistence, high mortality of invasive infections, and ability to cause prolonged health care setting outbreaks.[1] Health authorities should assess the feasibility of screening (e.g. laboratory considerations) and work towards developing a targeted screening program based on local risk assessment, epidemiology, and patient risk factors. Patients should be screened for *C. auris* risk factors and screening specimens collected for patients who meet the criteria.

Additional considerations for targeted screening include the following:

- Screening for patients who have received health care (e.g., admitted to acute care, long-term care, or received intensive medical care at outpatient settings, such as hemodialysis clinics, oncology clinics, bone marrow or solid transplant clinics) outside of Canada within the last 12 months or transferred from a Canadian health care facility with an ongoing *C. auris* outbreak (if known).[1,3]

- Screening specimens: combined bilateral axilla and groin, and if applicable clinically relevant sites (e.g., wounds and line/device exit sites). [1,3]

- A patient with identified risk factors for *C. auris*, must be placed on empirical contact precautions while awaiting testing results.[1]

- In the event of an initial negative test, and in consultation with IPC physician/professional, additional specimens should be considered with a minimum of two additional specimens collected a week apart for patients at high risk of having *C. auris*.[1]

Case management

A patient suspected or confirmed to have *C. auris* must receive respectful, patient-centred care that maintains dignity, privacy, and confidentiality, while ensuring appropriate and adequate protection of health care workers, visitors, and other patients. Early identification, adherence to routine IPC practices, and implementation of additional measures are critical to prevent transmission of *C. auris* within health care facilities.

In addition to organizational IPC policy and procedures, the following are recommended for a patient suspected or confirmed to have *C. auris*[1–3]:

- Follow routine practices, including hand hygiene with alcohol-based hand rub or plain soap and water.
- Implement contact precautions including wearing gloves and long-sleeve protective gowns. Use additional personal protective equipment based on point-of-care risk assessment.
- Place patient in a single occupancy room with a dedicated bathroom. If a dedicated bathroom is not available, provide a dedicated commode or urinal. Consult with IPC professional for alternate placement options when a single occupancy room is not available.
- Place additional precaution sign (i.e. contact precautions) at the entrance of the patient room. Use additional precaution signs from your organization or signs available on the PICNet website.
- Use single use and disposable patient care equipment (where possible) or use dedicated reusable patient care equipment. Where reusable patient care equipment is used, it must be thoroughly cleaned and disinfected before use on another patient.
- Provide visitors with education on the on the importance of and instructions for additional IPC measures, including how to clean their hands and if needed proper PPE donning and doffing procedures. Visitors should wear gloves and long-sleeve protective gowns when providing direct patient care.[1] Communication strategies should be tailored to meet communication or language barriers (e.g., providing demonstrations, illustrated visuals, or printed materials in different languages).
- Flag patients with confirmed *C. auris* in the organizational medical record system.
  - Maintain contact precautions on subsequent admissions to acute care settings.
  - Clearance testing is not recommended due to prolonged colonization persistence and potentially false negative results.
- In long-term care (LTC) settings, place a patient with an active *C. auris* infection on contact precautions for the duration of infection. Consult with health authority IPC physician/professional for a long-term management plan of a resident colonized with *C. auris*. Quality of life and care must be balanced with IPC measures to prevent spread to others. LTC facilities may opt to use the enhanced barrier precaution sign based on local health authority guidance.

Cleaning and Disinfection

- Perform twice daily environmental cleaning and disinfection of the patient room with a focus on high-touch surfaces.
- Use a disinfectant with a Health Canada issued drug identification number (DIN) and an efficacy claim against *C. auris* (e.g., accelerated hydrogen peroxide, 1,000 ppm chlorine or sodium hypochlorite), for environmental and non-critical equipment cleaning and disinfection. Quaternary ammonium compounds are not considered effective against *C. auris* and should not be used.[1]

- Ensure disinfectant remains wet for the manufacturer specified contact time. Reapply disinfectant if it dries before achieving the required contact time.
- Additional precaution discharge cleaning and disinfection of the patient room must be done after the patient is discharged/transferred. Additional precaution sign should remain in place until cleaning and disinfection is completed.
- No-touch disinfection technologies (e.g., ultraviolet-C light and vaporized hydrogen peroxide) with demonstrated effectiveness against *C. auris,* may be considered (where available) as a supplemental measure to reduce environmental bioburden, and used in addition to the above cleaning and disinfection practices.[1]

Patient Transfer

- Avoid non-essential patient transfers between or within facilities unless they are medically necessary of part of a care transition (e.g. from acute care to long-term care).
- Notify both the transporting personnel and the receiving unit or department before the transfer to ensure appropriate precautions are taken. Transporting personnel should wear PPE during the transfer.
- Instruct and assist the patient to perform hand hygiene and change into clean clothing or a new patient gown before leaving their room.
- Clean and disinfect all transport equipment, including mobility aids, stretchers, bed rails, and handles, before removing them from the patient's room.

Exposure and Contact Management

Consult with organizational IPC professional (where available) or Public Health for follow-up and management of close patient contacts. Contacts can include past and present roommates or patients who occupied an insufficiently disinfected room (e.g. disinfected with quaternary ammonium compounds) after an unrecognized case. Additional patient contacts (e.g., other patients on an acute care unit, or other residents in a long-term care facility) may be considered at the discretion of IPC or Public Health, depending on the type and duration of exposures.

- Place patients identified as contacts on empirical contact precautions and collect screening specimens for *C. auris.*
- In the event of an initial negative test, and in consultation with IPC physician/professional, additional specimens should be considered with a minimum of two additional specimens collected a week apart.[1]
- Discontinuation of additional precautions must be done in consultation with IPC physician/professional (where available) or Public Health.

- Follow additional measures recommended by IPC and/or Public Health, which may include contact tracing, point prevalence testing, environmental sampling, IPC compliance monitoring, and enhanced unit cleaning and disinfection.
- For health-care worker exposures and contact management, consult with the Provincial Workplace Health Contact Centre (for health authority operated settings) and Public Health.

Notification

Notify organizational IPC physician/professional and Public Health of all newly identified patients with *C. auris*. *C. auris* is a reportable communicable disease under the *Public Health Act*.[8]

Transmission Events and Outbreaks

Any transmission of *C. auris* among patients within a health care setting warrants implementation of additional IPC measures to mitigate and control further spread, in consultation with IPC physician/professional (where available) and Public Health.

- Notify organizational IPC physician/professional, facility administration, and Public Health when a *C. auris* transmission event or outbreak is suspected or confirmed. Outbreaks are reportable to Public Health/Medical Health Officer in accordance with the Reporting Information Affecting Public Health Regulation (B.C. Reg. 167/2018) under the *Public Health Act*.[8]
- Follow the Provincial Surveillance Protocol for CPO and *C. auris* in BC for notification of transmission investigation reporting requirements to PICNet for further dissemination to health authority IPC partners.[1]
- Formulate a multi-disciplinary outbreak management team (OMT) to meet frequently and oversee the investigation, transmission event confirmation, communications, and implementation and coordination of additional IPC interventions, corrective actions, and any further recommendations. The OMT should consist of IPC physician/professional, unit/facility leadership, environmental services, and Public Health. Additional representatives may be included as needed (e.g., medical microbiology, facilities maintenance and operations, Workplace Health and Safety). Additional IPC measures should include the following:
    - Enhanced environmental cleaning and disinfection of the affected area/unit to include twice daily cleaning of washrooms, frequently touched surfaces (e.g., hand and bedrails, light cords, light switches, door handles, furniture) and horizontal surfaces in patient rooms, common areas, and care team/nursing station.
    - Contact tracing and/or point prevalence testing to identify possible transmission, in consultation with IPC physician/professional or Public Health.
    - Pre-emptive contact precautions for patients until contact tracing and/or point prevalence testing results are confirmed.
    - Assessments for adherence to IPC measures (e.g., hand hygiene, PPE, and environmental cleaning and disinfection audits).

  - Additional health-care worker IPC education and support as needed.
  - Additional IPC measures as recommended by IPC physician/professional and Public Health.

- Consider contacting BCCDC Public Health Lab to assist with high-volume *C. auris* screen testing of clinical or environmental samples using Polymerase Chain Reaction (PCR) assays.

Surveillance

Refer to the following surveillance resources:

- PICNet Surveillance Reports for health care-associated infections and Provincial Surveillance Protocol for CPO and *C. auris* in BC.
- Canadian Nosocomial Infection Surveillance Program (CNISP) for *Candida auris* available on the CNISP website.

Additional Resources

- Public Health Agency of Canada.
  - Candida auris Infection Prevention and Control in Canadian Healthcare Settings
  - Candida auris: Infection prevention and control in Canadian healthcare settings — Infographic
  - Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings
- U.S. Centre for Disease Control and Prevention (CDC)
  - Preventing the Spread of C. auris
  - Infection Control Guidance: Candida auris
- PICNet
  - British Columbia Best Practices for Environmental Cleaning for Prevention and Control of Infections in Healthcare Settings and Programs
  - Best Practices for Hand Hygiene in All Healthcare Settings and Programs

References

1. Public Health Agency of Canada (PHAC). Candida auris Infection Prevention and Control in Canadian Healthcare Settings. Published December 23, 2024. Accessed February 27, 2025. https://www.canada.ca/en/services/health/publications/diseases-conditions/candida-auris-infection-prevention-control-canadian-healthcare-settings.html

2. Chen J, Tian S, Han X, et al. Is the superbug fungus really so scary? A systematic review and meta-analysis of global epidemiology and mortality of Candida auris. *BMC Infect Dis*. 2020;20:827. doi:10.1186/s12879-020-05543-0

3. US Centre for Disease Control. Infection Control Guidance: Candida auris. Published April 24, 2024. Accessed June 5, 2024. https://www.cdc.gov/candida-auris/hcp/infection-control/index.html

4. Lionakis Michail S., Chowdhary Anuradha. Candida auris Infections. *New England Journal of Medicine*. 2024;391(20):1924-1935. doi:10.1056/NEJMra2402635

5. Osei Sekyere J. Candida auris: A systematic review and meta-analysis of current updates on an emerging multidrug-resistant pathogen. *Microbiologyopen*. 2019;8(8):e00901. doi:10.1002/mbo3.901

6. Cadnum JL, Shaikh AA, Piedrahita CT, et al. Effectiveness of Disinfectants Against Candida auris and Other Candida Species. *Infection Control & Hospital Epidemiology*. 2017;38(10):1240-1243. doi:10.1017/ice.2017.162

7. Vinayagamoorthy K, Pentapati KC, Prakash H. Prevalence, risk factors, treatment and outcome of multidrug resistance Candida auris infections in Coronavirus disease (COVID-19) patients: A systematic review. *Mycoses*. 2022;65(6):613-624. doi:10.1111/myc.13447

8. Government of British Columbia. Reporting Information Affecting Public Health Regulation. Accessed June 26, 2024. https://www.bclaws.gov.bc.ca/civix/document/id/lc/statreg/167_2018#Schedule