

The CDPH Healthcare-Associated Infections (HAI) Program created the *C. auris* Quicksheet to provide guidance to local health departments (LHDs) responding to *C. auris* cases at **all levels** of local *C. auris* endemicity. This Quicksheet is designed to be used alongside the CDPH Regional *C. auris* Prevention and Response Strategy¹ (“Response Phases” document), which provides additional infection prevention and control (IPC) and screening recommendations that change based on local or regional *C. auris* epidemiology. **Implementing some practices (e.g., cohorting) in this guidance can be challenging or not feasible in some healthcare facilities, but this should not preclude facilities from accepting and caring for patients and residents with *C. auris*.**

Background and Epidemiology

- *C. auris* was first identified in 2009 and is an emerging, often multidrug-resistant yeast. Rarely, *C. auris* strains are resistant to echinocandins (the first-line treatment for *C. auris* bloodstream infections), or all three available classes of antifungals (pan-resistant).²
- *C. auris* colonizes the skin and other body sites and can cause serious infections, including bloodstream infections. In a Los Angeles County study, crude 30-day mortality was 26% in cases with sterile site specimens (including blood) vs. 20% in cases with non-sterile site specimens.³
- In California, most *C. auris* cases were identified through colonization testing (e.g., axilla/groin swabs); 13% of colonized cases subsequently had clinical cases. About 30% of *C. auris* clinical cases were from blood specimens; however, the majority were identified from non-sterile sites (Fig. 1).

Fig. 1. *C. auris* Clinical Cases by Specimen Source through 2023 (N=1530)

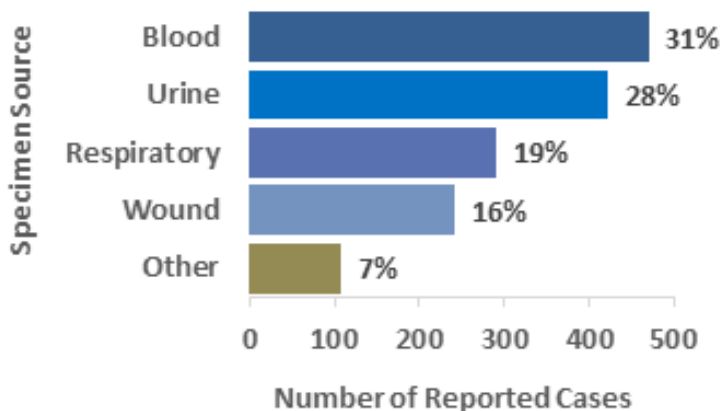
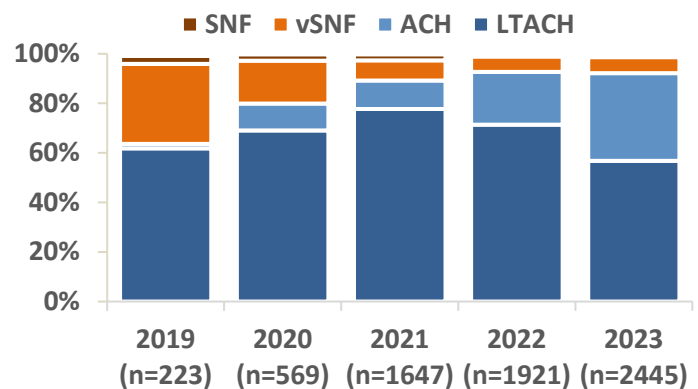


Fig. 2. *C. auris* Cases by Facility Type, 2019–2023 (N=6805)



- Risk factors include presence of indwelling medical devices and broad-spectrum antibiotic or antifungal use.²
- In California, *C. auris* has been identified primarily among patients in long-term acute care hospitals (LTACHs)⁴ and is increasingly being identified in ACHs, likely a result of wider admission screening (Fig. 2). The remaining cases have mainly been identified in ventilator-equipped skilled nursing facilities (vSNFs).
- *C. auris* can spread patient-to-patient via transient contamination of the hands or clothing of healthcare personnel, or via contaminated equipment or the healthcare environment, where *C. auris* can persist for weeks.
- Early detection, IPC, and interfacility communication can limit the spread of *C. auris*.²

¹ [CDPH Response Phases](https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Cauris_Phases.pdf) (PDF) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Cauris_Phases.pdf)

² [CDC About *C. auris*](https://www.cdc.gov/fungal/candida-auris/candida-auris-qanda.html) (www.cdc.gov/fungal/candida-auris/candida-auris-qanda.html)

³ [Oyong et al. 2023](https://doi.org/10.1093/ofid/ofad500.2067) (doi.org/10.1093/ofid/ofad500.2067)

⁴ [Karmarkar et al. 2021](https://doi.org/10.7326/m21-2013) (doi.org/10.7326/m21-2013)

C. auris Reporting and Laboratory Submission Requirements^{5, 6, 7}

- ✓ *C. auris* is reportable by healthcare providers and laboratories.
- ✓ Report unusual infectious disease occurrences and outbreaks to CDPH Licensing & Certification if in a licensed healthcare facility.
- ✓ Forward *C. auris* isolates identified in sterile site specimens to a public health laboratory.

C. auris Containment Recommendations

1. Surveillance

a. Identification of *C. auris* from Clinical Isolates

- Ensure clinical labs can identify *C. auris*,⁸ and if not, know when to suspect it, and send those isolates to public health for further testing.
- Identify all *Candida* isolated from normally sterile sites (e.g., blood) to the species level.
- For *Candida* isolated from non-sterile sites, consider species-level identification:
 - for monomicrobial cultures that grow *Candida* species only
 - when clinically indicated for patient care
 - when *C. auris* has been detected in the facility as part of prospective surveillance
 - at high-risk facilities (i.e., LTACH or vSNF) or ACH unit (e.g., ICU, burn, oncology)
 - for high-risk patients (see section 1b).
- *C. auris* testing is available at some local public health labs and the CDPH Microbial Diseases Laboratory (MDL).⁹
- Clinical labs immediately notify clinicians and infection prevention staff whenever *C. auris* is identified.

b. Enhanced Detection among High-Risk Populations

- Healthcare facilities screen for *C. auris* and implement empiric Contact Precautions or

Enhanced Standard Precautions (ESP) in SNF with no outbreak, and ensure use of proper disinfectant for patients at risk for *C. auris* acquisition or transmission, including:

- patients admitted **to** any LTACH or vSNF ventilator unit
 - patients admitted **from** any LTACH, vSNF ventilator unit, or other facility with known *C. auris* outbreak.
 - In ACH, alternatively or additionally consider screening patients admitted to high-risk units (e.g., ICU).
 - high-risk contacts of a confirmed *C. auris* case, including roommates, those who shared a bathroom, those who occupy the same bedspace immediately after the index patient.¹⁰
 - Consider patients in the same unit or facility based on LHD phase¹ and facility type.
 - Consider screening patients not included above with other known risk factors such as patients:
 - with indwelling devices, particularly those who are mechanically ventilated or trached;
 - colonized or infected with a CPO, especially those requiring high-level care (e.g., indwelling medical devices, mechanical ventilation); and
 - with healthcare exposure outside of California in the past 12 months.
 - See “Response Phases” guidance for additional screening considerations.¹
- #### 2. Investigation
- A single, confirmed case of *C. auris* from any specimen source is cause for investigation and notification to public health in Phase 1 jurisdictions. LHD staff in Phase 2-4 jurisdictions may provide specific recommendations for individual case investigation and notification.¹

⁵ [CDPH C. auris Reporting FAQ](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CaurisReportingFAQ.pdf) (PDF) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CaurisReportingFAQ.pdf)

⁶ [CDPH Reportable Diseases and Conditions](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Reportable-Disease-and-Conditions.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/Reportable-Disease-and-Conditions.aspx)

⁷ [CDPH All Facilities Letter 23-08](http://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-08.aspx) (www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-08.aspx)

⁸ [CDC Identification of C. auris](http://www.cdc.gov/fungal/candida-auris/identification.html) (www.cdc.gov/fungal/candida-auris/identification.html)

⁹ [CDPH MDL Submission Instructions and Forms](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/MDLSubmissionInstructionsandForms.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/MDLSubmissionInstructionsandForms.aspx)

¹⁰ [CDPH Screening Decision Tree](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Tier2_Pathogen_Screening_Decision_Tree.pdf) (PDF) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Tier2_Pathogen_Screening_Decision_Tree.pdf)

3. Initial Response and Recommendations

- LHD ensures the following information is complete in the case report:
 - Patient name, date of birth, race, ethnicity, gender, collection facility, collection facility type, date of collection, specimen source
- Phase 1 and 2 LHDs¹ collect additional epidemiological information for all healthcare exposures from at least 30 days prior to specimen collection (using CalREDIE or line list as relevant):
 - Dates of admission, discharge, initiation of Contact Precautions or ESP (if SNF)
 - Previous, subsequent healthcare exposure
 - Locations (e.g., units, rooms)
 - Additionally collect information about healthcare exposures outside California or the U.S. in the previous 12 months
- In hospitals, implement Contact Precautions and place the patient in a single-bed room. In SNFs, implement ESP if no outbreak; if no single-bed room is available, cohort with another resident colonized with *C. auris*, whenever possible.¹¹
- Use an Environmental Protection Agency (EPA)-registered hospital-grade List P disinfectant effective against *C. auris* (List K or bleach, if not accessible) for daily and terminal cleaning and disinfection of patient care environment and reusable medical equipment.¹²
- Inform receiving facilities of patient's *C. auris* status and recommended IPC measures at time of transfer (see section 5).

4. Additional IPC Recommendations

Room Placement Considerations

- Facilities with multiple patients with *C. auris* may create cohorts within rooms or in the same geographic area of the facility. Factor in other communicable disease status (e.g., CPO) when creating cohorts, whenever possible.¹¹
- In multi-bed rooms, treat each bed space as a separate room, even when patients are cohorted.

Healthcare personnel (HCP) must change gown and gloves and perform hand hygiene between contact with patients in the same room.

Hand Hygiene

- Follow and audit hand hygiene practices, including the use of alcohol-based hand sanitizer as the preferred method for cleaning hands if not visibly soiled; if visibly soiled, wash with soap and water.

Transmission-based Precautions

- Contact Precautions consist of HCP use of gowns and gloves upon entry to the patient room; patients may only leave room when medically necessary.
- Continue Contact Precautions for the duration of admission in hospitals, including LTACHs.
- In SNFs, implement Contact Precautions during *C. auris* outbreak; in the absence of an outbreak, implement ESP consisting of gown and glove use during high-contact care activities. Residents may leave their room if they can be maintained in hygienic condition and don clean clothing.¹³
- Do not perform repeated cultures or screening to demonstrate *C. auris* "clearance" for purposes of discontinuing Transmission-based Precautions, as patients may remain colonized for many months or years, possibly indefinitely.

Dedicated Equipment and Staff

- Dedicate patient care equipment as much as possible to patients with *C. auris*, and consider using single-use, disposable devices.
- In facilities with *C. auris* cohorts, dedicate primary HCP (e.g., nursing) to care only for patients with *C. auris*, whenever feasible.
- Consider providing physical therapy or other ancillary care for patients with *C. auris* in their room or scheduling at the end of the day.

Environmental Cleaning and Disinfection

- Conduct and audit daily and terminal cleaning and disinfection of patient care environment including high-touch surfaces, and non-dedicated equipment

¹¹ [CDPH Cohorting Guidance](https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/MDROCoorting.pdf) (PDF) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/MDROCoorting.pdf)

¹² [CDC C. auris Environmental Disinfection](https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html#disinfection) (www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html#disinfection)

¹³ [CDPH Enhanced Standard Precautions](https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx) (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx)

after use, with a List P disinfectant effective against *C. auris* (List K or bleach, if not accessible).¹²

- During an outbreak or when transmission is difficult to control, consider double terminal cleaning in rooms with patients with *C. auris* or on affected units, i.e., perform two rounds of terminal cleaning and disinfection, with a fluorescent marker audit after each.

Adherence Monitoring and Feedback

- Conduct regular adherence monitoring to evaluate implementation of IPC measures using standardized tools and provide feedback to HCP and facility leadership.¹⁴
- During an outbreak, increase the frequency of adherence monitoring and feedback (e.g., weekly).

Onsite IPC Assessment

- LHDs can recommend an onsite IPC assessment in response to a *C. auris* case or outbreak; CDPH HAI Program may be consulted as needed.

5. Communication and Follow-up

When transferring a patient with *C. auris* to another healthcare facility, communicate the patient's *C. auris* status, including recommended IPC measures to the receiving facility at **time** of transfer.¹⁵

- When receiving transferred patients, facilities should actively seek information on multidrug-resistant organism status.
- Facilities with *C. auris* outbreaks must inform facilities to which they transfer patients. Receiving facilities should screen such patients for *C. auris* and place them on empiric Contact Precautions or implement ESP in SNF pending the test result.
- If a patient tests positive for *C. auris* on admission, notify transferring facility of *C. auris* status. The transferring facility should also conduct a contact investigation or PPS.
- LHDs may request to be notified when healthcare facilities transfer patients with *C. auris*.

- Flag the medical record of patients with *C. auris* to ensure IPC measures are implemented upon readmission. Do not rescreen patients who have previously tested positive for *C. auris*.
- Provide education materials to patients, their families, and HCP as needed.¹⁶

- A template letter is available that healthcare facilities can provide to patients when they discharge home.

6. Considerations for Other Healthcare Settings (e.g., dialysis, outpatient, home health)¹⁷

- IPC practices for *C. auris* are similar across other healthcare settings. Ensure:
 - hand hygiene before and after entering the patient's room and providing care.
 - implementation of Contact Precautions, or ESP for inpatient settings.
 - scheduling the patient to receive care at the end of the day, whenever possible.
 - environmental cleaning and disinfection of the patient's care environment and any reusable medical equipment with a disinfectant effective against *C. auris*.
 - the patient's *C. auris* status is communicated if the patient needs to be transferred to a healthcare facility.
- Healthcare settings within correctional facilities should generally follow the recommended IPC practices for the type of healthcare provided. Specific IPC measures are generally not indicated for non-healthcare settings in correctional facilities.
- Many of these practices could be adapted to non-healthcare congregate residential settings (e.g., implementation of ESP in assisted living facilities, group or board and care homes).
- In any of these settings, screening contacts may be indicated in certain circumstances.
- LHD may consult with HAI Program for additional guidance.

¹⁴ [CDPH Adherence Monitoring](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/MonitoringAdherenceToHCPracticesThatPreventInfection.aspx)

(www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/MonitoringAdherenceToHCPracticesThatPreventInfection.aspx)

¹⁵ [CDPH Interfacility Transfer Communications](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/InterfacilityCommunication.aspx)

(www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/InterfacilityCommunication.aspx)

¹⁶ [CDPH C. auris for Patients and their Families](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Candida-auris_InfoForPatientsAndFamilies.aspx)

(www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Candida-auris_InfoForPatientsAndFamilies.aspx)

¹⁷ [CDC IPC for C. auris](http://www.cdc.gov/fungal/candida-auris/candida-auris-infection-control.html) (www.cdc.gov/fungal/candida-auris/candida-auris-infection-control.html)