

Candida auris

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| Signs and Symptoms | <i>Candida auris</i> has no definitive clinical symptoms. Common infections caused by <i>C. auris</i> include wound, urine, and blood stream. | |
| Incubation | <i>C. auris</i> can colonize the skin and other body sites without symptoms and may cause subsequent infection in a subset of cases, therefore the incubation period is not well defined. | |
| Case classification | Clinical criteria: None | |
| | Confirmed clinical case: Person with confirmatory laboratory evidence from clinical specimen collected for diagnosing or treating disease. | Confirmed colonization/screening case: Person with confirmatory laboratory evidence from a swab collected for screening for <i>C. auris</i> colonization. |
| | <i>Candida</i> species that undergo testing at a PHL and are not confirmed as <i>C. auris</i> should be classified as “ruled out.” | |
| Differential diagnosis | <i>C. auris</i> can be mistakenly identified as other <i>Candida</i> species by some traditional phenotypic methods, see section 4. | |
| Treatment | Consultation with an infectious disease specialist is recommended when caring for patients with <i>C. auris</i> infection. CDC does not recommend decolonization or treatment of <i>C. auris</i> identified from non-invasive sites (such as respiratory tract, urine, and skin) when there is no evidence of infection. See Clinical Treatment of C. auris Infections . | |
| Duration | <i>C. auris</i> can colonize human skin and persist for long periods. | |
| Exposure | <ul style="list-style-type: none"> • Healthcare, particularly high acuity healthcare settings and indwelling medical devices. • Direct contact with colonized or infected skin or body fluids. • Indirect contact <ul style="list-style-type: none"> ○ <i>C. auris</i> can persist on surfaces for long periods, including shared/mobile medical equipment and other contaminated surfaces in the healthcare environment. ○ Healthcare workers’ hands. • Healthcare where <i>C. auris</i> is more common. | |
| Laboratory testing | <p>PHL performs</p> <ul style="list-style-type: none"> • Species identification for <i>C. auris</i> and other non-albicans <i>Candida</i> isolates. Pre-approval not required. • Antifungal susceptibility testing on <i>C. auris</i> clinical isolates. • <i>C. auris</i> colonization screening. Pre-approval required. • All isolates and samples must be submitted using the Electronic Test Ordering and Results (ETOR) system. • See ARLN Lab Test Menu Washington State Department of Health for instructions on specimen collection and submission. | |
| Public health actions | <p>Local health jurisdictions: notifiable to Washington State Department of Health (DOH) Office of Communicable Disease Epidemiology (CDE) within 3 days of receipt of case or lab report.</p> <p><i>Infection Control:</i></p> <ul style="list-style-type: none"> • Cases in hospitals should be placed on Contact Precautions and in nursing homes, at a minimum, on Enhanced Barrier Precautions. • Reinforce hand hygiene, proper PPE use, and environmental cleaning with effective disinfectant (see EPA list P or List K). • See What to do if you identify a targeted multidrug resistant organism in your facility, and Appendix I in this document. | |

Candida auris

1. DISEASE REPORTING

A. Purpose of Reporting and Surveillance

1. To increase awareness of *Candida auris* by public health and healthcare professionals.
2. To promote appropriate infection control interventions to prevent transmission of *Candida auris* between patients in healthcare facilities and between healthcare facilities.
3. To rapidly identify *Candida auris* and prevent or eliminate sources or sites of ongoing transmission within Washington.
4. To characterize the epidemiology of *Candida auris* infections in Washington to guide response.

B. Required Reporting

- Health care providers and Health care facilities: notifiable to the **local health jurisdiction** within 24 hours.
- 1. Laboratories: Positive lab results by any method are notifiable to **local health jurisdiction** within 24 hours;
 - Samples that are positive for *C. auris* from culture independent testing (CIDT) including, but not limited to, nucleic acid detection (NAT or NAAT) or whole genome sequencing, should be reported but not submitted to PHL.
 - Isolate submission required within 2 business days. All isolates and samples must be submitted using the Electronic Test Ordering and Results (ETOR) system.
 - See [ARLN Lab Test Menu | Washington State Department of Health](#) for instructions on specimen collection and submission.

Reporting and submission of other non-*albicans* *Candida* species is encouraged but not required. See Section 4A for details about laboratory testing.

3. Local health jurisdictions: notifiable to Washington State Department of Health (DOH) Office of Communicable Disease Epidemiology (CDE) within 7 days of case investigation completion or summary of information required within 21 days.

C. Local Health Jurisdiction (LHJ) Investigation Responsibilities

1. LHJs should investigate and report all *C. auris* cases to identify the source and whether transmission has occurred. Enter the case into the Washington Disease Reporting System (WDRS) under Highly Antibiotic Resistant Organism (HARO).
2. Any outbreak or suspected outbreak of *Candida* species in a healthcare facility is immediately reportable to LHJs and should be investigated.
3. LHJs should ensure proper infection prevention precautions are in place in the healthcare facility where the case receives care. See Section 5B for detailed recommendations about infection prevention in healthcare settings.

2. THE DISEASE AND ITS EPIDEMIOLOGY

A. Etiologic Agent

Candida auris is an emerging, often multidrug resistant, yeast first identified in Japan in 2009. It can cause invasive healthcare associated infections with high mortality. Whole genome sequencing suggests that several different clades of *C. auris* emerged simultaneously in different parts of the world.

B. Description of Illness

There are no definitive symptoms of *C. auris* infection. *C. auris* can cause a range of infections from superficial (skin) infections to more severe, life-threatening infections, such as bloodstream. Healthy people typically do not get *C. auris* infection. Patients who require high acuity medical care, including patients with invasive medical devices like breathing or feeding tubes or catheters, are most commonly infected. Mortality associated with *C. auris* infections is estimated to be 30-60%, however, most cases have other serious comorbidities which may cause or contribute to death.

C. auris may also colonize the skin and other body sites. Colonized patients are at risk for invasive infection from their own endogenous colonization when indwelling devices are present. Recent national surveillance suggests that approximately 7% of colonized individuals subsequently develop an invasive infection.

C. *Candida auris* in Washington State

C. auris was first reported in Washington in 2023 and since January 2024 has been detected in patients in several healthcare facilities and counties. The DOH [MDRO Dashboard](#) provides a summary of *C. auris* surveillance in Washington. As in many US states, *C. auris* may continue to spread among patients in healthcare. *C. auris* infection tends to occur in highly vulnerable patients in high acuity long term care facilities. Facilities can minimize transmission by strengthening infection prevention programs and auditing practices.

D. Reservoirs

C. auris has been detected in the natural environment. It can tolerate hypersaline environments and higher temperatures than many other *Candida* species. It can colonize human skin and persist for long periods, survive on inanimate surfaces for weeks, and withstand commonly used healthcare disinfectants such as quaternary ammonium compounds.

E. Modes of Transmission

Compared to other pathogenic fungi, *C. auris* has an unusual ability to spread between patients in healthcare facilities. Transmission of *C. auris* may occur through direct contact with bodily fluids, skin contact, and contamination from shed skin cells. In healthcare settings, *C. auris* can be spread via the hands of healthcare workers and inanimate objects including shared/mobile medical equipment, such as thermometers, and frequently touched surfaces such as bed rails and computer keyboards.

F. Incubation Period

Because *C. auris* can colonize the skin and other body sites without causing infection, the

incubation period is not well defined.

G. Period of Communicability

People can potentially transmit *C. auris* as long as the organisms are present in bodily fluids or on skin. Patients can be intermittently positive on serial surveillance cultures and may be colonized for long periods of time.

H. Treatment

For infections, use antifungal susceptibility testing (AFST) results to guide antifungal therapy and consider consulting an infectious disease specialist for treatment recommendations. CDC does not recommend treatment of *C. auris* identified from noninvasive sites (such as respiratory tract, urine, and skin) when there is no evidence of infection. See [Clinical Treatment of C. auris Infections](#). PHL performs AFST on all *C. auris* isolates from clinical infections.

3. CASE AND CONTACT DEFINITIONS

A. Clinical Criteria for Diagnosis of Cases

There are no specific clinical criteria for diagnosis.

B. Laboratory Criteria for Diagnosis of Cases

C. auris: Detection of *C. auris* from any body site using either culture or a culture independent diagnostic test (CIDT) (e.g., Polymerase Chain Reaction [PCR]).

C. Case Classification

Confirmed clinical case: Person with confirmatory laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care. This includes specimens from sites reflecting invasive infection (e.g., blood, cerebrospinal fluid) and specimens from non-invasive sites such as wounds, urine, and the respiratory tract.

Confirmed colonization/screening case: Person with confirmatory laboratory evidence from a swab collected for the purpose of screening for *C. auris* colonization regardless of site swabbed. Typical colonization/screening specimen sites are skin (e.g., axilla, groin), nares, rectum, or other external body sites. Swabs from wounds or draining ear are considered clinical.

Submitted *Candida auris* isolates that are not confirmed at a PHL should be classified as “ruled out.”

D. Criteria to distinguish a new case

A patient who is colonized or infected with *C. auris* based on culture or PCR should be considered colonized indefinitely. The following criteria should be used for surveillance of *C. auris*.

- A person with a clinical case should not be counted as a colonization/screening case thereafter (e.g., patient with known infection who later has colonization of skin is not counted as more than one case).

- A person with a colonization/screening case can be later categorized as a clinical case (e.g., patient with positive screening swab who later develops bloodstream infection would be counted once in both categories).

4. DIAGNOSIS AND LABORATORY SERVICES

A. Diagnosis

C. auris is diagnosed by species identification from an isolate or by PCR from a specimen.

C. auris can be misidentified as a number of different fungi when using traditional phenotypic methods. Some yeast identification assays, including VITEK 2 YST, API 20C, BD Phoenix yeast identification system, and MicroScan, can misidentify *Candida auris* as other *Candida* species such as *Candida haemulonii*, *Candida duobushaemulonii*, *Rhodotorula glutinis*, *Candida intermedia*, *Candida sake*, *Saccharomyces kluyveri*, *Candida catenulate*, *Candida famata*, *Candida guilliermondii*, *Candida lusitanae*, and *Candida parapsilosis*. Laboratories should know the limitations of their yeast identification system by reviewing [Identification of Candida auris](#) to avoid mistakenly identifying *C. auris* as another fungal species. Labs should consider reporting and submitting these isolates to PHL for confirmatory testing. Labs may serve as *Candida* sentinel labs and submit to PHL all *Candida* species except *albicans*. For information about sentinel labs, please contact the Washington Antibiotic Resistance Lab Network at ARLN@doh.wa.gov.

B. Services Available at the Washington State Public Health Laboratories (PHL)

At PHL, *C. auris* and non-*albicans Candida* isolates submitted for species identification undergo MALDI-TOF and antifungal susceptibility testing (AFST) by broth microdilution following the most current CLSI interpretations. AFST is performed on *C. auris* isolates from clinical infections. Pre-approval for isolate submission is not required.

Specimens submitted from patients for *C. auris* colonization screening undergo qPCR performed to confirm *C. auris*. Culture-based testing is performed on qPCR positive specimens and those with indeterminate results. PHL provides appropriate screening supplies and instructions for collection. **Pre-approval is required for *C. auris* screening.**

When submitting *C. auris* isolates or other samples to PHL for *C. auris* testing, follow submission instructions on the [ARLN Lab Test Menu](#).

5. CASE INVESTIGATION

Conduct a public health investigation for all confirmed *C. auris* cases. Any person suspected or known to have *C. auris* in a hospital should be placed on Contact Precautions and in nursing homes, at a minimum, on Enhanced Barrier Precautions.

Review clinical history, medical records, and laboratory records and interview the case or others who may be able to provide pertinent information, as needed, to complete the investigation. Complete a WDRS case report under “Highly Antibiotic Resistant Organism” (HARO) and the HARO wizard question package including the “Clinical and Laboratory” tab.

The guidance, [What to do if you identify a targeted multidrug resistant organism in your facility](#), provides response actions for healthcare facility infection preventionists to prevent transmission to others and to quickly collect information regarding potential exposure to other patients. DOH HAI MDRO Program staff are available to assist and can be reached at MDRO-AR@doh.wa.gov.

A. Case Management

See section 2.H. for treatment guidance. Decolonization is not recommended. Communicate *C. auris* status to healthcare providers in outpatient settings and upon return to a healthcare facility using an [inter-facility infection control transfer form](#), or a similar method, to avoid spread.

B. Case Follow Up

Confirmed cases are entered in the DOH Antibiotic Resistance Information Exchange (ARIE) which sends alerts to public health when they interact with healthcare in the future. The ARIE captures all Washington hospital care (except the long-term acute care hospital) and approximately 75% of skilled nursing facility care. Hospitals can access alerts directly by contacting their Point Click Care customer support to request direct email alerts for flagged MDRO cases.

C. Ensure Infection Control

Because of the potential for transmission of *C. auris* to vulnerable patients in healthcare settings, caregivers should immediately place cases on appropriate transmission-based precautions. Providers should communicate infection or colonization status to patients and family members and educate them about how to prevent transmission in the home using the [Candida auris Fact Sheet](#) and should notify receiving facilities and providers when patients transfer care using an [inter-facility infection control transfer form](#).

In acute care settings such as hospitals and long-term acute care hospitals, *C. auris* positive patients should be on indefinite contact precautions, ideally in a private room. Nursing homes may consider initially placing *C. auris* positive residents on Contact Precautions and transition to [Enhanced Barrier Precautions](#) (EBP) only after educating staff, reinforcing and auditing infection prevention practices, and ensuring use of effective disinfectants (see [EPA list P or List K](#)). At a minimum, in nursing homes, EBP must be used. Adult family homes and home health providers should strictly follow standard precautions and consult with their LHM for additional recommendations. The following resources provide detailed guidance on infection prevention precautions for targeted MDROs including *C. auris*.

- [Multi-Drug Resistant Organism Quick Reference Guide and Job Aid Combined \(PDF\)](#)
- [Enhanced Barrier Precautions Quick Guide \(PDF\)](#)
- [Managing Residents with Targeted Multidrug-Resistant Organisms \(MDROs\) in Licensed Family Homes Guidance for Public Health \(PDF\)](#)
- [Managing Residents with Targeted Multidrug-Resistant Organisms \(MDROs\) in Licensed Family Homes Guidance for Facility Owners and Staff \(PDF\)](#)

- [Infection Prevention Recommendations for Carbapenemase-Producing Organisms and Candida auris in Outpatient Settings \(PDF\)](#)

D. Identify Potential Sources of Acquisition and Potentially Exposed Persons

Public health should investigate all *C. auris* cases to identify the source, evaluate for lapses in infection control in healthcare settings, and identify potential transmission to other patients. Identify current and recent past healthcare, including any hospital or long-term care admissions, surgeries, dialysis, indwelling catheters, or international healthcare or travel, focusing on the 12 months prior to diagnosis. If the index case has had many healthcare encounters and public health resources are limited, focus the investigation on the 30 days prior to diagnosis. For cases who are in or have recently been in a healthcare facility, the guidance, [What to do if you identify a targeted multidrug resistant organism in your facility](#), can guide facilities through the response and investigation.

6. CONTROLLING FURTHER SPREAD

A. Infection Control Recommendations

See section 5.C for infection prevention in healthcare facilities. Patients with *C. auris* who return to a home setting should be instructed in good hand hygiene. At home, non-professional health caregivers assisting patients with *C. auris* should perform hand hygiene frequently, especially after contact with wounds, dressings and other contaminated objects or surfaces or helping the patient with toileting and consider using gloves when anticipating contact with body fluids or blood. Professional health caregivers should follow healthcare standards for infection prevention.

When discharging a patient to home, health care providers should communicate *C. auris* status to the patient's primary care team and other healthcare providers in outpatient settings.

B. Contact Management

Response screening of epi linked patients is recommended when there is potential for spread to others in a healthcare setting. For cases who are currently in or have recently been in a healthcare facility, LHJs should share [What to do if you identify a targeted multidrug resistant organism in your facility](#) with facility staff and request that they complete the worksheet on pages 5-6 in order to identify risks for transmission and whom to screen. Screening healthcare personnel and healthy household contacts is not recommended unless implicated in transmission. **For detailed guidance on whom to target for screening, see Appendix I.**

Please note [CDC MDRO Containment](#) and [Prevention Strategy](#) classifies targeted MDROs into tiers 1, 2 and 3. DOH classifies *C. auris* as tier 2. **See Appendix I for detailed guidance on response activities for tier 2 organisms.**

Screening in response to a case can be performed free of charge at PHL. Consult with HAI Program staff at MDRO-AR@doh.wa.gov for screening instructions and proper collection materials. See section 4.B for specimen collection and submission instructions.

C. Environmental Evaluation

In healthcare settings, ensure that environmental cleaning procedures adhere to [CDC environmental disinfection guidance for *C. auris*](#). Facilities should audit environmental services practices and ensuring use of [EPA-approved disinfectants for *C. auris*](#), adherence to proper contact time, and completeness of cleaning. Ensure that reusable medical equipment is properly cleaned and disinfected between use, and there is a clear procedure for identifying whether equipment is clean and ready for use.

7. ROUTINE PREVENTION

A. Routine Prevention

Prevention of *C. auris* transmission in healthcare settings requires collaboration and coordination between public health agencies and healthcare facilities, including surveillance, rapid identification of colonized and infected patients in healthcare settings, and implementing facility-specific and regional interventions to prevent transmission.

Core measures that facilities should follow include hand hygiene, contact precautions, education of healthcare personnel, minimizing device use, cohorting staff and patients, laboratory notification, antimicrobial stewardship, and screening for *C. auris* when indicated.

B. Prevention Recommendations

All persons can adhere to good health hygiene to stop the spread of pathogens by washing hands frequently, especially

- Before preparing or eating food
- After using the bathroom or helping another person with toileting or diapers
- After blowing the nose, coughing or sneezing
- After touching used tissues or handkerchiefs
- Before and after changing wound dressings or bandages

ACKNOWLEDGEMENTS

We would like to acknowledge the Oregon Department of Human Services for developing the format and select content of this document.

UPDATES

December 2022:

For 2023 WAC revision combined provider and facility reporting requirement, updated laboratory submission (Section 1B)

Updated to include EPA List P of disinfectants effective against *C. auris*, and use of Electronic Test Order and Reporting (ETOR) for submission of screening specimens.

February 2024:

Updated to reflect detection of *C. auris* in Washington.

June 2024: CDC links updated.

August 2024:

Section 1: Revised laboratory submission section to indicate that positive samples other than isolates should not be submitted.

Section 2: Edited to align with current CDC surveillance findings and risk factors.

Section 6: Removed details infection prevention guidance and referred to CDC and DOH resources for details.

July 2025:

Sections 5 and 6 were updated to match guidance in the carbapenem resistant organism guidance.
Appendix I was added to describe how to tailor response actions depending on tier..

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Appendix I: Tier 2 and Tier 3 Targeted MDRO Containment Response

This appendix guides LHJ investigators in response actions based on whether the MDRO is classified by DOH as tier 2 or tier 3. LHJs may apply their own tier categorization.

Definitions

| Tier 2 Targeted MDROs | Tier 3 Targeted MDROs |
|--|---|
| <ul style="list-style-type: none"> • <i>Candida auris</i> • OXA-48-like, NDM, VIM, & IMP carbapenemases • Pan-resistant KPC carbapenemases • Pan-resistant OXA-23-like & OXA-235-like carbapenemases in <i>Acinetobacter</i> | <ul style="list-style-type: none"> • KPC carbapenemases (if not pan-resistant) • OXA-23-like & OXA-235-like carbapenemases in <i>Acinetobacter</i> (if not pan-resistant) |

Containment Response Actions for Tier 2 and 3 targeted MDROs

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|--|
| <p>1. Initial Response</p> <ul style="list-style-type: none"> • Promptly implement appropriate transmission-based precautions (TBP) in current facility. • If resources allow, consider offering an Infection Control Assessment and Response (ICAR) visit to facility where case is currently if none conducted in prior 6 months or if the infection preventionist is new. • If a facility has recently participated in a prior ICAR visit, assess their progress in mitigating previously identified infection control gaps. • Ensure patient and home caregivers have been notified and educated about the MDRO. • Ensure healthcare personnel who care for the patient are notified about the organism (e.g., infection control department, current healthcare staff, primary care provider). If the organism was likely present on admission, ensure the prior facility is notified. |
| <p>2. Healthcare Investigation</p> <ul style="list-style-type: none"> • For cases who are currently in, or have recently been in, a healthcare facility, LHJs should share What to do if you identify a targeted multidrug resistant organism in your facility with facility staff and request that they complete the worksheet on pages 5-6 in order to identify risks for transmission and whom to screen. • Complete the HARO wizard question package including the “Clinical and Laboratory” tab. • Conduct interview except in rare cases when a known outbreak or international healthcare is the most likely source. • Review healthcare in the prior 12 months, focusing on the most recent 30 days. <p><i>Special considerations for tier 3</i></p> <ul style="list-style-type: none"> • Limit healthcare investigation to current facility unless <ul style="list-style-type: none"> ○ Healthcare in prior 30 days was in a facility/region where organism has never/rarely been identified. ○ Healthcare in prior 30 days was in a high acuity* or long length of stay facility.** ○ Organism was present on admission and previous facility was likely place of acquisition. |

3. Contact Investigation

- Recommend response screening of other patients at facilities where index case received care in the prior 30 days, prioritizing current facility and high acuity* or long length of stay facilities.**
- Timing of screening influences whom to screen. Ideally, screening should be performed within several days of case identification.
 - Consider limiting screening to epi-linked patients (e.g., those in nearby rooms or who received similar care such as wound care, respiratory care, mobile x-ray, physical therapy) if the facility can identify epi-linked patients and screen within several days (≤ 1 week) of index case identification.
 - If screening > 1 week after index case is identified, a point prevalence survey on the unit is recommended.
- Always screen those who shared a room or bathroom, even if the index patient was on appropriate TBP.
 - For *C. auris*, consider screening patient(s) currently admitted to room/bed spaces where the index case stayed, and the patient who occupied the space just AFTER index case if still hospitalized.
 - For patients who shared these spaces and already discharged home, LHJs can notify and screen these patients, or ask the healthcare facility to flag their chart for screening if they are readmitted in the next 6 months.
 - For CPOs, screening is recommended unless the patient was either
 - Admitted for < 24 hours on a lower acuity, short stay ward, or was
 - On appropriate TBP for the entire hospitalization
 - For *C. auris*, screening is recommended in all inpatient medical settings including nursing homes except when the diagnosis was known on admission, the patient was on appropriate transmission based precautions, and an [effective disinfectant](#) was in use.

Special considerations for Tier 3

- Limited screening of epi-linked patients:
 - Always screen those who shared a room or bathroom, as for tier 2.
 - Follow tier 2 screening guidance for screening other epi linked patients if
 - The patient likely acquired the organism in the facility.
 - The case was identified in a facility or region where the organism has never or rarely been identified.
 - Admission was to a high acuity* or long length of state facility.**
 - The KPC or CRAB OXA carbapenemase is pan-resistant.
 - If there is other evidence or suspicion for transmission on the unit.
- For tier 3 organisms, outside of the criteria above, no additional screening is recommended.

*High acuity healthcare facility/setting: Intensive care, burn, cancer, or pediatric care unit, ventilator capable skilled nursing facility (vSNF), long term acute care hospital (LTACH)

**Long length of stay facility: Nursing home, vSNF, LTACH.