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Candida auris: Emerging fungal pathogen in the US

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Abstract: *Candida auris* (*C. auris*) is a human pathogen that can colonize the skin and various body sites without signs or symptoms or cause serious invasive infections with high mortality. The number of cases involving drug-resistant *C. auris* infections have increased in the US in recent years. This article provides an overview of *C. auris* and important infection prevention and control measures.

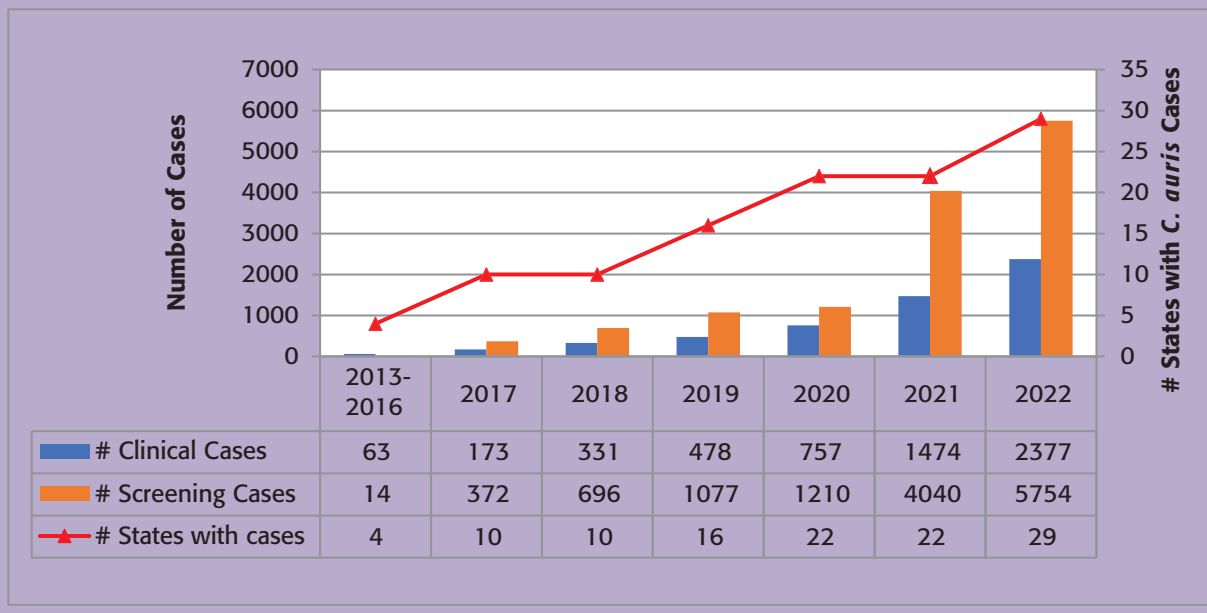
Keywords: *Candida auris*, *C. auris*, antifungal resistance, infection prevention, surveillance

Candida auris (*C. auris*) is a yeast (a type of fungus). It has been associated with an increasing number of cases and outbreaks in healthcare settings globally.^{1,2} *C. auris* has been classified as an urgent antimicrobial resistance threat due to those cases and outbreaks and some strains' resistance to multiple antifungal drugs or, for specific species, resistance to all available classes of antifungal agents.³ In March 2023, the CDC stated in a press release that cases of drug-resistant *C. auris* infections in healthcare facilities in the US increased between 2020 and 2021 and that trends indicated a continued rise in 2022.¹

C. auris was first identified in Japan from external ear discharge in 2009; its name is derived from the Latin word for ear—"auris."^{4,6} Retrospective testing of isolate collections indicates that the earliest known infection with *C. auris* occurred in South Korea in 1996.^{5,7} By 2016, *C. auris* had been reported to be associated with clinical cases and outbreaks in healthcare settings in nine countries on four continents.⁷

US microbiology records from reporting hospitals and reference labs showed that the first US case was identified in 2013 in a patient transferred from a hospital in the Middle

US *C. auris* cases by year⁹



East one week prior.⁸ As of December 2022, 2,377 clinical cases and 5,754 screening cases were recorded in that calendar year (see *US C. auris cases by year*).⁹

C. auris can cause serious infections with a 30% to 60% mortality rate.^{6,10} More than one in three patients die within 1 month due to invasive *C. auris* infection diagnosis.¹¹ This high mortality is associated with the organism's natural resistance to antifungal agents.

Four different clades, or strains, of *C. auris* have been identified based on geography and all four strains have been identified in the US, pos-

sibly associated with international travel and subsequent spread in US healthcare facilities.³ A potential fifth clade of *C. auris* has been identified, but only one case has been reported (see *C. auris clades by geographic region*).^{12,13} The clades have different characteristics and antifungal resistance profiles.⁴

C. auris has characteristics that contribute to its resistance to antifungal agents, its ability to survive in the environment and on environmental surfaces, and its ability to cause infection (pathogenicity) and evade the immune system.^{4,13-15} These characteristics, which vary somewhat by clade, include biofilm formation that contributes to resistance to or protection from antifungal agents, efflux pumps that dump harmful molecules such as antifungal agents from the cell, and genetic mutations that enable survival in hostile environments.^{14,15}

Biofilm formation assists *C. auris*' long viability on surfaces. *C. auris* can persist on plastic devices for up to 14 days and on moist surfaces for up to 7 days.⁶ Biofilm formation also

protects *C. auris* against many disinfectant products (see *Biofilms*).

Morbidity and mortality risk factors

Individuals with the highest risk for *C. auris*-associated morbidity and mortality are those with underlying comorbidities or receiving complex medical care (see *Morbidity and mortality risk factors*). Outbreaks of *C. auris* have been reported in high-acuity healthcare settings providing complex care, such as ICUs, acute inpatient rehabilitation settings, and post-acute skilled care nursing facilities with mechanical ventilator units.^{4,5,11}

Immunocompetent individuals, including healthy healthcare workers and household members of persons with *C. auris*, have a low risk for *C. auris* infection.^{1,5,16} However, they may have transient colonization on their hands or in their nose.

Clinical manifestations

There are no clinical manifestations unique to *C. auris*. Patients can be either colonized without

C. auris clades by geographic region^{4,12,13}

South Asian	Clade I
East Asian	Clade II
African	Clade III
South American	Clade IV
Iran	Clade V

Clades I through IV have been identified in the US. Clade V only has one known isolate.

any signs or symptoms (asymptomatic colonization) or infected (clinical case) and have signs and symptoms consistent with the body site of infection (see *Colonization vs. infection with C. auris*).^{5,16,17} Clinical presentation may range from mild signs and symptoms to sepsis or organ failure with invasive disease. Types of infection include bloodstream, wound infection, skin abscesses, and external ear canal infection.^{5,16,18} About half of the US clinical cases were bloodstream infections.¹⁸ About half of the other infections were in noninvasive body sites without spreading to adjacent tissue. *C. auris* has been detected in specimens from respiratory and urinary tracts and biliary fluid, but it is unclear if positive cultures from these sites represent colonization or infection.^{5,7}

Diagnosis

C. auris infection is usually diagnosed by cultures of blood or other body fluids.⁵

The lab should identify, to the species level, all yeast isolates from normally sterile body sites, such as

the bloodstream or cerebral spinal fluid.¹⁸ While many clinical labs do not routinely determine species of yeast from nonsterile areas, species-level identification can be beneficial and should be considered when clinically indicated in the care of a patient, when *C. auris* has been detected in a facility or unit, or when the patient has had an overnight stay in healthcare facility outside the US.¹⁸

Identification parameters such as algorithms specific for *C. auris* species may not be included or up to date in some automated lab diagnostic equipment. Standard or traditional phenotypic methods for yeast identification, such as VITEK 2 YST, API 20C, BD Phoenix yeast identification system, and Microscan without parameters specific to *C. auris* may incorrectly identify *C. auris* as another organism.¹⁹ Diagnostic testing based on matrix-assisted laser desorption/ionization time-of-flight (MALDI-TOF) can differentiate *C. auris* from other *Candida* species.¹⁹

Communication between the lab and clinicians to alert them of a

Biofilms^{15,16}

A biofilm is a community of microcolonies of organisms irreversibly attached to a surface (that is, it cannot be easily detached). The space between the microcolonies and surrounding the aggregate comprises an extracellular polymeric substance matrix. This matrix allows the organisms to adhere or attach to surfaces and resist antimicrobial agents.

Biofilms can form on implants or invasive devices within the human body and on environmental surfaces. Examples of implants with a risk for biofilm development include tissue grafts and prosthetic devices. Invasive devices such as intravascular catheters and indwelling urinary catheters, often made of Teflon or plastic, are hydrophobic and nonpolar, thus favorable for biofilm formation.

suspected or confirmed isolate of *C. auris* is critical for the timely implementation of infection prevention and control measures.¹⁸

Whole genome sequencing of *C. auris* isolates can assist in epidemiologic tracking or linking cases in an outbreak; however, this level of testing may not be available at the facility level.²⁰ The CDC's Antimicrobial Resistance Laboratory Network²¹ can assist with more detailed organism identification and testing, but requests should be coordinated through the local, state, or territorial public health authorities.¹⁹

C. auris has been a National Notifiable pathogen—one that must be reported to local, state, or territorial public health officials due to contagiousness, severity, or frequency—in the US since 2018.^{9,17,22,23} Clinical cases with *C. auris* are reportable to public health jurisdictions in all US states and territories. *C. auris* colonization, identified from screening surveillance, is reportable in some public health jurisdictions.

Morbidity and mortality risk factors^{1,4-8,11,13,16,27}

Risk factors associated with acquiring *C. auris* and potential for morbidity and mortality

- Critical illness and admission to a high-acuity setting, such as an ICU, acute inpatient rehabilitation setting, or post-acute skilled nursing facility with a mechanical ventilator unit
- Mechanical ventilation
- Presence of invasive devices such as intravascular devices, endotracheal intubation, urinary catheters, feeding tubes, or peripheral nutrition
- Underlying comorbidities such as immunocompromise, diabetes, stroke, and inability to perform activities of daily living
- Broad-spectrum or carbapenem antibiotics or antifungal medications in the previous 90 days
- Skin colonization with *C. auris*
- Increased length of hospital stay
- Hospitalization in acute care or high-acuity post-acute care setting within the previous 6 months
- Surgical procedure

Colonization vs. infection with *C. auris*^{5,16,17,24,25}

	Colonization (screening case)	Infection (clinical case)
Definition	<i>C. auris</i> detected from a culture without accompanying signs or symptoms of infection.	<i>C. auris</i> detected from a culture with accompanying signs or symptoms of infection. Signs and symptoms are consistent with the type and site of infection but not uniquely specific to <i>C. auris</i> .
Location/body site	Skin is the primary site, especially the axillae and groins. It may be present in noninvasive body sites.	The most common sites are blood, wounds, skin abscesses, and the external ear canal.
Duration	It can persist for months, possibly indefinitely.	Infection resolves with treatment but may remain colonized.
Management	Transmission-based precautions to prevent spread for the duration of inpatient stay.	Transmission-based precautions to prevent spread continue after completion of treatment for the duration of inpatient stay.
Treatment	No treatment or decolonization.	Treat infection.

Treatment

Antifungals are generally indicated only if a clinical case is present.²⁴ Patients on antifungal treatment should be monitored for clinical improvement. Treatment includes supportive care as indicated for the severity of the clinical case. Consultation with an infectious disease specialist is highly recommended.

There are three classes of antifungal drugs for treating *C. auris* infections: Echinocandins, including anidulafungin, caspofungin, and micafungin; Triazoles, including fluconazole, voriconazole, and other second-generation triazoles; and Polyenes, such as Amphotericin B.^{24,25}

Echinocandins are usually the first agents used in the US.¹⁶ While most

C. auris strains in the US have been susceptible to echinocandins, reports indicate that echinocandin-resistant or pan-resistant strains are increasing.²⁴

In the US, about 90% of *C. auris* isolates were resistant to fluconazole, and approximately 30% were resistant to amphotericin B.²⁵ Levels of antifungal resistance can vary across isolates and there are currently no established *C. auris*-specific susceptibility breakpoints. It is ideal to have antifungal susceptibility testing of the *C. auris* isolate to guide the selection of the treatment agent;²⁵ however, susceptibility testing may require sending the organism to a reference lab.

Data about the most appropriate therapy for pan-resistant strains of *C. auris* are incomplete. If available, combination antifun-

gal treatment or investigational drugs against *C. auris* may be options for patients with pan-resistant *C. auris*.²⁴

Patients who have received antifungal agents to treat invasive infections may remain colonized for an extended period. Thus, all infection prevention and control measures should continue during and after treatment while in a healthcare setting.²⁴

Antifungal treatment is not recommended for colonization, such as when *C. auris* is isolated from body sites without evidence of infection.

Decolonization

At the time of this writing, there are no recommendations for

Transmission examples

Infection prevention issue	Detail
Product design ³⁰	Product design and material prevented complete cleaning and disinfection of reusable skin temperature probe; change to disposable probe resolved outbreak.
Practice issue—nonadherence with the manufacturer's instructions for use (IFU) and procedure ³¹	Appropriate disinfectant for environmental surface but not used per IFU, such as incorrect contact time
Practice breaches—inconsistent adherence with infection prevention and control (IPC) measures ³¹	Failure to implement contact precautions Failure to perform hand hygiene (despite available hand sanitizer) Failure to use personal protective equipment
Practice issue—overlooked items not cleaned/disinfected ³²	Infrequent or lack of disinfection of cloth lanyards on access keys for controlled drugs; removal of lanyard resolved outbreak.

decolonization when an infection is absent.²⁶ While high levels of chlorhexidine are active against *C. auris*, the effects of chlorhexidine on reducing *C. auris* skin burden or infection have not been systematically assessed. Facilities utilizing chlorhexidine bathing have also observed outbreaks and transmission.²⁶

Transmission in healthcare facilities

C. auris is spread by direct and indirect contact with colonized or infected patients or their contaminated environment, such as bedding and equipment.⁵ *C. auris* is not an airborne pathogen. The complexity of care provided to at-risk patients in high-acuity settings and *C. auris*' ability to persist on environmental surfaces present opportunities for spread. *C. auris* may be introduced into a facility via a patient transferred from another facility or returning from receiving healthcare in a country where resistant *C. auris* has been reported.⁵ There have been reports of spread associated with the sharing of patients between interfacility healthcare networks.²⁷⁻²⁹

IPC recommendations²⁶

- Adherence to hand hygiene—alcohol-based hand sanitizer (ABHS) is preferred when hands are not visibly soiled. If visibly soiled, wash with soap and water. Wearing gloves is not a substitute for hand hygiene.
- Appropriate use of transmission-based precautions based on the setting for the entire inpatient stay
- Single patient room is preferred. If limited single-patient rooms, prioritize patients at higher risk of pathogen transmission, such as those with uncontained secretions, acute diarrhea, and draining wounds. Cohorting may be an option.
- Cleaning and disinfection of the patient-care environment (daily and terminal cleaning) and reusable equipment after each use, including mobile equipment, such as glucometers and BP cuffs, with products that are EPA-registered hospital-grade disinfectants with a label claim for *C. auris* (EPA List P)
 - Follow manufacturers' IFU for all products, including disinfecting environmental surfaces.
 - Monitor adherence with IFU and cleaning and disinfection procedures.
- Reprocess medical devices following the device manufacturer's IFU. If liquid sterilant products are used, ensure they have an FDA-cleared label claim.
- Communication regarding the patient's *C. auris* status to all involved in patient care, including internal and external transfers to the facility
- Lab surveillance of clinical specimens to detect additional cases by identifying *Candida* isolates to the species level and reporting *C. auris*
- Consider targeted surveillance such as admission screening or point prevalence surveys to identify patients colonized with *C. auris*; early recognition facilitates implementation of IPC measures.
- Monitor IPC practices and provide feedback and remediation as needed.
- Report suspected and known cases of *C. auris* to local, state, and territorial public health jurisdictions and the CDC.

Failure to perform hand hygiene, use personal protective equipment and precautions, and a lack of or inadequate cleaning and

disinfection of equipment and environmental surfaces can facilitate spread (see *Transmission examples*).³⁰⁻³²

Cohorting³³

Definition

Grouping patients infected or colonized with the same infectious agent to confine their care to one area and prevent contact with susceptible patients. During outbreaks, healthcare personnel may be assigned to a cohort of patients further to limit opportunities for transmission (cohorting staff).³³

Options for cohorting patients with *C. auris* if single patient rooms are not available^{26,34}

Cohort by patient room	<ul style="list-style-type: none"> • Patients with <i>C. auris</i> together in same room, preferred. • Patients with <i>C. auris</i> and MDRO^a • Patients with <i>C. auris</i> and same MDRO, preferred. • Patients with <i>C. auris</i> and any MDRO^b
Cohort by unit, partial unit, floor	All patients colonized or infected with <i>C. auris</i> in one defined area

Considerations for cohorting staff

Designated staff to only care for patients with *C. auris* by shift

Dedicated staff to only care for patients with *C. auris*, such as a 1:1 ratio

^aMDRO = Multidrug-resistant organism, for example, *Clostridioides difficile*

^bConsult with local, state, and territorial health jurisdictions for additional guidance regarding cohorting options.

Transmission-based precautions by healthcare setting^{26,34}

	Contact precautions	Enhanced barrier precautions
Where (facility type)?	<ul style="list-style-type: none"> Acute care hospitals Long-term acute care hospitals 	Nursing facilities ^a *
Who (target population)?	Every patient colonized or infected with <i>C. auris</i> or other multidrug-resistant organism (MDRO)	<ul style="list-style-type: none"> Every patient requiring high-contact activities^b, the presence of an indwelling device, or a wound regardless of MDRO status Infection or colonization with an MDRO when Contact Precautions^c do not otherwise apply
What to use?	Gowns and gloves	Gowns and gloves
When to use?	Every room entry	For high-contact activities in any resident
How long?	<i>C. auris</i> —for duration of inpatient stay	Duration of resident stay
Patient/resident activity?	Restricted to room except for medically recommended care	No room restriction; the resident may participate in group activities.
Dedicated equipment?	Yes	Yes
Cohorting?	Single room preferable; cohorting is an option	<i>C. auris</i> is an MDRO. Cohorting is an option. Conduct a risk assessment for patient placement.

Note: Standard Precautions are basic precautions for patient care in all healthcare settings.

^aCheck with public health authorities to see if Enhanced Barrier Precautions are an option for your facility.

^bHigh-contact resident care activities (regardless of MDRO status)³⁴

- Dressing
- Bathing/showering
- Transferring
- Providing hygiene
- Changing linens
- Changing briefs or assisting with toileting
- Device care or use: central venous access device, urinary catheter, feeding tube, tracheostomy, or mechanical ventilator
- Wound care: any skin opening requiring a dressing

^cContact precautions for nursing facilities* apply in these situations³⁴

- Infection or colonization with MDRO
 - Acute diarrhea, draining wounds, or other secretions or excretions that cannot be covered or contained
 - In consultation with public health authorities during suspected or confirmed MDRO outbreaks
 - When otherwise directed by public health
- Infections or conditions for which Contact Precautions are recommended, such as *C. difficile* and norovirus³³

*long-term care such as nursing homes and skilled nursing facilities

Infection prevention and control (IPC)

Strict adherence to IPC measures by everyone is necessary to prevent the transmission of *C. auris* (see *IPC recommendations*).²⁶

Facility plan

Healthcare facilities should develop a multidisciplinary plan for the IPC management of *C. auris* at unit and facility levels similar to or as part of the plan for other multidrug-resistant organisms.¹¹

All healthcare personnel should be educated about *C. auris* and the appropriate IPC measures and re-educated as needed. Ensure that proper and adequate supplies are available to perform IPC activities.

Patient placement

A single patient room, if available, is the preferred patient placement in all facilities. If single-patient rooms are not available, placing patients with *C. auris* together (cohorting) may be

considered.^{26,33,34} Patients may be cohorted to separate those with *C. auris* from those without, such as by room or room clusters (parts of a unit, whole unit). Healthcare personnel may be designated to provide care by patient cohort groups (see *Cohorting*).

The advantages and disadvantages of cohorting should be considered, including staffing and difficulty moving patients.^{26,27,34}

Patients colonized or infected with *C. auris* may be discharged to

home or transferred to a different care level based on clinical criteria and the receiving facility's ability to provide care.²⁶ The receiving facility or unit should be notified of the patient's *C. auris* infection or colonization status, including transmission-based precautions.³⁵

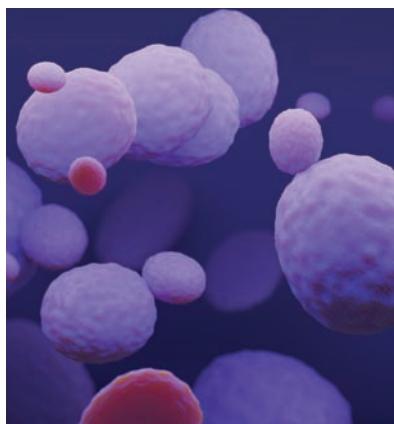
Transmission-based precautions

Standard precautions, such as wearing a mask or other facial covering to protect against splashes on the face, and transmission-based precautions for *C. auris* should be maintained for the inpatient stay due to the persistence of *C. auris* colonization for months and perhaps indefinitely (see *Transmission-based precautions by healthcare setting*).²⁶

Communicate the *C. auris* status to all who provide care for or have contact with the patient.^{34,36} For example, precautions and information can be relayed through signage at the door to the patient's room, electronic health record alerts, and handoffs between healthcare personnel and/or departments and other facilities.

Cleaning and disinfection

Environmental surfaces and patient-care equipment are the major reservoirs for *C. auris* in healthcare settings.⁶ Meticulous cleaning and disinfection is essential



Healthcare facilities should develop a multidisciplinary plan for the IPC management of *C. auris* at unit and facility levels.

to prevent transmission of *C. auris* via shared environmental surfaces (see *Cleaning and disinfection*).

The care environment (patient room and unit) should be cleaned at least daily and terminally.²⁶ Reusable and mobile shared equipment should be cleaned after each use. Dedicated equipment should be assigned to patients with *C. auris* when possible.

EPA-registered hospital-grade disinfectants approved specifically for *C. auris*; EPA List P should be used.³⁷ There is increasing evidence that some quaternary ammonia compounds are ineffective against *C. auris* despite being fungicidal against related *Candida* species.²⁶

When using cleaning and disinfectant products, the manufacturer's IFU including contact time should be followed.

Healthcare personnel should be educated on which items they are responsible for cleaning and how to do it properly. Adherence and effectiveness with feedback and remediation, as indicated, should be monitored through observation audits of cleaning and disinfection practices, checklists, or proxy methods like fluorescent markers.

Culturing environmental surfaces (environmental sampling) for *C. auris* to assess cleaning and disinfection processes is not recommended due to time and fiscal constraints and cannot be used to confirm the absence of *C. auris*. If considering environmental sampling, the local, state, or territorial public health department should be consulted.²⁶

"No touch" devices, such as germicidal UV irradiation and vaporized hydrogen peroxide, may be used as a supplement after standard cleaning and disinfection methods.²⁶ Items and surfaces must be cleaned and disinfected per IFU before initiating these methods so that the UV irradiation or vapor can contact all surfaces and complete disinfection. Data on parameters for and effectiveness of such devices are limited.

If processing medical devices using sterilization or high-level disinfection, the IFU for devices and the method of sterilization or high-level disinfection should be followed. One should note that all liquid sterilants have an FDA-cleared label claim for the product.²⁶

Cleaning and disinfection

- Focus on high-touch surfaces, such as bed rails of infected patients. These have been reported to be highly contaminated.²⁹
- Include all shared reusable equipment, especially mobile devices such as glucometers and BP cuffs. Disinfect after each use, label as clean, and store separately from soiled equipment.²⁶
- Consider dedicating equipment to a patient with *C. auris*.
- Do not overlook commonly handled moveable objects that are infrequently cleaned and may contribute to the spread.³²
- Monitor cleaning and disinfection processes and practices and provide the results as feedback to healthcare personnel.
 - Correct product—complies with manufacturers' IFU and is US Environmental Protection Agency (EPA) registered hospital-grade disinfectant with a label claim for *C. auris*.
 - Correct procedure as per IFU and correctly completed method for the item or surface.

Monitoring

Preventing the spread of *C. auris* depends on adherence to IPC measures. Monitoring can be accomplished via regular audits of observed versus desired practices. Suboptimal IPC practices should be identified and remediated.²⁶

Antimicrobial stewardship

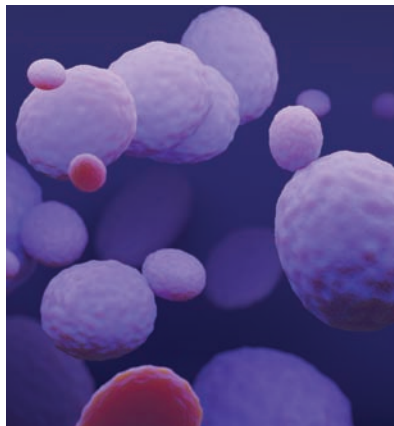
Ongoing antimicrobial stewardship is important since skin and intestinal microbiome disruption by antibiotics and antifungals may predispose a patient to *C. auris* colonization, thus increasing the risk of infection.²⁷ *C. auris* resistance can also be affected by the frequency of antifungal use within a facility.³⁸ Knowledge of a healthcare facility's antimicrobial utilization may be helpful in considering treatment options for patients with *C. auris*.

Surveillance and screening

Surveillance can provide early identification or recognition of patients with *C. auris*. Local, state, or territorial public health jurisdictions should be consulted before surveillance begins for advice and assistance as they may have resources unavailable in individual institutions.³⁹

Surveillance screening for *C. auris* colonization is accomplished via skin swabs. Screening cultures for colonization involves obtaining a swab of the skin from both axillae and both groins with a single swab.⁴⁰ Surveillance can be targeted to specific populations or broadly such as point prevalence surveys.

Screening for *C. auris* at admission is an example of targeted surveillance and may be targeted toward patients from a facility with *C. auris* cases or a patient who had an overnight stay in a healthcare facility outside the US within the previous year.³⁹



Knowledge of a healthcare facility's antimicrobial utilization may be helpful in considering treatment options for patients with *C. auris*.

Point prevalence surveys (PPS) may be appropriate when there is ongoing spread in a facility.³⁹ PPS utilize periodic screening with the combination axillae/groins skin swab for *C. auris* of all patients on units with known *C. auris* cases or the whole facility during an outbreak. PPS can identify new cases of *C. auris* and IPC measures such as precautions can be initiated quickly and interrupt spread. Public health jurisdictions can be consulted regarding such surveillance activities.

Once a patient has been identified as colonized with *C. auris*, they should not be repeatedly screened, especially if they continue to require complex medical care.²⁶ Colonization can persist for an extended time and repeat colonization swabs can alternate between detecting and not detecting *C. auris*.^{26,29} Decolonization is not recommended.

Immunocompetent healthcare workers and healthy household members of persons with *C. auris* do not require screening for *C. auris*.¹⁶

Nursing considerations

In addition to strict adherence to IPC measures, patient care should be provided as indicated by the clinical disease process and the patient's clinical status. Invasive devices should be removed as soon as they are no longer needed. For surgical procedures, meticulous skin preparation with alcohol-based products, unless contraindicated, should be used in the OR.²⁶

All healthcare personnel, including ancillary departments, who care for the patient should know about precautions to prevent transmission. If a patient is suspected or known to be *C. auris*-positive, notify the lab about specimens sent for *C. auris* identification. Likewise, the lab should notify the clinical team when *C. auris* is identified in the lab. Monitor adherence with IPC measures, reeducate, and remediate improper practices as indicated.

Patient/Family education

Patients and their families or caregivers should be educated about *C. auris* and how to prevent its spread. Visitors should comply with infection control measures while the patient is in an inpatient setting, including hand hygiene and transmission-based precautions.

C. auris colonization and surveillance cultures for *C. auris* should be explained to patients.

Discuss with the patient and family/support person the antifungal agents being used to treat *C. auris* infection. At discharge from the healthcare setting, educate the patient and family or support person on how to take the antifungal medication, potential adverse

reactions, and when to contact their care provider.

The risk of *C. auris* infection for healthy household members, even those with extensive contact with the patient at home, is low.^{5,26} Family and household members do not need to be screened or treated for *C. auris*.^{5,16} Nurses should instruct household members who require admission to a healthcare facility to advise the clinicians that they live with someone colonized with *C. auris* so that colonization testing can be considered.^{5,26}

Patients do not need to isolate at home. The patient and household members should practice good hand hygiene through the use of ABHS or frequent handwashing with soap and water. Household members could consider wearing disposable gloves while providing high-touch care to a person with *C. auris*, such as changing the dressing on an infected wound and performing hand hygiene after glove removal.²⁶

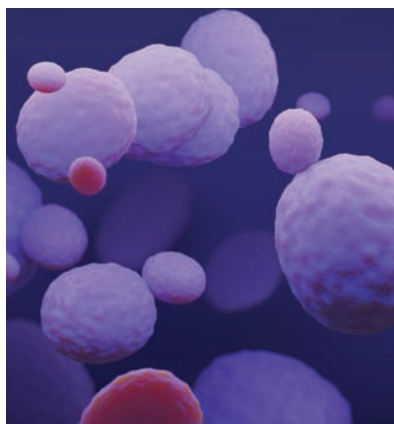
Conclusion

C. auris is an emerging pathogen and an urgent public health threat. It has been associated with an increased risk of infection for patients with underlying comorbidities and is the cause of healthcare-associated outbreaks. It has been identified in healthcare settings globally with an increasing number of cases in the US since 2016.

Nurses play a pivotal role in preventing the spread of *C. auris*, particularly in coordinating IPC activities, communicating with other clinicians and ancillary personnel caring for the patient, and providing direct patient care and education. ■

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