



## Candida auris: infection control in community care settings

### Introduction

*Candida auris* is a yeast species first isolated from the ear canal of a patient in Japan in 2009. Since then *C. auris* has been associated with a variety of clinical presentations including ear infections, wound infections, and bloodstream infections, in countries around the world. It is commonly resistant to the first-line antifungal agent fluconazole, and can develop resistance to other classes of antifungal agents.

Colonisation of patients has been reported from affected hospitals around England. Clinical experience to date suggests that colonisation is difficult to eradicate and tends to persist, making infection prevention and control strategies particularly important, including after discharge from hospital. This guidance is aimed primarily at nursing homes but can be adapted for residential homes and other community care settings.

As *C. auris* has only recently been identified as a pathogen in the United Kingdom, evidence for the most effective control measures is still emerging. This document therefore draws heavily on similar guidance for other multi-resistant organisms, including carbapenemase-producing *Enterobacteriaceae* (CPE) and meticillin-resistant *Staphylococcus aureus* (MRSA).

### Infection control considerations

There is no reason for non-acute or community care settings to refuse admission or readmission of service users on the grounds that they are or have been colonised or infected with *C. auris*.

It is recommended that service users are accommodated in a single room with en-suite facilities. If a single room is not possible, the individual should not share a room or bay with an immunocompromised individual.

Communal activities should continue as normal for the service user if standard precautions and effective environmental hygiene can be maintained. If the service user is not continent, please seek further advice from your local infection control advisor or microbiologist.

It is important that cleaning of the environment is thorough and that local procedures are followed. A chlorine-based agent is currently recommended for cleaning the environment at 1000 ppm of available chlorine. Particular attention should be given to surfaces that have had contact with service user or staff hands such as bed rails and door handles, and bathrooms.

Avoid having extra equipment or large quantities of single use items in the individual's room; it will hinder effective cleaning and need to be decontaminated or discarded when the room is vacated.

Ensure that standard infection control precautions (see appendix) are maintained at all times by service users and staff, and that all employees including cleaning and domestic staff are trained in hand hygiene and the correct use of personal protective equipment (PPE).

Staff should take particular care when undertaking dressings, and managing or changing urinary catheters and other devices. A discharging wound should be secured with an impermeable dressing and any environmental contamination, from the wound or other body fluids, cleaned immediately according to your Infection Prevention and Control policy. Waste should be discarded into a clinical waste bag.

Cleaning standards should be monitored and audited on a regular basis to ensure standards are maintained.

## Communications

There is no reason for non-acute or community care settings to refuse admission or readmission of service users on the grounds that they are or have been colonised or infected with *C. auris*.

It is however important that all care settings are aware of the individual's status so they can take necessary control measures. In particular, ensure that any hospitals are informed in advance of outpatient appointments or inpatient admissions.

Additionally, it is important that individuals and their families understand both their diagnosis and the importance of infection control measures such as hand washing.

## Further advice

Please seek further advice from your usual infection control advisor (e.g. community or CCG Infection Prevention and Control team/nurse, or local microbiologist). Alternatively, you can get further advice and signposting through your local PHE Centre: <https://www.gov.uk/health-protection-team>.

## Resources and further reading

NICE Guideline CG139 [Prevention and control of healthcare-associated infections in primary and community care](#). NICE 2012 updated 2017

[Toolkit for managing carbapenemase-producing Enterobacteriaceae in non-acute and community settings](#). PHE 2015

[Guidance for the laboratory investigation, management and infection prevention and control of cases of \*Candida auris\*](#). PHE August 2017

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## Appendix:

Summary of key points from the 'NICE standard principles [standard precautions] of prevention and control of infections in primary and community care'

*Please note: This section provides a summary only. For education and training purposes, organisations should refer to the [full NICE guidance available online](#).*

### Hand decontamination

Educate patients and carers about:

- the benefits of effective hand decontamination
- the correct techniques and timing of hand decontamination
- when it is appropriate to use liquid soap and water or alcohol hand rub
- the availability of hand decontamination facilities
- their role in maintaining standards of healthcare workers' hand decontamination

Hands must be immediately decontaminated in all of the following circumstances:

- before and after every episode of direct patient contact or care, including aseptic procedures
- after any exposure to body fluids
- after any other activity or contact with a patient's surroundings that could potentially result in hands becoming contaminated
- after removal of gloves

Decontaminate hands by:

- using **liquid soap and water** when hands are visibly soiled or potentially contaminated with body fluids
- using **an alcohol hand rub** (conforming to BS EN 1500), when not visibly soiled or contaminated with body fluids

To ensure that hands can be decontaminated carers should ensure that they are:

- bare below the elbow when delivering direct patient care including:
  - not wearing false nails or nail polish
  - not wearing a wrist-watch or hand jewellery, including stoned rings
  - wedding bands are permitted
- wearing short-sleeved garments (or being able to roll up sleeves)
- making sure that fingernails are short and clean
- covering cuts and abrasions with waterproof dressings

An effective hand washing technique involves three stages: washing, rinsing, and drying.

## Use of personal protective equipment (PPE)

Selection of protective equipment depends on risk of:

- transmission of microorganisms to the patient,
- contamination of the healthcare worker's clothing and skin by patients' blood or body fluids.

### Gloves

Gloves used for direct patient care must conform to current EU legislation (CE marked as medical gloves for single use) and should be appropriate for the task. Do not use polythene gloves for clinical interventions. Gloves must be worn:

- for invasive procedures, and contact with sterile sites and non-intact skin or mucous membranes
- for all activities carrying a risk of exposure to blood or body fluids, or to sharp or contaminated instruments
- as single-use items

Gloves must be put on immediately before an episode of patient contact or treatment and removed as soon as the activity is completed. Gloves must be changed between caring for different patients, and between different care or treatment activities for the same patient.

### Aprons

- wear a single use plastic apron if there is a risk that clothing may be exposed to blood or body fluids,
- use aprons as single-use items for one procedure or one episode of direct patient care, and ensure they are disposed of correctly.