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UK Health Security Agency

Guidance

Summary of recommendations

Updated 19 March 2025

Contents

This publication is available at https://www.gov.uk/government/publications/candida-auris-laboratory-investigation-management-and-infection-prevention-and-control/summary-of-recommendations

Introduction

This companion document summarises the recommendations outlined in the main Candidozyma auris (C. auris) guidance (https://www.gov.uk/government/publications/candida-auris-laboratory-investigation-management-and-infection-prevention-and-control). It is designed to support the adoption and implementation of the main guidance within acute healthcare settings. This document should be used in conjunction with the main guidance, which provides the supporting evidence and rationale underpinning these recommendations.

The recommendations were developed by a multidisciplinary group and represent examples of good practice, based on expert opinion informed by the available evidence. Although the working group identified these recommendations as best practice, no cost-effectiveness studies were available to directly inform implementation costs. Recommendations relating to laboratory procedures and screening practices require local risk assessment and contextual considerations prior to adoption.

Investigation in clinical laboratories

As a minimum, perform species-level identification of Candida spp:

- when isolated from:
  - invasive sites
  - critical care units
  - augmented care settings[footnote 1] and other ward settings, as determined by local risk assessment [footnote 2] and screening policy
- when treatment is being considered to guide empirical management

Conduct an organisational risk assessment to identify gaps in laboratory surveillance that may lead to reservoirs of C. auris going undetected.

In an outbreak setting, consider identifying Candida isolates to the species level from hospitalised inpatients and high-risk outpatients as determined by the incident management team, if not already routine.

Culture-based identification

Perform full identification of suspected isolates using MALDI-TOF MS or a robust molecular method to confirm the identification of C. auris.

Consider C. auris isolate retention of between 3 to 6 months, depending on local resource.

Biochemical identification

Do not use biochemical methods to identify C. auris.

MALDI-TOF MS identification

Ensure the appropriate version of spectral library is installed to support accurate identification via MALDI-TOF MS.

Antifungal susceptibility testing

Perform antifungal susceptibility testing on invasive isolates and isolates from patients requiring treatment. This includes repeat isolates from patients with suspected treatment failure.

Submit C. auris isolates exhibiting resistance to non-azole antifungal agents to a reference laboratory for confirmation and further characterisation.

Clade typing and whole genome sequencing (WGS)

To support outbreak investigation, the following isolates should be referred for WGS:

- sentinel isolates from new centres
- the first 3 to 4 isolates of any outbreak, occurring within a three-month period of each other
- isolates from protracted outbreaks, particularly after apparent control, to determine whether ongoing transmission is occurring or a novel transmission has taken place

Screening

All trusts are encouraged to develop a screening policy, informed by local risk assessment, that aligns with their specific circumstances and resources.

The risk assessment should consider:

- patient risk factors, including high-risk groups
- organisation-specific factors, such as high-risk units
- local and regional epidemiology
- laboratory capability and capacity
- IPC infrastructure
- resource availability
- outbreak preparedness.

Patient screening

Screen:

- patients who have had an overnight stay in a healthcare facility outside of the UK in the previous year
- patients coming from affected units in the UK (see the ‘Notification, reporting and information sharing’ section)

Consider screening patients on high-risk wards or units, subject to local risk assessment [footnote 2].

Swab the axilla, groin and nose, with additional sites added depending on the clinical presentation.

Develop and implement local protocols to ensure the correct collection of screening swabs.

Contact screening

Screen contacts of patients with C. auris.

Screen all patients on units or wards with ongoing transmission of cases.

Consider the need to conduct periodic patient screens as part of active surveillance on units or wards where C. auris patients are being managed.

Setting-specific and healthcare worker screening

Do not routinely screen:

- healthcare workers
- the environment

Conduct a point prevalence screen on augmented [footnote 1] or critical care settings following a novel, suspected or confirmed healthcare-associated case of C. auris.

Consider the need for an initial point prevalence screen on other ward settings as determined by the incident management team.

Management and de-isolation of contacts

Consider isolating or cohorting contacts of C. auris cases until screening results are available.

Contacts may be de-isolated after 3 consecutive negative screens at least 24 hours apart.

Inform receiving healthcare providers of C. auris contacts.

Management of patients who test positive for C. auris (colonised or infected)

Isolate or cohort patients colonised or infected with C. auris.

Use standard infection control and transmission-based precautions (contact precautions) (https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-2-transmission-based-precautions-tbps/) for direct contact with the patient or their immediate environment.

Use clinical and screening microbiology to guide cohorting decisions, including for other multidrug-resistant organisms (MDROs) as appropriate.

Consider assigning dedicated staff to care for C. auris positive patients, particularly during outbreaks.

Maintain isolation or patient cohorting until discharge for patients colonised or infected with C. auris.

Maintain isolation or patient cohorting on re-admission for patients colonised or infected with C. auris.

Treatment of the infected symptomatic patient

Do not offer treatment to patients colonised with C. auris unless there are clear signs or symptoms of clinical infection. This includes isolates identified from the respiratory tract, urine or wounds.

Use an echinocandin as the first-line empirical treatment for C. auris infection in adults, children and neonates.

Decolonisation and skin antisepsis

Do not routinely offer decolonisation therapy to C. auris patients.

Antimicrobial stewardship

Ensure appropriate antimicrobial use and stewardship to optimise service user outcomes and reduce the risk of adverse events and antimicrobial resistance (Criterion 3, Health and Social Care Act 2008 (https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance)).

Prioritise antimicrobial stewardship interventions in outbreak settings to reduce exposure to antimicrobials.

Patient communications

Provide comprehensive information on C. auris to patients, ensuring materials are accessible and available to support non-English speakers.

Clearly document and record the patient's infection status and communicate to receiving healthcare providers upon discharge or transfer.

Infection prevention and control (IPC)

Consider the recommendations outlined in this section alongside the National IPC manual for England (NIPCM) (https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/) and the Health and Social Care Act 2008: code of practice on the prevention and control of infection (https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance).

Principal IPC measures to be undertaken to prevent transmission of C. auris in healthcare settings include:

- standard infection control and transmission-based precautions (contact precautions):
  - consistent and sustained adherence to hand hygiene
  - patient placement considerations for patients colonised or infected with C. auris and their identified contacts
- effective cleaning and disinfection of patient equipment and environment with a product effective against C. auris
- safe management of linen and waste
- comprehensive screening strategies
- clinical surveillance of cases and those at risk
- laboratory surveillance (retrospective and prospective)
- communication of C. auris results to relevant teams, organisations and stakeholders
- education of healthcare workers

- education of patients, carers and visitors

Use the same IPC measures for patients colonised or infected with C. auris.

Personal protective equipment (PPE)

Wear gloves and aprons during contact with the patient or their care environment.

Wear long-sleeved gowns when high-contact patient care activities are anticipated that would result in prolonged contact between the patient and healthcare worker’s clothing or exposed skin.

Patient placement (including transfer and movement)

Place patients colonised or infected with C. auris in single rooms or cohort.

Limit patient movement within the facility to medically necessary procedures to reduce the risk of environmental contamination.

Plan and communicate visits to other departments to allow for appropriate infection prevention and control mitigations.

Management of invasive medical devices

Review the need for invasive medical devices in patients colonised or infected with C. auris to minimise the risk of invasive disease.

Safe management of the care equipment

Use single-use and disposable equipment wherever possible.

Assign dedicated, reusable non-invasive equipment to the isolation room or cohort area.

Ensure thorough cleaning and disinfection of care equipment is performed in accordance with the manufacturer’s instructions, including adherence to

recommended contact times for disinfectant solutions.

Pay particular attention to the cleaning and disinfection of reusable equipment from the bed space, including mobile equipment and equipment personally owned by healthcare workers, that may act as a reservoir for cross-transmission of C. auris.

Safe management of the care environment

Perform thorough cleaning of the care environment prior to disinfection.

Develop local cleaning and disinfection policies tailored to the level of contamination and case load, focusing on frequently touched surfaces.

Use 1,000 ppm of available chlorine, or an alternative effective disinfectant, following the recommended contact times.

Avoid using quaternary ammonium compounds due to insufficient evidence of efficacy against C. auris.

Use hydrogen peroxide vapour and ultraviolet light systems only as supplementary measures, not as replacements for full cleaning and disinfection.

Review cleaning and disinfection practices in outbreak settings to identify and implement improvements.

Perform terminal cleaning and disinfection of all surfaces in the patient's environment as detailed in the NIPCM (https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/).

Safe management of linen and waste

Refer to the NIPCM (https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/) for detailed guidance on both the management of infectious linen and the disposal of clinical waste.

Visitors

Ensure visitors perform hand hygiene before entering and on leaving the patient environment.

Laboratory surveillance (prospective and retrospective)

Conduct retrospective and prospective laboratory surveillance on confirmation or suspicion of a healthcare-associated case of C. auris.

Notification, reporting and information sharing

Submit electronic reports of all colonising and infecting C. auris episodes to UKHSA via the Second Generation Surveillance System (SGSS).

Outbreak notification

Conduct an incident investigation when a novel, suspected or confirmed healthcare-associated case of C. auris is identified and consider convening an Incident Management Team.

Declare an outbreak when 2 or more C. auris cases are identified that are linked in time and place, and:

- there is a high index of suspicion for local transmission and/or
- cases emerge without either a history of an overnight stay in a healthcare facility abroad or links to other affected hospitals or units in the UK

It is expected that affected organisations share information with relevant NHS and independent hospitals and organisations (including commissioners, providers and regulatory bodies as appropriate) within their locality and referral networks. IPC teams should share information directly with receiving hospitals when patients are being transferred from any affected units.

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1. Augmented care settings are defined in Box 2 in the UKHSA Framework of actions to contain carbapenemase-producing Enterobacterales

(https://www.gov.uk/government/publications/actions-to-contain-carbapenemase-producing-enterobacterales-cpe).

2. The risk assessment should consider: patient risk factors (including high-risk groups), organisation-specific factors (such as high-risk units), local and regional epidemiology, laboratory capability and capacity, IPC infrastructure, resource availability and outbreak preparedness.
