HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Infection Prevention and Control Department		
Document:	Multidisciplinary Policy and Procedure (MPP)		
Title:	Candida Auris Infection Prevention and Control Guidelines		
Applies To:	All MCH Department		
Preparation Date:	November 14, 2024	**Index No:**	IPC-MPP-031
Approval Date:	November 24, 2024	**Version :**	
Effective Date:	December 24, 2024	**Replacement No.:**	IPC-MPP-031 (N)
Review Date:	December 24, 2027	**No. of Pages:**	5

1. PURPOSE:

1.1 Identifying patients colonized with C. auris is a main step in containing the spread of C. Auris in healthcare facility.

1.2 To prevent and control the candida auris morbidity and mortality and to improve the prevention mesures awareness' of C. auris.

2. DEFINITONS:

2.1 Candida Auris (C. Auris) is an emerging fungus that presents a serious global health issue as it was first reported in Japan in 2009; it resistant to multiple antifungal drugs commonly used to treat Candida infections.

2.2 Colonization means the presence and growth of a microorganism on a body with growth and multiplication but without tissue invasion or cellular injury or symptoms.

2.3 Screening is a process to identify patients at risk of being colonized with antimicrobial-resistant organisms.

3. POLICY:

3.1 C. Auris infections have been found in patients of all ages, from preterm infants to the elderly

3.2 Education and training: Raising awareness and providing education to all healthcare workers is an essential to manage the c. auris infections

3.3 Ensure adequate supplies (i.e hand hygiene supplies, cleaning and disinfection agents, PPES) are available to implement and maintain appropriate infection prevention and control measures.

3.4 All patients with risk factors admitted to the critical care units should be screened to rule out Candida auris colonization based on scientific risk factors .

3.5 Standard precautions must be observed for all patient care.

4. PROCEDURE:

4.1 Risk Factors:

- 4.1.1 A prolonged hospital days.
- 4.1.2 Carbapenem-Resistant Entero Bacterales (CRE) positive patient (infected and colonized).
- 4.1.3 Current or active outbreak in the healthcare facility.
- 4.1.4 An indwelling medical device, such as central venous catheter, urinary catheter, biliary catheter or wound drain.
- 4.1.5 An impaired immune system.
- 4.1.6 Prolonged use or misuse of broad-spectrum antibiotics or antifungals drugs.
- 4.1.7 Patients in critical care areas (ICU, NICU, PICU).

4.2 Transmission:

- 4.2.1 Candida auris is transmissible whether a patient has C. Auris infection or colonization. Typically, it spreads in hospitals and other healthcare facilities through contact with

contaminated surfaces or equipment. It can also spread from person to person due to that cases infected or colonized with C. auris that shed the fungus.

4.3 Laboratory identification

4.3.1 C. auris detection requires blood tests as well as those of other bodily fluids. Laboratory diagnosis via culture is the only way to diagnose C. Auris infection or colonization. C. auris usually diagnosed by culture of blood or other body fluids such as urine or respiratory secretions.

4.3.2 Safety considerations for laboratory diagnosis of Candida auris:

4.3.2.1 Use a biological safety cabinet (BSL2) when manipulating known or suspected C. Auris isolates. C. Auris can contaminate surfaces extensively, and it is difficult to eradicate. MOH approved high level environmental disinfections should be used for cleaning the work area with consideration of manufacturer recommendations to avoid equipment damage.

4.4 Case description:

4.4.1 Clinical symptoms:

4.4.1.1 Colonization with C. Auris is asymptomatic. Colonization is generally on the skin, nares, and other external body sites. However , the symptoms that appeared on the infected cases are as following: fever, chills, sweats, and low blood pressures

4.4.2 Case Identification:

4.4.2.1 Suspected case: A person with a non-Candida albicans species isolated from a diagnostic or screeing specimen.

4.4.2.2 Confirmed case:A person with Candida Auris (C. auris) isolated from a diagnostic or screening specimen irrespective of phenotypic susceptibility.

4.4.2.3 A confirmed C. auris case can be identified as follows:

4.4.2.3.1 Clinical Confirmed C. Auris 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.

4.4.2.3.2 Screening Confirmed C. Auris Case
Person with confirmatory evidence from a swab collected for screening for C. Auris colonization regardless of site swabbed.

4.4.3 Treatment

4.4.3.1 The selection of antifungal must be based on a case-by-case basis and depending on the site of infection as well as the infectious diseases and the treating physicians' recommendations.

4.4.4 Preliminary investigation:

4.4.4.1 Every identified case of C. auris, regardless of the degree of antimicrobial resistance, requires immediate investigation to determine the probable source of c. auris and to assess the risk of transmission within the healthcare facility.

4.4.5 Contact tracing

4.4.5.1 Contact defines as; an individual who is exposed to a case colonized or infected with c. auris in a manner that might allow transmission to occur, or an individual who is exposed to a c. auris – contaminated environment environment where there is an increased risk of acquisition of c. auris.

4.4.6 Screening

4.4.6.1 Patients with an indwelling medical device, such as central venous catheter, breathing aid tubes, urinary catheter, biliary catheter or wound drain.

4.4.6.2 Any patient transferred from another healthcare facility or long term facility.

4.4.6.3 Roommates were exposed to C. auris-positive patients for more than 48 hours.

4.4.6.4 Individual with current multidrug-resistant gram-negative bacteria who received healthcare outside of the kingdom within the last 12 months. Patienyts transferred from a unit with xcurrent transmission of C. auris within the healthcare facility or recent transmission within the last 30days.

4.4.6.5 Carbapenem-resistant enterobacterales (CRE) positive patient(infeted or colonized).

4.4.6.6 Immunocompromised patient.

4.4.6.7 Others:Screening is recommende in departments that are experiencing outbreaks or having an increase in the number of ongoing cases/ or colonization.

4.4.7 Screening of healthcare workers (HCWs) and the environment:

4.4.7.1 Routine screening of the healthcare workers and the environment are not recommended unless epidemiological evidence links to transmission or indicated by the infection prevention and control (IPC) team.

4.4.8 Screening Sites:

4.4.8.1 Screen for c. auris colonization using a composite swab of the patient's bilateral axilla and groin. Also consider screening the following sites (if clinically indicated or previously positive):Nares, mouth, external ear canals, urine (especially if there is a urinary catheter in-situ), cannula entry sites, endotracheal secretions drain fluid(abdominal/pelvic/mediastina), wounds and rectum, these sites are usually less sensitive for colonization screening.

4.4.8.2 C. Auris detection requires blood tests as well as those of other bodily fluids (right and left axilla , Groin).

4.4.8.2.1 Rub both sides os the swab tip over the left axilla skin surface and then the right, targeting the crease in the skin where the arm meets the body (i.e., swab both armpits , swiping back and forth 5 times per armpit)

4.4.8.2.2 With the same swab used on the axilla, rub both sides of the swab tip over left groin skin surface, targeting the inguinal crease in the skin where the leg meets the pelvic region and repeat with the right side(I.e., swab the skin of both hip creases swiping back and forth 5 times per hip crease).

4.9 Infection prevention and control measures:

4.9.1 Hand hygiene

4.9.1.1 Strict adherence to proper hand hygiene practices.

4.9.2 Application of contact-based precautions

4.9.2.1 In addition to standard precutions, contct precutions are necessary to prevent the transmission of C. auris that are likely to be transmitted from the patient or the patient's environment.Patients on contact precaution should be placed in a single-patient room whenever possible.

4.9.3 Improved adherence to bundles of care for venous and urinary catheters as well as tracheostomy care is essential.

4.9.4 Enhanced environmental cleaning and disinfecting (daily and terminal cleaning) using recommended disinfectants

4.9.5 Single-patient use items such as blood pressure cuffs and stethoscope should be considered, especially in outbreak situations.

4.9.6 If single-use items not available, reusable equipment should be properly cleaned and disinfected with the recommended disinfectants post providing patient care, and shared mobile equipment (e.g glucometers, blood pressure cuffs) should be focused on.

4.9.7 Limit patient transfer and if mandatory, infection prevention and control measures should be strictly applied. Use portable machines such as portable x-ray machines to limit patients transportation Isolation transportation card.

4.9.8 Laboratory surveillance of clinical specimens should be applied to detect additional cases. Specific considerations should be applied to specific healthcare department and program.

4.9.9 Flag the patient's record to institute recommended infection control measures in case of readmission.

4.9.10 Invasive /surgical procedures, strict adherence to care bundles including skin decolonization processes is critical to reduce the risk of invasive C. Auris infection . Placing the c. auris colonized patient last on the list is recommended where feasible to enable cleaning to be applied after the episode of care

4.10 Visitors and Patients

4.10.1 Entry to the patient's room should be restricted only for the responsible healthcare workers Visitors to the infected or colonized C. auris patients should be avoided as possible.

Educating patients and families when being discharged with C. auris / colonization.

4.11 Decolonization:

4.11.1 C. auris decolonization not recommended in evidence. However, regular routine body washing, skin preparation for invasive procedures, and care bundles by using approved skin disinfectants should be implemented for all critical care patients.

4.12 Duration of transmission based precautions:

4.12.1 Patients often remain with C. auris for long period of time lasting for several months even after an acute infection (if present) has been treated and resolved. Continue contact isolation precautions for the whole duration of all inpatient healthcare stays, including those in long-term healthcare settings.

4.13 Antimicrobial Stewardship Program:

4.13.1 The implementation of antimicrobial stewardship program effectively is likely to mitigate the risks of C. auris acquisition and transmission, as well as being an essential component of strategies to reduce antimicrobial resistance in general.

5. MATERIALS AND EQUIPMENT:

5.1 **Forms and Records:**

5.1.1

5.2 **Materials and Equipment**

5.2.1

6. RESPONSIBILITIES:

6.1 It is the responsibility of IPCD to implement this policy.

7. APPENDICES:

7.1 N/A

8. REFERENCES:

8.1 General Directorate of Infection Prevention & Control of Healthcare Facilities (GDIPC). Candida Auris Screening Guidance. Version 1.0. August 2023

8.2 General Directorate of Infection Prevention & Control of Healthcare Facilities (GDIPC). Guidance for Candida Auris Infection Prevention and Control Measures. Version 2.0. 2023

\

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Marilou C. Magallano	IPC Practitioner		November 14, 2024
Prepared by:	Ms. Wadha Mohd Al Shammari	IPC Coordinator		November 14, 2024
Reviewed by:	Ms. Awatif Hamoud Al Harbi	IPC Director		November 17, 2024
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Nursing Director		November 18, 2024
Reviewed by:	Mr. Abdulellah Ayed Al Mutairi	Quality & Patient Safety Director		November 19, 2024
Reviewed by:	Dr. Thamer Naguib	Medical Director		November 21, 2024
Approved by:	Mr. Fahad Hazam Al Shammari	Hospital Director & IPC Committee Chairman		November 24, 2024