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Similar to other multidrug-resistant organisms (MDROs), C. auris spreads easily in healthcare settings and can cause outbreaks. C. auris can colonize patients for many months, persist on surfaces, and is not killed by some commonly used healthcare facility disinfectants. Hand hygiene, appropriate precautions, and environmental disinfection prevent and control outbreaks. The primary infection control measures for prevention of C. auris transmission in healthcare settings are: In most instances, facilities equipped to care for patients with other multidrug-resistant organisms (MDROs) or Clostridioides difficile can also care for patients with C. auris. C. auris can persist on surfaces in healthcare settings. C. auris has been cultured from multiple locations in patient rooms. The fungus has been found on both high-touch surfaces, such as bedside tables and bedrails, and surfaces farther away from the patient, such as windowsills. Several common hospital disinfectants are not effective against C. auris.

Some products with C. albicans or fungicidal claims may not be effective against C. auris. Accumulating data indicate that products solely dependent on quaternary ammonia compounds (QACs) are NOT effective. CDC recommends using an Environmental Protection Agency (EPA)–registered hospital-grade disinfectant effective against C. auris. See EPA's List P for a current list of EPA-approved products for C. auris.

If the products on List P are not accessible or otherwise suitable, facilities may use an EPA-registered hospital-grade disinfectant effective against C. difficile spores (List K). It is important to follow all manufacturer's directions for use, including applying the product for the correct contact time for all products. Research about disinfection

effective against C. auris is ongoing. Data on "no-touch" devices, such as germicidal UV irradiation and vaporized hydrogen peroxide, are limited. The parameters required for effective disinfection are not yet well understood. These methods should only be used as a supplement to standard cleaning and disinfection methods. Perform thorough routine (at least daily) and terminal cleaning and disinfection of patients' rooms and areas where patients receive care. Appropriately disinfect radiology, physical therapy, and other areas of the hospital patients may have visited. Medical equipment that is shared between patients can spread C. auris. Clean and disinfect equipment after each use. Label disinfected equipment and separate it from dirty equipment. Examples include: CDC and health department outbreak investigations have found that healthcare personnel are not always aware of ftheir responsibilities for cleaning mobile and shared equipment. Responsibilities for cleaning all mobile and reusable equipment should be well-established. Healthcare personnel should be aware of which equipment they are responsible to clean and trained in disinfection methods. When caring for patients with C. auris, healthcare providers should follow standard hand hygiene practices. Alcohol-based hand sanitizer is preferred for C. auris when hands are not visibly soiled. If hands are visibly soiled, wash with soap and water. Wearing gloves is not a substitute for hand hygiene. The Transmission-Based Precautions and Enhanced Barrier Precautions for C. auris are similar to those used for other multidrug-resistant organisms (MDROs). In most instances, facilities equipped to care for patients with other MDROs or Clostridioides difficile can also care for patients with C. auris. In acute care and long-term acute care hospitals, healthcare providers should use Contact Precautions. In nursing homes and skilled nursing facilities, healthcare providers should use either Contact Precautions or Enhanced Barrier Precautions (EBP), based on the situation and local or state jurisdiction recommendations. Refer to the CDC Guidance on Enhanced Barrier Precautions for more details about when Contact Precautions versus Enhanced Barrier Precautions would apply. Hospitals and nursing homes Patients

on Contact Precautions should be placed in a single-patient room whenever possible. In situations where limited single-rooms are available, prioritize placing patients with higher likelihood of transmission (such as those with uncontained secretions or excretions, diarrhea, and draining wounds). Facilities can group C. auris patients together in a dedicated unit or part of a unit. This decreases movement of healthcare personnel and equipment to non-affected areas. Facilities could also consider dedicating healthcare personnel (e.g., nurses, nursing assistants) who provide regular care to these patients during a shift. In nursing homes, facilities with the capacity may consider placing patients with C. auris in single-patient rooms. Healthcare providers can find recommendations about patient placement in nursing homes using Enhanced Barrier Precautions (EBP) in CDC's FAQs about Enhanced Barrier Precautions in Nursing Homes. When single rooms are not available, facilities may choose to cohort patients with C. auris together in the same room. It is preferable to cohort patients with the same MDROs together. However, facilities may assign rooms based on single (or a limited number of) high-concern MDROs (e.g., C. auris or carbapenemase-producing Enterobacterales) without regard to co-colonizing organisms. Reducing transmission in cohort settings Facilities must implement strategies to help minimize transmission between roommates when patients are placed in shared rooms. The following strategies apply for all shared rooms, regardless of patient colonization or infection status: Before making decisions to cohort patients according to C. auris or other high-concern MDROs, consider the benefits and drawbacks. Ensure these practices are implemented without increasing the risk of pathogen spread in dedicated units or areas in a facility. Placing patients with C. auris or other high-concern MDROs in the same room, or in a dedicated unit, wing, or area (even if in single-patient rooms) with dedicated staff can help prevent the transfer of healthcare personnel and equipment between those colonized or infected with C. auris and those who are not. This strategy may be best used for initial room assignments in facilities performing admission

screening for select MDROs or for a single MDRO in facilities with an acute outbreak. Moving patients to the same room, unit, or areas based on MDROs increases patient movement, and in some circumstances, increases C. auris transmission. This risk increases if there are gaps in environmental cleaning. Facilities choosing to implement this strategy should do so in a way that reduces overall exposures throughout the facility. This includes avoiding frequent room changes that lead to environmental contamination in more areas and more healthcare contacts that could be exposed. Patient transfer Notify the receiving facility or unit of the patients C. auris infection or colonization status when transferring a patient. This includes recommended Transmission-Based Precautions. An example of an infection control transfer form to aid this communication can be found at the top of the Healthcare-Associated Infections Prevention Toolkits web page. Ensuring that all healthcare personnel adhere to infection control recommendations is critical to preventing transmission of C. auris, other MDROs, and communicable diseases. Consider taking the steps outlined below to enhance adherence. The following is interim guidance for patients with C. auris who require dialysis care. Further updates will be provided as additional information becomes available. In addition to following Standard Precautions and infection control practices routinely recommended for the care of all hemodialysis patients, facilities and healthcare personnel at dialysis centers should follow the guidance outlined below. Inform and educate appropriate personnel about the presence of a patient with C. auris and the need for specific infection control measures. Use alcohol-based hand sanitizer as the preferred method for cleaning hands when they are not visibly soiled. If hands are visibly soiled, wash with soap and water. Wearing gloves is not a substitute for hand hygiene. Wear gowns and gloves using proper donning and doffing techniques when caring for patients with C. auris or touching items at the dialysis station. Remove gowns and gloves, dispose of them carefully, and perform hand hygiene when leaving the patient's station. Minimize exposure to other patients by dialyzing the patient at a

station with as few adjacent stations as possible (e.g., at the end or corner of the unit), and consider dialyzing the patient on the last shift of the day. Properly clean and disinfect reusable equipment brought to the dialysis station after each use. Thoroughly clean and disinfect the dialysis station (e.g., chairs, side tables, machines) between patients by using products approved for use against C. auris (see above for more information about these disinfectant products and List P). If the patient is transferred to another healthcare facility, inform the receiving facility of the patient's C. auris status. Communication tools can be found in Healthcare-Associated Infections Prevention Toolkits. In addition to following Standard Precautions and infection control practices routinely recommended for care of all patients in outpatient settings, facilities and healthcare personnel should follow the guidance outlined below. Inform and educate appropriate healthcare personnel about the presence of a patient with C. auris and the need for infection control measures outlined below. Use alcohol-based hand sanitizer as the preferred method for cleaning hands when they are not visibly soiled. If hands are visibly soiled, wash with soap and water. Wearing gloves is not a substitute for hand hygiene. As always, perform hand hygiene when entering and leaving the patient's room. Wear gown and gloves using proper donning and doffing techniques if extensive patient contact is anticipated or contact with infected areas is planned (e.g., debridement or dressing of colonized or infected wound). Remove gowns and gloves, dispose of them carefully, and perform hand hygiene when leaving the patient's room. Thoroughly clean and disinfect the areas in the facility the patient came into contact with (e.g., chairs, exam tables) by using products with EPA-registered claims for C. auris (List P). Properly clean and disinfect reusable equipment (e.g., blood pressure cuffs) used in the care of the patient after each use. If the patient needs to be admitted or referred to another facility, inform the receiving facility of the patient's C. auris status. In addition to following Standard Precautions and infection control practices routinely recommended in home healthcare settings, personnel should follow the guidance

outlined below. If possible, schedule patients with C. auris as the last visit of the day. Use alcohol-based hand sanitizer as the preferred method for cleaning hands when they are not visibly soiled. If hands are visibly soiled, wash with soap and water. Wearing gloves is not a substitute for hand hygiene. As always, perform hand hygiene when entering and leaving the patient care area. Wear gown and gloves using proper donning and doffing techniques when entering the area of the house where providing patient care. Remove gowns and gloves and dispose of them carefully when leaving the area. Properly clean any reusable equipment (e.g., blood pressure cuffs) brought to the home after each use. If the patient needs to be admitted or referred to another facility, inform the receiving facility of the patient's C. auris status. The risk of C. auris infection for otherwise healthy household members, even those with extensive contact with the patient, is believed to be low. Nearly all cases of C. auris colonization detected to date have been associated with admission to a healthcare facility. Household members should practice good hand hygiene (i.e., use of alcohol-based hand sanitizers 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 perform hand hygiene after glove removal. Although the risk of C. auris colonization among healthy household members is thought to be very low, household members who require admission to a healthcare facility can inform healthcare providers that they live with someone colonized with C. auris so that colonization testing can be considered. Patients in healthcare facilities often remain colonized with C. auris for many months, perhaps indefinitely, even after an acute infection (if present) has been treated and resolves. CDC recommends continuing Contact Precautions or Enhanced Barrier Precautions, depending on the healthcare setting, for the entire duration of all inpatient healthcare stays. This includes patients in long-term healthcare facilities. Surveillance has identified patients that remained colonized for longer than 4 years and it is likely that

colonization may even persist longer. Repeat colonization swabs may alternate between detecting and not detecting C. auris. A considerable number of patients have had a positive C. auris specimen after multiple negative swabs. CDC does not recommend routine reassessments for C. auris colonization. Long-term follow-up of colonized patients in healthcare facilities, especially those patients who continue to require complex medical care, such as ventilator support, suggests colonization persists for a prolonged period of time. In a publication by Pacilli et al. (Clin Infect Dis 2020), among patients who had a positive C. auris screening result followed by one or more negative screening results, more than 50% had a subsequent positive screening result. Additional information is being collected to understand the duration of colonization and the role of colonization in spread of C. auris. The decision to discharge a patient from one level of care to another should be based on clinical criteria and the ability of the accepting facility to provide care—not on the presence or absence of infection or colonization. At this time, no specific intervention is known to reduce or eliminate C. auris colonization. Laboratory evidence suggests that high levels of chlorhexidine are active against C. auris. However, the effects of chlorhexidine on reducing C. auris skin burden or infection have not been systematically assessed. C. auris outbreaks and transmission have been observed in facilities routinely using chlorhexidine bathing. C. auris is an emerging fungus that can cause severe, often multidrug-resistant, infections. It spreads easily among patients in healthcare facilities. Languages Language Assistance Languages Language Assistance

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