A new strain of fungal pathogen is emerging in UK hospitals, demonstrating the increasing threat from microbial-resistant organisms. *Candida auris* was first isolated in 2009 from the ear canal of a patient in Japan and has since spread across five continents; it is proving hard to control in hospital and community care settings.

Public Health England has published updated guidance on managing and preventing *C. auris* (PHE, 2017a) and on controlling it in community care settings (PHE, 2017b).

According to PHE, by July 2017, *C. auris* had been detected in over 200 patients in 20 NHS trusts and private care providers, and over 35 other UK hospitals had received patients with known *C. auris* infection.

What is *Candida auris*?

*C. auris* is a species of candida – yeasts that live on the skin and inside the human body. Some people carry *C. auris* without symptoms or becoming ill, however, in hospitalised patients and unwell people, it can spread and cause infection. *C. auris* can enter the body during medical treatment; for example, during surgery or insertion of urinary catheters or intravenous cannulae. This can result in bloodstream, wound and ear infections. It can also cause urinary tract infections and, less commonly, respiratory infections, with a risk of pneumonia. It mostly affects critically ill patients in high-dependency settings.

PHE warns that, unlike more common forms of candida – such as *C. albicans*, which can cause thrush – *C. auris* “appears to be highly transmissible between patients and from contaminated environments” (PHE, 2017a). It is often resistant to the first-line antifungal, fluconazole, and can develop resistance to other antifungal agents. Multiresistant strains have been reported from South America, but are still uncommon in the UK.

Although serious infections are rare, and no one has yet died from *C. auris* in the UK, the organism is hard to eradicate and often persists, including after hospital discharge. Outbreak detection and management have been further hindered by difficulties distinguishing *C. auris* from other candida species in the laboratory and uncertainty about its precise modes of transmission (PHE, 2017a).

Transmission

Reports from countries experiencing significant *C. auris* outbreaks, including the UK, suggest it can contaminate the environment and equipment of colonised or infected patients. This could include blood pressure cuffs, stethoscopes and other devices, as well as more invasive...
**Box 1. Candida auris guidance for community care settings**

Public Health England says there is no reason to refuse admission of service users with *C. auris* colonisation or infection, but staff should:

- House individuals in single en-suite rooms wherever possible, or avoid them sharing with anyone who is immunocompromised;
- Continue normal communal activities as long as “standard precautions and effective environmental hygiene can be maintained”. If the person is incontinent, seek specialist infection control advice;
- Clean the patient environment thoroughly using chloride-based agent (1,000ppm of available chlorine), particularly high-contact surfaces such as bed rails, door handles and bathrooms. Monitor and audit cleaning standards regularly;
- Avoid storing unused equipment and single-use items in the person’s room to simplify cleaning, decontamination and disposal;
- Ensure staff and patients take standard infection control precautions, and train all employees, including cleaning and domestic staff, in hand hygiene and correct use of personal protective equipment;
- Take particular care when changing dressings and managing or changing urinary catheters and other devices. Secure discharging wounds with impermeable dressings and clear up any environmental contamination from the wound or other body fluids immediately;
- Inform hospitals and care settings of the person’s status in advance of medical appointments, and brief patients and families (see Communication).

**Screening and diagnosis**

Trusts are encouraged to develop a screening policy for *C. auris* following local risk assessments. Screening is recommended for patients coming from affected hospitals and those admitted on units with newly identified and/or ongoing cases or colonisation. Staff should:

- Screen close contacts of newly diagnosed patients in intensive care;
- Ensure speciation of candida isolates for four weeks from patients who shared a ward with a newly identified patient;
- Check for an increased detection of candida on the ward/unit in the four weeks before a patient was newly identified, as this may represent unrecognised transmission;
- If a newly identified patient was not isolated, isolate or cohort patients who were in the same bay in the 48 hours before identification, using enhanced infection control (see below), until they have three consecutive negative screens at least 24 hours apart.

When staff screen patients, they should consider the following sites and sampling based on candida species’ colonisation of skin and mucosal surfaces:

- Groin and axilla (the most persistently positive);
- Urine (persistent urinary colonisation has been found in catheterised patients);
- Nose and throat;
- Perineal swab;
- Stool sample or rectal swab (may be better for detecting colonisation than transmission).

Others, if clinically indicated, include:

- Low vaginal swab, sputum and endotracheal secretions, drain fluid, cannula entry sites and routine wound swabs. Staff should report positive and negative results of patient screening to the local PHE health protection team.

**Infection prevention and control Patients**

When colonisation or infection occurs (or is a risk), staff should:

- Isolate screen-positive patients for the rest of their hospital stay, in single en-suite rooms wherever possible, and screen at least once a week in case of reoccurrence;
- Isolate patients transferred from another affected hospital until screen results are available;
- Follow the same isolation and screening procedures if previously colonised patients are readmitted;
- Follow enhanced hygiene precautions.

**Environment and equipment**

Once the patient has left the room or bay, staff should:

- Clean and disinfect all high-contact horizontal surfaces and items, ensuring good contact before disinfectant dries;
- Use hypochlorite to clean the environment (1,000ppm of available chlorine);
- Clean and disinfect first, even if any non-contact disinfection is used (for example, gaseous hydrogen peroxide or UV);
- Change privacy curtains and decontaminate dynamic mattresses;
- Discard any used or unused single-use items and consider discarding inexpensive items that are hard to decontaminate;
- Train and supervise domestic staff until competent, ensuring they change gloves and aprons and follow strict hand hygiene afterwards;
- Schedule last in the day any medical procedures requiring the patient to move to a different area, and afterwards clean as above.

Equipment, including monitoring devices and mobility aids, should be cleaned following manufacturer instructions.

**Waste and linen**

Staff should ensure they:

- Bag and isolate used linen and waste;
- Dispose of used nappies in paediatric and neonatal units;
- Never discard or wash contaminated material in clinical hand-wash basins.

**Communication**

Nurses and other staff should ensure patients and visitors understand the diagnosis and what precautions to take. PHE has produced a new guide for patients and visitors to help with this (PHE, 2017c).

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**References**


