Examining *Candida auris* Screening Protocols in the Medical Intensive Care Unit and Step-Down Unit at Henry Ford St. John Hospital

Ashna Patel, BS[1]; Jennifer Madigan, MPH, CIC[2]; Mamta Sharma, MD, FACP, FIDSA, FSHEA[2],
Department of Infection Prevention and Control
[1]University of Michigan School of Public Health, Ann Arbor, MI
[2]Henry Ford St. John Hospital, Detroit, MI

Background

Candida auris is a rapidly emerging, multidrug resistant yeast that causes severe infections and outbreaks in hospitalized patients, particularly in ICUs[1].

- It often colonizes the axilla, groin, nares, respiratory tract, and urinary tract[1], and is difficult to treat due to resistance to standard antifungal therapies[2]
- *C. auris* can persist on surfaces and spread person-to-person, necessitating strict infection control and disinfection practices[1]
- According to the CDC, U.S. clinical cases increased from 2,928 in 2022 to 4,514 in 2023[3]
- Identified risk factors include indwelling devices, prior infections, antimicrobial use, chronic disease, older age, and residence in long-term acute care facilities[1]

A protocol for *C. auris* screening was implemented in January 2025 in the medical intensive care unit (MICU) and 4W step-down unit at Henry Ford St. John Hospital. Under this protocol, patients are screened upon admission to both units and again before discharge if the length of stay is greater than five days. Patients who are transferred from Omni, Select Specialty Hospitals, Riverview Jefferson, Riverview North, Vibra DMC, or Vibra Taylor are deemed high risk and placed under contact precautions while awaiting microbiology lab results. Isolation is discontinued for high-risk patients who screen negative and continued or implemented for all patients who screen positive.

Objectives

1. To assess compliance with the protocol for isolation and screening for *C. auris*; and
2. To identify patient groups for screening protocol expansion

Methods

This project is a retrospective chart review of all patients who were admitted to the MICU or 4W since the current screening protocol was implemented on January 15, 2025 to May 31, 2025. A chart review was conducted in eCare® to assess *C. auris* screening and isolation measures.

Factors assessed include:

- A healthcare Epi-link to a known or suspected *C. auris* positive person (e.g. roommate, shared bathroom, etc.)
- Admission from any long-term acute care facility
- Infection with other multidrug resistant organisms (MDROs)
- Length of hospital stay

Additionally, the project also assessed adherence of contact precautions for *C. auris* patients by healthcare personnel, and disinfection practices of reusable medical devices by tracking patient room numbers, services utilized, and placement of contact precautions. Microbiology laboratory results for positive *C. auris* cases were matched to isolation data to ensure all colonized patients had proper precautions in place during their stay.

Results

- As of July 18, 2025, data has been extracted for **148** out of **655** patients admitted to the MICU and 4W step-down unit
- Preliminary analysis showed **98.6%** (146/148) of patients met the defined criteria for screening
  - Two patients who did not meet screening criteria were excluded from protocol compliance analysis
- Among those meeting screening criteria, **64.4%** (94/146) were screened according to protocol, while **35.6%** (52/146) were not
- Protocol compliance was similar between units: **64.6%** (73/113) in the MICU and **63.6%** (21/33) on 4W
- A total of **3** patients (2.0%) screened positive for *Candida auris*

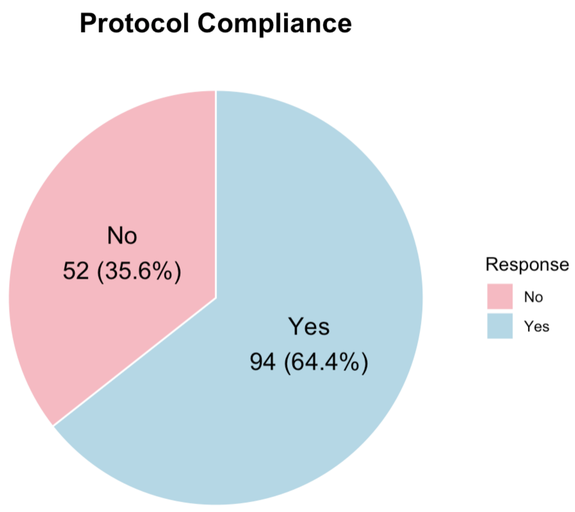


Figure 1. Pie chart of *C. auris* screening protocol compliance (N= 146).

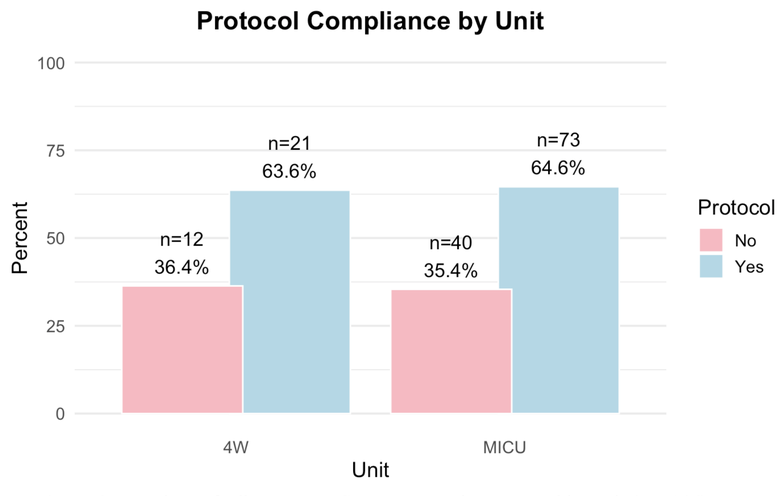


Figure 2. Bar chart of adherence to *C. auris* screening protocol by unit (N= 146).

Conclusions

- *Candida auris* screening compliance was moderate, with over 60% of eligible patients screened according to protocol across both units
  - This suggests partial implementation of the hospital's *C. auris* admission screening initiative and ongoing opportunities to strengthen adherence to infection prevention policies
- Compliance rates were comparable between the MICU and 4W step-down unit, suggesting consistent protocol adherence across units
  - Comparable performance across units suggests that the education, workflow reminders, and staff engagement strategies used during rollout were effective
- Early implementation of a standardized screening process helped identify a small number of *C. auris* positive patients
  - Detecting colonized individuals early helps reduce the risk of hospital transmission and supports patient and staff safety
- Ongoing education and monitoring are needed to further improve adherence and ensure timely screening upon admission and transfer

Future Directions

- Integrate compliance tracking into EHRs to automate reminders and streamline documentation
  - Embedding prompts at admission and transfer points may improve timeliness of screening and reduce missed cases
- Evaluate the impact of screening on infection control outcomes and resource utilization
  - Future analyses can assess whether higher compliance correlates with lower *C. auris* transmission rates, fewer isolation-related exposures, and more efficient allocation of infection prevention resources
- Continue multidisciplinary collaboration among infection prevention, laboratory services, nursing, and clinical leadership
  - Maintaining strong communication across departments is essential for adapting the screening process as new evidence and guidelines emerge
- Expand *C. auris* screening to additional high-risk units in the hospital
  - The remainder of the data abstractions need to be completed to identify groups for screening protocol expansion

References

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