STOP THAT YEAST!
Mitigating Spread of *Candida auris* Through "Command Center" Approach

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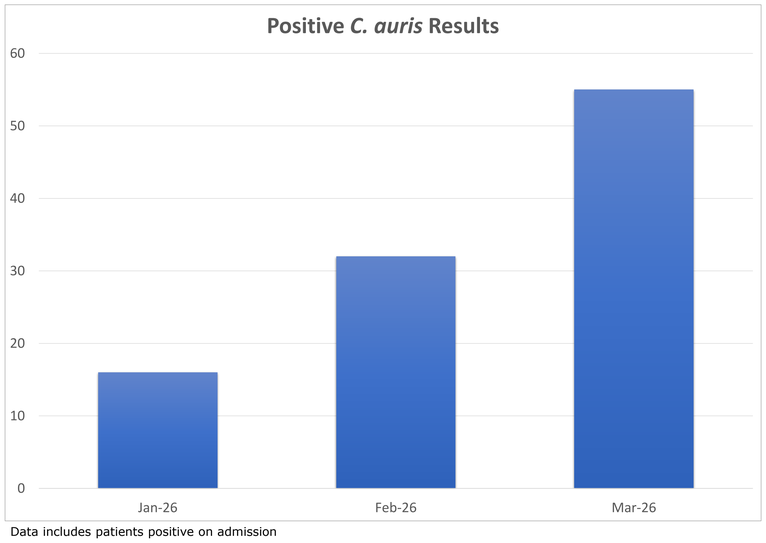
BACKGROUND

Candida auris (*C. auris*) is a rapidly emerging, multidrug-resistant yeast that can cause severe illness and spread easily among patients in health care facilities. Unfortunately, *C. auris* is no longer an infrequent lab result but instead a daily buzzword for infection preventionists (IP). Appropriate testing, isolation, personal protective equipment (PPE) use and cleaning will prevent spread of the emerging multidrug-resistant fungus in the health care environment; but there can be infringements in basic prevention strategies.

PURPOSE

Exposure surveillance testing resulted in increased identification of *C. auris* cases among patients at a complex academic medical center.

This presentation describes how initiation of a multidisciplinary "Command Center" improved communication and increased attention to *C. auris* mitigation due to its severity and significant negative impact on patient outcomes.



Data includes patients positive on admission

Department	*C. auris* Mitigation Responsibilities
Chief Medical Officer	• Organizational priority • Resource allocation • Physician accountability
Infection Prevention	• Meeting leaders • Data report out • Daily rounds on all *C. auris* positive patients with tracked compliance • Just-in-Time training for any identified opportunities • Health department reporting • Staff education
Bedside Nursing	• Isolation adherence • Hand hygiene • Clinical accountability • Bleach blitz
Environmental Services	• Enhanced cleaning – UV equipment • Light duty employee support
Ancillary Services	• Respiratory • Imaging • Transport

METHOD/DESIGN

Considering the numerous departments involved in acute patient care, a multidisciplinary command center approach was initiated. This meeting was led by IP leadership with fluid frequency and was initially scheduled daily by the hospital Chief Medical Officer (CMO) to emphasize urgency and participation. This daily touchpoint gave clinical leaders opportunities to standardize care for *C. auris* patients and ancillary departments, such as imaging, transport and respiratory therapy, the opportunity to discuss plans to mitigate spread. Additionally, opportunities for mitigation, such as enhanced cleaning, were discussed in detail and then implemented.

RESULTS

This Command Center approach allowed multiple leaders throughout a very large academic medical center to discuss processes and opportunities. It gave IP the opportunity to provide guidance for isolation, dedicated nursing care and cleaning to a wide audience to maintain consistencies in mitigation strategies. Within one month of performing exposure surveillance testing on units with possible facility spread, there were zero positive *C. auris* results.

CONCLUSION

Frequent, multidisciplinary huddles to discuss prevention practice standardization is essential for consistent expectations and communication. Basic infection prevention practices continue to be the primary strategy to prevent spread of infection.

Infection Prevention Practices
Isolation Gown, Gloves
Hand Hygiene 5 Moments
Cleaning Equipment, Patient Environment List K, List P

PUBLIC HEALTH SIGNIFICANCE

Strict, standardized prevention strategies eliminate spread in vulnerable patients who will eventually be discharged to public.

REFERENCE

Centers for Disease Control and Prevention. Candida auris. Accessed April 13, 2026. https://www.cdc.gov/candida-auris/about/index.html