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-Protecting Patients. Elevating Excellence. Preventing Infections-

Candida auris Outbreak Investigation

From Detection to Containment:
Leading Effective Outbreak Response Across the Healthcare Continuum

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Protecting Patients Through ***Early Detection,*** ***Rapid Response,*** ***Resilient*** *Infection Prevention Systems.*

Presenter

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CEO, Infection Control Consultant, J.A.D. Infection Control Experts

24+ YEARS IN INFECTION PREVENTION & REGULATORY COMPLIANCE

FOUNDER OF J.A.D. INFECTION CONTROL EXPERTS (2007)

PASSIONATE ABOUT HELPING ORGANIZATIONS SUCCEED

INTERNATIONAL SPEAKER & EDUCATOR

AUTHOR & INDUSTRY CONTRIBUTOR

Joi has worked in the post-acute environment in nursing leadership and in infection prevention and control and regulatory compliance for over **24 years**. She founded J.A.D. Infection Control Experts in 2007 helping hospitals, long term care facilities, SNFs, and ALFs be proactive in survey readiness. She is passionate about helping organizations succeed in their journey to survey readiness every day! She is an international speaker on infection prevention and regulatory compliance. She has been an item writer for the CIC exam, for the APIC Learning System for CIC Book 1 & 2, and LTC-CIP Book 1 & 2 and has served as a SME on the APIC LTC Policy Pro. She has been featured as a panelist on Infection Control Today as a SME for LTC and Transmission Control Regulatory Compliance series. She is the immediate past President of the APIC Miami-Dade Chapter.

Author of ***"Survey Ready Every Day- A Guide To Resilient Leadership"***

She is a wife and mother of two children and ***loves to sing and dance.***

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PROTECTING PATIENTS. • ELEVATING EXCELLENCE. • PREVENTING INFECTIONS.

DISCLOSURES

The presenter has **no financial** relationships to disclose related to the educational content presented.

The recommendations discussed are based on **current evidence**, national guidance, and accepted infection prevention practices.

Any product examples shown are for **educational purposes only** and should not be interpreted as endorsements.

EVIDENCE. INTEGRITY. TRUST. COMMITTED TO EXCELLENCE IN INFECTION PREVENTION.

Objectives

At the conclusion of this session, participants will be able to:

01

Recognize the epidemiology, transmission pathways, and healthcare risks associated with *Candida auris* across multiple care settings.

02

Develop a systematic outbreak investigation using surveillance data, laboratory findings, epidemiologic principles, and interdisciplinary collaboration.

03

Implement evidence-based containment strategies to interrupt transmission, protect vulnerable populations, and strengthen organizational preparedness.

OUR GOAL: Better Outcomes. Stronger Systems. Safer Care.

J.A.D. INFECTION PREVENTION

Why *Candida auris* Has Changed Infection Prevention

- **Spreads efficiently** within healthcare environments
- **Persists** on surfaces for prolonged periods
- Frequently **colonizes** patients without symptoms
- Demonstrates **resistance** to multiple antifungal medications
- Can be **difficult to identify** without specialized laboratory methods
- **Moves with patients** across the healthcare continuum
- Requires **rapid, coordinated** response to prevent transmission

Why *Candida auris* Has Changed Infection Prevention

One Organism. Multiple Challenges. System-Wide Impact.

What Makes *Candida auris* Different?		Why It Matters
Persists in the healthcare environment	→	Increased opportunity for environmental transmission
Colonizes patients without symptoms	→	Silent spread before detection
Frequently resistant to antifungal therapy	→	Limited treatment options
Difficult to identify without specialized laboratory methods	→	Delayed recognition and response
Moves with patients between healthcare facilities	→	Regional and statewide spread
Can rapidly become an outbreak	→	Requires immediate investigation and coordinated response

Small Organism. | Serious Threat. | Stronger Prevention. | Safer Patients.

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Could This Be Happening in Your Facility Right Now?

Candida auris often spreads before anyone realizes it is there.

ONE POSITIVE LABORATORY RESULT MAY REPRESENT WEEKS—OR EVEN MONTHS—OF *UNDETECTED* TRANSMISSION.

Resident Transfers Drive Transmission Across the Healthcare Continuum

- Hospital
- Long-Term Acute Care
- Skilled Nursing Facility
- Dialysis Center
- Emergency Department
- Hospital

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PREPARED TEAMS. PROTECTED RESIDENTS. STRONGER COMMUNITIES.

Where Are We Seeing *Candida auris*?

Understanding Who Is at Risk

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HIGHEST-RISK HEALTHCARE SETTINGS

- Acute Care Hospitals
- Long-Term Acute Care Hospitals (LTACHs)
- Skilled Nursing Facilities
- Ventilator-Capable Units
- Dialysis Centers
- Rehabilitation Hospitals
- Frequent Interfacility Transfers

RESIDENTS AT GREATEST RISK

- Mechanical ventilation
- Tracheostomy
- Central venous catheter
- Indwelling urinary catheter
- Recent broad-spectrum antibiotic exposure
- Multiple healthcare admissions
- Long lengths of stay
- Complex medical conditions

Risk increases when vulnerable patients move frequently between healthcare settings.

INVESTIGATOR CHALLENGE

Think about your facility. Which of the settings to the right do your residents interact with most? What opportunities exist to strengthen communication and prevention during those transitions?

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Recognizing an Outbreak

The First Positive Result Is the Beginning of the Investigation—Not the End.

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Positive *Candida auris* Result

↓

Confirm the Laboratory Result

↓

Is this colonization or infection?

↓

Could transmission already be occurring?

↓

Initiate the Outbreak Investigation

QUESTIONS EVERY INFECTION PREVENTIONIST SHOULD ASK

- Is this the first known case— or simply the first detected case?
- Has this resident recently been transferred from another healthcare facility?
- Who shared the room or care environment?
- What equipment was shared?
- Are there additional residents who should be screened?
- Does this meet our facility's outbreak response criteria?
- Have we notified leadership and public health, if appropriate?

INVESTIGATOR CHALLENGE

Friday at 4:15 PM...

A resident in your skilled nursing facility is reported positive for *Candida auris*.

What are your first five actions before leaving the building today?

(We'll answer this together over the next several slides.)

Every positive result should trigger critical thinking— not assumptions.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

The First 24 Hours

Your Immediate Response After Identifying a *Candida auris* Case

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The actions you take in the first 24 hours can determine the course of the outbreak.

0–2 HOURS

Verify the laboratory result
Confirm the identification method and need for confirmatory testing.

Notify key stakeholders
Inform leadership, nursing, medical staff, and laboratory.

Implement appropriate transmission-based precautions
Initiate Contact Precautions immediately.

Begin a case investigation file
Document all information and communication from the start.

2–8 HOURS

Develop a line list
Start capturing essential data immediately.

Review resident movement and room history
Identify locations, dates, and transfers.

Identify close contacts
Determine who had direct or indirect exposure.

Review recent admissions, transfers, and discharges
Include the past 30–90 days based on risk assessment.

8–24 HOURS

Assess environmental cleaning practices
Ensure EPA-registered disinfectants effective against *C. auris* are used.

Evaluate shared medical equipment
Review cleaning and disinfection process between residents.

Determine the need for screening
Assess risk and develop a screening plan.

Notify public health, if indicated
Follow local or state reporting requirements.

Schedule the outbreak response team meeting
Bring key disciplines together to guide the investigation.

The goal is not simply to respond to the positive case—it is to determine whether transmission has already occurred.

INVESTIGATOR'S REMINDER
Every hour without investigation is another hour transmission may continue.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Building the Line List

Your Most Valuable Outbreak Investigation Tool

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A well-constructed line list organizes information, reveals patterns, and helps determine the scope and source of transmission.

Line List Elements	IDENTIFIER	LOCATION HISTORY	DATES	CLINICAL INFORMATION	RISK FACTORS / DEVICES	EXPOSURES	LABORATORY INFORMATION	NOTES / ACTIONS
	Unique way to distinguish each resident.	Where the resident has been during the infectious period.	Key dates help establish timing and potential exposures.	Helps assess risk factors and clinical relevance.	Invasive devices and other risks increase likelihood of colonization and infection.	Who or what the resident may have been exposed to.	Results guide decisions about transmission and interventions.	Document actions taken and additional observations.
What It Tells You	Tracks cases individually	Finds common areas or units	Identifies timing and connections	Understands severity and vulnerability	Identifies higher-risk residents	Reveals potential transmission pathways	Determines extent of transmission	Supports decision making and follow-up

EXAMPLE LINE LIST *(Sample – Not Real Residents)*

Resident ID	Location History (10 days before positive)	Date of Admission	Date of Positive Culture	Clinical Status / Symptoms	Devices / Risk Factors	Shared Room / Close Contacts	Laboratory Result & Specimen Type	Notes / Actions Taken
A	Acute Care Hospital (5/1–5/8) SNF Unit B (5/8–5/12)	5/8/24	5/12/24	Colonization (AX Swab) No symptoms	CVC, Foley Ventilator Diabetes	Roommate: B Close contact: C, D	*C. auris* detected (AX Swab)	Contact Precautions started 5/12 Line list initiated
B	SNF Unit B (5/6–present)	5/6/24	5/15/24	Colonization (AX Swab) No symptoms	Foley CKD Antibiotics	Roommate: A Close contact: E, F	*C. auris* detected (AX Swab)	Screening expanded 5/15
C	SNF Unit B (5/2–present) Dialysis M/W/F	5/2/24	5/16/24	Infection (Blood culture) Fever	CVC ESRD on HD Antibiotics	Roommate: G Close contact: A, D *Dialysis center*	*C. auris* detected (Blood culture)	Infection treatment started 5/16 Public Health notified 5/16

HOW TO USE YOUR LINE LIST

- Add new cases daily as they are identified.
- Update locations and exposures regularly.
- Look for patterns in time, place, and people.
- Share key findings with your outbreak team.
- Use data to guide screening, cleaning, and education.

Good data leads to good decisions and better outcomes.

INVESTIGATOR CHALLENGE

What information on this line list would help you answer these critical questions?

- Is there transmission occurring within the facility?
- Are there common locations or exposures?
- Do we need to expand screening?
- Are additional interventions needed?

INVESTIGATOR'S REMINDER

A line list is not just a list—
it is a story of transmission.
The more complete the story,
the better your response.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Finding the Pattern

Connecting the Dots During an Outbreak Investigation

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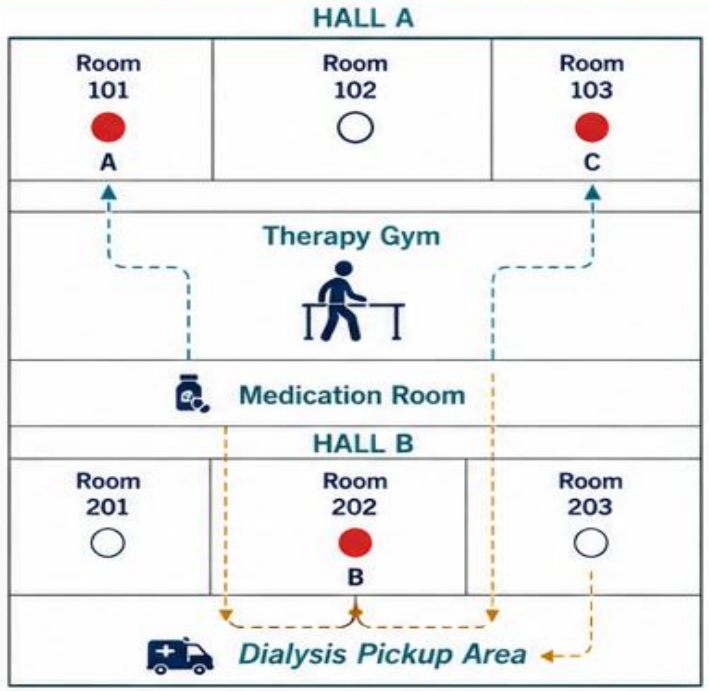
A line list tells you who. Pattern recognition tells you how.

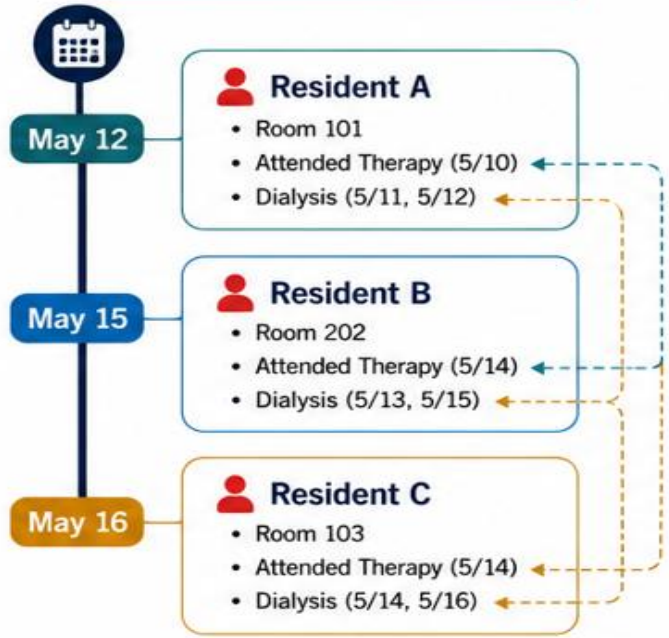
FACILITY MAP *(Example Skilled Nursing Unit)*



LEGEND

- Confirmed Case
- No Known Case
- Shared Therapy
- Dialysis Transportation

CASE TIMELINE



What this pattern suggests:
Residents A and C shared therapy.
All three residents used the same dialysis transportation service. Resident B never shared a room with A or C.

QUESTIONS THE DATA SHOULD ANSWER

- Do cases overlap in time?
- Do they share locations or common areas?
- Do they share caregivers or staff?
- Do they share medical equipment or devices?
- Do they attend therapy together?
- Do they leave the facility for dialysis or other appointments?
- Are additional residents at risk?

The goal is to identify common exposures so we can interrupt transmission.

Outbreaks are solved by identifying common exposures—not simply counting cases.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Who Should Be Screened?

Expanding Surveillance During a Candida auris Investigation

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Positive *Candida auris* Resident

Was the resident sharing a room?

- **YES** → Screen roommate immediately.
- **NO** → Evaluate other epidemiologic links.

Shared Therapy?

YES

- Screen residents who attended during the same timeframe.
- Consider frequency, duration, and location of therapy.

Shared Dialysis?

YES

- Evaluate transportation.
- Review chair assignments.
- Look at treatment dates and time overlap.
- Identify other riders or treatment partners.

Shared Medical Equipment?

YES

- Review cleaning and disinfection process.
- Identify all residents who used the equipment.
- Expand screening if indicated by findings.

CONSIDER SCREENING WHEN RESIDENTS HAVE SHARED:

- Room
- Bathroom
- Therapy Gym or Rehabilitation
- Dialysis (transportation or treatment)
- Medical Equipment
- High-contact caregivers
- Units during known transmission period
- Other epidemiologic links (e.g., dining room, activities, procedure areas)

Always document the reason for screening decisions.

Screen based on epidemiologic risk—not simply proximity.

INVESTIGATOR PEARL

Every resident does not need to be screened.
Every exposure should be investigated.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → **INVESTIGATION** → CONTAINMENT → RECOVERY

Conducting a Point Prevalence Survey

Finding Hidden Colonization Before It Becomes the Next Case

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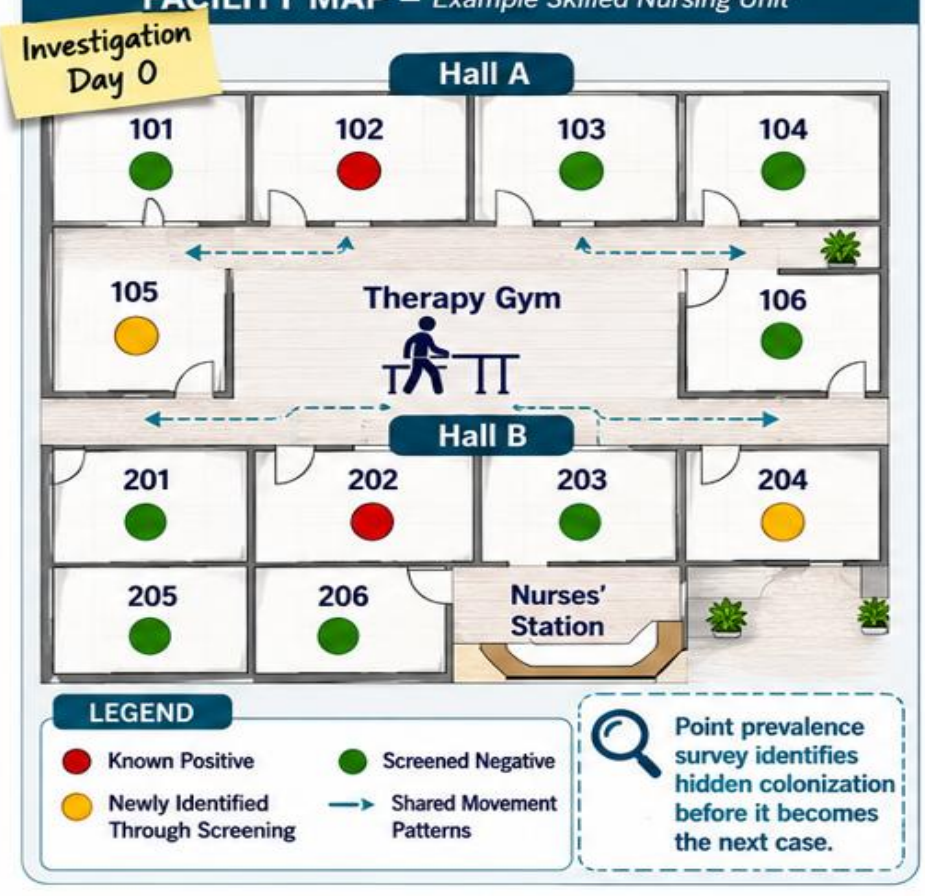
FACILITY MAP — *Example Skilled Nursing Unit*



POINT PREVALENCE SURVEY PROCESS

1. **Define the screening population**
   Based on epidemiologic investigation.
2. **Collect screening specimens**
   Follow current guidelines and coordinate with the laboratory.
3. **Review laboratory results**
   Identify newly colonized residents.
4. **Update the line list**
   Add new residents and exposures.
5. **Reassess the scope of the outbreak**
   Are there new patterns or connections?
6. **Determine whether additional screening is needed**
   Narrow, expand, or repeat as indicated.

ASK YOURSELF

- Did screening identify additional colonized residents?
- Were they previously connected?
- Are there new epidemiologic links?
- Has transmission extended beyond one unit?
- Should screening expand?
- Have interventions impacted transmission?

Each round of screening helps refine your investigation and strengthen your response.

The goal of a point prevalence survey is not to find more cases—it is to find transmission before transmission finds you.

Update the line list. Update the story.

INVESTIGATOR REMINDER

Consistent timing, specimen collection, and documentation drive accuracy.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → **INVESTIGATION** → CONTAINMENT → RECOVERY

Interrupting Transmission

Containment Strategies That Work

Successful outbreak management depends on layered interventions—not a single solution.

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1 CONTACT PRECAUTIONS

- Implement promptly
- Appropriate PPE
- Staff education
- Reinforce hand hygiene

2 COHORTING

- Cohort residents when indicated
- Dedicated care teams when possible
- Minimize movement in and out of the cohort

3 ENVIRONMENTAL CLEANING

- EPA-registered disinfectants effective against *C. auris*
- Focus on high-touch surfaces
- Include shared equipment and bathrooms
- Audit and provide feedback

INTERRUPT TRANSMISSION

4 EQUIPMENT MANAGEMENT

- Clean and disinfect between residents
- Dedicate equipment whenever possible
- Audit cleaning practices
- Ensure supplies available at point of care

5 COMMUNICATION

- Shift report and huddles
- Interfacility transfers
- Public health partners
- Dialysis centers
- EMS and transport
- Therapy and ancillary services

6 ONGOING SURVEILLANCE

- Repeat screening as indicated
- Update line list daily
- Review new cultures
- Monitor trends over time
- Audit compliance with interventions

No single intervention stops an outbreak.
MULTIPLE LAYERS WORKING TOGETHER DO.

COMMON SHARED ITEMS THAT CAN DRIVE TRANSMISSION


Blood Pressure Cuffs


Wheelchairs


Thermometers


Pulse Oximeters


Therapy Equipment


Wound Care Carts

COMMUNICATION IS CRITICAL
If others don't know, we can't protect our residents.
Share early. Share often. Share clearly.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Measuring Success

How Do You Know Transmission Has Stopped?

Successful outbreak management requires continuous evaluation—not assumptions.

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DAILY SURVEILLANCE DASHBOARD

NEW CASES IDENTIFIED

Day 1	2
Day 4	1
Day 8	0
Day 15	0

TREND IMPROVING

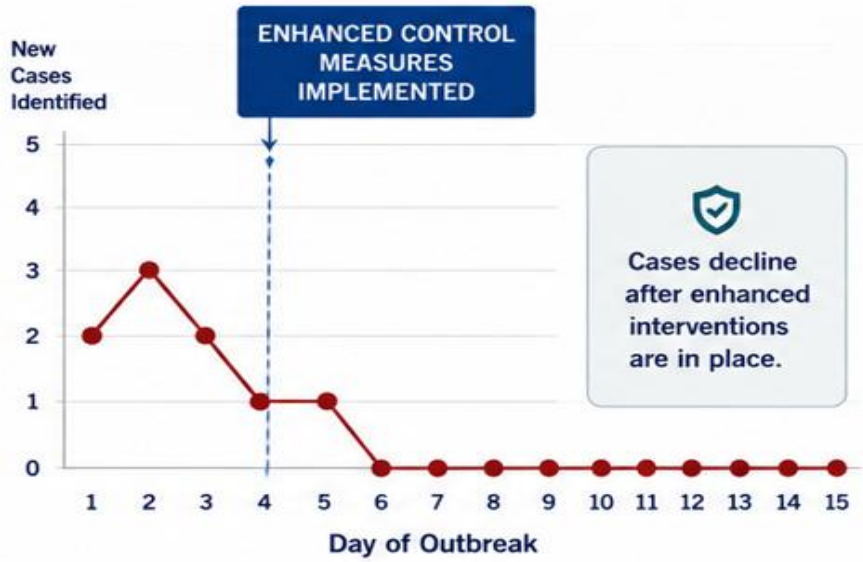
RESIDENTS SCREENED
48 of 48 completed

ENVIRONMENTAL AUDITS
97% compliance

HAND HYGIENE AUDITS
94% compliance

SHARED EQUIPMENT CLEANING
100% documented

NEW CASES OVER TIME



Continue to monitor for at least two full incubation periods after the last identified case.

QUESTIONS TO ASK DAILY

- Are new cases still occurring?
- Are cases linked to previous exposures?
- Have environmental deficiencies been corrected?
- Are staff consistently following precautions?
- Have screening results stabilized?
- Can transmission still be explained?

INVESTIGATOR REMINDER

No new cases + strong compliance + negative follow-up screening = growing confidence that transmission has been controlled.

AN OUTBREAK IS NOT OVER BECAUSE TIME HAS PASSED.
IT IS OVER WHEN TRANSMISSION HAS BEEN INTERRUPTED.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Data, vigilance, and consistency guide us from detection to resolution.

INVESTIGATOR CHALLENGE #1

It's Friday at 4:37 PM...

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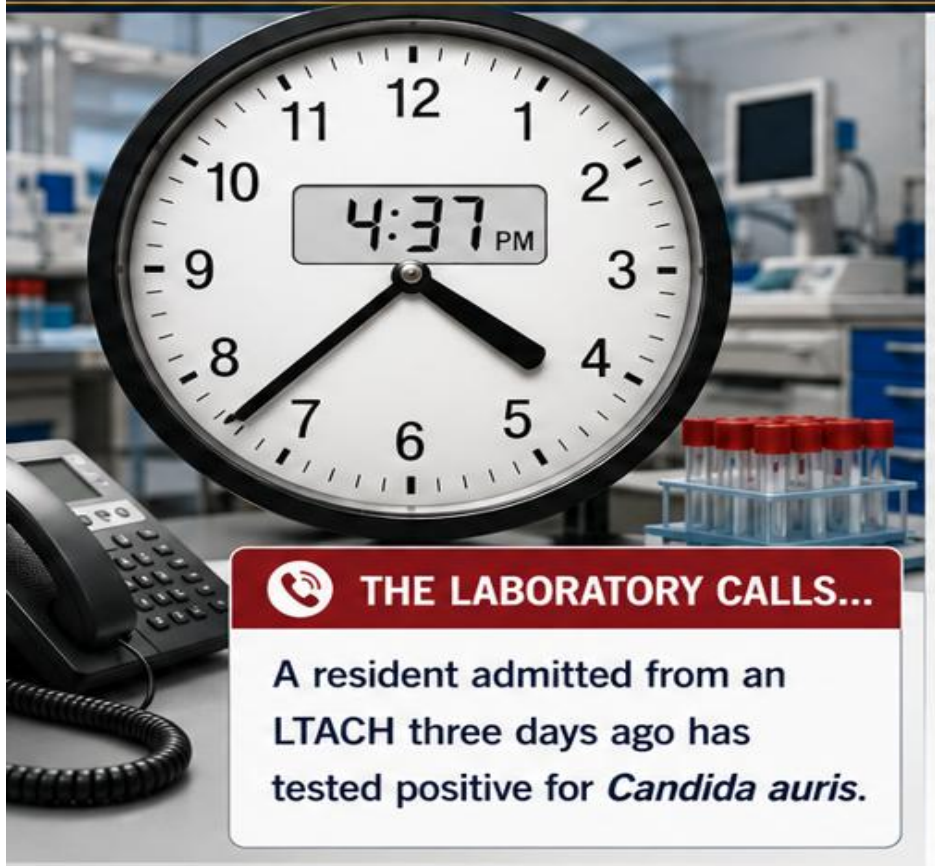

THE LABORATORY CALLS...

A resident admitted from an LTACH three days ago has tested positive for *Candida auris*.

WHAT YOU KNOW

- Admitted 3 days ago
- Shared a semi-private room with a roommate
- Attended physical therapy yesterday
- Left for dialysis this morning
- Environmental Services already terminally cleaned the original room after the roommate transferred
- No additional cases identified... yet

WHAT IS YOUR FIRST PRIORITY?

- **A** Start screening the entire facility
- **B** Notify the Administrator
- **C** Begin the outbreak investigation
- **D** Wait for confirmatory testing before acting

ZOOM CHAT CHALLENGE

Type A, B, C, or D in the chat before we reveal the answer.

Take a moment to think...

There are no wrong answers— just different perspectives!

INVESTIGATOR CHALLENGE #1

It's Friday at 4:37 PM...

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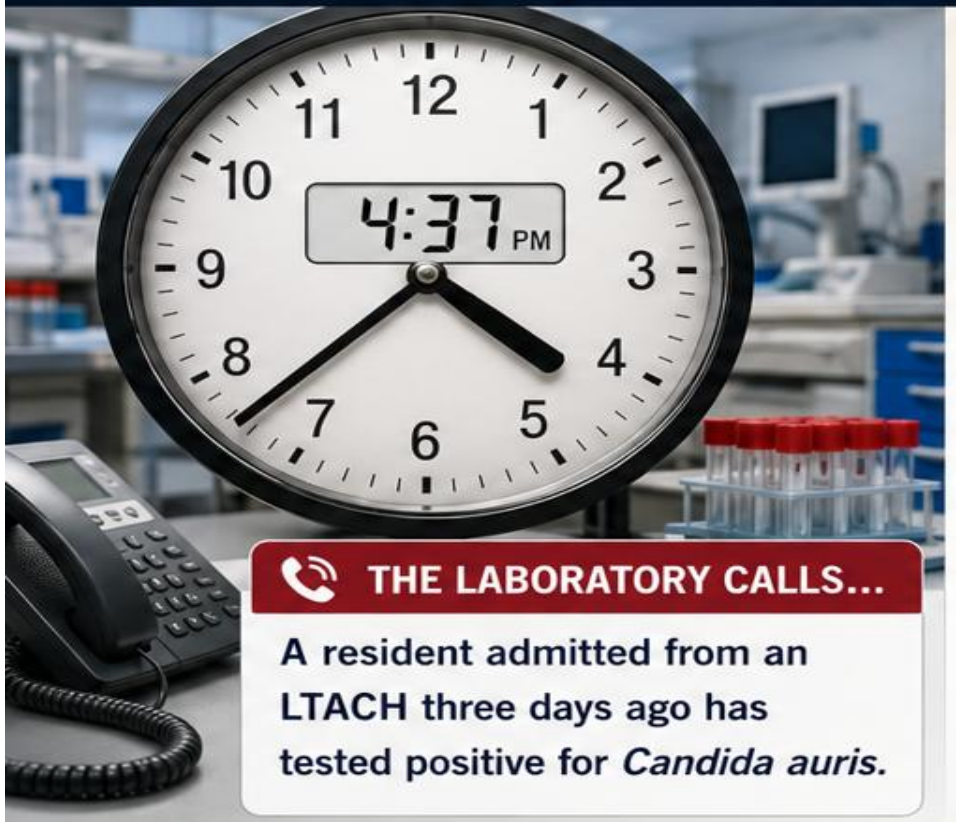

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ZOOM CHAT CHALLENGE

Type one letter (A, B, C, or D) in the chat with your answer!

ANSWER IN THE CHAT BEFORE THE ANSWER IS REVEALED.

There are no wrong answers—just different perspectives!

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

LET'S WALK THROUGH THE RESPONSE

The First Positive Case Triggers an Investigation—Not Just a Notification

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1 VERIFY THE LABORATORY RESULT

- Confirm organism identification
- Review specimen source
- Determine colonization vs. infection
- Coordinate with the laboratory if additional information is needed

2 IMPLEMENT APPROPRIATE PRECAUTIONS

- Place the resident on appropriate Transmission-Based Precautions
- Reinforce PPE use
- Notify frontline staff
- Ensure appropriate signage and supplies are available

3 NOTIFY KEY STAKEHOLDERS

- Administrator
- Medical Director
- Nursing Leadership
- Environmental Services
- Laboratory
- Public Health (when indicated)

BEGIN THE OUTBREAK INVESTIGATION

4 START THE INVESTIGATION

- Begin the line list
- Review roommate history
- Assess resident movement
- Review recent admissions and transfers

5 EVALUATE EXPOSURES

- Shared therapy
- Dialysis
- Medical equipment
- Caregiver assignments
- Common areas

6 DETERMINE NEXT STEPS

- Decide who requires screening
- Assess need for point prevalence survey
- Expand investigation if additional cases are identified

ONE LABORATORY RESULT SHOULD TRIGGER A COORDINATED RESPONSE—NOT ISOLATED ACTIONS.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Investigator Challenge #2

The Outbreak Just Got Bigger... Now What?

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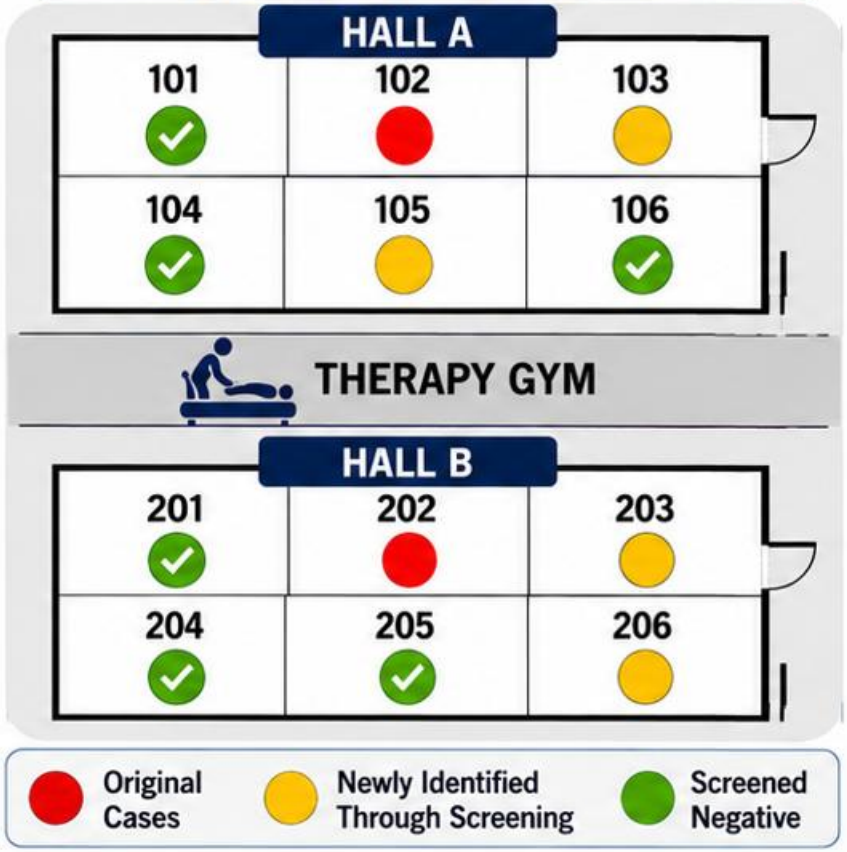
48 Hours Later...

Your point prevalence survey is complete.

- **4** newly identified colonized residents
- **3** different hallways
- All attended therapy
- **3** receive dialysis at the same center
- No residents shared the same room

UPDATED FACILITY MAP



WHAT'S YOUR NEXT PRIORITY?

A Close the investigation because all positives have been identified.

B Continue the investigation to identify the common source and interrupt ongoing transmission.

C Transfer all positive residents to another facility.

D Repeat screening tomorrow for the entire building.

*Finding additional colonized residents **does not** mean the investigation failed— **it means the investigation is working.***

ZOOM CHAT CHALLENGE
Type A, B, C, or D in the chat before we discuss the next step.

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

Investigator Challenge #2

WHY THE ANSWER IS B

Continue the Investigation
to identify the common source and interrupt ongoing transmission.

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WHAT WE'VE LEARNED SO FAR

- One case triggered the investigation.
- A point prevalence survey identified 4 additional colonized residents.
- Residents are on 3 different hallways.
- All attended therapy.
- 3 receive dialysis at the same center.
- No residents shared the same room.

1 EXPAND EPIDEMIOLOGIC LINKS

- Review resident movement beyond their room
- Compare staff assignments
- Evaluate overlapping activities and locations

2 REASSESS SHARED EQUIPMENT

- Identify equipment used by multiple residents
- Review cleaning and disinfection processes
- Ensure adequate supply of equipment

3 OBSERVE THERAPY WORKFLOWS

- Observe therapy gym processes and flow
- Review equipment cleaning between residents
- Assess hand hygiene opportunities

CONTINUE THE INVESTIGATION

to identify the common source and interrupt ongoing transmission.

4 EVALUATE DIALYSIS COMMUNICATION

- Communicate with the dialysis center IP contact
- Review transport and staffing practices
- Determine any shared risks during dialysis

5 REVIEW ENVIRONMENTAL CLEANING PRACTICES

- Verify cleaning of high-touch surfaces and equipment
- Review cleaning products and contact times
- Validate EVS training and competency

6 STRENGTHEN INTERDISCIPLINARY COMMUNICATION

- Hold regular huddles with key teams
- Share updates and findings consistently
- Ensure everyone understands the plan and their role

KEY TAKEAWAY

Additional cases don't mean we failed—

they help us find the source and STOP transmission.

Our goal is not just to find cases, but to find the why behind them.

A thorough investigation today prevents more cases tomorrow.
Stay curious. Ask questions. Follow the data. Protect our residents.

ZOOM CHAT CHALLENGE RECAP
The correct answer is B.
How did you decide?
Let us know in the chat!

THE OUTBREAK INVESTIGATION ROADMAP

RECOGNITION → DETECTION → INVESTIGATION → CONTAINMENT → RECOVERY

WHEN IS THE OUTBREAK REALLY OVER?

Recovery Begins When Transmission Has Been Interrupted—Not Simply When Time Has Passed

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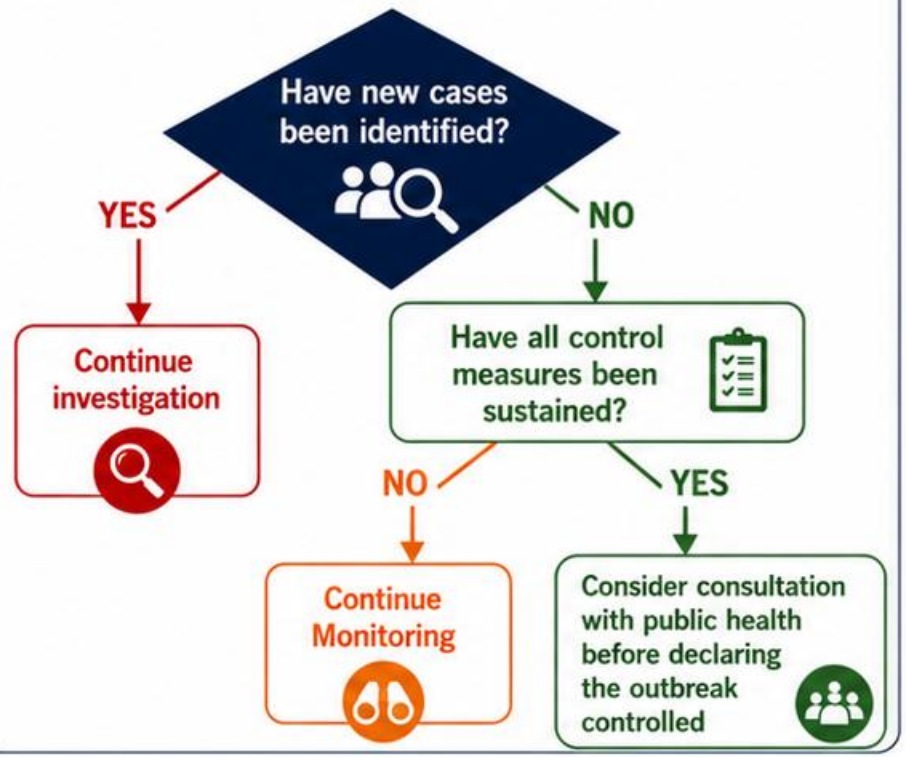
BEFORE YOU DECLARE SUCCESS...

- ☑ No newly identified cases through ongoing surveillance
- ☑ Follow-up screening completed, when indicated
- ☑ Epidemiologic investigation supports interruption of transmission
- ☑ Environmental cleaning and disinfection processes validated
- ☑ Compliance audits demonstrate sustained improvement
- ☑ Communication with public health completed, as appropriate

OUTBREAK RECOVERY DECISION PATH



RECOVERY DOESN'T MEAN WE STOP

Recovery Means We Continue To...

MONITOR	Ongoing surveillance for early detection
OBSERVE	Watch for changes in trends and patterns
AUDIT	Verify compliance and effectiveness
COMMUNICATE	Keep stakeholders informed and aligned
EDUCATE	Reinforce learning and best practices
IMPROVE	Strengthen processes and system resilience

THE END OF AN OUTBREAK IS THE BEGINNING OF A STRONGER INFECTION PREVENTION PROGRAM.

LEADERSHIP REMINDER
Recovery is a process—not an event.

LEADERSHIP REFLECTION

Ask yourself:
If another *Candida auris* case was admitted tomorrow, would your team respond differently than they did when this outbreak began?

EVIDENCE
Not assumptions

JUDGMENT
Not the calendar

CONFIDENCE
Not coincidence

COMMUNICATION CAN STOP TRANSMISSION

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The Right Information. The Right People. The Right Time.

Strong communication builds trust, strengthens response, and supports coordinated outbreak management.

NURSING STAFF
Need to Know:
- Precautions
- PPE expectations
- Resident care changes
- Workflow updates

ENVIRONMENTAL SERVICES
Need to Know:
- Cleaning priorities
- EPA-registered disinfectant selection
- Contact times
- High-touch surfaces
- Shared equipment

MEDICAL PROVIDERS
Need to Know:
- Clinical status
- Laboratory updates
- Treatment considerations
- Resident movement

INFECTION PREVENTIONIST
The Communication Hub

RECEIVING / SENDING FACILITIES
Need to Know:
- Current Transmission-Based Precautions
- Colonization/infection status
- Required communication during transitions of care
- Ongoing recommendations

PUBLIC HEALTH
Need to Know:
- New cases
- Investigation updates
- Screening activities
- Requests for support

RESIDENTS & FAMILIES
Need to Know:
- What is happening
- What precautions are being taken
- How they can help
- Where to ask questions

PEOPLE FEAR WHAT THEY DON'T UNDERSTAND.
COMMUNICATION BUILDS CONFIDENCE.

LEADERSHIP TIP
- Communicate early.
- Communicate consistently.
- Communicate honestly.

THE AFTER-ACTION REVIEW

Turning an Outbreak Into Organizational Improvement

Every outbreak should leave your organization stronger than it found it.

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1 WHAT WENT WELL?

- Early recognition of the case(s)
- Rapid communication
- Strong teamwork and collaboration
- Leadership support and resources
- Timely implementation of interventions

2 WHAT COULD HAVE GONE BETTER?

- Delays in identification or notification
- Documentation or data gaps
- Communication barriers or gaps
- Supply or resource challenges
- Staff education or competency gaps

AFTER-ACTION REVIEW

3 WHICH SYSTEMS FAILED?

- Equipment cleaning workflow
- Environmental cleaning & disinfection
- Resident/patient movement and transfer communication
- Surveillance and screening process
- Policies or procedures not followed

4 WHAT NEEDS TO CHANGE?

- Policies and procedures
- Staff education and training
- Auditing and feedback processes
- Resources, staffing, or supplies
- Environmental and equipment processes

5 WHO NEEDS TO BE INCLUDED?

- Nursing
- Infection Prevention
- Environmental Services
- Therapy / Rehab
- Laboratory
- Medical Staff
- Leadership / Administration
- Other Key Partners

6 HOW WILL WE MEASURE SUCCESS?

- Compliance with key practices
- Audit results and trends
- Surveillance and screening outcomes
- Staff competency
- No ongoing transmission
- Feedback from staff and partners

THE OUTBREAK ENDS.
THE LEARNING SHOULD NOT.

LEADERSHIP REFLECTION

Ask yourself:
What will our organization do differently because of what we learned?

EVERY OUTBREAK SHOULD PRODUCE...

- A revised policy
- Updated education
- Better surveillance
- Stronger partnerships
- System improvement

Focus on systems, not blame. | Be open and honest. | Use data, not assumptions. | Commit to continuous improvement. **Stronger systems. Safer patients. Every time.**

The Infection Preventionist's Outbreak Management Toolkit

A Practical Checklist for Every Facility

Whether you're responding to your first case or managing a complex outbreak,
these are the actions that should never be overlooked.

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1. CONFIRM & VERIFY

- ☐ Verify laboratory identification
- ☐ Confirm specimen source
- ☐ Differentiate colonization vs. infection
- ☐ Notify the laboratory if clarification is needed

2. PROTECT

- ☐ Implement appropriate Transmission-Based Precautions
- ☐ Ensure PPE and signage are available
- ☐ Reinforce hand hygiene
- ☐ Educate frontline staff

3. INVESTIGATE

- ☐ Start the line list
- ☐ Review resident/patient movement
- ☐ Identify shared equipment and common exposures
- ☐ Assess therapy, dialysis, procedures, and transfers

4. CONTAIN

- ☐ Validate environmental cleaning
- ☐ Audit equipment disinfection
- ☐ Determine screening strategy
- ☐ Communicate with public health as appropriate

5. MONITOR

- ☐ Review surveillance data daily
- ☐ Update the line list
- ☐ Monitor compliance audits
- ☐ Reassess interventions

6. COMMUNICATE

- ☐ Keep leadership informed
- ☐ Update frontline staff
- ☐ Coordinate during transitions of care
- ☐ Provide clear information to residents, patients, and families as appropriate

STOP • **THINK** • **INVESTIGATE** • **COMMUNICATE** • **IMPROVE**

Every step matters. *Every person plays a role.*

Use the data. *Follow the process.*

Work together. *Protect everyone.*

Better today. *Stronger tomorrow.*

Remember

A checklist doesn't replace critical thinking.

It helps ensure critical steps aren't missed.

TOP 10 MISTAKES *That Prolong a Candida auris* OUTBREAK

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Avoid these pitfalls. Act early. Stay consistent. Stop transmission.

1 WAITING FOR MULTIPLE CASES BEFORE ACTING
Delays allow silent transmission to spread throughout the facility.

2 DELAYING COMMUNICATION WITH KEY STAKEHOLDERS
Late communication leads to confusion, delays, and inconsistent response.

3 ASSUMING ROOMMATES ARE THE ONLY CONTACTS
Shared equipment, therapies, and staff can drive transmission.

4 FOCUSING ONLY ON INFECTED PATIENTS INSTEAD OF COLONIZED PATIENTS
Colonized patients can be the engine of transmission.

5 INCONSISTENT ENVIRONMENTAL CLEANING AND EQUIPMENT DISINFECTION
Inconsistent practices create opportunities for *C. auris* to persist.

6 NOT VALIDATING CLEANING EFFECTIVENESS THROUGH AUDITS
If you don't verify, you can't be sure cleaning is effective.

7 POOR COMMUNICATION DURING TRANSFERS OF CARE
Incomplete information leads to missed precautions and continued transmission.

8 STOPPING SURVEILLANCE TOO EARLY
Premature discontinuation can lead to undetected ongoing transmission.

9 TREATING THE OUTBREAK AS AN INFECTION PREVENTION PROBLEM INSTEAD OF AN ORGANIZATIONAL RESPONSE
Outbreaks require leadership, resources, and teamwork.

10 FAILING TO CONDUCT AN AFTER-ACTION REVIEW
Missed opportunities to learn and strengthen the organization.

Remember

Outbreaks rarely happen because of **one** mistake.

They happen because of **multiple** missed opportunities.

MOST OUTBREAKS ARE PROLONGED BY MISSED OPPORTUNITIES—NOT A LACK OF GUIDANCE.


ACT EARLY


WORK TOGETHER


STAY FOCUSED


FOLLOW THE DATA


CONTINUOUSLY IMPROVE

LEADING BEYOND THE OUTBREAK

Preparedness Is the Greatest Infection Prevention Strategy

The strongest organizations don't wait for the next outbreak—they prepare for it every day.

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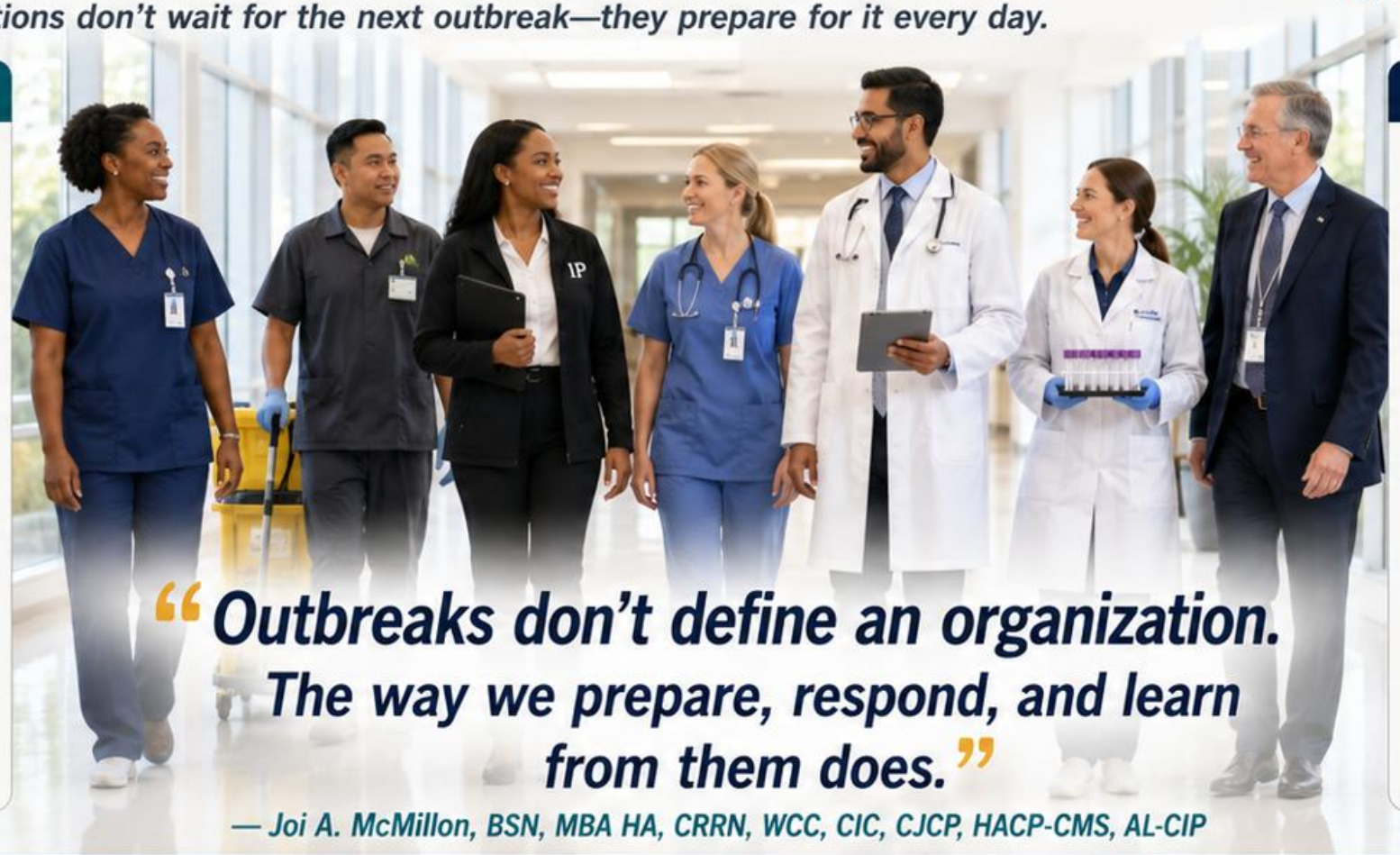
OUTBREAKS TEST...

- SYSTEMS
- COMMUNICATION
- LEADERSHIP
- SURVEILLANCE
- PROCESSES



> ***"Outbreaks don't define an organization. The way we prepare, respond, and learn from them does."***
>
> *— Joi A. McMillon, BSN, MBA HA, CRRN, WCC, CIC, CJCP, HACP-CMS, AL-CIP*

STRONG ORGANIZATIONS BUILD...

- ✓ PREPAREDNESS
- ✓ COLLABORATION
- ✓ TRUST
- ✓ ACCOUNTABILITY
- ✓ CONTINUOUS IMPROVEMENT

TURNING COMPLIANCE INTO DAILY EXCELLENCE

One patient. One resident. One decision at a time.

BE PREPARED · WORK TOGETHER · KEEP PEOPLE SAFE · KEEP LEARNING · KEEP IMPROVING

QUESTIONS, *Challenges* & SHARED EXPERIENCES

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Let"s learn from one another.

Your questions help us all *grow.*

Let's Discuss Together

- What challenges have you faced managing or preventing *Candida auris*?
- What strategies have worked well in your facility?
- What resources or support would be most helpful?
- What questions do you have about today's content?

Every experience shared today strengthens **ALL** of us.

Together, we make healthcare safer.

Your insights may be the solution someone else needs.
Thank you for contributing!

CONNECT WITH ME

Let's Stay in Touch

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Scan the QR code to save my contact information and connect with me.

Scan Me!

Scan once.
Connected always.

TOGETHER, WE CAN STOP THE SPREAD AND PROTECT THOSE WE SERVE.

COLLABORATE | SHARE IDEAS | SOLVE PROBLEMS | MAKE AN IMPACT

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DISCLAIMER

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Presentation developed using current guidance available from the CDC, APIC, EPA, and public health resources as of June 2026.
Attendees should verify updates as recommendations evolve.