BCU quarterly training. Currently, 8 of 17 IPs are active TOs. IP integration into BCU training and operations fosters increased trust and a heightened sense of safety across the team. Dedicated TOs with the sole responsibility to ensure healthcare worker safety allows for deeper specialization and improved adherence to safety standards, unburdening other clinicians from balancing multiple roles between bedside and operational safety. **Conclusion:** Embedding IPs as TOs within RESPTC preparedness plans and BCU response operations—beyond their traditional role in developing standard operating procedures, processes, and protocols—is a best practice to promote a culture of safety and an innovative approach to support operational efficiency for patient care in high-level isolation environments.

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Incremental yield of adding anterior nares to axilla/groin for *Candidozyma auris* surveillance among hospitalized patients‡

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Background: Previous studies demonstrated that the addition of anterior nares to axilla/groin skin testing substantially improved the detection of Candidozyma auris colonization (Proctor et al., Nature Medicine, 2021; Sansom et al., CID, 2024), but these observations were limited by small sample sizes and reflected mostly nursing home residents. We aimed to assess the benefit of adding nares testing to axilla/groin testing among hospitalized patients participating in C. auris point prevalence surveys (PPSs). Methods We conducted a prospective observational study at three long-term acute care hospitals (LTACHs) in the Chicago region, one of which also included distinct inpatient rehabilitation floors. Facilities participated in quarterly public health-led C. auris PPSs from May 2024 to October 2025. Patients underwent swab sampling at two sites: composite bilateral axillae/groin (swab 1) and bilateral anterior nares (swab 2). Samples were processed at a central laboratory for C. auris detection by PCR using a validated assay with enzymatic preprocessing and automated DNA extraction. Primary analyses were restricted to patients with results available from both sampling sites; a positive C. auris test from either body site was considered the reference standard. Analyses were performed using R v4.5.2 (www.r-project.org) and Stata/SE v18.0 (Stata Corp., College Station, TX). Results Across 18 PPSs, 769 of 867 (89%) eligible patients participated. The overall C. auris prevalence was 46% (317/685) among LTACH patients and 15% (13/84) among rehabilitation patients. Among all patients who tested positive for C. auris, 64% were in Contact Precautions for any reason at time of PPS and 34% were previously known to be C. auris colonized. After excluding 16 patients who were missing a body site specimen, 753 patients were eligible for analysis (670 LTACH, 83 rehabilitation). Among 320 patients with C. auris detected at any body site, 301 were detected by axilla/groin screening (94% sensitivity; 95% confidence interval 91% to 96%) and 234 (73%) tested positive at the anterior nares for C. auris. Inclusion of nares swabbing identified 19 additional patients who would have been missed by axilla/groin screening alone, corresponding to an incremental increase of 6%. Conclusion Among LTACH and rehabilitation patients, C. auris colonization was common and PPSs identified a substantial number of patients not previously known to be colonized. The incremental benefit of adding nares screening was modest compared to axilla/groin screening alone. Testing more body sites can identify more C. auris colonized patients, but facilities should balance benefit versus cost of expanded screening approaches.

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Leveraging the Electronic Medical Record to Identify Patients at Risk for Carbapenemase-producing organisms‡

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Background: Carbapenemase-producing organisms (CPO) are a serious public health threat. The Centers for Disease Control and Prevention (CDC) guidelines for combating CPO includes a recommendation to screen selected high risk patients. We describe a program to identify and screen patients at risk for CPO. Setting: An academic, tertiary care center with 2,059 licensed beds and 74,359 admissions a year. **Methods:** A report was created in the electronic medical record (EMR) to identify adult patients admitted in the previous 24 hours who were from countries and states with known CPO transmission based on address and zip code. A nursing protocol was subsequently developed in the EMR to facilitate CPO screening for eligible patients at admission. After the CPO order is placed, an electronic communication is sent via the EMR alerting the patient care team of the order, the rationale for screening, details on swab collection, and links to a toolkit with resources to help answer patient questions. A single perirectal swab is obtained by the patient's primary nurse and is tested for Klebsiella pneumoniae Carbapenemase (KPC), New Delhi metallo-β-lactamase (NDM), oxacillinase-48 (OXA-48), and Verona integron-encoded metallo-β-lactamase (VIM) by polymerase chain reaction (PCR). Patients may refuse testing. **Results:** From May 2018 through November 2025, 6,039 patients were identified for CPO screening using case-finding report. Of these patients, 2,424 had CPO swabs completed. Eighteen patients with CPO were identified with an overall yield of 0.75% on admission screening. There was one patient who tested positive for KPC, 10 patients who tested positive for NDM, and 5 patients who tested positive for OXA-48. Two patients were identified to have both NDM and OXA-48. **Conclusions:** The EMR can be leveraged for early identification and screening of patients with epidemiologically significant pathogens. Use of the nursing protocol has enabled IPAC to complete timely CPO surveillance and prevent transmission to other patients. Protocols within the EMR can be effectively replicated for a timely response to emerging infections.

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Implementing Admission Screening for Candida auris‡

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Background: Candida auris is a globally emerging, multidrug-resistant fungal pathogen that causes serious, difficult-to-treat infections in hospitalized patients. C. auris cases in the United States have been linked to receipt of healthcare overseas. Outbreaks have also occurred in New York City, New Jersey, Illinois, Nevada, and California. We provide care

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to patients from all 50 states and 138 countries and are therefore, at risk for encountering C.auris within our facility. **Methods:** A case-finding tool was created by Infection Prevention and Control (IPAC) within the electronic medical record (EMR) to identify patients for screening. Inclusion criteria was centric to patients who were admitted in the previous 24 hours with a primary address in a foreign country or in areas of the United States with known C. auris transmission. Patients who are positive for Carbapenamase-producing organisms (CPO) are also included in screening criteria. In 2020, Clinical Microbiology validated a polymerase chain reaction (PCR) test in partnership with the State Health Department and IPAC. In January 2022, IPAC created a protocol that allows IPAC staff to order C. auris screening directly in the EMR utilizing the validated PCR test. The order is paired with communication from IPAC alerting the patient care team that C.auris screening is indicated. Instructions on test collection and information on C. auris are also included in messaging. The patient's primary nurse then obtains verbal consent from the patient to collect a composite axilla–groin skin swab. Swabs are sent to Clinical Microbiology for testing, and results are reported directly into the EMR. **Results:** Since the introduction of the nursing protocol in January 2022, 2,660 patients have been identified for C. auris screening through November 2025. Of the 2,660 patients identified for testing, 1,111 patients had screening completed. Two patients tested positive for C. auris on screening. Both patients had prolonged travel to regions with known C. auris transmission. **Conclusion:** The EMR can be leveraged for early identification and screening of patients at risk of C.auris colonization. Case finding tools, combined with nursing protocols and communication strategies within the EMR can be effectively replicated and modified to respond to emerging infections.

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Omission at Admission: A Retrospective Review of an Admission Surveillance Protocol for Candida auris‡

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Background Illinois has one of the highest regional Candida auris burdens nationwide. Our hospital has a surveillance protocol for Candida auris that dictates all patients with an admission in the prior 6-months to a skilled nursing facility (SNF), long-term acute care hospital (LTACH), and/or inpatient rehab (IR) be tested on hospital admission. Additionally, three high-risk units at our institution have an increased surveillance protocol that includes testing all patients on admission, transfer, and weekly for C. auris. Two years of first-positive C. auris cases were reviewed to investigate if our surveillance protocol was capturing all patients with C. auris present on admission. Method A retrospective chart review was conducted using our electronic database and medical record (EMR). All admitted inpatients between January 1, 2023 to December 31, 2025 with a first-positive Candida auris laboratory specimen were included. Prior positive laboratory tests and outside facility encounters or transfers were manually reviewed from the EMR. Results A two-year data review identified 121 unique patients with positive Candida auris clinical or surveillance results. Of the 121 patients, 99 (81.8%) had no documented history (NDH) or prior positive laboratory results for C. auris. These cases were categorized as hospital onset (HO) 74/99 (74.7%) or present on admission (POA) 25/99 (25.3%). Of the 25 POA/NDH patients, 14 (56%) were directly admitted from a SNF, LTACH, or IR. Of the 25 POA/NDH patients, 17 (68%) had exposure to SNF, LTACH, and/or IR in the 6 months prior to admission. There were 8/25 (32%) patients admitted directly from home or outside hospital (OSH) and had no SNF, LTACH, or IR admissions 6 months prior. These 8 patients did not qualify for surveillance testing when screened for admission. Of the 8 patients, 6 (75%) had an admission to an OSH in the 6 months before surveillance screening. Conclusion The 8 POA/NDH cases without exposure to SNF, LTACH, or IR raise the question of whether including OSH encounters into our screening questionnaire could increase the accuracy of our C. auris surveillance protocol. We have demonstrated that exposure to SNF, LTACH, and IR is a risk factor. Other regional hospitals should be encouraged to evaluate or begin surveillance protocols to help define whether hospital admissions are a risk factor for C. auris acquisition. Validating the accuracy of risk factors will help us better understand the epidemiology of C. auris and potentially prevent HO transmissions from missed POA cases.

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The C.A.R.E. Framework: A Strategic Approach to Controlling Candida auris Transmission at an Acute Care Hospital in New York City‡

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Background: Rates of Candida auris are rising across the US, particularly in New York. Due to C. auris' affinity for environmental contamination and prolonged skin colonization, rapid implementation of comprehensive infection prevention & control (IP&C) measures is essential. Given the complexity and multidisciplinary involvement required for these efforts, we developed the C.A.R.E (Candida Auris Response & Engagement) framework in response to an inpatient outbreak to guide multidisciplinary efforts and provide a model for other facilities facing similar challenges with C. auris or other pathogens with extensive contact transmission. **Methods:** A C. auris cluster was identified in an 862-bed New York City academic medical center between July and October 2025. 23 cases were found involving a medical stepdown unit and adjacent intensive care unit. Baseline IP&C C. auris efforts include isolation precautions (gown and gloves), twice-daily room cleaning/disinfection, dedicated equipment, ATP testing of high touch surfaces (HTS) post terminal room cleaning, observations of personal protective equipment (PPE) use and hand hygiene, and screening of exposed roommates. After an August point prevalence surveillance (PPS) identified additional cases, we expanded interventions across various categories. The C.A.R.E. framework (Fig. 1) summarizes baseline and expanded efforts during this cluster. Figure 1. The C.A.R.E. (Candida Auris Response & Engagement) Framework to approaching a rise in C. auris cases. **Results:** Of 23 cases, 83% (19/23) were detected through surveillance. Clinical cases included bloodstream (3/4) and respiratory (1/4) sources. Shared rooms, either roommates or subsequent room occupants, were associated with 52% (12/23) of cases. Following implementation of the C.A.R.E. framework, further transmission ceased, confirmed by two negative rounds of PPS on each unit (Fig. 2). Figure 2. A timeline of C.auris cases identified on 2 units with corresponding IP&C effort implementation. To address identified gaps, a C. auris task force was created to improve IP&C processes. Key actions included clarifying equipment cleaning responsibility in collaboration with Environmental Services and Nursing, reevaluating the C. auris isolation category, and expanding screening for high-risk patients. Further, we incorporated fluorescent marker audits alongside ATP testing into routine practices to monitor environmental and equipment cleaning. While not all measures in the C.A.R.E. framework may be needed for every outbreak, facilities can adapt and scale interventions based on feasibility and outbreak severity. **Conclusions:** Effective prevention of C. auris transmission requires coordinated and multidisciplinary efforts. Establishing a

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