Healthcare Facility Exposure Investigation Checklist Tool for a Single Case of *Candida (Candidozyma) auris (C. auris)*

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
1. Contact the healthcare facility and determine the exact dates the case patient was present within the facility.	☐ Pending ☐ Completed	Healthcare Facility Name: _____ _____ Date of Presentation: _____ Date of Admission (if applicable): _____ Date of Discharge/Transfer: _____
2. Notify the facility about the patient's positive *C. auris* test result.	☐ Pending ☐ Completed	Date Facility Notified of Positive Result: _____
3. Provide the healthcare facility with setting-appropriate infection prevention and control recommendations for *C. auris*.	☐ Pending ☐ Completed	☐ Recommendations provided verbally ☐ Recommendations provided in writing
4. Determine whether the case patient was on appropriate Transmission-Based Precautions (TBP) for any or all of their admission. a. Document the type of TBP implemented for the case patient and the specific dates TBP was in-place, as well as dates that TBP were not in-place.	☐ Pending ☐ Completed	TBP implemented: ☐ Contact Precautions ☐ Enhanced Barrier Precautions ☐ Droplet Precautions ☐ Airborne Precautions Date TBP Implemented: _____ Date TBP Discontinued: _____ Date(s) TBP Not In-Place: _____ _____
5. Determine the type(s) of unit(s) the patient was admitted to and the corresponding dates for each unit admission (e.g., ICU, vent unit, memory care unit). a. Document the unit types, room numbers and corresponding dates of admission to each room and unit.	☐ Pending ☐ Completed	Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____

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		Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____
6. Determine if the case patient had any roommates. a. Within CDRSS, document the prior and current roommates as contacts of the case under the Contact Tracing section. Document the roommates' names and dates of birth at a minimum. If available, document the dates they shared a room and their current location within the comments of the Contact Tracing section. b. Prior and current roommates that are still within the facility should be prioritized for colonization screening if they do not have a history of *C. auris*.	☐ Pending ☐ Completed	<u>Roommate #1</u>: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ <u>Roommate #2</u>: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____

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		Roommate #3: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ Roommate #4: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ Roommate #5: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ Roommate #6: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____
7. Determine when and where the patient was admitted from and if there are any other known healthcare facility admissions or overnight stays in the 30 days prior to positive specimen collection. a. Confirm all other healthcare facility addresses are listed as investigation addresses linked to the case within CDRSS. b. If new facilities of admission are identified, add them as investigation addresses linked to the case within CDRSS and notify the LHD with jurisdiction over the healthcare facility.	☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ N/A	Facility/Location Prior to Admission: _____ _____ Other Known Healthcare Facility Admissions & Dates: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

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8. Collect the remaining disease specific questionnaire (DSQ), risk factor and clinical status information from the facility and enter the information into the appropriate sections within CDRSS. a. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.	☐ Pending ☐ Completed	In the 30 days leading up to positive specimen collection, did the case patient receive any of the following healthcare services? ☐ Chemotherapy ☐ Imaging ☐ Ultrasound ☐ Inpatient dialysis ☐ Outpatient dialysis ☐ Wound care ☐ Physical therapy or rehabilitation ☐ Respiratory therapy ☐ None ☐ Other:_____ In the 30 days leading up to positive specimen collection, did the case patient have any of the following indwelling medical devices? ☐ Mechanical ventilation ☐ Tracheostomy ☐ Urinary catheter ☐ Abdominal feeding tube ☐ Central venous catheter ☐ Other intravenous line (e.g., midline) ☐ Hemodialysis catheter ☐ Intraabdominal drain/catheter ☐ Nephrostomy ☐ Surgical drain ☐ None ☐ Other:_____ Is the patient diabetic? ☐ Yes ☐ No ☐ Unknown Does the case patient have a history of colonization or infection with another MDRO? ☐ Yes ☐ No ☐ Unknown In the 30 days leading up to positive specimen collection, did the case patient have any of the following: ☐ Chronic wounds ☐ Immunocompromising condition ☐ Non-ambulatory status In the 6 months leading up to positive specimen collection, did the case patient have any of the following: ☐ An organ or tissue transplant

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		☐ An overnight stay at a healthcare facility in another state ☐ An overnight stay at a healthcare facility in another country Pre-existing conditions: ☐ Chronic lung disease ☐ Diabetes mellitus ☐ Cardiovascular disease ☐ Chronic renal disease ☐ Chronic liver disease ☐ Immunocompromised condition ☐ Neurologic/Neurodevelopmental/ Intellectual disability ☐ Other chronic diseases ☐ Cancer ☐ Obesity ☐ Congenital heart disease ☐ None Has the patient died? ☐ Yes ☐ No ☐ Unknown Date of death: _____
9. Determine if there were any other known *C. auris* case patients within the facility during/around the same time as the new case and assess potential epidemiologic links. a. Enter the collected information into the DSQ in CDRSS.	☐ Pending ☐ Completed ☐ Pending ☐ Completed	Were there any other known *C. auris* case patients admitted during the same time as the new *C. auris* case patient? ☐ Yes ☐ No ☐ Unknown If yes, does the new case have any of the following epi-links to any known cases? ☐ Common unit ☐ Shared staff ☐ Shared equipment/devices ☐ Other:_____ ☐ None
10. Determine if the case patient utilized any shared medical equipment or devices (e.g., vitals machines, glucometers, stethoscopes, lifts, imaging machines).	☐ Pending ☐ Completed	☐ No shared/reusable equipment or devices ☐ Any shared/reusable equipment or devices
11. Identify the specific disinfectant products and corresponding EPA registration numbers utilized for reusable equipment and devices (e.g., nursing carts, vitals machines, PT equipment). a. Document the disinfectant products utilized for patient care equipment and	☐ Pending ☐ Completed	Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____

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devices and their EPA registration numbers.		Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____ Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____
12. Identify the specific disinfectant products and corresponding EPA registration numbers utilized by the facility's environmental services (EVS) or housekeeping (HK) staff for environmental cleaning. a. Document the disinfectant products utilized for environmental cleaning (i.e., room and patient care environment cleaning) and their EPA registration numbers.	☐ Pending ☐ Completed	Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____ Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____ Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____
13. Determine whether the disinfectant products utilized for environmental disinfection and equipment/device disinfection are on EPA List P or EPA List K. a. Search for products' EPA registration numbers on EPA List P and EPA List K.	☐ Pending ☐ Completed	EVS/HK Disinfectants: ☐ On List P ☐ On List K ☐ Not on List P or List K Equipment/Device Disinfectants: ☐ On List P ☐ On List K ☐ Not on List P or List K
14. Contact NJDOH and provide documentation of all information collected during each healthcare facility exposure investigation to determine if colonization	☐ Pending ☐ Completed	Date Information Provided to NJDOH: _____

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screening is indicated. NJDOH will assist in coordinating any necessary colonization screening at impacted healthcare facilities. a. If NJDOH recommends colonization screening, proceed to step 15 or 16, depending on the situation. Otherwise, proceed to step 17.		
15. If/when NJDOH recommends colonization screening at the healthcare facility and testing is being conducted by the public health laboratory: a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH, the facility's shipping address and contact information (i.e., name, phone number, email) for the primary point(s) of contact at the healthcare facility; provide this information to NJDOH as soon as possible. b. Provide the healthcare facility with NJDOH's colonization screening recommendations, including potential dates when colonization screening can be supported by the public health laboratory as determined by NJDOH. c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility. d. Provide the healthcare facility with NJDOH's colonization screening instructions document and the line list template. Review colonization screening process and instructions with the healthcare facility prior to the date of scheduled specimen collection. e. Ensure the healthcare facility follows instructions for conducting *C. auris* colonization screening. f. Upon receipt of test results, refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.	☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed	Unit Floorplans Obtained: _____ _____ _____ _____ Unit 1: _____ Unit 1 Bed Count: _____ Unit 2: _____ Unit 2 Bed Count: _____ Unit 3: _____ Unit 3 Bed Count: _____ Unit 4: _____ Unit 4 Bed Count: _____ Unit(s)/Room(s) Being Screened: _____ _____ Scheduled Date for Testing: _____ Testing Laboratory: _____ # of Patients Approached: _____ # of Patients Screened: _____ # of New Positive Results:_____ Next Steps: ☐ Conclude facility investigation ☐ Proceed to initial outbreak investigation activities
16. If/when NJDOH recommends colonization screening at the healthcare facility and testing is being conducted by the facility's laboratory:		Unit Floorplans Obtained: _____ _____ _____

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a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH; provide this information to NJDOH as soon as possible. b. Provide the healthcare facility with NJDOH's colonization screening recommendations and determine when the facility will conduct colonization screening. c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility and the laboratory that will be conducting testing. d. Obtain a line listing of patients/residents included in the colonization screening from the healthcare facility that includes patient last name, patient first name, patient date of birth, patient sex, date of specimen collection and specimen source; provide to NJDOH upon receipt. e. Request copies of all colonization screening test results be provided by the healthcare facility as soon as results are finalized; provide to NJDOH upon receipt. f. Refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.	☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed	_____ Unit 1: _____ Unit 1 Bed Count: _____ Unit 2: _____ Unit 2 Bed Count: _____ Unit 3: _____ Unit 3 Bed Count: _____ Unit 4: _____ Unit 4 Bed Count: _____ Unit(s)/Room(s) Being Screened: _____ _____ _____ Scheduled Date for Testing: _____ Testing Laboratory: _____ # of Patients Approached: _____ # of Patients Screened: _____ # of New Positive Results:_____ Next Steps: ☐ Conclude facility investigation ☐ Proceed to initial outbreak investigation activities
17. Complete the Facility Exposure Investigation Status and Updates section within CDRSS; enter the required information for each healthcare facility exposure investigation conducted. a. Refer to the disease chapter or the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.	☐ Pending ☐ Completed	