Beyond the Audit: Aged Care Infection Control

Why passing the audit is not the same as controlling infection

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Prepared for IPC Leads, Directors of Nursing, clinical governance and quality teams in residential aged care.

Summary

Aged care is working under the biggest infection control reform in its history. The Aged Care Act 2024 and the Strengthened Quality Standards, in force from 1 November 2025, turned infection prevention and control from an operational task into a legal safety obligation.

A facility can pass a regulatory audit and still carry preventable infection risk in its daily work. That is not a failure of intent. It is what happens when systems are built to produce documents rather than verified results.

The evidence points the same way. A 2025 Australian study identified 11 distinct gaps between evidence and practice in residential aged care, gaps a documentation review does not reliably find. A study of 134 facilities found 44% of staff responsible for IPC held no specific IPC qualification.

What has changed

Standard 4, Outcome 4.2 requires a documented IPC system that includes how the provider responds to suspected or confirmed outbreaks. It must be evidence based, regularly evaluated and able to stand up to scrutiny.

Standard 5, Outcome 5.2 takes this into clinical practice: infection prevention is built into care planning, clinical decisions and ongoing staff competency.

The Aged Care Quality and Safety Commission can audit, issue compliance notices and impose sanctions. The question is no longer whether you have a policy. It is whether your system works.

Why compliance and outcomes drift apart

Audits have mostly checked that documents exist, that policies are in place and that staff can describe what they would do. Those checks are necessary. They are not sufficient.

The 2025 study used scenarios to look at what staff actually do. It found missed hand hygiene before resident contact and the wrong protective equipment for respiratory procedures. Those are not paperwork gaps. They happen at the point of care, and paperwork will not show them.

When performance is measured by documents rather than by observation and testing, the audit result and the hygiene result go separate ways.

The three real gaps

1. Training and competency

Competency gaps stay invisible until an outbreak exposes them. The Royal Commission named workforce training as a systemic failure, and investigations into COVID-19 outbreaks in New South Wales and Victoria both called for continuing IPC training outside outbreak periods. Attendance records do not close this gap. Confirmed competency at the point of care does, checked again over time.

2. Environmental verification

A surface that looks clean is assumed to be clean. The evidence does not support that assumption. A cleaning schedule confirms cleaning happened, not that it worked. The Aged Care IPC Guide (August 2024) is clear that monitoring infections alone will not change their rate unless it is linked to prevention and continuous improvement. Swab testing and periodic verification close the gap between assumed and actual results, and they give a facility evidence it can show.

3. Chemistry chosen inside the IPC system

Residents are not passing through. They live in these rooms around the clock. Which products are used, where, and how they are applied affects residents, staff and surfaces every day. Product selection is not just a purchasing decision. It belongs inside the IPC system, reviewed against each product's register entry, its label directions and the setting it is used in.

A framework for measurable control

The gap is closed by building the system around verification rather than documentation. Four parts work together.

1. Independent evaluation of practice. Watch what actually happens on the floor and compare it with the evidence, not just with a checklist.

2. Swab testing and environmental verification. Objective data on high touch and high risk surfaces, so results can be shown to a regulator, a family or a governance committee.

3. Validated workforce training. Documented competency, not attendance, rechecked regularly.

4. Considered product and process selection. Each product matched to its register entry and label, applied as directed, and suited to a place where people live.

When these four run together, the system does more than pass an audit. It produces results that can be measured, reported and defended.

Conclusion

In Q1 2025-26, infectious diseases and infection control made up 104 formal complaints to the Commission, with a further 98 about environmental cleanliness. Most of those facilities had IPC policies in place.

The hidden risk is not the absence of a system. It is the gap between what the system documents and what it delivers. The standard now is evidence of performance.

Sanifect ICM works with aged care providers to build processes that hold up, and to test them.
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Declared interest: Sanifect ICM is the national distributor of Nanocyn Advanced (Listed AUST L 520725). This paper is product agnostic.