# Environmental Disturbance Control Permit

Permit for the control of construction dust, debris and excavation dust to prevent outbreaks of aspergillosis or related nosocomial fungal infections in immunocompromised patients.

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| **Permit number** |  | Work order number: |  |
| Requested by name: |  | Phone number: |  |
| Company: |  | Vendor OIC name: |  |
| Start date: |  | Finish date: |  |
| Finish date: |  | Finish time: |  |
| Location: |  | | |
| Work Description: |  | | |
| Special considerations: |  | | |
| Clinical considerations: |  | | |

#### Associated Permits on Issue

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| --- | --- | --- |
| Working at height | Excavation | Communications room access |
| Fire services isolation | Electrical/Mechanical isolation | Fire penetration |
| Asbestos work area access | Hot work | Live (Energised) work |
| Confined space |  |  |

#### Environmental Disturbance Control Measures

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| --- | --- | --- |
| Infection prevention risk assessment completed | Construction barricades in place and area sealed off | Negative pressure air within construction area |
| Area access control to be implemented | Partitioning and/or temporary wall to be installed | Ceiling access risk assessment completed |
| Site cleaning procedures in place | HEPA filtered vacuum cleaner to be used | Environmental microbial sampling to occur |

#### Conditions of Permit

|  |  |  |
| --- | --- | --- |
| Communication and risk control plan: | Yes | No |
| Daily compliance survey: | Yes | No |
| Monitoring required: | Yes | No |
| Clinical clean to be undertaken: | Yes | No |

#### Approval

|  |  |
| --- | --- |
| *I understand the conditions of this permit and will abide by all safe work procedures.* | Officer in charge on site:  Name:  Signature: Date |
| *I am satisfied that persons impacted have been consulted. I approve the works specified in this permit.* | Infrastructure and Assets authorised person  Name:  Signature: Date |

#### Completion of Work

|  |  |  |
| --- | --- | --- |
| Did the work create dust or potentially disturb dust that could impact a floor of a building that has clinical or patient areas (including plants rooms with air intakes to clinical or patient areas) | Yes | No |
| Specify areas affected: | | |
| Has a clinical clean been undertaken in the identified areas: | Yes | No |
| Specify the cleaning process (i.e. waste removal, vacuum with HEPA filter, wet wipe with bacterial agent) | | |
| Is a “Certificate of Analysis” required for the areas impacted (attach a copy of the report) | Yes | No |
| Report Details (provide a summary of the air monitoring process undertaken i.e. passive or active, and the reported CFU at nominated intervals):  Service Provider Date | | |
| Can the impacted area be re-occupied | Yes | No |

|  |  |
| --- | --- |
| *I hereby certify that the work is complete, and areas inspected have been made safe. All services have been restored. Impacted staff have been notified* | Officer in charge on site:  Name:  Signature: Date |

#### Endorsement

|  |  |
| --- | --- |
| *I hereby advise that the work is complete, and areas inspected have been made safe* | Infection Prevention Control Officer  Name:  Signature: Date |

#### Close Out Permit

|  |  |
| --- | --- |
| *I hereby certify that the work is complete, and areas inspected have been made safe. All services have been restored. Impacted staff have been notified* | Infrastructure and Assets authorised person  Name:  Signature: Date |