#  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

|  |  |  |
| --- | --- | --- |
| [ ]  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  |