NHS Lothian

Manual Handling Assessment Risk Assessment For other areas

Hospital / Location		Date	
Area		Line Manager	
Specific area		Link/Key worker	

A) Staffing Levels

What are the core hours of work?
How many staff typically work each day?

Can additional staff be obtained at short notice?		YES / NO
If so explain how		

Have all staff attended a manual handling induction course?	YES / NO
Have all staff attended a manual handling update?	YES / NO
Are all staff, students and temporary staff shown how to use the manual handling equipment in your area?	YES / NO
Comments:	

B) Area Profile

Type of department	

Please indicate the number of the following facilities included in this area and give a brief description

Facility	Number	Description:
Beds / Plinths/ trolleys / couches (please indicate)		*Adjustable height?* *Fixed height?* *Profiling?*
Showers		
Toilets		
Offices, filing facilities, store rooms		
Corridors		

C) Area Design

Please complete the following questions. If problems are identified that require action, provide details and provide further comments if required.

Layout

Are there any features of the general layout of the area that interfere with moving and handling activities?	YES / NO

Floors

Defective	YES / NO	Uneven	YES / NO
Slippery	YES / NO	Sloping	YES / NO

Lighting

Is the lighting adequate to move patients / objects safely at all times of the day?	**YES / NO**
Is the lighting adequate to move patients / objects safely at all times of the night?	**YES / NO**

Housekeeping

Are working areas and access routes kept free of obstructions?	**YES / NO**

Space

Is there sufficient space to undertake the manual handling tasks required	**YES / NO**

Are corridors wide enough for the safe passage of trolleys, equipment, etc	**YES / NO**

Are the door mechanisms adequate to allow the safe passage of staff and patients?	**YES / NO**

Other factors

Do any of the following factors affect the ability of staff to undertake the manual handling tasks required safely?

Noise	**YES**	**NO**
Vibration	**YES**	**NO**
Weather	**YES**	**NO**
Heating	**YES**	**NO**
Ventilation	**YES**	**NO**
Uniform / clothing	**YES**	**NO**
Comments;		

D) Manual Handling Equipment

Please list below all mechanical lifting aids (mobile and fixed) available in the department. Aids to be considered include hoists, trolleys, sack trucks etc.
Indicate Safe Working Load (SWL) of equipment.

Equipment	**SWL Kg**	**Serial Number of hoist/ Equipment**	**Purchase Date**	**Date of Maintenance / LOLER Check**	**Comments** (Shared / borrowed from another area)

What other equipment is used for the transporting of loads within the department and to and from other areas, *e.g. wheelchairs, trolleys, back packs etc? Please comment on whether trolleys etc. are height adjustable.*

Equipment	**No**	**SWL Kg**	**Comments**

Do you have sufficient numbers of lifting aids ?	**YES / NO**
Do you have sufficient numbers of transportation equipment?	**YES / NO**
Do you have systems in place for inspection and maintenance of the above noted equipment?	**YES / NO**

Please indicate which of the following checks are in place:	
Annual Service of hoists and associated lifting equipment	**YES / NO**
Annual Insurance checks for lifting and electrical equipment	**YES / NO**
Before use safety checks for all equipment	**YES / NO**
Electrical safety check (Portable Appliance Test) for all electrical manual handling equipment	**YES / NO**
What is the procedure in place in case of fault or failure of equipment?	

List the equipment in your area for bariatric / heavy patients	
Do you require any additional equipment, please list and note on action plan	

Risk Assessment

Please assess all significant manual handling risks on the following form using the following scale for the severity of the risk;

GREEN

Risk is well controlled, precautions are sufficient and reliable

YELLOW

Risk is acceptable but borderline. The combination of the severity of the consequences and the likelihood indicates that improvements would be desirable in the medium term; serious adverse effects are most likely.

ORANGE

Risk is unacceptable. Remedial action is necessary

RED

Risk is unacceptable. Remedial action is urgent; consideration should be given to stopping the work until the risk can be reduced.

E) Specific task assessment form (complete a separate page for each manual handling task with a significant risk of injury)

Task / Activity	Complete the relevant details of the activity being assessed

Risk factors		List all risk factors here: Lifting, lowering, pushing, pulling, twisting, carrying and working with an awkward posture.
		The Task
		Holding away from trunk Twist, stoop, reach, Lift or carry distance Frequency/recovery time.
		The Load
		Heavy, bulky, unstable, sharp, or hot surface etc.
		The Environment
		Space, floor, thermal, lighting, clothing etc.
		Individual capacity
		Pregnant, health problem, requires special training
Individuals or groups exposed		Highlight staff at risk and the likely maximum numbers exposed.

Current control measures					List current control measures, Eliminate the need to handle, redesign the task or load. Provide handling equipment, improve environment, vary work, job rotation, team handling, information instruction and training, supervision, enforcement of policy, protective measures and monitoring procedures.
With these controls the risk is (tick)	**GREEN**	**YELLOW**	**ORANGE**	**RED**	

Further control measures required	Include any additional controls identified to eliminate or reduce the risk further.

Date					
Initial					

Use a new box each time this assessment is reviewed

F) Action Plan

If control measures required to reduce risks to an acceptable level are beyond the budget or authority of the ward/area manager then list these in the Action Plan in the following section. Identify the problem area; the controls that are required to reduce risks to an acceptable level; who is to action the controls; and target and completion dates. Examples of actions that may be required are: Equipment purchase or repair, Buildings alterations of repair (e.g. widen doorways, repair floors) Organisational changes (e.g. working practices, staffing levels)
Training requirements (e.g. use of equipment, moving & handling training, health & safety awareness).

Problem	Risk Level	Controls Required	Designated Person	Target Date	Date of Action

Designation	Date	Print name	Signature
Assessor			
Ward/Area Manager			
Senior Manager			

Assessment review date				
Assessor name				
Assessor signature				
Assessment still valid?	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**

Keep this form in the ward/area as a written record of your assessment. This form must be reviewed and updated annually or when ever there is a change to the record.