**MANUAL HANDLING RISK ASSESSMENT**

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| **Service Director:** | **Section:** | **Assessment Ref:** |
| **Assessor’s Name:** | **Assessor’s Signature:** | **Assessment Date:** |
| Task name: | | |
| Task Description: | | |
| Site/Location of Task: | | |
| List those who may be at risk/harmed: | | |

**Section A – Detailed Task Description and Existing Control Measures**

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| **Detailed description of operations covered by the assessment**:  *(including load weight, frequency of lift; carry distances (if applicable) and diagrams/photographs)* |

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| **Existing Control Measures.** |

**Section B – T.I.L.E Assessment**

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| **TASK**  Does the task involve; | Yes | No | N/A | Describe possible problems occurring from the task | Are existing controls adequate? Y/N  *(if ‘No’ complete section C)* |
| Holding loads away from Torso? |  |  |  |  |  |
| Twisting? |  |  |  |  |  |
| Stooping? |  |  |  |  |  |
| Reaching upwards? |  |  |  |  |  |
| Large vertical movement? |  |  |  |  |  |
| Long carry distances? |  |  |  |  |  |
| Strenuous pushing or pulling? |  |  |  |  |  |
| Unpredictable movements of loads? |  |  |  |  |  |
| Insufficient rest or recovery? |  |  |  |  |  |
| Repetitive handling operations? |  |  |  |  |  |
| High work rate imposed? |  |  |  |  |  |
| **INDIVIDUAL CAPABILITY**  Does the job; | Yes | No | N/A | Describe possible problems occurring from the task | Are existing controls adequate? Y/N  *(if ‘No’ complete section C)* |
| Require unusual capability? |  |  |  |  |  |
| Pose a risk to those with a health problem? |  |  |  |  |  |
| Pose a risk to those who are pregnant? |  |  |  |  |  |
| Pose a risk to new workers/young people? |  |  |  |  |  |
| Require special information/training? |  |  |  |  |  |
| **LOAD**  Are the loads: |  |  |  |  |  |
| Heavy? |  |  |  |  |  |
| Bulky or unwieldy? |  |  |  |  |  |
| Difficult to grasp? |  |  |  |  |  |
| Unstable or unpredictable? |  |  |  |  |  |
| Harmful (e.g. sharp/hot)? |  |  |  |  |  |

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| **ENVIRONMENT**  Are there: | **Yes** | **No** | **N/A** | If yes describe possible problems occurring from the task | Are existing controls adequate? Y/N  *(if ‘No’ complete section C)* |
| Constraints on posture? |  |  |  |  |  |
| Poor floors? |  |  |  |  |  |
| Variations in levels? |  |  |  |  |  |
| Hot/cold/humid conditions? |  |  |  |  |  |
| Strong air movements (e.g. high winds)? |  |  |  |  |  |
| Poor lighting conditions? |  |  |  |  |  |
| **OTHER FACTORS** |  |  |  |  |  |
| Is movement or posture hindered by clothing, equipment or PPE? |  |  |  |  |  |
| Is team lifting required? |  |  |  |  |  |

**Section C – Remedial Action to be taken** *(if required)*

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| --- | --- | --- | --- |
| Remedial Action required *(In order of priority)* | Person responsible | Target completion date | Completed Y/N |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |

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| **Management Confirmation** | | | |
| **I have noted the above assessment and will take appropriate steps to ensure all the actions raised are completed satisfactorily.** | | | |
| **Name** (Block Capitals):  (Manager responsible for activity) |  | **Signed:** | **Date:** |

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| **Risk Assessment Review** | | |
| **I confirm that the assessment remains valid, controls remain effective and there has been no increase in risk.** | | |
| Review Date: | **Name:** | **Signed:** |
| Review Date: | **Name:** | **Signed:** |
| Review Date: | **Name:** | **Signed:** |

**Section D – Managers confirmation**