|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FIRST AID NEEDS ASSESSMENT** | | | | | | |
| **Name of business** |  | | | | | |
| **Number and brief description of locations** |  | | | | | |
| **Number of employees** |  | | | | | |
| **Occupancy levels during normal hours** |  | | | | | |
| **Risk level of business** | **Low** |  | **Med.** |  | **High** |  |

The minimum provision on any worksite should be:

1. A suitably stocked first aid box
2. An appointed person to take control of the first aid arrangements and boxes
3. Training/information to all employees giving details of first aid arrangements

**It is recommended that you complete this assessment in conjunction with the HSE leaflet**

**(INDG214 “First Aid at Work”)**

|  |  |
| --- | --- |
| **Risk consideration** | **Comments** |
| Significant hazards present within the workplace  **e.g. Hazardous substance, Confined space, Dangerous machinery** |  |
| Are there workers who are inexperienced, who have disabilities or particular health problems |  |
| Previous injuries and illnesses that have occurred nature of accident incident and locations |  |
| **Do your employees do any of the following:** | **Comments** |
| Travel a lot? |  |
| Do shift work? |  |
| Work out of hrs? |  |
| Lone work? |  |
| Work remotely? |  |
| Premises layout  **e.g. Several buildings on the site, Multi-floor buildings** |  |
| **Proximity to emergency services** | Please record the name of the nearest hospital and the time taken to get there from your location |
| **Provision for employees working on other sites**  **Details contained within the CDM plan for each site** | Please detail here if the site staff carry a first aid kit and where it is located |
| Provision for sickness and holidays  **(Cover for current first aider/appointed person)** |  |
| Do members of the public visit your premises?  Is there provision for visitors?  **(Under the current regulation you have no legal duty to provide first aid for non -employees, but the HSE strongly recommends that you include them in your first aid provision** |  |
| What is your procedure for a suspected case of COVID-19 at work? | **Detail your controls here or see BESA COVID-19 risk assessment** |

|  |
| --- |
| **Nature of first aid requirements** |
| X 1 appointed person  Name----------------------------------------------------------  Contact number----------------------------------------------------------  Please details how many appointed persons and record their names here  Please detail how many first aid boxes there are and their locations |

|  |
| --- |
| **Other comments** |
|  |

|  |  |
| --- | --- |
| **Name (Please print)** |  |
| **Signature** |  |
| **Assessment date** |  |
| **Review date** |  |