

Pharmacist Home Medication Review – Pre-Visit Safety Checklist

This checklist is designed to ensure safety for both the pharmacist and patient before conducting a home medication review. It should be completed prior to confirming the visit.

1. Environment and Access

| | Y/N | Notes |
|--------------------------------------------------------------------------|----------------------------------------------------------|-------|
| Is the home easily accessible (any gates, stairs, or security codes)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are there any parking restrictions or difficult-to-access areas? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is the home easy to find and visible from the street? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are there any outdoor hazards (e.g., uneven paths, poor lighting, pets)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Will anyone be home to assist with entry if needed? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

2. People in the Home

| | | |
|--------------------------------------------------------------------------------|----------------------------------------------------------|--|
| Who else will be present during the visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is anyone in the home known to be aggressive or unpredictable? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Might anyone be under the influence of alcohol or substances during the visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are there children or others requiring supervision during the visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

3. Animals and Pets

| | | |
|--------------------------------------------|----------------------------------------------------------|--|
| Are there any pets in the home? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Will the pets be secured during the visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

4. Smoking and Air Quality

| | | |
|---------------------------------------------------------|----------------------------------------------------------|--|
| Does anyone in the home smoke/vape? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Can smoking be avoided during the visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any vaping, incense, or air quality issues to consider? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

5. Infection Control and Hygiene

| | | |
|----------------------------------------------------------------------|----------------------------------------------------------|--|
| Is anyone in the home currently unwell (e.g., cold, flu, COVID-19)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any recent infectious conditions (e.g., MRSA, VRE)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any hygiene or environmental concerns (e.g., mould, clutter, pests)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

6. Cognitive, Behavioural or Mental Health Concerns

| | | |
|--------------------------------------------------------------------|----------------------------------------------------------|--|
| Any behavioural or cognitive issues that may affect communication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any history of distress, agitation or anxiety during visits? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

7. Environmental Hazards

| | | |
|------------------------------------------------------------------|----------------------------------------------------------|--|
| Any hazards inside or outside the home (cords, oxygen, clutter)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Adequate heating/cooling and ventilation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any bushfire, flood or local risks to consider? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

8. Communication and Technology

| | | |
|--------------------------------------------------------------|----------------------------------------------------------|--|
| Is there reliable phone reception at the home? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Can the patient/carer be contacted to confirm visit details? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Preferred contact person if plans change? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

9. Consent and Awareness

| | | |
|---------------------------------------------------------------------|----------------------------------------------------------|--|
| Is the patient/carer aware of the purpose of the medication review? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does the patient/carer consent to the home visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Would the patient like a carer or family member present? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

10. Other Situational Factors

| | | |
|-----------------------------------------------------------------|----------------------------------------------------------|--|
| Is an interpreter required for the visit? If so, what language? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Preferred or safest time of day for the visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are there any potential safety concerns in the home or weapons? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Clinician Self-Check Before Visit

| | | |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--|
| Is your phone charged and reception adequate? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Have you notified your manager/buddy of visit details? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you have accurate patient contact details and directions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Ask the patient to have all medications available for the medication review including OTC, eye drops, inhalers & prns | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Completed by: _____ Date: _____

Signature: _____ Contact No: _____