

Patient ID Label

Clozapine Side Effect Monitoring Care Plan

Consultant:

Named Nurse/
Key Worker:

Identified Need No: _____

	Date	Ward/Team
Admitted(if applicable)		
Transferred		
Transferred		
Transferred		
Transferred		

Clozaril Patient Monitoring Service Number	
Date Commenced on Clozapine	

Frequency of FBC Monitoring	Date Commenced	Date Reviewed/Changed	Baselines & Dates	Dates when reviews repeated														
			BMI															
			Physical Examination															
			ECG															
			FBC															
			Urea & Electrolytes															
			CRP															
			Troponin 1															
			Liver Function Test															
			Thyroid Function Test															
			HbA1c															
			Blood Lipids															
			Clozapine Plasma Levels															
			GASS Clozapine variant															








Signature of Named Nurse/Key Worker or other Registered Nurse		Date		Frequency of Review		Date	
Signature of patient (or reason for no signature)		Date		Date Identified Need Discontinued		Date	

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<p>Patient ID Label</p>	<p>_____ is prescribed Clozapine. There is the potential for developing significant unwanted effects & close monitoring is required when taking this medication to prevent &/or manage these.</p> <p>Nursing, pharmacy & medical staff will also require to provide on-going guidance, education & advice, regarding Clozapine to, _____ during 1:1 sessions & record this in Chronological Account of Care.</p>	
<p>Sore Throat, Mouth Ulcers, Cold/Flu Type Symptoms. (potential Neutropenia/Red Alert Blood Result)</p> <p><u>Actions</u> Liaise with Medical Staff & Pharmacy Team regarding further procedures, e.g. stopping Clozapine, administration of antipyretic if high temp etc. Blood test, Full Blood Count and Differential should be taken immediately and analysed at the local hospital laboratory. Monitor Blood Pressure, Pulse and temperature. Liaising with medical staff regarding results. Record actions and outcomes in chronological account of care liaising with medical staff & pharmacy team should patient require to attend hospital for further input.</p>	<p style="text-align: center;">Incontinence</p> <p><u>Actions</u> Ascertain frequency and occurrence and record in Chronological Account of Care. Advise reduction in amount of fluids consumed prior to bed time. Liaise with medical staff & pharmacy team regarding further interventions and record actions and outcomes in Chronological Account of Care.</p>	
<p style="text-align: center;">Constipation</p> <p><u>Actions</u> Discuss bowel movements & record in the Bowel Movement Record Chart. Nursing staff to note any recent changes in the chronological account of care and discuss with medical staff & pharmacy team. Liaise medical staff regarding prescribed laxative as and when required. Record action and outcome in chronological account of care Encourage _____ to have a high fibre diet, containing plenty of cereals and fruit and adequate fluids. Minimum of 1 ½ Litres per day. If evidence of constipation/diarrhoea or if _____ experiences stomach pains for more than a few days (2-3), inform medical staff immediately. This could potentially be a sign of faecal impaction which can be life threatening. Liaise with medical staff & pharmacy team regarding further interventions and record actions and outcomes of same in chronological account of care.</p>	<p style="text-align: center;">Risk of developing Cardiac Problems. Eg: tachycardia, Dizzy Spells, Faints & “funny turns”</p> <p><u>Actions</u> Risk of postural hypotension also risk of falls. Ensure Cannard Risk Assessment is completed and up to date (if inpatient). Monitor blood pressure (lying & standing) and record actions and outcome in chronological account of care. Advise _____ to take time and move slowly from lying/sitting to standing positions.</p> <p>Pulse to be monitored & staff to check rate & rhythm, observing for any abnormalities, tachycardia, bradycardia, irregular beats. Liaise with medical staff regarding performing of an ECG & any requirement on for referral to Acute Services. Liaise with medical staff & pharmacy team regarding actions and outcomes and record in Chronological Account of Care.</p>	
<p style="text-align: center;">Hypersalivation</p> <p><u>Actions</u> Monitor frequency and occurrence. Provide _____ with guidance regarding use of chewing gum/sugar free sweets to boost salivation and swallowing. Suggest propping up with pillows in bed at night when asleep Liaise with medical staff & pharmacy team regarding the prescription of an anticholinergic to reduce hypersalivation. Record actions and outcome in Chronological Account of Care. Note anticholinergic drugs will increase the likelihood of developing constipation.</p>	<p style="text-align: center;">Weight Gain</p> <p><u>Actions</u> Monitor BMI and Weight. Regularly monitor waist circumference (increased waist circumference indicates higher risk of incidence of heart disease. Record any changes and liaise with dietician regarding healthy eating plans as and when required. Record all actions and outcomes in chronological account of care. Liaise with medical staff & pharmacy team regarding further review & interventions.</p>	
<p style="text-align: center;">Sedation</p> <p><u>Actions</u> Ascertain from _____ onset, time of day and record in chronological account of care. Liaise with medical staff regarding discussion of changes in timing of doses of Clozapine. (e.g. higher proportion of the dose being taken at bedtime) Record actions and outcomes in chronological account of care.</p>	<p style="text-align: center;">Other required monitoring</p> <p><u>Actions</u> The Glasgow Antipsychotic Side Effect Rating Scale – clozapine variant, will be completed during initiation of therapy and regular thereafter. (Weekly/monthly/every 3 months/every 6 months/_____) * (indicate frequency) & completed 1 month after any change to clozapine dose. Results & any required interventions will be recorded in chronological account of care by nursing staff liaising with medical staff & pharmacy team.</p>	

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Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

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Glasgow Antipsychotic Side Effect Scale (GASS) for Clozapine

Name:		Current Medications:
Date		
Caffeine intakecups/day	
Smoker: Yes / Nocigarettes/day	
Has there been a recent change in your smoking habit? Yes / No		Increase/Decrease bycigarettes/day

This questionnaire is being used to determine if you are suffering from excessive side effects from your medication.
Please put a tick in the column which best indicates how often or how severely you have experienced the following side effects.

		Never	Once	A few times	Everyday	Tick here if severe or distressing
Over the <u>past week</u>:						
1.	I have felt sleepy during the day					
2.	I felt drugged or like a zombie					
3.	I felt dizzy when I stood up or have fainted					
4.	I have felt my heart beating irregularly or unusually fast					
5.	I have experienced jerking limbs or muscles					
6.	I have been drooling					
7.	My vision has been blurry					
8.	My mouth has been dry					
9.	I have felt sick (nauseous) or have vomited.					
10.	I have felt gastric reflux or heartburn					
11.	I have had problems opening my bowels (constipation)					
12.	I have wet the bed					
13.	I have been passing urine more often					
14.	I have been thirsty					
15.	I have felt more hungry than usual or have gained weight.					
16.	I have been having sexual problems.					

I have also experienced:

(please write down any other side effects **OR PHYSICAL PROBLEMS OR COMPLAINTS** that you may have experienced over the past week)

17.	
18.	
19.	
20.	

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Staff Information

1. Allow the service user to fill in the side-effect scale themselves. All questions relate to the previous week.

2. **Scoring**

0 Points	"Never"
1 Point	"Once"
2 Points	"A few times"
3 Points	"Everyday"

3. **Results**

0-16	absent / mild side-effects
17-32	moderate side-effects
33-48	severe side-effects

4. **Side-effects covered include:**

1-2	Drowsiness & sedation
3	Postural hypotension
4	Tachycardia
5	Myoclonus
6	Hypersalivation
7-8	Anticholinergic side-effects
9-10	Gastrointestinal side-effects
11	Constipation
12	Nocturnal enuresis
13-14	Screening for diabetes mellitus
15	Weight gain
16	Sexual dysfunction

5. The column relating to the severity/distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user's views & condition.
6. Questions 17 to 20 invite the service user to report any other side-effects or problems not already mentioned. These questions should not be scored but may instigate a discussion with the service user if clinically appropriate.