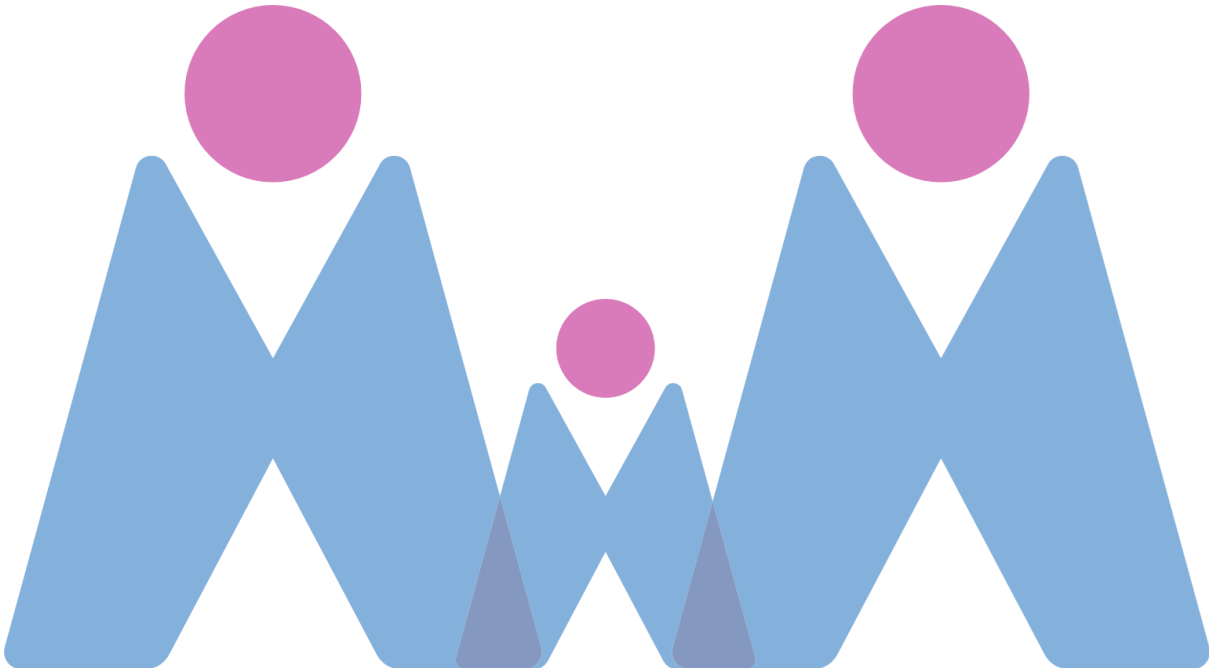
NHS
Manchester University
NHS Foundation Trust

Saint Mary's Hospital
Gynaecology Division

Endometriosis

Practice handbook guide & competencies for Trainee Endometriosis CNS



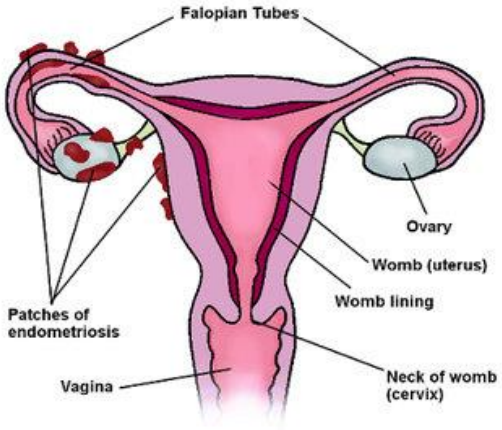
Contents

What is Endometriosis?

Endometriosis is the name given to the condition where cells similar to the ones in the lining of the uterus are found elsewhere in the body.

Each month these cells react in the same way to those in the womb, building up and then breaking down and bleeding. Unlike the cells in the womb that leave the body as a period, this blood has no way to escape.

In the UK, around 1.5 million women and those assigned female at birth are currently living with the condition, regardless of race or ethnicity. Endometriosis can affect people from puberty to menopause, although the impact may be felt for life.



During the menstrual cycle, the body goes through hormonal changes each month. Hormones are naturally released which cause the lining of the womb to increase in preparation for a fertilized egg. If pregnancy does not occur, this lining will break down and bleed – this is then released from the body as a period.

In endometriosis, cells similar to the ones in the lining of the womb grow elsewhere in the body. These cells react to the menstrual cycle each month and also bleed. However, there is no way for this blood to leave the body. This can cause inflammation, pain and the formation of scar tissue.

Endometriosis can have a significant impact on a person's life in a number of ways, including:

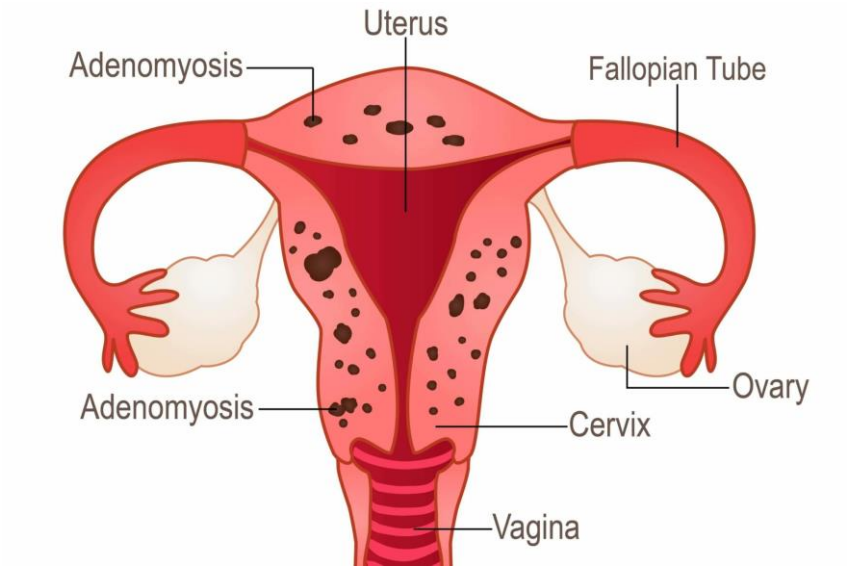
- Chronic pain
- Fatigue/lack of energy
- Depression/isolation
- Problems with a couple's sex life/relationships
- An inability to conceive
- Difficulty in fulfilling work and social commitments

Adenomyosis

Adenomyosis is a condition where endometrial tissue grows into the muscular wall of the uterus (womb). In a way, similar to endometriosis, this tissue continues to respond to the hormonal changes in the menstrual cycle and thickens, breaks down and bleeds.

Adenomyosis can cause menstrual pains, heavy prolonged menstrual periods, lower abdominal pressure, and abdominal bloating.

It can be located throughout the entire uterus or localised in one spot (adenomyoma).



Other locations of Endometriosis

GI Tract	Urinary Tract	C-section scar/ Abdominal surgery	Umbillicus
Liver	Thoracic	Peri-anal	Vaginal

Symptoms

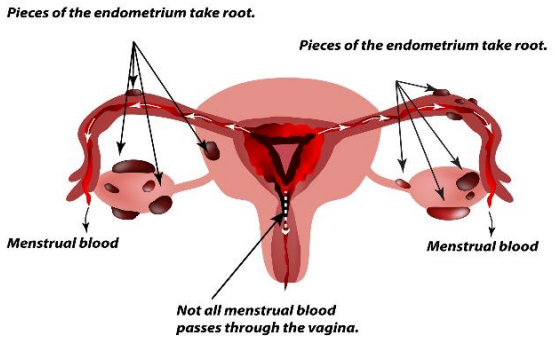
- Menorrhagia
- Dysmenorrhea
- Painful ovulation
- Chronic pelvic pain
- Acute flare up of pain
- Anaemia
- Fatigue/lack of energy
- Depression/isolation
- Dyspareunia; Problems with a couple's sex life/relationships
- An inability to conceive
- Painful bowel movements (Dyschezia),
- Bladder pain, pain with urination
- PR bleeding
- Haematuria, renal obstruction
- Difficulty in fulfilling work and social commitments

(Proposed) Pathophysiology

The actual cause of endometriosis is unknown.
There are several theories about the cause of endometriosis, but none fully explains why endometriosis occurs. It is possible that a combination of the following factors could be causing endometriosis to develop in some of those affected by the condition:

Retrograde menstruation

When you have a period, some of the endometrium (womb lining) flows backwards, out through the fallopian tubes and into the abdomen. This tissue then implants itself on organs in the pelvis and grows. It has been suggested that everyone who has periods experiences some form of retrograde menstruation, but their bodies are able to clear this tissue and it does not deposit on the organs. This theory does not explain why endometriosis has developed in some cases after hysterectomy, or why, in rare cases, endometriosis has been discovered in some men when they have been exposed to oestrogen through drug treatments.



Genetic predisposition

Some research suggests that endometriosis can be passed down to new generations through the genes of family members. Some families may be more susceptible but the causes of this are unclear.

Lymphatic or circulatory spread

Endometriosis tissue particles are thought to somehow travel round the body through the lymphatic system or in the bloodstream. This could explain why it has been found in areas such as the eyes and brain.

Immune dysfunction

It is thought that in some cases the immune system is not able to fight off endometriosis. Many of those with endometriosis appear to have reduced immunity to other conditions. It is not known whether this contributes to endometriosis or whether it is as a result of endometriosis.

Environmental causes

This theory suggests that certain toxins in our environment, such as dioxin, can affect the body, the immune system and reproductive system and cause endometriosis. Research studies have shown that when animals were exposed to high levels of dioxin they developed endometriosis. This has not yet been proven for humans.

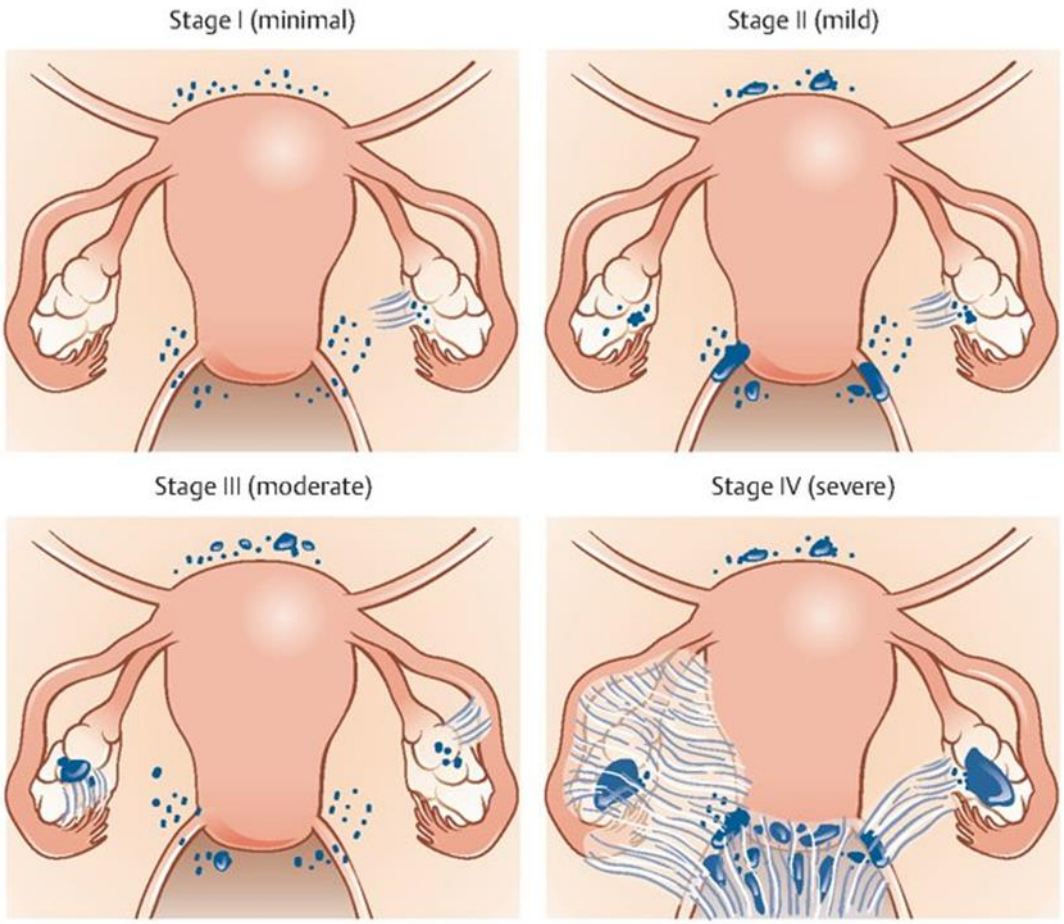
Metaplasia

Metaplasia is the process where one type of cell changes or morphs into a different kind of cell. Metaplasia usually occurs in response to inflammation and enables cells to change to their surrounding circumstances to better adapt to their environment. In the case of endometriosis, metaplasia would explain how the endometriosis cells appear spontaneously inside the body – and how they appear in areas such as the lung and skin. It would also explain the appearance of endometriosis cells in women with no womb – or in men who have taken hormone treatments.

During development in the womb, metaplasia allows for the development of the human body as a natural process. To explain endometriosis, some researchers believe this change from one type of cell into an endometriosis cell happens as an embryo (developing baby in the womb), when the baby's womb (uterus) is first forming. Other researchers believe that some adult cells retain the ability they had as an embryo to transform into endometriosis cells.

Endometriosis Grading

Endometriosis can be classified into four stages. The American Society of Reproductive Medicine (ASRM) bases these stages on the lesions themselves, particularly the number of endometrial deposits and their depth.



Stage I (1-5 points)	• Minimal • Few superficial deposits
Stage II (6-15 points)	• Mild • More and deeper deposits
Stage III (16-40 points)	• Moderate • Many deep deposits • Small cysts on one or both ovaries • Presence of filmy adhesions
Stage IV (>40 points)	• Severe • Many deep deposits • Large cysts on one or both ovaries • Many dense adhesions

Hormone Treatments

As endometriosis responds and grows when exposed to the female hormone oestrogen, a number of hormone treatments attempt to block or reduce the production of oestrogen in the body. This means the endometriosis will be unable to continue growing and will help to relieve symptoms.

Hormone treatments work by reducing levels of oestrogen in the body preventing the lining of the womb and any endometriosis tissue from growing quickly. Some treatments work by causing a medical menopause. All treatments are temporary and are reversed when the patient has stopped taking the hormones. Please note that these drugs have no effect on adhesions neither do they help to improve fertility.

The following hormone treatment options are available to those with endometriosis:

Combined oral contraceptive pill

Mirena Coil

Progestogen only pill (POP)

Norethisterone / Provera

Depo provera injection

Contraceptive implant

Dienogest

GnRH analogues + add back HRT

Other medication

Tranexamic Acid: is an anti-fibrinolytic. It helps prevent fibrinolysis by stopping the fibrin from being broken down. It is used to prevent bleeding, it is taken to manage heavy periods when hormonal treatments may not be suitable.

Pain Relief

The main symptom of endometriosis is pelvic pain - there are various pain relief and pain management options available.

Painkillers

NSAIDs such as Ibuprofen, Voltarol and Ponstan (mefanemic acid) block the production of prostaglandins in the body. Prostaglandins occur naturally, in response to injury or disease, and cause pain and inflammation. They have a number of functions including making the womb contract during a period (which helps with the shedding of the womb lining). These contractions can cause pain. It is thought that people with endometriosis may produce more prostaglandins than those without the condition.

NSAIDs only work effectively if they are taken before the body produces prostaglandins. Many people take NSAIDs as they would other painkillers such as paracetamol. It is best to start taking NSAIDs the day before, or several days before, a period or pain is expected. Common side effects of NSAIDs include nausea, vomiting, diarrhoea, stomach upsets and stomach ulcers. These side effects can be reduced by taking the drugs with food or milk.

Codeine-based painkillers are effective painkillers but can cause constipation and gastro-intestinal upset, which may aggravate symptoms in those with endometriosis.

Simple analgesics such as paracetamol can be used to treat mild pain.

Pain modifiers

These drugs work by altering the body's perception of pain. Tricyclic anti-depressants (example – Amitriptyline) are drugs that are mainly used to treat depression but have been found to have an effect on the nervous system and the way the body manages pain. The pain messages travel through the body's central nervous system, but these drugs can help to stop those messages from reaching the brain.

Complementary Therapies

Heat and comfort

A simple hot water bottle or hot bath may help to reduce pain. Some people also find heated wheat bags to be effective. Being comfortable and reducing stress is also beneficial.

Acupuncture

An alternative approach to pain management and relaxation, acupuncture has gained wide popularity. Of the several studies that have examined the effectiveness of this treatment, two recent studies suggest that patients who receive acupuncture treatment tend to be more relaxed. Since muscle tension and stress play an important role in chronic pain symptoms, it is reasonable to explore whether acupuncture might provide some pain relief as one of the components of a pain management plan.

Transcutaneous Electrical Nerve Stimulator (TENS) machines

TENS machines are an alternative to pain killers. They are small, unobtrusive machines with electrodes that attach to the skin and send electrical pulses into the body. This does not hurt but instead feels mildly ticklish. The electrical pulses are thought to work by either blocking the pain messages as they travel through the nerves or by helping the body produce endorphins which are natural pain-fighters. Some TENS machines can be clipped to a belt. Check with your GP before using a TENS machine as they are not suitable for those who may be pregnant or who have a heart condition

Physiotherapy

Physiotherapists can develop a programme of exercise and relaxation techniques designed to help strengthen pelvic floor muscles, reduce pain, and manage stress and anxiety. After surgery, rehabilitation in the form of gentle exercises, yoga, or Pilates can help the body get back into shape by strengthening compromised abdominal and back muscles.

Surgery

As a treatment for endometriosis, surgery can be used to alleviate pain by removing the endometriosis, dividing adhesions or removing cysts.

There are three options of surgery for treating endometriosis:

Conservative surgery
Conservative surgery aims to remove or destroy the deposits of endometriosis and is usually done via a laparoscopy (keyhole surgery). The surgeon can either cut out the endometriosis (known as excision) or destroy it using heat or laser. Although surgery can provide relief from symptoms, they can recur in time.

Complex Surgery
Depending on the severity of the endometriosis, a more complex surgery that involves different organs within the body, such as the bowel or the bladder. These types of surgery will often include a multi-disciplinary team such as a colorectal surgeon, and are usually carried out via laparoscopy.

Radical surgery
More radical surgery can be considered if an individual has not responded to drug treatments or conservative surgery and is not planning to start a family. Radical surgery refers to a hysterectomy or oophorectomy.

Common diagnostic tools

Procedure / Test	What is it?	Important Info
USS	To assess for any abnormality involving the Uterus, Endometrium, Ovaries & Adnexa to help aid diagnosis of endometriosis or give cause of acute symptoms.	Imaging (US or MRI) should be used in the diagnostic work-up for endometriosis. It is important to know that patients may still have (peritoneal) endometriosis, even if the imaging tests were negative.
MRI	To assess for deeper endometriosis involving other pelvic organs.	
Laparoscopy	To provide definite diagnosis by visualising lesions. Patient's will usually undergo laparoscopy +/- excision of endometriosis, or Laparoscopy may be used to stage a person's endometriosis in more severe cases.	If medical treatment did not work, and no endometriosis could be detected during imaging, a laparoscopy for diagnosis and treatment of suspected endometriosis is recommended.
Histopathology	To confirm endometriosis following biopsy or excisional surgery	Endometriosis can be destroyed during excision and therefore may not be confirmed through Histopathology
Urinary Tract USS	To assess the function of the urinary tract when a person may be experiencing changes to bladder function including haematuria, dysuria, incontinence, difficulty passing urine	Ultrasound scans are important look for any blockage in the pipes draining the kidneys (ureters)
Renogram	To assess the structure and location of the kidneys and to check how well they are working	In cases where endometriosis are affecting kidney function this test helps to tell us the extent of any damage
CA-125	Can be raised in persons with endometriosis	CA-125 is not used to diagnose endometriosis but may have been requested as prior investigation following the persons presentation to GP/Gynaecology service.
AMH	A surrogate marker of egg reserve (how many eggs are remaining)	The levels are only reliable in telling us how one might respond to IVF treatment and does not determine the likelihood of natural conception.

History Taking

There are several consultation models which are useful to frame (and remember) your questions when taking a patients' history. Medical schools in the UK often use the Calgary-Cambridge model ***(please refer to history taking* competency**). Including:

- Presenting complaint.
- History of presenting complaint, including: investigations, treatment and referrals already arranged and provided.
- Fertility desires, previous pregnancies and pregnancy outcomes
- Past medical history: significant past diseases/illnesses; surgery, including complications; trauma.
- Medication history: now and past, prescribed and over-the-counter medicines, allergies.
- Family history: especially parents, siblings and children.
- Social history: smoking, alcohol, recreational drugs, accommodation and living arrangements, marital status, baseline functioning, occupation, pets and hobbies.
- Systems review: cardiovascular system, respiratory system, gastrointestinal system, nervous system, musculoskeletal system, genitourinary system.

Communication skills & Counselling

Good communication leaves patients and clinicians happier and can help to improve health outcomes.

Content adopted from: 16 ways to improve your communication skills with patients - BHF

Be attentive

"Listen completely and attentively. That's how you build up rapport and trust, and have meaningful discussions about treatment. Don't just think about your next question." – Dr Graham Easton

Ask open questions

"Always start with an open question – patients will often talk about what's on the top of their mind and when this is addressed, they are able to relax and be receptive to other topics you might need to discuss in the session." – Tootie Bueser

Be curious

"Maintain a sense of curiosity about your patient. Ask yourself: 'What's going on with this person? Why are they saying that in this way?'" – Dr Roger Neighbour

Summarise throughout

"Summarise what the patient is saying, not just at the end of the consultation but all the way through. Asking the patient if you've correctly understood the key points of their story shows that you are listening and care that you've got it right." – Dr Graham Easton

Involve friends and family

"Ensure patients in more complex situations have their peers with them. When alone and under stress, some people find it hard to remember all that has been said and to see all sides of the story. Family or friends can help them to reflect on the issues and explore the options. If I'm facing a tough consultation, I'll ask patients when their relatives are coming in, and will wait until they're there to speak with them." – Professor Rod Stables

Use the right tone

"Simple and concise language is important without 'talking down' to patients. Non-verbal communication is just as important as this conveys a sense of warmth and empathy which allows the patient to open up." – Tootie Bueser

Be aware of your patient's situation

"Be mindful of what's going on in their life – maybe they've had a bereavement recently, or are caring for someone who's unwell. Your holistic assessment of the patient will affect how you manage them." – Dr Nesan Shanmugam

Get help from colleagues

"Using a multidisciplinary approach can be a good way of overcoming communication barriers. Our heart failure specialist nurses are fantastic at educating our patients. So after a consultation I often introduce my patient to the nurse and say they can also help to answer their questions. It gives them an option of having someone else to talk to." – Dr Nesan Shanmugam

Be aware of bias

"We must reflect on our biases, acknowledge them and ensure we take steps to minimise them and not let this affect how we care and communicate with patients. In this way, patients don't feel judged and are comfortable sharing deeply personal and possibly embarrassing issues pertinent to their care." – Tootie Bueser

Communicate in different ways

"Find ways to support your communication with tools and analogies. In my hospital we create custom-built information sheets for each procedure. We provide a graphical representation of the risk – for example, 98 dots coloured white and two coloured black can represent 2%. Some of my colleagues use analogies like 'one person on a full double-decker bus'." – Professor Rod Stables

Adopt shared decision making

"Keep shared decision making in mind. However good their intentions, doctors often revert to saying 'I think you need this', because they think it works and is quicker – but often it doesn't work." – Dr Graham Easton

Try active listening

"Active listening allows us to tailor the information we give to patients and gives us cues for when we need to probe a bit more and if the patient has understood our message. Oftentimes, just being listened to is enough to decrease anxiety and stress." – Tootie Bueser

Speak up

"Adopt a 'freedom to speak out' model in your team. If people are prepared to share ideas with you, and you're prepared to listen to them, you can learn a lot. We try to avoid unquestioning respect for authority and we never assume that any individual is so good that they will not benefit from some advice from time to time." – Professor Rod Stables

Keep records

"Accurate documentation of our exchanges with patients helps sharing information with others in the healthcare team much easier and patients do not have to repeat their story over and over again." – Tootie Bueser

Setting

The layout of the consulting room can assist good consulting. It can facilitate establishing rapport with patients by, for example, allowing for good eye contact, enabling easy access to computers or notes and avoiding 'distance'

Emotional and Psychological Support

Endometriosis affects more than just the physical body and can have a profound emotional impact on those living with the condition. It is important to acknowledge this when counselling patients. Referrals to counselling support or charity networks may be required.

Common referrals

Provider	When To Refer	Important Info
Colorectal	Bowel involvement requiring colorectal surgeon. Function bowels issues.	Outpatient Referral
Urology	Bladder involvement requiring Urologist at surgery.	Outpatient Referral
Urogynaecology	Functional bladder/urinary tract issues, including incontinence, difficulty & pain passing urine	Outpatient Referral
Chronic Pain Team	Chronic Pain. Long history of endometriosis with multiple surgeries. GP unable to manage pain. Pelvic Physio	Outpatient Referral Patient must complete questionnaire within timeframe for referral to be accepted. GP can refer to local pain service if necessary
Fertility Services	No conception following 12 months of UPSI	GP to refer
Sexual Rehabilitation	Difficulty with intercourse due to history of dyspareunia	Outpatient referral via Benign Gynaecology (select Sexual rehab clinic)
Physiotherapy	Pelvic floor issues Post operative physio	Outpatient Referral
Endometriosis UK	For further support/advice/information	Helpline/Webchat/Support Groups
GP	Management of analgesia Mental Health assessment	Communicate appropriately. Letter/email/telephone
A&E	Signpost for: Management of acute episodes of pain Management of acute episodes of mental health issues	Mental Health Liaisons available if in crisis

Endometriosis MDT

Endometriosis *Multi-Disciplinary Team* meetings are held monthly.
Members include:
Radiologist
Consultant Gynaecologist, specialist in complex endometriosis
Consultant Colorectal Surgeon
Consultant Urologist
Consultant in Pain Management
Clinical Nurse Specialist in Endometriosis
Advanced Clinical Practitioner, specialist in complex endometriosis
Surgery Scheduler
MDT co-ordinator

Specialist Nurse Involvement

- Invite members to arranged meetings (in case MDT co-ordinator absent)
- List patients for discussion using HIVE snapboard (in case MDT co-ordinator absent)
- Completion of the PREP NOTES:

Consultant	Who is responsible for their care
Listed for surgery	Proposed procedure Weeks Wait
Reason for discussion	Surgical planning Requirement of colorectal/urology Complex case, to determine best course of ongoing management
Past Medical History/Symptoms	Including impact of condition on QoL
Past Surgical History	Previous surgeries Any known issues
Drug History	Including historic & current use of Hormonal treatment
Body Mass Index	If available, should be <35 for surgery
Fertility	Parity / pregnancy desired or not

- Record MDT (in case MDT co-ordinator absent)
- Able to transcribe notes from meeting and document relevant actions
- Communicate actions with relevant team members
- Complete own actions, for example referrals to other specialities
- Communicate MDT outcome with patient if required, through letter and/or telephone conversation
- Complete attendance audit (excel Spreadsheet)

Data Collection

The Complex Endometriosis Service is accredited through the British Society of Gynaecological Endoscopy (BSGE). To gain and maintain accredited status the service is required to obtain and submit the Pain and Quality of Life Questionnaire together with the Surgical Findings data. The centre must submit 12 cases per consultant per year, January – December. The last day of submission is 31st December.

- The specialist nurse should be able to obtain and submit the data using the BSGE database (login and password required).
- The specialist nurse should be able to liaise with the consultant team regarding the cases they have/require for submission and be able to present this if required.
- The BSGE also recommends obtaining and submitting follow up data (Pain and Quality of Life Questionnaire) at 6, 12 and 24 month intervals, this can be sent directly from the BSGE database/website.

Further Guidance

- ESHRE Endometriosis Guideline: Available at: https://www.eshre.eu/Guidelines-and-Legal/Guidelines/Endometriosis-guideline
- NICE Endometriosis Diagnosis & Management: https://www.nice.org.uk/guidance/ng73
- NICE Endometriosis Quality Standard: https://www.nice.org.uk/guidance/qs172
- Endometriosis UK: https://www.endometriosis-uk.org/
- BSGE: Resources for Endometriosis CNS | BSGE
- NHS England: https://www.england.nhs.uk/wp-content/uploads/2018/08/Complex-gynaecology-severe-endometriosis.pdf

Competency	Criteria	Assessors Signature:
History Taking	Is aware of and can apply the Medical-Model to obtain history Timekeeping *(See Separate competency for further requirements)*	
Knowledge of Endometriosis	Can discuss Endometriosis • What is Endometriosis • Causes • How to diagnose Can direct to relevant information • Leaflets • Endometriosis UK • Other	
Treatment options	Can discuss treatment options • COCP • PO preparations • Higher dose progestogens • Dienogest • GnRH • HRT Can identify side effects • Able to locate drug information (EMC/BNF) Can discuss associated risks • VTE • Breast Cancer Can identify when treatment options not appropriate/contraindicated • Able to locate drug information (EMC/BNF)	
Knowledge of Complimentary Therapies	Basic Knowledge of complimentary therapies	
Communication Skills	Uses appropriate communication skills	
Counselling	Listen, respond appropriately, respect, non-judgemental. Professional boundaries	
Refer & Signpost to other services	• A&E/GP • Pain team • Colorectal • Urology / Urogynae • Physio • Signpost to Endometriosis UK / other charities	
Ordering and Interpreting Diagnostic tools	Able to make appropriate decision following assessment regarding necessary investigations. Can advise a patient when investigation not required. Can interpret results adequately: • MRI • USS • Bloods • Operative details	

Data Collection & Management	Pelvic Pain and Quality of life Questionnaire • Pre op • 6/12/24 month follow up Can access and manage the BSGE database	
MDT	• Planning • Prepping • Presenting • Finalising • Can identify when action required, complete action or send action to relevant clinician.	
Education	• Able to support junior team with Endometriosis related queries / injection administration	

History Taking – Telephone Consultation:	Criteria:		Assessor Signature:
Set the stage for the consultation	• Ensure correct patient identity • Introduce self • Ensure patient ok to talk – is in adequate, private environment • Remove communication barriers where possible. • Establish Patient comfort		
Presenting complaint & set agenda for the consultation	• Confirm reason for call • Obtain list of issues patient wants to discuss. • Summarise/finalise agenda, prioritise items for current encounter versus future encounter		
Presenting Complaint	• Ask open ended questions to elicit problems • Use active listening and appropriate silences		
History of Presenting complaint	• Use focused, but open-ended questions to obtain description of physical symptoms • Explore patient description of symptoms, emotional or social context of symptoms		
Transition to the clinician-centred process	• Summarise conversation, confirm accuracy of information • Advise patient of change in style of questioning (I'm going to ask you several specific medical questions about your symptoms)		
Pain	• Cyclical • Sporadic • Constant	• Location • Radiates • Sharpe/dull/period type	
Past Medial History	• Other medical problems		
Past Surgical History	• Previous surgery		
Drug History	• Use of prescribed and non-prescribed medications • Analgesics & how often taking • Allergies		

Family History	• Immediate family medical problems	
Social History	• Living arrangements • Relationship status • Employment • Alcohol/smoking/recreations drug use • Exercise	
Periods	• Menarche • Cycles ?/? • Menorrhagia/Dysmenorrhoea • Intermenstrual/post coital bleeds • Cervical screening history	
Fertility	• Dyspareunia • Parity • Mode of deliveries if children • Currently trying to conceive ○ Longer than one year?	
Bladder	• Dysuria • Haematuria • Difficulty emptying • Cyclical symptoms	
Bowels	• Dyschezia • Blood in stool Diarrhoea/Constipation/Fluctuations • Cyclical symptoms • Difficulty emptying, repositioning required	
Establish Patient Priority	• Pain Management • Fertility • Improve periods • Other	
Previous Investigations	• Ultrasound – can relay finding's • MRI – can relay finding's	
Close Consultation	• Summarise history • Confirm Plan • Give Information & contact details	

Training exposure:			Date Completed
BSGE CNS EDUCATION DAY	BSGE	BIANNUAL ATTENDANCE	
ENDOMETRIOSIS NURSE TRAINING	ENDMEOTRISOIS UK	*Dates TBC*	
Evidence of Service Evaluation	MFT - Self/Team led	Patient feedback & implementing a change to improve service	
Service Improvement	MFT - Self/Team led	Identify areas for improvement. Use a recognised tool to implement change and review improvement (SUDA)	
Contributing to patient information leaflets	MFT - Self/Team led	Updating leaflets & implementing new leaflets	
Networking with areas providing direct patient care	MFT - Self/Team led	Increase others knowledge of condition to improve care. Role model CNS service.	
Service Development	MFT - Self/Team led	Directly involved in developing new services for patients (forum in conjunction with endometriosis UK)	

Zoladex Implant Injection Assessment of Competency Tool

Name:	**Department:**		**Date:**
The practitioner has read the MFT Injectable Medicines Policy			**Practitioner Signature:**
The practitioner is deemed competent for Injectable Medicines in the medication competency booklet			**Practitioner Signature:**
STANDARD	**Competent**	**Not Competent**	**Comments**
The practitioner has checked the patient's identification			
The practitioner is able to state the indications for use			
The practitioner is able to state the contraindications to use and action to take			
The practitioner checks whether the patient is on add back HRT and can refer appropriately if any concerns			
The practitioner is able to prepare the patient for the procedure			
The practitioner is able to provide an appropriate explanation of the procedure to the patient			
The practitioner is able to answer any questions regards the treatment			
The practitioner is able to effectively communicate any side effects of Zoladex			
The practitioner has positioned the patient correctly maintaining privacy and dignity			
The practitioner can administer Zoladex following MFT ANTT policy			
The practitioner can administer Zoladex following MFT medicine policy			
The practitioner can accurately record administration of Zoladex on HIVE in patients MAR			
The practitioner is able to ensure the patients next appointment is booked appropriately			
Accessors signature:	**Candidates signature:**		
Comments:			

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REFLECTIVE ACCOUNTS FORM

You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user, colleague or other individuals. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in *How to revalidate with the NMC*.

Reflective account:

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

How did you change or improve your practice as a result?

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust