

**Standard operating procedure**

**LOCAL SAFETY STANDARDS (LocSSIPs) FOR INVASIVE DENTAL PROCEDURES**

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| Relevant Staff Groups: | All clinical dental staff at Somerset Partnership NHS Foundation Trust, including temporary, locum, bank, agency and contracted staff. |

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**Document Summary**

This Standard Operating Procedure has been produced in line with National Safety Standards for Invasive Procedures (NatSSIPs), a key initiative by National Health Service (NHS) improvements in 2015, which brought together national and local learning from the analysis of Never Events, Serious Incidents and near misses. This does not replace the existing WHO Surgical Checklist (Appendix A), but instead, enhances it by considering additional factors such as education and training, which supports the NHS to provide safer patient care and reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events, Serious Incidents and near misses can occur.

The aim behind NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This means that organisations need to collaborate with dental staff to develop their own set of Local Safety Standard for Invasive Procedures (LocSSIP) and have it in place in all clinics. This SOP is primarily a LocSSIP for Exodontia procedures throughout Somerset Partnership Primary Dental Service operating in Somerset, Dorset and the Isle of Wight.

**1. INTRODUCTION**

This toolkit is aimed at all clinical dental teams involved in invasive dental treatment. It also gathers together recommendations regarding the development of safety standards in all dental settings to reduce the risk of Never Events. For dentistry, these include (1) wrong implant/prosthesis placement; (2) retained foreign object post-procedure and; (3) wrong site surgery, particularly focussing on dental extractions. The ultimate responsibility for wrong tooth extraction remains with the dentist, as identification of teeth is outside the General Dental Council’s (GDC’s) core Scope of Practice for dental nurses. However, by utilising an empowered dental nurse as an assisting member of staff in all stages of the pathway, where necessary, it will engender the correct team mind-set and approach to improving patient safety. All members of the team are encouraged to speak up if they have any concerns. Safety is not just about checklists, teamwork or human factors, it is about checklists AND teamwork AND human factors.

**2. PURPOSE AND RATIONALE**

2.1 This SOP applies to all clinical dental staff at Somerset Partnership NHS Foundation Trust, and includes Temporary, Locum, Bank, Agency and Contracted staff.

2.2 To define the nature of a NatSSIPs ‘invasive procedure’, a Never Event (which requires specific LocSSIPs) and explain why they might happen.

2.3 To reduce the risk of wrong site surgery in dentistry, specifically wrong tooth extraction, by developing a robust procedural framework and patient safety culture amongst all dental staff that ensures good clinical practice. The lead dentist must also provide a supportive environment where the Duty of Candour and learning is encouraged should a safety incident occur.

2.4 To introduce a specific Procedure Safety Checklist (PSC) for patients requiring dental extractions.

2.5 The GDC fully supports the introduction of LocSSIPs in dentistry to minimise the potential for patient harm. It is specified in the professional Standards requirements to observe the Duty of Candour regulations, which encourages incident reporting when events do occur and an open and honest learning environment.

**3. POLICY STATEMENT**

* 1. Somerset Partnership NHS Foundation Trust will review and develop their own set of Local Safety Standard for Invasive Procedures (LocSSIPs) and ensure they are compliant with the new national standards. This SOP is primarily a LocSSIP for exodontia procedures throughout Somerset Partnership Primary Dental Service operating in Somerset, Dorset and the Isle of Wight.
  2. LocSSIPs are intended to cover the part of the patient pathway that pertains specifically to the performance of an invasive procedure, such as extraction of a tooth. They start at the point at which a patient is admitted to the dental surgery or hospital theatre (the ‘procedure area’) and end at the point at which the patient is discharged from the procedure area.
  3. However, it is appreciated that the delivery of safe patient care and the avoidance of Never Events starts well before the performance of the invasive procedure and ends well after it. Organisations providing NHS-funded care should consider the invasive procedure patient pathway as a whole. This includes the:

1. Referral.
2. Initial decision to treat.
3. Thorough assessment of the patient’s fitness and suitability for the procedure.
4. Advance discussion and planning of admission, procedure, post-procedure care and discharge.
5. Passage of key patient information between different parts of the organisation and other organisations.
6. Consent process and documentation of the process.
7. Post-procedural management, review and surveillance after the procedure.
8. Learning from near misses and never events.
9. Audit and clinical governance of the whole patient pathway.

LocSSIPs should therefore be considered a part of a larger patient pathway, and should be included in the continuum of care rather than becoming the sole focus.

**4. DEFINITIONS**

4.1 The latest NHS England (2015) defines a Never Event as a particular type of serious incident that meet **all** the following criteria:

* They are **wholly preventable**, where guidance or safety recommendations that provide strong systemic protective barriers **are available at a national level, and should** have been implemented by all healthcare providers.
* Each Never Event type **has the potential to cause serious patient harm or death**. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
* There is evidence that the category of Never Event **has occurred in the past**, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.
* **Occurrence of the Never Event is easily recognised and clearly defined** – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.

4.2 To try and understand why Never Events happen, it is necessary to understand the underlying influences on human behaviours that can lead to error, namely clinical human factors. This means understanding the effects on human behaviour of teamwork, tasks, equipment, workspace, culture and organisation, with the application of that knowledge in clinical settings. Reviews of instances of wrong-site surgery have identified contributory factors that include:

* Workspace and environment
* Work design
* Organisation and culture
* Task factors
* Communication
* Policies and procedures

4.3 Non-technical skills are also important. Non-technical skills are ‘the cognitive, social and personal resource skills that complement technical skills and contribute to safe and efficient task performance’. These include:

* 1. **Situation awareness**: not gathering enough information; overlooking anomalies; not communicating *with* others; not recognising increased risks.
  2. **Decision-making**: proceeding with the task rather than checking when uncertain; an over-reliance on assumptions as to correct location such as prepositioned patients.
  3. **Teamwork**: failures in the team to speak up when the checklist was not followed; inadequate exchange of information to ensure a shared understanding of what was to be done.
  4. **Leadership**: not demonstrating procedural compliance, such as using the checklist; not ensuring the whole team had a shared awareness of the task.

**Coping with stress**: not dealing effectively with work pressures, requiring staff to work faster.

4.4 The relevant non-technical skills need to be identified, and then a training course is designed to improve understanding of the skills and to explain how they can influence safety and efficiency. These are often classroom-based courses with exercises, demonstrations and opportunities for structured practice and feedback.

4.5 Most analysed incidents involve a combination of technical and non-technical factors. Human factors experts have concluded that the causes of Never Events should be seen as a reflection of the current state of safety

within an organisation, showing the underlying cultural and systems issues that need to be addressed at a wider level than that of the incident itself.

4.6 The response to new safety incidents should not be new policies and procedures, but the simplification and standardisation of existing policies, making sure that they are directly relevant to the areas in which they are used. While team members may have perfect technical skills to perform the procedures, it is often failures in the non-technical skills that contribute to Never Events.

4.7 A near miss is defined as a mistake resulting in no harm. Near misses should be shared anonymously with all members of the team as part of the learning process

4.8 **Invasive procedures** are those procedures that have the potential to be associated with a Never Event if safety standards are not set and followed. For dentistry, these might include:

* All surgical and interventional procedures (e.g. exodontia), performed in dental surgeries, operating theatres, outpatient treatment areas, and other procedural areas within an organisation.
* Biopsies and other invasive tissue sampling.
* Incorrect sedation titration technique, resulting in oversedation of the patient and hazardously reduced respiratory function.

This definition is slightly different to The National Institute for Health and Care Excellence’s (NICE) definition of an “interventional procedure”, which means (1) gaining access to the inside of a patient's body, or body cavity with or without making a cut or a hole, or; (2) using electromagnetic radiation (i.e. X-rays, lasers, gamma- rays and ultraviolet light) for therapeutic purposes.

4.9 It is not intended that NatSSIPs and LocSSIPs address procedures that involve the simple penetration of the skin or entry of a body cavity, such as the insertion of an intravenous line, or the use of ionising radiation to take a plain dental radiograph. However, it is recommended that providers of NHS-funded care, when creating policies for the safe performance of all procedures that come under NICE’s definition of “interventional procedure”, but are not included in our definition of “invasive procedure”, take NatSSIPs guidance into consideration when developing local policies for safe patient care. This may be of particular importance to procedures such as the insertion of throat packs during general anaesthesia (GA), as there have been Never Events relating to the accidental retention of throat packs.

4.10 **Procedural team**, to include all those involved in the implementation of the procedure.

**5. DUTIES AND RESPONSIBLITIES**

5.1 The **Senior Management Team (SMT) and Trust Board** shall be ultimately responsible for overseeing the creation of LocSSIPs, their implementation, governance, audit and modification, and will be accountable for these to Clinical Commissioning Groups and to the Care Quality Commission.

5.2 **Procedural teams**, which include dentally qualified, registered and indemnified dentists, hygienists, therapists and dental nurses, will be responsible for the development, implementation and continuous appraisal of the safety and efficacy of LocSSIPs, working with patient groups where appropriate. This may also include allied multidisciplinary professionals for specific procedures (e.g. theatre staff). The line of accountability will pass up from these teams through clinical and non-clinical managers to the Senior Management Team, Trust Board or equivalent.

5.3 The responsibility for ensuring that the LocSSIPs are followed accurately for every patient will be the primary responsibility of the Lead Dentist, but also every member of the procedural team. Those members of the team who are registered healthcare professionals will be accountable both to their registering bodies and to their employers.

5.4 The fundamental basis of the delivery of LocSSIPs in the patient pathway is the sharing of responsibility between every member of the procedural team. When a document is signed as indicating that a step in a LocSSIP has been performed by a member of a procedural team, that member is signing on behalf of the whole team, and every member of the team therefore shares the responsibility for the performance of the LocSSIP, while sharing accountability for its full completion. The basis of safe care is teamwork, and the aim of both NatSSIPs and LocSSIPs is to promote and develop teamwork.

5.5 Existing knowledge tells us that team briefing works well in improving the running of clinical procedures. Allocating five minutes before the start of the list will enable the procedural team to meet to discuss the requirements of the procedure, including any patient safety concerns, equipment requirements and staffing resources.

5.6 **Debriefing** is a valuable method of improving practice. Allocating time at the end of the list will enable the procedural team to reflect on any issues that may have occurred, highlight any concerns, what went well, discuss specific incidents or identify how to prevent them happening again in future.

**6. DENTAL EXTRACTION LocSSIPs INDIVIDUAL PATIENT PATHWAY (Appendix B)**

6.1**. Pre-patient identification and verification safety briefing**

This takes place when the patient attends for their exodontia appointment whether in primary or secondary care, but before any local anaesthesia, sedation or general anaesthesia is given. First stage informed consent

should have already been undertaken prior to the procedure appointment.

6.1.1 Check patient identity (name, date of birth and address), and record the patient identification on the Procedure Safety checklist (Appendix C).

6.1.2 Procedural team members should understand their roles, introduce themselves to the patient and other members of the procedural team (if not known), and all members of the team should be encouraged to voice concerns at any time should they occur.

6.1.3 Check medical history, treatment plan/dental chart, relevant radiographs, and cross-check the extraction plan against the radiograph. The Lead dentist performing the extraction should ensure it makes clinical sense to remove the tooth stipulated in the treatment plan.

6.1.4 The signed consent form should agree with the patient’s clinical records and treatment plan. If there is any confusion or uncertainty, the Lead Dentist must discuss and clarify with the patient and/or liaise with referring dentist. If confusion persists then treatment must be postponed.

6.1.5 Treatment must not begin without the presence of a Dental Nurse (second appropriate person). Change over of staff during treatment should be avoided.

# 6.2 Sign in checks

6.2.1 Operator, dental nurse and any other member of the procedural team should introduce themselves to the patient/relative/carer.

6.2.2 Confirm with patient/relative/carer the exact tooth/teeth planned for removal. Cross reference with clinical notes, investigation results (e.g. blood tests), radiographs and the signed consent form. At this stage, consider the need for reasonable adjustments to communication, such as an interpreter.

6.2.3 Get the patient/relative/carer to point to the tooth being extracted themselves if possible. You may need to use a mirror.

6.2.4 Ask the patient/relative/carer if they have any questions before proceeding.

**6.3. Time out (pause) before you take out**

All patients undergoing any invasive procedure, including exodontia, under general, regional or local anaesthesia, or under sedation, must undergo safety checks immediately before the start of the procedure. The time out should not be performed until any omissions, discrepancies or uncertainties identified in the sign in checks have been fully resolved.

On rare occasions, such as emergency care, the immediate urgency of a procedure may mean it has to be undertaken without the full resolution of omissions, discrepancies or uncertainties. This should be reported as a safety incident.

6.3.1 The Lead Dentist or appropriately trained Dental nurse may act as checklist coordinator. All members of the procedural team must be present during the time out, and ensure they have stopped other tasks and are listening to confirm (1) correct patient; (2) correct treatment plan; (3) correct tooth/teeth for extraction.

6.3.2 Preoperatively, ensure the most recent radiograph/relevant investigations are on display. Ensure confirmed consent form is visible and accessible.

6.3.3 Write out the tooth/teeth for extraction on the Procedure Safety checklist (Appendix C).

6.3.4 The Lead Dentist and Dental Nurse must then cross reference the tooth/teeth on the checklist, and again, with those written on the consent form and treatment plan in the clinical notes.

**6.4 ‘Stop before you block’**

Immediately before the insertion of any anaesthetic, the Lead Dentist and Dental Nurse must:

6.4.1 Confirm correct local anaesthetic needle positioning with each other before placement.

6.4.2 Count out loud from the midline to posterior dental arch, to identify the tooth for extraction. Take this counting from at least three teeth anterior to the tooth in question. Repeat for any subsequent extractions.

6.4.3 Confirm with each other that they agree this count is correct.

6.4.4 Gently place the luxator or forceps on the tooth identified.

**6.5 Pause before you pull**

6.5.1 The Lead Dentist must confirm with the Dental Nurse that this is the correct tooth for extraction before proceeding.

6.5.2 Extract the correct tooth.

6.5.3 Complete the same process for each tooth being extracted.

**6.6 Check for retained foreign objects**

6.6.1 The Lead Dentist should check the mouth and ensure there are no retained foreign objects.

6.6.2 Any specimens for laboratory analysis must be labelled correctly, including patient name and site of specimen excision.

**6.7 Sign out**

6.7.1 The Lead Dentist and Dental Nurse must sign the Procedure Safety Checklist (Appendix C) to confirm that the LocSSIP was followed. It must then be placed in the patient’s clinical notes.

6.7.2 Confirm that all safety checks have taken place and post-operative care instructions given, before the patient is discharged.

**6.8 Debrief**

Procedural team debriefing is a key element of practice in the delivery of safe patient care during invasive procedures. It forms part of both the World Health Organisation (WHO) Surgical Safety Checklist, and the Five Steps to Safer Surgery.

6.8.1 The content of the team debriefing should be modified locally and must be relevant to the patient and the exodontia procedure.

6.8.2 The debrief discussion should include, but is not limited to, (1) things that went well; (2) any problems with equipment or other issues; (3) areas for improvement.

6.8.3 Records of debriefings should be written in the patient’s clinical notes and include an action log that can be used to communicate examples of good practice or any other issues identified.

**7. MONITORING COMPLIANCE AND EFFECTIVENESS**

**7.1 Monitoring arrangements for compliance and effectiveness**

* Overall monitoring will be by the Senior Management Team, by review of incident reporting.
* Procedural document compliance (record keeping) and effectiveness will be monitored by Dental Nurses and discussed with all Dental Staff at Clinical Governance team meetings.

**7.2 Methodology to be used for monitoring**

* Incident reporting through The National Reporting and Learning System via DATIX and the Senior Management Team.
* Concerns/Complaints monitoring.
* Audit of patient notes at regular intervals, particularly looking at completion of the Procedure Safety Checklist.
* Care Quality Commission (CQC) inspections

**7.3 Frequency of monitoring**

* Discussion at monthly Clinical Governance meetings with all dental staff of near misses and never events.
* CQC inspections.
* Annual staff appraisals.

**7.4 Development and review of monitoring to improve performance**

* Audit results will be presented at Senior Management Team meetings, staff Clinical Governance meetings and Quality Assurance Group (QUAG) meetings for consideration and to identify good practice, shortfalls, action points and lessons learnt.
* Audit results will be made available to and monitored by the relevant Best Practice Groups and discussed at the Clinical and Social Care Effectiveness Group*.*

**7.5 How will learning take place?**

* The checklists must be conducted by dental teams who have trained together and who have received appropriate education in the human factors that underpin safe teamwork. Safety is not just about checklists, teamwork or human factors, it is about checklists AND teamwork AND human factors.

**8. TRAINING AND COMPETENCY REQUIREMENTS**

8.1 Specific training will be required to support implementation of this SOP, so that procedural team members are able to fulfill their roles safely, effectively and consistently (Appendix D). The Procedure Safety checklist will be introduced at staff meetings and selected teams will trial it. Staff will be given the opportunity to feedback on its appropriateness for use.

8.2 Organisations must accept that rapid developments can occur in procedural techniques and performance, and should ensure that the training of all team members is maintained and updated as appropriate. Training must not only be on an individual basis but must also include training as multidisciplinary and multidisciplinary procedural teams – ideally, team members should train together in the delivery and development of LocSSIPs.

8.3 Procedural teams must also receive regular training in human factors and non-technical skills. When new members join teams, particular care should be taken to introduce them to the teams and to ensure that their care is harmonised with that of other team members and teams.

8.4 Appraisal, revalidation, performance development and review processes should include active participation in LocSSIPs and the learning deriving from the clinical governance of LocSSIP and NatSSIP processes.

8.5 Continuous safety improvement depends on continuous audit of outcome and compliance with safety standards, and on the collection and analysis of data on adverse patient events and near misses. It is important that team members are given regular opportunities to suggest improvements in LocSSIPs and patient care.

8.6 Providers of NHS-funded care should, as part of their commitment to the development, implementation and ongoing management of LocSSIPs, schedule regular Safety Meetings for multidisciplinary procedural teams of adequate length and frequency to allow training, analysis of adverse incidents and near misses, review of audits of compliance with LocSSIPs, and teamwork development and practice.

**9. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS**

**References**

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**Acknowledgements**

Somerset Partnership NHS Foundation Trust would like to acknowledge NHS England’s NatSSIPs document (2015) for the use of elements of their guidelines in this SOP.

**Cross reference to other procedural documents**

* Being Open and Duty of Candour Policy
* Serious Incidents Requiring Investigation (SIRI) Policy

All current policies and procedures are accessible in the policy section of the Policies and Procedures’ public website. Trust Guidance is accessible to staff on the Trust Intranet.

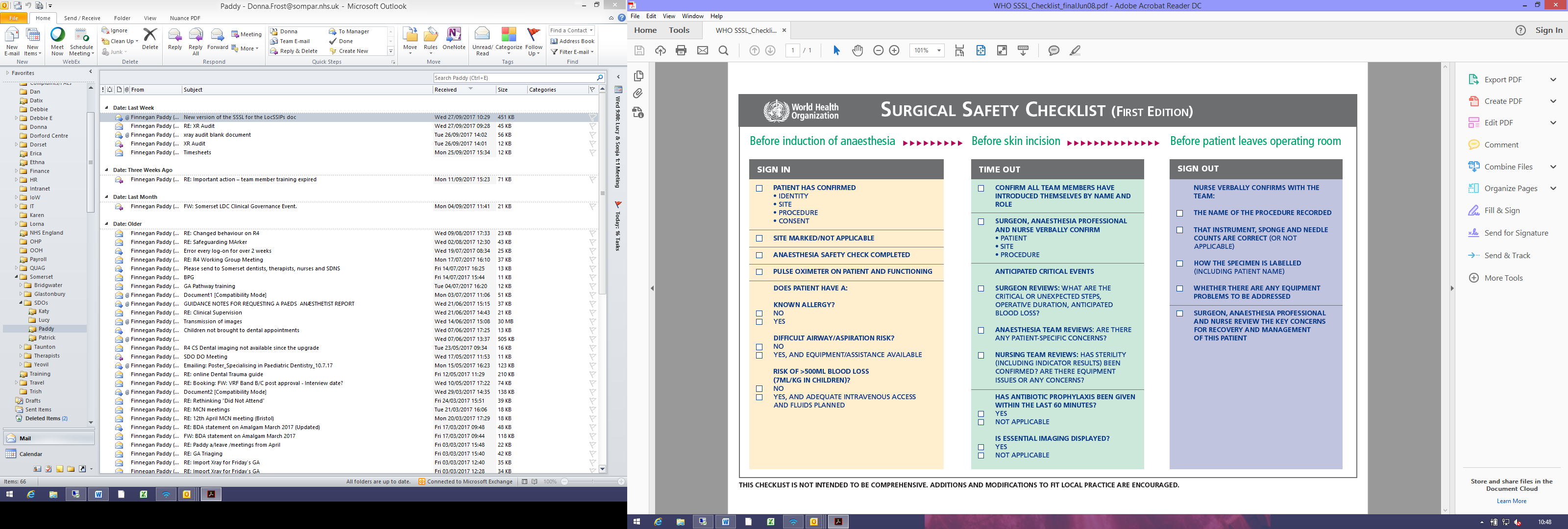
**10. APPENDICES**

10.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.



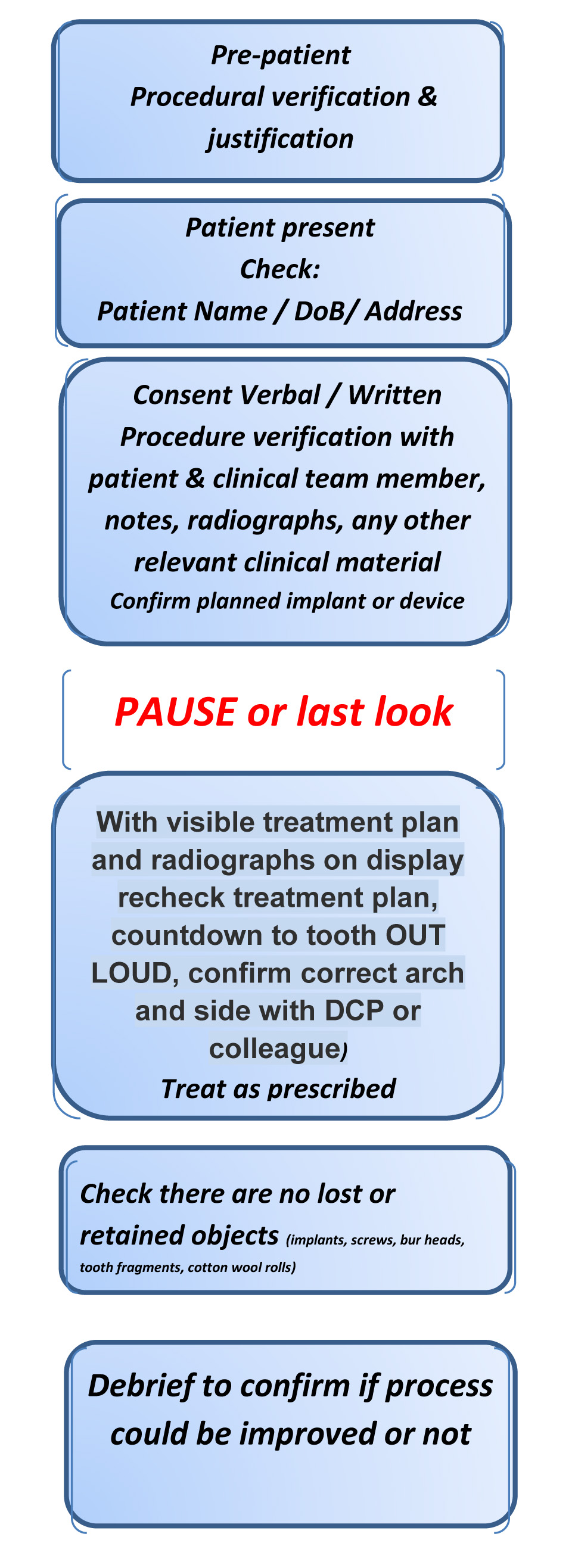
**Appendix A**

**World Health Organisation Surgical Safety Checklist**



**Appendix B**

**DENTAL EXTRACTION LOCSSIPs INDIVIDUAL PATIENT PATHWAY**



**Appendix C**

**Procedure Safety Checklist**

Name................................................................

DOB.................................................................

Patient ID   …………………………………….…

Time into surgery………………….…….

Time of discharge………………………..

Date....................................................................................

1. Intended procedure

Teeth to be extracted    \_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

/

Other preoperative tests              Please specify……...………………………………………………………………….………

Complicating factors                    Please specify …………………………………………..…………………………………….

**TIME OUT**

1. Team members introduced themselves by name and role
2. Patient/parent/carer confirmed their/the patient’s identity
3. Treatment site confirmed and viewed by both clinician and nurse
4. Relevant radiographs present  Yes N/A
5. Checked  with treatment plan     Yes N/A
6. Consent confirmed                      Type 1, 2 , 3 , 4 please circle
7. Consent form visible and accessible and legible
8. Relevant medical history …………………………………………………………………………………….…………
9. Does the patient have a known allergy? Yes No
10. **CHECK OUT**

Mouth checked for retained foreign object

Correct teeth extracted recorded in the notes

Equipment or staffing issues identified and addressed

Please specify…………………...........................................................................................................................................

Name and Signature of Dental Nurse ........................................ ……………………………………….......................

Name and Signature of Clinician................................................ ……………………………………….........................

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Knowledge and Skills for Local Safety Standard for Invasive Procedures** | | **Self Assessment** | | |
| Score | Tick | Date and Comments |
| **1** | Read and understand the SOP | 1 |  |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| **2** | Observe a process | 1 |  |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| **3** | Complete a process | 1 |  |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |

**Appendix D**