



**Singapore Healthcare  
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# TOOTH WARRIORS

*“Safety starts with me!”*

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## INTRODUCTION

The DSA team from Clinic 4 brainstormed on how to enhance patient safety. They have decided to focus on the correct patient receiving right treatment.

## UNDERSTANDING THE ROOT CAUSES

The DSA team uses the ‘5WHY’ technique to understand the root cause of the problem and concluded that it is due to staff negligence/carelessness. Negligence can be in the form of:

### 1) Misidentifying patients’ details which can lead to serious harm and in some cases, it can be fatal.

- Unscheduled appointments/treatments (eg. patients might get the wrong treatment. As such, '2 Identifiers' will help identify and organize);
- Wrong prescriptions (eg. patient has the wrong prescription when it’s meant for someone else);
- Extracting the wrong tooth (eg. through the '2 identifiers', the DSA can check with the Doctors and patients to identify the correct tooth to be extracted);
- Ensuring patient has the right dentures (eg. the issuance of the dentures does not match the patient’s record because the '2 identifiers' is not used); and
- X-ray (eg. mixing up of patient's X-ray records)

### 2) Hectic work schedule may result in recording incomplete information.

This negligence may lead to malpractice. The DSA team believes that we can minimise all of the above scenarios. Like all problems, there is always a solution. Sometimes the solution comes directly and some are not. Fortunately, this problem can be eradicated if all staff believe & practise safety **AT ALL TIMES**.

## OBJECTIVES

The team aims to achieve **ZERO WRONG Patient Identification** in Level 4.

## INTERVENTIONS

The team brainstormed for possible solutions and came up with one that focuses solely on improving patient identification. The solution is; To practise '2 identifiers' religiously with a prominent reminder at strategic location. The team gave a refresher course to all DSA/DA on 'What is '2 Identifiers'' and 'How to use '2 Identifiers'' in Level 4.

The team wants to make the '2 Identifiers' as ubiquitous as possible so as to ingrain this practice into our daily work habit. They suggested sticking a reminder label - *Figure 1* on the printer to remind/alert the Doctors and DSAs to check the patient’s Name & IC No. before giving the prescription, MC or referral letter.

In short, it is to check that they are returning the correct document to correct patient. As per the PDPA policy, patient’s information cannot be shared with another patient.



Figure 1

## CONCLUSION

The DSA team believes that by practising ‘2 Identifier’ diligently, it will achieve **ZERO WRONG PATIENT IDENTIFICATION** which will also cause unnecessary stress to the healthcare worker.