MODULE 17 | FINAL PRACTICAL REVIEW

Final Practical Review Covering the Whole Course

65

LECTURE

An integrated review for Medical Superintendents in Punjab

Make the decision. Explain the authority.
Show the evidence and verify the result.

AUTHOR

Dr Qurban Hussain Khan

Edition 1.0 | 5 October 2026

SELF-STUDY PDF

Use the whole course to make a sound decision

The final review brings together the work of a Medical Superintendent (MS): safe care, lawful decisions and reliable follow-through.

- Identify the urgent risk and the decision required.
- Use the right authority and supporting evidence.
- Test resources, alternatives and assumptions.
- Explain how the result will be checked.

SOURCE AND SCOPE

Named laws, standards and guidance; their status is stated.

WORKING METHOD

A practical control or teaching format to adapt to the authorised system.

TEACHING CASE

An invented hospital example, used to practise applying the correct process.

Study output

A complete decision paper, an evidence index and an action plan for one hospital problem.

Module 17 | Lecture 65. Work through one case at a time. All explanations and model answers are on the pages.

Contents and case navigation

Select a section below. Use the PDF bookmarks to move between individual pages.

Decision framework	A method for every case; all sixteen modules.	**5**
Case A | Service disruption	Safety, medicines, utilities, data and continuity.	**11**
Case B | Purchase and audit	Funding, procurement, payment and accountability.	**19**
Case C | Complaint and staff	Evidence, fair process, training and privacy.	**27**
Case D | New service	Demand, costs, development and readiness.	**35**
Final assessment	Integrated questions, answers and self-review.	**44**
Apply it at work	Decision paper, registers and a 90-day review.	**50**
Sources and scope	Official instruments, standards and guidance.	**61**

Each case is invented. Cases are not descriptions of RIC or any actual institution.

WORKING METHOD | Illustrative material is identified in the text.

Attempt the decision before reading the answer

Work through the four cases in separate sittings if needed. The suggested study method is not an accredited examination.

1	**Write**	Record the first action, the authority, the evidence needed and the decision you would request.
2	**Compare**	Read the model answer. Notice what it can establish and what remains uncertain.
3	**Correct**	Rewrite your answer where it assumed a power, missed a risk or treated an estimate as a fact.
4	**Apply**	Use the final tools on one non-confidential service problem; ask the relevant colleagues to review it.

A different answer can be sound if it protects patients, follows the applicable process and explains its evidence.

WORKING METHOD | Illustrative material is identified in the text.

Six questions for every management decision

Use these questions before making a commitment or giving an instruction.

01 Risk

Who may be harmed, and what needs attention now?

02 Facts

What is verified, what is alleged and what is unknown?

03 Authority

Who may decide this exact matter, under which current power?

04 Resources

Are money, people, equipment and support actually available?

05 Options

What lawful alternatives exist, and why choose this one?

06 Follow-through

Who acts, by when, with what evidence of completion?

Urgent protective action and the formal decision process may need to proceed at the same time.

WORKING METHOD | Illustrative material is identified in the text.

Check which rules govern this institution

A teaching hospital may be governed by an institutional Act, a university framework or other specific arrangements.

Check	What to establish
Institution	The applicable Act, notification, rules and legal status of the hospital.
Decision-maker	The powers of the Board, Executive Director, MS and other officers; relevant delegation and conditions.
Transaction or person	The funding source, type of purchase, employment status or service licence involved.
Current version	The source edition, amendments, applicable order and effective date; obtain advice where the route is unclear.

A Board resolution or a senior officer's direction must operate within the applicable law. Record and escalate a doubtful instruction.

Sources: **G1**: 2003 framework | **G3**: 2020 framework | **G4**: 2025 framework | **G2**: official cases

Governance and public money

First column: module number | lecture range. Use the earlier lectures for the detailed procedures.

Module | lectures	Subject	Decision to test	Evidence to request
1 | 1-4	Statutory foundations and authority	Who can approve this?	Current authority register.
2 | 5-7	Secretariat and official cases	What exact decision is requested?	Complete case with indexed annexures.
3 | 8-12	Budgets, accounts and payments	Is the spending both funded and authorised?	Sanction, commitment and payment records.
4 | 13-18	Purchases and contracts	Which procurement route is justified?	Need, competition or exception, and contract file.

DAC = Departmental Accounts Committee; PAC = Public Accounts Committee; PHC = Punjab Healthcare Commission.

WORKING METHOD | Illustrative material is identified in the text.

Accountability, people and safe care

First column: module number | lecture range. Use the earlier lectures for the detailed procedures.

Module | lectures	Subject	Decision to test	Evidence to request
5 | 19-22	Internal controls, audit, DAC and PAC	What is the evidence and formal status?	Audit reply, minutes and compliance evidence.
6 | 23-28	Staff and disciplinary cases	Which service law and process apply?	Status, competent authority and fair case file.
7 | 29-33	Safe care, PHC standards and quality	Is the care process working safely?	Clinical checks and measured improvement.
8 | 34-37	Complaints, cases and integrity	Which concerns need separate routes?	Preserved evidence and reasoned responses.

DAC = Departmental Accounts Committee; PAC = Public Accounts Committee; PHC = Punjab Healthcare Commission.

WORKING METHOD | Illustrative material is identified in the text.

Services and their supporting resources

First column: module number | lecture range. Use the earlier lectures for the detailed procedures.

Module | lectures	Subject	Decision to test	Evidence to request
9 | 38-41	Planning, costs and funding	Can the service be delivered and sustained?	Capacity, costs and funding assumptions.
10 | 42-45	Medicines, controlled drugs and blood	Is each product lawful, safe and traceable?	Custody, storage and issue records.
11 | 46-48	Equipment, assets and disposal	Is equipment usable throughout its life?	Acceptance, maintenance and asset record.
12 | 49-51	Buildings, utilities, waste and safety	Can the environment support safe care?	Technical checks and waste controls.

DAC = Departmental Accounts Committee; PAC = Public Accounts Committee; PHC = Punjab Healthcare Commission.

WORKING METHOD | Illustrative material is identified in the text.

Development, learning and resilience

First column: module number | lecture range. Use the earlier lectures for the detailed procedures.

Module | lectures	Subject	Decision to test	Evidence to request
13 | 52-55	Development and new services	Are approval, delivery and opening aligned?	Project approvals and commissioning file.
14 | 56-58	Training, accreditation and research	Is this programme or study properly approved?	Recognition, supervision and ethics records.
15 | 59-61	Information systems, records and data	Are information and access reliable?	Data definitions, access and recovery evidence.
16 | 62-64	Emergencies, security and continuity	Can essential care survive disruption?	Tested response and recovery arrangements.

DAC = Departmental Accounts Committee; PAC = Public Accounts Committee; PHC = Punjab Healthcare Commission.

WORKING METHOD | Illustrative material is identified in the text.

An interrupted service with more patients expected

All people, events and hospital details in this teaching example are invented. They do not describe an actual hospital event.

08:00 report	A storm has interrupted mains power. A monitored care area is on backup power. Ambulance control reports possible additional arrivals; the number is not confirmed.
Capacity	There are 12 safe spaces. The available team can cover 10. Working equipment and supporting services can cover 8. Six patients already need these places.
Fuel	1,200 litres are measured; 200 are unusable. Current consumption is 100 litres/hour. A higher load could use 120 litres/hour. Replacement fuel is expected in 11 hours.
Other concerns	Electronic records are unavailable. Pharmacy and the blood service report an uncertain temperature history. One access route is obstructed.

The capacities and consumption figures are invented assumptions, not clinical staffing or engineering standards.

Your decisions before the first briefing

Write your answer and the reason before turning to the next page.

1 | Protect care

What should happen now, and who needs to lead each response?

Write four immediate actions.

2 | Check capacity

How many additional supported places are available? How long will usable fuel last?

Show both calculations.

3 | Control uncertainty

Can the hospital promise to receive every patient or continue using every stored product?

State what must first be checked.

Compare your reasoning with the next six pages. Do not treat an expected delivery as a confirmed safe bridge.

Establish control while protecting current patients

Suggested response sequence. Clinical and technical leads decide the immediate safe measures within their responsibilities.

1	**Activate**	Use the approved emergency plan and named activation authority. Confirm a responsible lead and the next briefing time.
2	**Protect**	Clinical staff assess current patients. Engineering checks power and loads. Security clears a safe access route with appropriate assistance.
3	**Verify**	Check actual fuel, equipment, staffing and storage conditions. Assign owners to each unconfirmed report.
4	**Coordinate**	Tell the health authority, ambulance control and receiving hospitals the verified capacity and unresolved limits through the authorised route.

The MS coordinates the hospital response; powers held by police, rescue or district authorities do not transfer automatically.

Sources: **E1**: disaster-management duties | **E4**: Rescue powers | **E2**: hospital response guidance

Only two additional supported places are available

Assume the staff, equipment and utilities can support the same eight places.

Safe space	12 places are physically suitable.
Limiting resource	The team can cover 10, but equipment and support can cover only 8. Usable total capacity is therefore 8.
Existing patients	Six places are already occupied: 8 - 6 = 2 additional supported places.
Management decision	Report two additional places for the stated type of care, subject to clinical matching and continued support. Reassess when arrivals or resources change.

An empty bed does not establish clinical capacity. These figures cannot be used as a staffing ratio.

Fuel will run out before the expected delivery

Usable fuel is 1,200 - 200 = 1,000 litres. The expected delivery is 11 hours after 08:00.

Current load	1,000 / 100 = 10 hours of cover, ending at 18:00. Expected delivery at 19:00 leaves a one-hour gap.
Higher load	1,000 / 120 = 8.33 hours, or 8 hours 20 minutes. Cover ends at 16:20, leaving a 2-hour 40-minute gap.
Required decision	Seek a verified earlier supply or a technically and clinically safe alternative now. Prepare transfer arrangements if essential support cannot be sustained.
Limits	The calculation assumes stable consumption and usable fuel. Engineers must verify the load, stock, equipment and delivery time.

Do not cut power or oxygen to occupied clinical areas as an administrative shortcut.

Sources: **E3**: service continuity planning

Preserve safe medicines, blood and supporting services

Ask the responsible pharmacy, blood-service and facilities professionals to confirm the position.

01 Affected stock

Hold stock with uncertain storage conditions for authorised assessment.

02 Patient need

Arrange clinically suitable alternatives through lawful supply or referral routes.

03 Blood

Maintain identity, storage and traceability; obtain authorised release.

04 Controlled drugs

Keep secure custody and complete transfer or issue records during disruption.

05 Waste

Maintain segregation and secure handling when routine collection is delayed.

06 Equipment

Record failed assets; obtain competent repair and safety checks before reuse.

Uncertainty is a reason to assess and control stock; it is not, by itself, proof that every affected product must be destroyed.

Sources: **M1**: storage | **M2**: blood | **M3**: controlled drugs | **W1**: waste

Keep a usable record while systems are unavailable

Suggested downtime controls. The approved local procedure should define identifiers, custody and later reconciliation.

Task	Evidence needed
Patient care	Unique patient identity, clinical entries, medicines, tests and handovers on controlled temporary records.
Situation report	Time, verified capacity, resource limits, actions, assistance requested and the next review.
Communication	Consistent service information for staff, families and referrers; patient details shared only for a lawful need.
Restoration	Reconcile temporary entries and duplicate records; check recovery before relying on the system.

A working computer is not proof that all missing clinical information has been safely restored.

Sources: **P1**: hospital information standards | **E3**: continuity planning

Reopen after the required checks

Suggested checks must be adapted to the affected service. A delivery, a repair or a reassuring message is only part of the evidence.

1	**Technical readiness**	Competent staff verify power, equipment, gases, water and relevant environmental conditions.
2	**Clinical readiness**	Clinical and nursing leads confirm staff, products, records, patient placement and support services.
3	**Authorised decision**	The responsible authority records the scope and timing of reopening, any restrictions and the next review.
4	**Learning**	Review the response, assign corrections and test whether they work. Keep unresolved risks visible.

Case A tests Modules 7, 10, 11, 12, 15 and 16, supported by the authority principles in Module 1.

Sources: **P1**: emergency and facility standards | **E3**: continuity and recovery

An urgent purchase and an unsupported invoice

All people, events and hospital details in this teaching example are invented. They do not describe an actual hospital event.

Supply position	There are 1,200 packs of a critical consumable. Two hundred are quarantined and unavailable. Use is 250 packs/day; routine delivery is expected in six days.
Funding	For the same permissible budget purpose and period, PKR 12 million is released and available to pay. PKR 4 million is paid; PKR 5 million of unpaid commitments is already recorded.
New proposal	A supplier offers a PKR 4 million purchase. Someone proposes splitting it into smaller orders and completing the approval file later.
Existing invoice	A separate invoice claims 100 boxes at PKR 20,000 each. Ninety arrived: 80 were accepted and 10 are held for assessment. Ten have not arrived. No advance payment applies.

The quantities, prices and funding figures are invented. No procurement threshold or delegation limit is implied.

TEACHING CASE | Illustrative material is identified in the text.

Your purchasing and payment decisions

Write your answer and the reason before turning to the next page.

1 | Supply

How many usable days remain? Does the stock position itself authorise a direct purchase?

Calculate and identify the decision route.

2 | Funding

How much remains after unpaid commitments? Can the new order be placed on these facts?

Explain the funding gap.

3 | Invoice

What value is supported by accepted delivery? What else is needed before payment?

Separate receipt, acceptance and authority.

Use the stated assumptions. Do not invent an emergency declaration, a budget transfer or a sanction.

TEACHING CASE | Illustrative material is identified in the text.

Treat urgency as a fact to assess

Punjab Procurement Regulatory Authority (PPRA) rules provide the applicable framework; the permitted route depends on the verified facts.

Supply and safe alternatives

- Usable stock = 1,200 - 200 = 1,000 packs. At 250/day, cover is four days. Delivery in six days leaves a two-day gap.
- Ask clinical and supply leads about lawful redistribution, suitable substitutes, expedited existing supply and any necessary service adjustment.

Procurement decision

- Check whether a permitted procurement method or emergency provision actually applies, who may approve it and what evidence must be recorded.
- Do not split the requirement to avoid the applicable process. Investigate poor planning separately from the action needed to protect current care.

Urgency does not create a general exemption. Record the exact rule, justification, competent approval and price assessment.

Sources: **F2**: procurement principles, planning and permitted methods

Only PKR 3 million remains uncommitted

The calculation is a control check within the same authorised budget purpose. It does not confer spending power.

Released and available	PKR 12 million, under the assumptions in the case.
Prior use	PKR 4 million paid + PKR 5 million unpaid commitments = PKR 9 million already used or committed.
Balance and gap	PKR 12 million - PKR 9 million = PKR 3 million. A new PKR 4 million commitment exceeds this by PKR 1 million.
Required response	Verify the commitment register and seek a lawful funding decision or revised option before placing the new commitment. Confirm separate financial sanction and procurement authority.

An MS is not automatically the Drawing and Disbursing Officer (DDO). Verify the actual appointment and delegation.

Sources: **F1**: budget and financial controls | **F3**: financial delegation | **G1**: institutional scope

Accepted delivery supports PKR 1.6 million

The case assumes payment against accepted goods, with no applicable advance-payment arrangement.

Invoice claimed	100 boxes x PKR 20,000 = PKR 2,000,000.
Accepted goods	80 boxes x PKR 20,000 = PKR 1,600,000. The other 20 boxes are either unaccepted or undelivered.
Before payment	Check the contract, partial-payment terms, inspection record, invoice correction, sanction, budget, deductions and authorised certification.
Unresolved balance	Record the 10 held boxes and 10 missing boxes. Apply the contract and the lawful dispute route; do not certify them as accepted.

PKR 1.6 million is the gross value supported by accepted quantity, not an instruction to pay that sum immediately.

Sources: **F4**: payment verification | **F1**: financial controls | **F2**: contract framework

Build the answer from the transaction record

An audit observation questions unsupported payment and missing acceptance evidence. A reply must address the actual issue.

Part of reply	Content to establish
Position	State the observation accurately, the amount involved and which facts the hospital accepts or disputes.
Evidence	Index the sanction, contract, delivery, inspection, stock, invoice, payment and accounting records.
Gap and correction	Identify missing evidence honestly. Establish what can be verified; obtain authorised decisions on correction or recovery where required.
Control and follow-up	Explain the cause, assign a responsible officer and date, and show how repeat failure will be prevented and checked.

Do not backdate an inspection or manufacture a missing approval. A later explanatory note must carry its true date.

Sources: **A1**: evidence and follow-up | **A3**: audit records

Keep the formal status of the issue clear

A departmental reply, a committee direction and formal settlement are different events.

Stage	Record and management response
Audit observation	Keep the exact paragraph, financial amount, departmental position and supporting records.
DAC consideration	Use the recorded Departmental Accounts Committee decision; identify verification, recovery or other action still required.
PAC consideration	Prepare the authorised brief for the Public Accounts Committee and comply with its recorded directions through the proper route.
Follow-up	Track each direction, evidence submitted and confirmation required. Claim closure only when the competent process supports it.

Sending a reply is not the same as formal settlement. A recovery does not automatically resolve every other issue.

Sources: **A1**: audit follow-up | **A2**: Punjab legislative financial oversight

Keep incompatible checks sufficiently separate

Suggested controls must fit the authorised establishment, staffing and financial system.

01 Need

The user department verifies the service requirement and quantity.

02 Selection

The authorised procurement process assesses offers and records reasons.

03 Interests

Declare conflicts and arrange an authorised replacement when needed.

04 Acceptance

Competent staff check actual delivery against the contract.

05 Payment

Accounts checks authority and evidence, including duplicate-payment risk.

06 Reconciliation

An independent review compares stock, payments, commitments and records.

Case B tests Modules 3, 4 and 5, with the integrity safeguards in Module 8. Suspected supplier wrongdoing needs its proper process.

WORKING METHOD | Illustrative material is identified in the text.

A complaint involving a trainee and a leaked record

All people, events and hospital details in this teaching example are invented. They do not describe an actual hospital event.

Patient concern	A family reports that a trainee performed a procedure without adequate supervision. The patient still needs clinical review.
Staff concern	A biometric alert suggests absence by the named supervisor. The duty roster and access records have not yet been compared.
Information concern	A clip showing part of the patient record is circulating online. A researcher asks for the same records for a study that has no documented ethics decision.
Formal process	A legal notice arrives. A manager asks for an immediate punishment letter to show that action has been taken.

The allegation, attendance alert and online clip are information to assess. They do not establish all the facts or legal conclusions.

TEACHING CASE | Illustrative material is identified in the text.

Your response to the complaint

Write your answer and the reason before turning to the next page.

1 | Immediate action

Who needs protection or clinical review now? Which evidence could disappear?

List actions before reaching a finding.

2 | Correct routes

Can the complaint, staff case, legal notice and research request be decided in one letter?

Identify the separate responsible routes.

3 | Fair conclusion

What can the biometric alert establish? What training authorisation must be checked?

State the missing evidence.

Write an answer that protects the patient while leaving factual and disciplinary conclusions open.

TEACHING CASE | Illustrative material is identified in the text.

Run the necessary processes in parallel

Link the files, but keep the decision-maker, purpose and deadline of each process clear.

Concern	Appropriate response
Patient safety	Arrange clinical review and safe ongoing care; review supervision and any immediate service risk.
Complaint and facts	Acknowledge the concern, identify issues and preserve records. Use an authorised fact-finding or complaint process.
Staff conduct	Confirm employment status, applicable service law and competent authority before any formal disciplinary step.
Legal notice and data	Diarise the actual deadline, inform the authorised legal officer and preserve relevant records; separately control disclosure and research access.

Patient protection, fact-finding, disciplinary action and legal representation have different purposes.

Sources: **H1**: disciplinary authority and procedure | **P1**: patient safety and complaints | **R1**: privacy and disclosure

Preserve originals and explain each copy

Suggested evidence controls for the authorised custodian and review team.

1	**Identify**	Collect the relevant clinical record, roster, attendance, supervision logs, device or system logs and available witness accounts.
2	**Preserve**	Protect originals and relevant electronic logs from loss or routine overwriting. Record who secured them and when.
3	**Describe**	Record the source, dates, authors and gaps. Separate direct observation from reported statements and inference.
4	**Control access**	Provide authorised copies through a recorded handover; keep the original record and a traceable correction history.

Never delete an inconvenient record or silently rewrite a clinical entry. Corrections must remain attributable and traceable.

Sources: **P1**: information and record standards

Use the applicable disciplinary process

The Punjab Employees Efficiency, Discipline and Accountability Act 2006 (PEEDA), where applicable, has a defined competent authority and procedure.

1	**Confirm status**	Check the appointment and employment terms. Do not assume every employee is governed by the same service law.
2	**Check the facts**	Compare the roster, authorised changes, leave, biometric data and clinical duties. An alert alone does not prove misconduct.
3	**Use proper authority**	Refer a supported case to the competent authority. Apply the required notice, response, inquiry or other lawful procedure.
4	**Record the decision**	Reach findings on evidence, give reasons and communicate the applicable remedy or appeal route through the proper process.

A temporary safety arrangement is not a finding of guilt. Do not issue a punishment merely to demonstrate activity.

Sources: **H1**: scope and process | **H2**: conduct framework and applicable service rules

Separate lawful disclosure from research access

Different requests need different checks. Neither secrecy nor unrestricted sharing is a complete policy.

Request	Decision checks
Patient or representative	Verify identity, entitlement, scope and the authorised access route; record what is released.
Court or investigating body	Verify the order or lawful power, required scope and response route with the authorised legal officer.
Public or media request	Use the designated route; apply the law, including relevant privacy exceptions and any lawful public-interest test.
Research request	Require the applicable ethics and institutional decisions before access; apply consent or an authorised waiver where appropriate and protect the data.

A published clip does not remove confidentiality. A research proposal is not permission to use identifiable hospital records.

Sources: **R1**: public information requests | **P1**: patient information and records | **T2**: research ethics

Check the specific programme and supervision

Training approval, professional registration and permission to perform clinical work answer different questions.

What to verify

- Check the exact programme, training site, specialty, supervisor, trainee registration and permitted intake with the relevant recognising bodies.
- Confirm the trainee's competence, the approved supervision arrangement and who was actually available for that procedure.

What the evidence can show

- A recognised institution does not automatically establish recognition of every programme or training place.
- If supervision was inadequate, protect care and correct the arrangement. Any individual misconduct finding still needs the applicable fair process.

PM&DC = Pakistan Medical and Dental Council; CPSP = College of Physicians and Surgeons Pakistan. Check the relevant university route too.

Sources: **T1**: PM&DC standards | **T3**: CPSP recognition and registration

A concise initial submission to the competent authority

Illustrative internal brief. It reports a problem and requests decisions without pretending that the investigation is complete.

Verified position	A complaint and legal notice have been received. Clinical review and preservation of relevant records have been initiated. A supervision allegation and attendance discrepancy remain under verification.
Action requested	Confirm the authorised review lead and legal response route. Approve or refer any temporary staffing measure within the proper powers.
Evidence and timing	Attach the complaint, notice, roster and evidence index. Record the actual legal deadline; set named owners and a stated next reporting time.
Open questions	Who performed and supervised the procedure? Was the roster changed? What does each source establish? Which authority may decide any staff case?

Case C tests Modules 2, 6, 7, 8, 14 and 15. Keep patient identifiers within the controlled case file.

A donated machine and a proposed new service

All people, events and hospital details in this teaching example are invented. They do not describe an actual hospital event.

Proposal	Open a new day-procedure service. A donor offers equipment valued at PKR 60 million. Site work will cost PKR 20 million; setup and initial training will cost PKR 5 million.
Activity	The business case predicts 1,200 completed cases/year. The checked service plan can deliver five cases/session, four sessions/week, for 48 weeks/year.
Annual budget	Fixed annual operating cost is PKR 30 million. Variable consumables cost PKR 6,000/completed case. Reliable annual funding for running costs is PKR 28 million.
Readiness gaps	After-sales support is unresolved. No final commissioning record exists. Training recognition is being assumed. An opening date has been announced.

The cost and capacity figures are teaching assumptions. Clinical leads must validate an actual service model.

Your recommendation on the new service

Write your answer and the reason before turning to the next page.

1 | Donation

Does free equipment mean the service has no capital funding gap or continuing obligation?

Identify the remaining costs.

2 | Activity

Can the stated plan deliver 1,200 cases? What happens to annual cost and unit cost at feasible output?

Show the capacity and cost calculations.

3 | Opening

What decisions and checks remain? What should the Board or competent authority be asked to approve now?

Give a reasoned recommendation.

A useful proposal can merit further development while still being unready for clinical opening.

TEACHING CASE | Illustrative material is identified in the text.

Establish the service problem before choosing equipment

Suggested planning review with clinical, nursing, finance, engineering and patient-access input.

Question	Evidence and options
Need	Who needs the service, where are delays occurring and which patients face barriers to access?
Alternatives	Compare improving the existing pathway, referral or shared provision, a smaller service and the proposed expansion.
Capacity	Check the complete pathway: assessment, procedure, recovery, diagnostics, staff, supplies and referral support.
Value	Compare expected benefits, costs, risks and feasible delivery. Explain why the recommended option is preferable.

A donor offer is one input to the decision. It does not prove that this equipment is the best answer to the service need.

Sources: **D1**: development appraisal | **Q1**: device donations

The proposal needs PKR 25 million beyond the donation

The equipment donation is valued at PKR 60 million; that value is not cash available for the other work.

Initial resources	Equipment 60 + site work 20 + setup 5 = PKR 85 million in total initial resources.
Hospital funding need	The donation covers equipment only. Site work and setup still need PKR 25 million in lawful funding and approvals.
Feasible activity	5 cases/session x 4 sessions/week x 48 weeks/year = 960 cases/year, assuming every planned session works as stated.
Planning consequence	The 1,200-case forecast exceeds this model by 240 cases. Revise the forecast or demonstrate a safe, funded increase in capacity.

Validate session duration, case mix, cancellations and recovery support. The arithmetic does not prove clinical feasibility.

TEACHING CASE | Illustrative material is identified in the text.

A lower feasible output increases average cost

Teaching assumption: fixed cost stays at PKR 30 million/year; variable cost stays at PKR 6,000 for each completed case.

At 1,200 cases	Consumables = 1,200 x 6,000 = PKR 7.2 million. Total annual operating cost = PKR 37.2 million; average = PKR 31,000/case.
At 960 cases	Consumables = 960 x 6,000 = PKR 5.76 million. Total = PKR 35.76 million; average = PKR 37,250/case.
Funding gap	At 960 cases: PKR 35.76 million cost - PKR 28 million funding = PKR 7.76 million/year still unfunded.
Meaning	Annual spending falls with fewer cases, but fixed costs are shared across fewer outputs. Average cost rises. The service is still not fully funded.

This example excludes capital-use cost, financing and inflation. It is not a full economic evaluation or an authorised patient tariff.

TEACHING CASE | Illustrative material is identified in the text.

Keep project approval and spending decisions distinct

Use the current Punjab scheme procedure and competent approval forum. PC forms do not themselves grant approval.

Stage	Evidence to obtain
Planning	Where required, PC-II for studies; PC-I for the proposed project, with appraisal and the competent forum's decision.
Funding and execution	Approved scope and cost, budget and release, administrative and technical sanctions as applicable, and lawful procurement.
Change and monitoring	Evidence of physical and financial progress; authorised variations and revised project approval where required.
Completion and results	The required completion report, including PC-IV where applicable; operational handover and later performance review, including PC-V where prescribed.

A contractor variation, project revision, financial sanction and clinical opening are separate decisions.

Sources: **D1**: project cycle and forms | **D2**: Punjab annual development guidance

Require evidence for the complete care pathway

Suggested opening review. A named lead should confirm each required item and identify unresolved conditions.

01 People

Competent staffing, supervision, rosters, leave cover and escalation.

02 Equipment

Lawful supply, acceptance, safety, user training and funded maintenance.

03 Environment

Utilities, infection control, recovery space, waste and emergency access.

04 Clinical support

Medicines, diagnostics, blood support where needed and safe onward care.

05 Information

Patient records, consent, reporting definitions and downtime arrangements.

06 Approvals

Applicable service licences and scope; separate training and research approvals.

A recognised training programme, a service licence and a passed technical inspection are different forms of assurance.

Sources: **P1**: applicable hospital standards | **T1**: training recognition | **M2**: blood-service scope

Plan maintenance, replacement and disposal before acceptance

A donation transfers responsibilities as well as an asset. Confirm who will fund and perform each obligation.

Before acceptance and use

- Check title, condition, suitability, compatibility, accessories, consumables, warranty, service support and total costs.
- Complete acceptance and commissioning; enter the asset, serial number, location, custodian and service history in the register.

During use and at retirement

- Test performance and maintain the asset according to the appropriate technical requirements and contract.
- When retirement is needed, separate technical condemnation, authorised write-off, disposal, proceeds, data removal and any special regulatory route.

Neither delivery nor a donation ceremony establishes readiness for clinical use. A write-off does not itself complete disposal.

Sources: **Q1**: donation responsibilities | **Q2**: inventory and maintenance guidance

Recommend a defined next stage, with open gaps visible

Illustrative submission to the competent authority. Insert the actual source of power and the evidence references in live use.

Decision requested	Authorise the next appraisal and funding steps within the applicable powers. Defer clinical opening and any training claim pending the required approvals and readiness evidence.
Reason	The current model supports 960 cases/year. PKR 25 million of initial expenditure and PKR 7.76 million/year of recurrent funding remain to be secured.
Conditions	Resolve equipment support; confirm staff, facilities and licensing scope. Compare alternatives and update the project, procurement and service plans.
Accountability	Assign planning, finance, technical and clinical leads. Set dates for the funding decision, readiness review and revised submission; attach an indexed evidence file.

Case D tests Modules 1, 2, 9, 11, 12, 13 and 14, with finance and procurement checks from Modules 3 and 4.

TEACHING CASE | Illustrative material is identified in the text.

Final challenge | decisions under pressure

Write your answer and the reason before turning to the next page.

1 | Senior direction

A Board member says: "The service matters. Sign the contract now; the papers can follow."

What do you do and record?

2 | Conditional settlement

Audit minutes say: "Settled subject to verification." Your office marks the matter closed immediately.

Is that status supported?

3 | Data problem

A dashboard reports a 50% reduction in complaints. The first period had 20 complaints/1,000 visits; the second had 10/400.

Calculate the rates and interpret cautiously.

Write the answer, the reason and the evidence you would request before turning to the next page.

TEACHING CASE | Illustrative material is identified in the text.

Answers and reasons

Use the evidence, the calculation and the cited source.

1 | Check authority and protect the service

Record the instruction and service need. Verify the lawful decision-maker, funding, sanction and procurement route. Seek the precise missing decision while arranging lawful interim care. A member's request is not a substitute for the applicable institutional decision.

2 | Keep the condition open

The status remains subject to the stated verification. Identify the required evidence, submit it and obtain the prescribed confirmation before claiming final settlement.

3 | Compare like with like

The first rate is 20 complaints per 1,000 visits; the second is 10/400 x 1,000 = 25 per 1,000. The count fell 50%, but the rate rose by 5 per 1,000 visits. Check definitions, recording and complaint access before inferring care quality.

A complaint count or rate alone is not a complete measure of patient safety.

Sources: **G1**: institutional power | **A1**: follow-up and verification

Final challenge | a plausible shortcut

Write your answer and the reason before turning to the next page.

4 | Attendance

A staff member is flagged absent by the device but says they were covering another unit. A fine is proposed immediately.

What should precede a finding?

5 | Research

A senior researcher asks the MS to release identifiable records today; ethics approval will be sought later.

What decision is needed first?

6 | Opening

Construction is complete, a generator starts and an opening ceremony is arranged. Staff cover and equipment safety checks are incomplete.

Can these facts establish readiness?

For each answer, identify who should act next and the document or check needed.

TEACHING CASE | Illustrative material is identified in the text.

Answers and reasons

Use the evidence, the calculation and the cited source.

4 | Verify and use the proper process

Compare the duty roster, authorised reassignment, actual work, device data and explanation. Arrange any needed safe cover. Refer a supported staff case under the applicable law to the competent authority; do not impose an ad hoc fine.

5 | Obtain the required decisions before access

Ask for the protocol and the appropriate ethics, institutional and data-access decisions. A valid consent basis or authorised waiver may be required. Seniority and the MS's signature do not replace those decisions.

6 | Complete the readiness review

Obtain competent technical and clinical checks, resolve safe staffing and confirm the required approvals. Opening requires an authorised decision on a supported service scope; construction completion and a ceremony are insufficient.

Name the missing decision and its responsible officer. "Follow the rules" is not a complete administrative answer.

Sources: **H1**: competent authority and fair process | **T2**: research ethics | **P1**: staffing and facility standards

Final challenge | clinical safety interfaces

Write your answer and the reason before turning to the next page.

7 | Infection signal

A ward reports several similar infections. Someone asks the MS to declare an outbreak and blame the cleaners before clinical review.

What needs action and verification now?

8 | Controlled stock

The controlled-drug balance does not match the physical count. A colleague suggests adjusting the previous register to make it agree.

How should the discrepancy be handled?

9 | Smoke and movement

Smoke affects a clinical area. Several patients need continuous support. Someone proposes moving everyone to an open car park.

What must govern the response?

State immediate protective actions, the appropriate specialist lead and the evidence needed.

TEACHING CASE | Illustrative material is identified in the text.

Answers and reasons

Use the evidence, the calculation and the cited source.

7 | Protect patients and verify the signal

Involve the responsible clinicians and infection prevention and control (IPC) team promptly. Verify diagnoses, timing, locations and relevant laboratory evidence; apply appropriate precautions and the required notification route. Investigate care processes and environmental risks without announcing an unsupported cause.

8 | Preserve the discrepancy and investigate it

Secure stock and involve the responsible pharmacist. Check the count, receipts, issues, administration, returns and handovers without silently changing originals. Preserve the discrepancy, assess diversion or loss and follow the applicable escalation and reporting duties; maintain safe lawful patient supply.

9 | Follow the site plan and clinical priorities

Raise the alarm and seek trained emergency assistance. Use the approved plan and competent clinical and technical advice for urgent protection or movement. Maintain necessary patient support, a suitable receiving place, identity and handover. Do not enter smoke or disconnect life-support systems indiscriminately.

A concern requires a prompt response. An accusation, a register adjustment or an unplanned evacuation is not a substitute for safe action.

Sources: **P1**: IPC, medicines and emergency standards | **M3**: controlled-drug scope | **E2**: emergency guidance

Your final practical assignment

Ask a relevant clinical, finance, HR, legal or technical colleague to challenge the parts within their expertise.

1	**Decision paper**	Choose one case or a non-confidential real problem. Write the issue, facts, authority, options, costs, recommendation and precise decision requested.
2	**Evidence index**	List each supporting record, date, custodian and location. Identify missing or contradictory evidence and its consequence.
3	**Action and review**	Assign each action an owner, due date and completion check. State what will trigger escalation and the next review.

Use the next pages to assess and improve your work. Do not include identifiable patient or restricted staff information in public coursework.

WORKING METHOD | Illustrative material is identified in the text.

Score the reasoning, then correct the gaps

Teaching rubric only. Give each criterion 0, 1 or 2. The maximum is 12; no pass mark or professional certification is implied.

Criterion	What a complete answer shows
Safety	Identifies immediate harm and a competent, practical protective response.
Authority	Names the applicable source, decision-maker and any missing approval.
Evidence	Separates facts, allegations, assumptions and unknowns; identifies supporting records.
Resources	Checks usable capacity, money, commitments, ongoing costs and key assumptions.
Decision	Compares feasible options and asks for a specific, reasoned decision.
Follow-through	Names owners, dates, escalation triggers and evidence that the action worked.

0 = absent or materially unsafe; 1 = partly correct but incomplete; 2 = clear, supported and usable. Re-score after revision.

WORKING METHOD | Illustrative material is identified in the text.

Correct serious errors regardless of the total score

A high score elsewhere cannot make these decisions acceptable. Rework the affected answer before completing the exercise.

Safety and authority errors

- Continuing care without essential clinical support or a safe alternative.
- Committing funds, signing a contract or imposing a penalty without the required authority.
- Opening a regulated service or claiming training recognition before the necessary approvals.

Evidence and fairness errors

- Backdating, fabricating, destroying or concealing relevant records.
- Releasing identifiable information without a lawful basis and proper controls.
- Treating an allegation as guilt, or calling an audit matter closed while a required condition remains open.

Identify the failed safeguard, the correct next step and the competent person who must decide it.

WORKING METHOD | Illustrative material is identified in the text.

The one-page management brief

Suggested structure for an Executive Director, Board or Secretariat briefing. Use the prescribed official format where one applies.

Field	Write this clearly
Decision	The exact approval, direction, referral or funding decision required.
Position now	Verified facts, patient or service impact, timestamp and current protective action.
Authority	Applicable source and competent decision-maker; identify any unresolved question.
Options and resources	Feasible alternatives, recommended option, cost, funding and operational limits.
Evidence and uncertainty	Key annexures, calculations, contrary evidence and information still needed.
Delivery and review	Named owner, deadline, next review and what will demonstrate success.

A decision-maker should be able to identify the request without searching through the annexures.

Sources: **G2**: case preparation

Keep an authority register that answers the actual question

Suggested fields for a live register. The entries below are prompts, not grants of authority.

Decision type	Evidence to enter	Conditions to record
Expenditure	Current financial delegation and any required sanction.	Amount, purpose, funding source and exclusions.
Procurement	Approved method, committee orders and contract-signing power.	Scope, process, conflict controls and required notices.
Staff case	Employee status, governing law and competent authority order.	Procedure, limits, review and appeal route.
Service opening	Institutional authority and applicable service approvals.	Permitted scope, readiness conditions and review date.

For every entry, add source date, effective period, document location and the officer who checked it.

An action register needs a closure test

Illustrative entries using Case A. Local reporting times are teaching choices, not statutory deadlines.

Action	Owner and next review	Evidence of completion
Close the fuel gap	Technical and logistics leads; report confirmed options at 08:30.	Verified safe supply or alternative support covers the required period.
Assess affected stock	Pharmacy and blood-service leads; update at the next incident briefing.	Recorded disposition of identified stock and a safe supply arrangement.
Reconcile care records	Clinical records and IT leads; review before routine system reliance resumes.	Missing entries and duplicates checked; discrepancies resolved or assigned.

Record status, obstacles and escalation. "Email sent" closes a dispatch task; it does not prove that the patient or service risk is resolved.

WORKING METHOD | Illustrative material is identified in the text.

Build an evidence index that another officer can follow

Suggested index. Keep confidential records in controlled storage and share only through the authorised route.

Group	Typical supporting records	Index fields
Authority	Act or rule, notification, delegation, approval and signed decision.	Reference, issuer, date and applicable scope.
Operational facts	Clinical or technical check, roster, stock, incident and system records.	Author, time, source and limitations.
Money and delivery	Budget, release, commitment, contract, acceptance and payment.	Amount, transaction reference and reconciliation.
Follow-up	Minutes, action log, reinspection, verification and formal status.	Owner, due date, evidence and unresolved conditions.

An index points to evidence. It does not replace the original record or prove that a control was followed.

WORKING METHOD | Illustrative material is identified in the text.

Use a small dashboard with clear definitions

Suggested management measures. Set local targets through the appropriate clinical and administrative process.

Measure	Definition and decision
Staff cover	Competent roles filled / roles required, by shift. Identify any unsafe gap.
Supply cover	Usable stock / daily use. Compare the result with verified resupply time.
Commitments	Unpaid obligations reconciled to accounts. Identify funds already committed.
Safety events	State the event, denominator, period and reporting gaps. Decide what to investigate.
Overdue actions	List open actions beyond their due dates. Escalate the serious unresolved risks.
Deferred care	Opening backlog + additions - completions or valid removals. Check whether it grows.

More incident reports may reflect better reporting. Interpret data with clinical context and verify the source.

WORKING METHOD | Illustrative material is identified in the text.

Test whether an improvement worked

Illustrative example: repeated delays in returning faulty monitors to safe use.

1	**Define the problem**	Record the fault-report and return-to-service times. Check how many repairs are missing a safety or acceptance record.
2	**Test a change**	Agree one fault-report route, a responsible officer and escalation point; preserve safe alternatives for patients.
3	**Measure again**	Compare like periods and equipment groups. Check repair time, missing checks, repeat faults and clinical disruption.
4	**Decide**	Continue, adapt or stop the change based on evidence. Standardise only what works and keep reviewing it.

A signed policy is evidence that a policy exists. Measured practice is needed to show that the problem improved.

Sources: **P1**: quality improvement | **Q2**: equipment maintenance

A 30-, 60- and 90-day review plan

Suggested learning and improvement timetable; adapt it to your responsibilities and the approvals required.

Period	Practical work	Result to review
First 30 days	Check one service pathway, its authority, risks, resources and records. Select a defined improvement.	A baseline, decision brief and agreed action plan.
By 60 days	Test the agreed change, reconcile the evidence and resolve barriers through the proper authority.	Measured progress, remaining gaps and revised actions.
By 90 days	Recheck the control and outcomes; arrange independent review of the important findings.	Evidence of what improved, what did not and the next decision.

Do not wait for a timetable to address an immediate safety risk. These dates are suggested review points.

WORKING METHOD | Illustrative material is identified in the text.

Maintain the sources and your working knowledge

This course supports learning. A live decision needs the current applicable instruments and facts.

1	**Keep the source**	Retain the official document, edition, amendments, applicable notification and retrieval date.
2	**Check before use**	Verify current financial limits, procurement directions, service law, licensing conditions and institutional orders when relevant.
3	**Update the lesson**	Record the change and affected procedure. Correct teaching material with a dated version when needed.
4	**Demonstrate the result**	Revisit one real decision: explain its authority, evidence, resource calculation, action and verified outcome.

The final test is whether another responsible officer can understand your decision and verify what followed.

WORKING METHOD | Illustrative material is identified in the text.

Sources and continued use | 1

Select a source title or its official-source link to open the document.

G1

Punjab Medical and Health Institutions Act 2003

Official compilation including the 2014 amendment shown. Sections 3, 8-9 and 13-16 concern institutional status, powers and funds. Apply only with the institution notification and valid rules and orders.

Government of Punjab | Health Department | **Official source**

G2

Manual of Secretariat Instructions 2023

Official edition amended up to February 2025. Paragraphs 4.3-4.18 cover clear case notes, recommendations, drafts and formal summaries. Use the authorised departmental route and current instructions.

Government of Punjab | S&GAD Regulations/O&M Wing | **Official source**

G3

Punjab Medical Teaching Institutions (Reforms) Act 2020

Act II of 2020. Sections 1(3), 3 and 7 identify a separate institutional framework. Application depends on the relevant notification; do not assume that it governs every teaching hospital.

Government of Punjab | Punjab Laws | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 2

Select a source title or its official-source link to open the document.

G4

Punjab Specialized Medical Institutions Act 2025

Act LVI of 2025; Gazette 25 June 2025. Sections 1(3), 3 and 8 concern notification-based application and Board powers. Section 8(3) delegation differs from the 2003 Act; check institutional regulations.

Government of Punjab | Health Department | **Official source** | **Official text**

F1

Punjab Public Financial Management Act 2022

Act XXXVII of 2022. Sections 33-35, 39-40 and 48 address expenditure, cash management, departmental controls and continuing rules. Identify the fund and applicable institutional framework; check later amendments and instructions.

Government of Punjab | Punjab Laws | **Official source** | **Official alternate copy**

F2

Punjab Procurement Rules 2014

Official compilation amended through 24 September 2025. Covers procurement principles, planning, methods, approvals, records and complaints. Check later notifications and applicable electronic procurement directions before a live purchase.

Punjab Procurement Regulatory Authority | Government of Punjab | **Official source** | **Later notifications**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 3

Select a source title or its official-source link to open the document.

F3

Punjab Delegation of Financial Powers Rules 2016

Base rules and schedules; particularly rules 3, 6 and 7. Read with later amendments and any valid institution-specific delegation. No current monetary ceiling is reproduced in this lecture.

Government of Punjab | Finance Department | **Official source** | **Finance Department**

F4

Accounting Policies and Procedures Manual

Government manual issued 13 February 1999; official academy copy. Supports payment verification, records and reconciliation. Apply its stated scope, subsequent changes and the authorised provincial or institutional accounting system.

Auditor-General of Pakistan | Pakistan Audit and Accounts Academy | **Official source** | **CGA manuals**

A1

Guidelines for Civil Audit Punjab

Official AGP audit methodology. The reporting and follow-up sections explain evidence, DAC discussion, minutes and continuing action. This is not a delegation of spending powers or a universal hospital reply timetable.

Department of the Auditor-General of Pakistan | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 4

Select a source title or its official-source link to open the document.

A2

Rules of Procedure of the Provincial Assembly of the Punjab 1997

Official November 2024 compilation, including September 2024 amendments. Rules 176-179 cover Public Accounts Committees; relevant general committee provisions also apply. Use the actual notice, allocation and directions.

Provincial Assembly of the Punjab | **Official source**

A3

Auditor-General's Ordinance 2001

Official text of the Auditor-General's functions and powers. Section 14 addresses audit access, record production and information. A records request and formal disposal of an observation are separate matters.

Auditor-General of Pakistan | **Official source** | **Official parliamentary text**

H1

Punjab Employees Efficiency, Discipline and Accountability Act 2006

PEEDA base text; use with 2014, 2017 and 2026 amendments and current authority notifications. Sections 1-2, 5, 7 and 9-14 support scope, authority and fair procedure. The linked base is not a 2026 consolidated edition.

Government of Punjab | Official Act and Gazette copies | **Official source** | **2026 amendment, Act XVII**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 5

Select a source title or its official-source link to open the document.

H2

Punjab Government Servants (Conduct) Rules 1966 and service instructions

Punjab Estacode 2024 and S&GAD notification index. Determine employee status before applying a rule. Check later amendments, including conduct and performance-report changes; an index is a route to the signed instrument.

Government of Punjab | S&GAD Regulations/O&M Wing | **Official source** | **Amendments and instructions**

P1

PHC Category I Hospital Minimum Service Delivery Standards

Reference manual 2024: 30 standards and 162 indicators across ten functional areas. Covers patient care, management, facilities, staffing and information. Use the applicable indicator requirements; a local dashboard is not official PHC grading.

Punjab Healthcare Commission | **Official source** | **Official MSDS catalogue**

R1

Punjab Transparency and Right to Information Act 2013

Official text read with the 2021 amendment. Sections 10-13 address public information requests, exceptions and severance; section 16 protects requested records from intentional destruction. It is not a general patient-consent code.

Government of Punjab | Punjab Laws | **Official source** | **2021 amendment**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 6

Select a source title or its official-source link to open the document.

E1

National Disaster Management Act 2010

National, provincial and district responsibilities; emergency powers remain with the authority named in the Act. Read with current notifications and the hospital's approved response arrangements.

Government of Pakistan | Pakistan Code | **Official source**

E4

Punjab Emergency Service Act 2006

Official consolidated text. Sections 3 and 5 address continuing responsibilities and Rescue functions; section 17 assigns emergency powers to rescuers. These powers do not automatically belong to the Medical Superintendent.

Punjab Emergency Services Department | **Official source**

E2

Hospital Emergency Response Checklist

WHO, 2011. All-hazards guidance on command, communication, safety, triage, surge capacity, continuity, staff, logistics and recovery. International guidance; apply current local arrangements and competent clinical judgement.

World Health Organization | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 7

Select a source title or its official-source link to open the document.

E3

Health Service Continuity Planning for Public Health Emergencies

WHO interim handbook, 2021. A planning method for facilities, essential services, dependencies, disruption and recovery. It does not prescribe Punjab staffing ratios or minimum reserve quantities.

World Health Organization | **Official source**

M1

Good Distribution Practices and Hospital Pharmacy Standards

DRAP distribution guidance, 2023, and hospital pharmacy standards, 2024. Cover medicine receipt, storage, monitoring, organisation and safe use. Apply product-specific conditions and the relevant statutory requirements.

Drug Regulatory Authority of Pakistan | **Official source** | **Hospital pharmacy standards, 2024**

M2

Punjab Blood Transfusion Safety Act 2016

Sections 10-17 address blood-establishment processes, records, traceability, serious-event reporting, data protection, registration and licensing. Check the actual activity and the conditions of the current licence.

Punjab Blood Transfusion Authority | Official Act | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 8

Select a source title or its official-source link to open the document.

M3

Controlled Drugs: Authorised Access, Custody and Records

Official federal Act copy; read with the 2001 rules and applicable Punjab law and amendments. Used for the need to verify authorised access and custody, not a universal hospital quota procedure.

Government of Pakistan | Sindh Judicial Academy copy | **Official source** | **Punjab Act 2025; read with later amendments**

W1

Punjab Hospital Waste Management Rules 2014

Rules cover responsibility, handling, oversight and authorisation. The EPA order of 4 November 2025 addresses rule 28 authorisation for outsourced risk-waste handling. Check later directions; its December 2025 deadline is historical.

Environment Protection Department, Government of Punjab | **Official source** | **EPA authorisation order, 2025**

D1

Manual for Development Projects and PC Forms, 2024

Federal project-cycle manual and PC-I to PC-V forms. Use for planning concepts; verify the procedure, forum, form and reporting instructions prescribed for the actual Punjab scheme.

Planning Commission, Government of Pakistan | **Official source** | **Official forms and publications**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 9

Select a source title or its official-source link to open the document.

D2

Punjab ADP Formulation Guidelines 2026-27

Annual Punjab guidance dated 10 October 2025. Covers programme formulation, priorities and departmental submissions. Use the applicable financial-year directions; inclusion and forward projections are not automatic spending authority or guaranteed funding.

Planning and Development Board, Government of Punjab | **Official source**

Q1

Medical Device Donations: Considerations for Solicitation and Provision

WHO, second edition, 2024. Assesses recipient need, suitability, responsibilities and arrangements before and after transfer. Technical guidance; local acceptance, financial and regulatory authority remain necessary.

World Health Organization | **Official source**

Q2

Inventory and Maintenance Management Information System for Medical Devices

WHO, 2025. Guidance on inventory, equipment information, maintenance records and monitoring. Supports service planning and evidence of safe maintenance; it does not confer authority to purchase or dispose of public assets.

World Health Organization | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 10

Select a source title or its official-source link to open the document.

T1

Postgraduate Medical and Dental Standards Regulations 2026

PM&DC programme standards and application requirements. Match the qualification, institution, site, approved intake and applicable decisions. Educational recognition and the hospital's service licence are separate checks.

Pakistan Medical and Dental Council | **Official source**

T3

CPSP Accreditation and Training Registration

Official institution searches and training-registration guidance. Verify the specialty, recognised venue, approved supervisor, trainee registration and current programme requirements. Employment or an application is not evidence of recognised training.

College of Physicians and Surgeons Pakistan | **Official source** | **Training-registration guidance**

T2

Research Ethics Review: Scope and Submission Routes

NBC-R defines national review scope and exemption procedures. Determine the institutional, national and regulatory reviews required by the actual study. Hospital permission does not replace ethics approval or authorise unrestricted access to patient records.

National Bioethics Committee for Research | NIH Pakistan | **Official source** | **Current ethics portal and notices**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.