

MODULE 7 | SAFE PATIENT CARE, PHC STANDARDS AND QUALITY IMPROVEMENT

Safe Care Across the Patient Journey

Practical hospital governance in Punjab, Pakistan

Keep each patient connected to the right care.
Make every handover and follow-up clear.

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LECTURE

Patient safety at each change of care

For the Medical Superintendent (MS): make sure the right person, information and resources are available at each stage.

- Recognise risks from arrival to discharge.
- Assign urgent reviews and pending tasks.
- Check medicines, procedures and transfers.
- Test safety through records and observation.

OFFICIAL SOURCE

A principle tied to a named law, standard or official guidance.

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 patient-journey review with one named owner, one action and one check for each gap.

Module 7 | Presentation 2 of 5. Allow 45-60 minutes with exercises. All explanations are on the pages; check the cited sources before live use.

The source and its status

Use the correct level of authority when turning a safety principle into hospital practice.

Source	How to use it	What to avoid
Punjab requirements	Apply the relevant law, PHC standards, licence conditions and lawful orders.	Calling an international recommendation a Punjab legal rule.
WHO guidance	Use the cited guidance to develop or improve approved clinical systems.	Assuming a WHO criterion is a PHC indicator with the same number.
Hospital procedure	State who acts, when, with what resources and what record.	Writing a procedure that staff cannot carry out.
Teaching method	Adapt the suggested registers, questions and case exercises.	Presenting an invented case or target as an official requirement.

Lecture 29 covers the PHC framework. This lecture explains practical care processes and their safety checks.

WORKING METHOD | Illustrative material is identified in the text.

Responsibility across the patient journey

A patient may move through several departments. Each unfinished task still needs an owner.

Stage	Main safety question	Useful evidence
Arrival	Who needs urgent care, and is this the correct patient?	Triage record and checked identity.
Assessment	What is the current problem, plan and review time?	Assessment, responsible team and care plan.
Treatment	Are staff, medicines, equipment and checks suitable?	Authorisation, monitoring and completed checks.
Transfer or discharge	Who accepts the patient and the unfinished work?	Handover, named recipient and follow-up plan.

The MS tests how departments connect. The treating team retains responsibility for individual clinical decisions.

WORKING METHOD | Illustrative material is identified in the text.

Triage and the waiting patient

WHO triage guidance prioritises patients by urgency. Queue position alone cannot establish clinical priority.

The clinical process

- Trained staff assess urgency through the approved triage system. Record the category, assessment time and destination.
- Patients who wait need a clear route for reassessment if their condition changes. Explain how to request help.

The management check

- Identify the staff covering triage on every shift, the immediate-care space and the backup when arrivals exceed capacity.
- Review delays by urgency and shift. Escalate crowding, absent cover or blocked access with a specific interim arrangement.

Reception staff need a rapid route to clinical help. Administrative registration must support timely emergency care.

Sources: **W1**: overview and routine triage | **P1**: para. xiv

Correct patient identification

WHO recommends at least two patient identifiers before care. A bed or room number is a location, not an identifier.

The routine check

- Use the hospital-approved pair, for example full name and medical record number. Match the patient, record and intended care.
- Ask the patient to state the details where possible. Check before medicines, samples, blood, procedures and transfer.

The system check

- Check that the identity band and electronic record agree. A band containing the wrong details can repeat an earlier error.
- Keep a safe route for an unconscious patient, an unknown identity or two patients with the same name.

Patient participation helps, but staff remain responsible for matching the person to the intended care.

Sources: **W2**: suggested actions and exceptions

Two patients have the same name

Invented example: two patients called Patient A occupy the same ward. A porter brings a procedure request for one of them.

Unsafe shortcut	The request says "Patient A, bed 12". Staff select the patient currently in bed 12.
Missing evidence	The bed allocation changed that morning. The name and location cannot distinguish the two people.
Safe response	Pause the planned movement and verify the approved identifiers against the patient, record and request.
System repair	Correct the request through the approved route. Review label printing and bed-move communication.

If care is immediately urgent, use the approved emergency identification process while the clinical team protects the patient.

A usable assessment and care plan

Suggested review questions for the clinical record. Each specialty should approve its own detailed requirements.

01 Problem

What brought the patient here, and what needs action now?

02 Assessment

What did the responsible clinician find and consider?

03 Risks

What allergies, vulnerabilities or urgent concerns matter?

04 Plan

What treatment, tests or consultation have been arranged?

05 Responsibility

Which team owns the plan and the outstanding tasks?

06 Review

When will the patient be reassessed, and what triggers earlier help?

Entries should show the author, date and time. Record uncertainty and planned reassessment when a diagnosis remains unclear.

WORKING METHOD | Illustrative material is identified in the text.

Recognition and response to deterioration

Deterioration means a concerning change in the patient's condition. The approved response must work throughout the day and night.

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|--------------------|---|
| 1 Recognise | Measure and record the observations required for that patient. Staff and family concerns also need attention. |
| 2 Escalate | Use the agreed triggers, contact route and urgency. Identify the next contact if the first person does not respond. |
| 3 Respond | A competent clinician assesses the patient and records the treatment, monitoring and further support needed. |
| 4 Confirm | Record who attended and when. The shift team checks that the plan actually happens. |

WHO guidance supports a hospital-wide response system. Local protocols must define observation intervals and response times.

Sources: **W3**: C.1.1.3

Clinical competence and permission to practise

A qualification, current professional registration and hospital permission for a procedure answer different questions.

Credentialing

- Credentialing means checking identity, qualifications, registration and relevant experience through reliable sources.
- The file should show what was verified, by whom and when. Include visiting staff, locums and other temporary practitioners.

Clinical privileges

- Clinical privileges define the services or procedures a practitioner may perform under the hospital's authorised system.
- Record limits, supervision and review. Trainees need a named supervisor and a clear route for help.

PHC requires a credential-verification process and current registration. Use the hospital's lawful approval process for clinical privileges.

Sources: **P2**: HRM-3, indicators 142-143 | **W3**: A.5.2.4

Patient rights in daily care

The WHO Patient Safety Rights Charter is international guidance. Apply it alongside the relevant local rights and duties.

Respect and access

- Protect dignity, privacy and confidentiality. Make communication accessible for language, hearing, sight and other needs.
- Explain who is providing care and how the patient can raise a safety concern or seek information.

Involvement

- Give understandable information and support informed decisions. Invite questions and concerns without dismissing them.
- Include family or carers according to the patient's wishes and the lawful decision-making arrangements.

A displayed rights poster needs a working process behind it. Test what patients experience at reception, bedside and discharge.

Sources: **W4**: Patient Safety Rights Charter

A complete consent discussion

PHC addresses information, understanding and substitute consent. These checks support the hospital's approved process.

01 Decision

Identify the procedure and who will perform it.

02 Explanation

Explain the expected benefit, material risks and alternatives.

03 Understanding

Use suitable language and check what the patient understands.

04 Choice

Allow questions and a voluntary decision without improper pressure.

05 Authority

Establish capacity and any lawful substitute decision-maker.

06 Record

Document the discussion, decision, date, time and required signatures.

A signed form alone cannot show that the patient understood. Use an authorised emergency process when urgent care creates an exception.

Sources: **P2**: PRE-1, indicators 74-75

Refusal, disagreement and confidentiality

These are practical controls for cases that require careful clinical and legal judgement.

When care is declined

- Ask what the patient understands and why they decline. Address pain, fear, cost concerns or communication problems where possible.
- The responsible clinician assesses decision-making capacity and explains likely consequences and alternatives. Record the decision and safety advice.

When information is shared

- Confirm who may receive information and through which authorised channel. Share only what is needed for the lawful purpose.
- Protect records in busy wards, photographs, teaching material and electronic messages. A relative's presence does not settle every disclosure question.

Escalate uncertainty about capacity, safeguarding, substitute authority or emergency exceptions through the clinical and legal route.

Medication reconciliation at a change of care

Medication reconciliation means comparing medicine lists and resolving unexplained differences when care changes.

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|----------------------|---|
| 1 Establish | Obtain the best available medicine history using the patient, carers and reliable records. |
| 2 Compare | Compare that history with the proposed admission, transfer or discharge medicines. |
| 3 Resolve | A qualified clinician or pharmacist checks omissions, duplicates and changes. Record the intended decision. |
| 4 Communicate | Give the updated list and reasons for changes to the next team and the patient. |

WHO identifies transitions as a priority for medication safety. Assign responsibility so reconciliation does not disappear between teams.

Sources: **W5**: structured processes and information quality

High-risk medicines and high-risk situations

WHO describes risks from the medicine, patient or provider, and the work environment. Controls should address all three.

Clinical and pharmacy controls

- Maintain an approved high-alert medicine list. Specify storage, prescribing, preparation, administration and monitoring safeguards.
- Use standard instructions and appropriate independent checks where the approved protocol requires them. Provide prompt access to advice.

Management controls

- Look for interruptions, workload, unfamiliar products, unclear labels and equipment difficulties. Correct the conditions that make an error likely.
- Review whether staff understand the safeguards and whether the required supplies and monitoring are available on each shift.

Examples may include anticoagulants, insulin and concentrated electrolytes. The approved local list and clinical protocols govern practice.

Sources: **W6**: high-risk situations and risk factors

Labels, allergies and confusing names

LASA means look-alike or sound-alike. Similar packaging and names can lead to selection of the wrong product.

Risk	Practical safeguard	What the MS can check
Confusing products	Read the medicine name and strength. Separate products known to cause confusion.	Pharmacy risk list and storage changes.
Unclear order	Clarify ambiguity before supply or administration. Use an authorised read-back process for essential verbal orders.	Whether staff can access the prescriber promptly.
Allergy information	Check and record the allergy and reaction. Resolve missing or conflicting information.	Agreement between clinical, pharmacy and discharge records.
Unlabelled preparation	Use the approved labelling process. Escalate any uncertainty about contents.	Labels and supplies available where medicines are prepared.

WHO guidance supports LASA safeguards. The allergy and preparation checks are suggested local review controls.

Sources: **W7**: suggested actions

The WHO surgical safety checklist

Use the complete approved checklist in practice. This summary explains the three safety pauses.

Pause	Main purpose	Leadership check
Before anaesthesia	Confirm identity, intended procedure, site and consent. Review anaesthetic readiness and patient risks.	The team resolves discrepancies before proceeding.
Before incision	The team confirms the patient and operation together, shares concerns and checks key preparations.	The relevant team members participate in the pause.
Before leaving theatre	Confirm the procedure, counts, specimen labels, equipment problems and recovery concerns.	Recovery staff receive the agreed plan.

Checklist use needs team participation and action on concerns. A completed form alone does not prove the checks occurred.

Sources: **W8**: checklist and implementation manual

Procedural care beyond the operating theatre

Suggested checks for catheter laboratories, endoscopy, radiology and other areas providing invasive care.

Before the procedure

- Confirm an authorised operator, appropriate consent and the correct patient, procedure and site. Reconcile conflicting documents.
- Check necessary equipment, trained assistance, monitoring and emergency support. Apply service-specific infection and radiation controls.

After the procedure

- Name the team responsible for recovery and the criteria for transfer or discharge. Record complications and required observations.
- Trace implants, devices and specimens through the approved records. Communicate any result or equipment concern needing later action.

Apply the standards specific to the service. An operating-theatre checklist may need an authorised adaptation for another procedure area.

Transfusion safety covers the whole process

WHO guidance treats safe blood and a safe clinical process as linked requirements. Detailed clinical decisions belong to trained staff.

01 Decision

Record the clinical need, prescription and required consent.

02 Identity

Match the patient, sample, request and issued blood correctly.

03 Blood service

Use the authorised source and approved compatibility process.

04 Handling

Control collection, transport, storage and bedside checks.

05 Monitoring

Ensure trained staff recognise and respond to adverse events.

06 Traceability

Keep records linking the component, recipient and outcome.

Review incidents and process failures through the appropriate clinical and transfusion governance arrangements.

Sources: **W9**: clinical transfusion process

The diagnostic process needs follow-up

WHO diagnostic-safety guidance emphasises communication, reliable referrals and systems to track results.

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|--------------------|--|
| 1 Request | State the clinical question and urgency. Use the correct patient details and requesting clinician. |
| 2 Track | Check that the specimen or examination reaches the service and that delays or rejection reach the clinical team. |
| 3 Review | A named clinician interprets the result in context and records the next decision. |
| 4 Follow up | Explain the result and plan to the patient. Keep pending work visible across transfer and discharge. |

A report appearing in the computer does not establish that anyone reviewed it or acted on it.

Sources: **W10**: health worker and facility-leader advice

A critical-result communication record

PHC requires immediate reporting of critical laboratory results to the relevant personnel. These are suggested register fields.

Record	Example field	Why it matters
Patient and result	Approved identifiers, test and verified result.	Prevents a message reaching the wrong record.
Communication	Caller, receiving clinician, time and confirmation.	Shows who received the information.
Escalation	Alternative contact and attempts if the first contact fails.	Keeps an unanswered call visible.
Clinical action	Assessment, decision, responsible person and review.	Shows whether the result led to a response.

Clinical services define critical thresholds and escalation. A message marked "sent" is incomplete evidence of a safe response.

Sources: **P2**: AAC-1, indicator 5

Specimen identity and tracking

A specimen needs a reliable connection to the patient from collection to the final report.

At collection

- Match the patient and request through the approved identity process. Label the specimen in the patient's presence.
- Record the collection details required by the laboratory. Keep different patients' specimens and labels clearly separated.

When something is wrong

- Use the laboratory's approved rejection and correction process. Inform the responsible clinician when care may be delayed.
- Do not guess a missing identity or silently change a label. Escalate an irreplaceable specimen for a documented specialist decision.

WHO supports identity controls throughout the specimen pathway. The exception-handling questions are a suggested management check.

Sources: **W2**: specimen labelling and identity controls

A structured clinical handover

WHO describes SBAR as one useful communication method. Use the hospital's approved structure and allow questions.

Element	Plain meaning	Information to convey
Situation	What is happening now?	Patient identity, current concern and urgency.
Background	What matters from earlier care?	Relevant history, treatment, allergies and recent change.
Assessment	What does the team think?	Current findings, concerns and uncertainty.
Recommendation	What needs to happen next?	Required action, responsible person, deadline and escalation.

Confirm who receives the handover. Use read-back or repeat-back for essential details and resolve disagreement.

Sources: **W11**: structured communication and questions

Referral and transport in Punjab

PHC referral guidance addresses care before movement, care during transport and the receiving hospital's arrangements.

Before departure

- The clinical team records why transfer is needed, the patient's condition and available treatment. Arrange care needed during transit.
- Communicate with the receiving service. Confirm suitable transport, equipment and escort for the patient's condition.

At the receiving hospital

- Prepare for the arrival. Receive the patient and the relevant clinical information, investigations and treatment record.
- Keep the referral and receipt records. Identify the next responsible team and any feedback needed by the referring facility.

The transfer decision requires clinical judgement about urgency, available care and transport risk. A referral slip alone cannot make a transfer safe.

Sources: **P1**: paras. i-ii, vii-viii, x, xii, xvi

Transfer readiness: six operational checks

Suggested review for an inter-hospital transfer or a move between hospital units.

01 Reason

What care does the patient need at the destination?

02 Readiness

What stabilisation and monitoring are needed before moving?

03 Acceptance

Who has agreed the receiving arrangements?

04 Transport

Are the escort, equipment and supplies suitable for the journey?

05 Information

Are the record, medicines, risks and pending tasks handed over?

06 Arrival

Who confirms arrival and assumes the ongoing care?

If the agreed destination or transport fails, escalate promptly through the approved emergency and referral arrangements.

WORKING METHOD | Illustrative material is identified in the text.

Daily risks need an individual plan

WHO guidance supports initial and repeated assessment for avoidable harm. The actions below are suggested checks within approved clinical protocols.

Risk	Care-team check	Management question
Falls	Assess mobility and assistance needs. Review after a relevant change.	Can staff provide the help the plan requires?
Pressure injury	Assess skin risk and record the prevention and review plan.	Are suitable supports and staff available?
Nutrition and swallowing	Identify concerns and arrange the appropriate assessment.	Does the correct diet or feeding plan reach the bedside?
Other harm	Consider clot risk, self-harm and other risks relevant to this patient.	Are screening findings followed by a documented action?

A completed risk score is a starting point. Check the care actually provided and reassess when the patient changes.

Sources: **W3**: C.1.2.4-5, C.1.2.8

Oxygen, devices and essential equipment

Suggested shift checks under the relevant clinical, engineering, fire and manufacturer requirements.

01 Availability

Is the required device or oxygen supply ready for this patient?

02 Competence

Can the assigned staff use it and recognise a problem?

03 Settings

Are the prescription, device settings and monitoring clear?

04 Connections

Are lines, leads and connections secure and correctly identified?

05 Backup

What happens if power, supply or the device fails?

06 Defect

Who isolates unsafe equipment and provides a safe replacement?

Use trained technical staff for repairs. Record a fault and its resolution instead of returning defective equipment to general use.

Discharge readiness

Suggested checks for the responsible team before the patient leaves hospital.

01 Clinical plan

Has an authorised clinician decided that the destination is suitable?

02 Medicines

Does the patient have an accurate list and access to the medicines?

03 Instructions

Are care needs, warning signs and the route for help clear?

04 Follow-up

Are the place, timing and purpose of further review recorded?

05 Pending work

Who will review unfinished tests and contact the patient?

06 Support

Are transport, mobility, equipment or carer needs addressed?

Use the approved discharge summary and handover route. A bed needed for another patient does not settle clinical readiness.

Pending results after discharge

Suggested task register. Discharge changes the care setting but does not remove the need to resolve pending work.

Task	Named responsibility	Evidence of completion
Awaiting result	The responsible team and a backup owner.	Expected date, tracking entry and receipt.
Review result	A clinician able to interpret and act on it.	Dated interpretation and decision.
Contact patient	The person assigned to explain the result and next step.	Verified contact, advice and follow-up arrangement.
Failed contact	The clinician overseeing the risk and escalation.	Attempts, risk review and further authorised action.

Check contact details before discharge. A patient portal or automated text requires a process for missed or unacknowledged results.

WORKING METHOD | Illustrative material is identified in the text.

Checking what the patient understands

A useful explanation lets the patient describe the plan in their own words.

Teach-back

- Ask the patient to explain what they will do at home and when they will seek help. This checks the explanation, not the patient's intelligence.
- Correct any misunderstanding and check again. Use a trained interpreter or other appropriate support when needed.

Practical discharge questions

- Can the patient explain which medicines changed, where the next review occurs and how to seek urgent help?
- Record a material difficulty and the response. Give information in a usable form and involve a carer when appropriate and authorised.

WHO handover guidance describes teach-back and communication at discharge. Adapt the wording to the patient's needs.

Sources: **W11**: teach-back and discharge communication

A critical result returns after discharge

Invented example: the hospital discharges a patient while a test is pending. The next day, the result requires urgent clinical review.

The gap	The discharge summary says "result awaited". No clinician or team is named to follow it up.
Immediate action	Identify the responsible clinical team, assess urgency and arrange the required patient contact and care.
Evidence	Record receipt, clinical review, contact attempts, advice and any further escalation.
System action	Assign an owner and backup to every pending discharge result. Check whether other unresolved results need review.

A statement that the patient should collect the report does not replace the hospital's agreed clinical follow-up responsibility.

Six questions during a patient-safety round

Use observation and a small record sample. Ask staff to show the working process, while protecting patient privacy.

01 Identity

How does the team confirm the correct patient before care?

02 Urgency

Who responds when a patient deteriorates on this shift?

03 Treatment

Which medicine or procedure check most often fails here?

04 Information

Who owns the patient's pending result or consultation?

05 Transition

How does the receiving team confirm the handover?

06 Understanding

Can the patient explain the next step and how to ask for help?

Give each confirmed gap an owner, an interim safety measure, a completion date and a check that the change works.

WORKING METHOD | Illustrative material is identified in the text.

Three decisions to practise

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

1. Correct patient

Two patients have the same name. The procedure request identifies one by a bed that has changed.

What must happen before movement?

2. Referral

A seriously ill patient needs care elsewhere. A relative offers a private car, but monitoring and support may be needed.

What must the clinical team decide?

3. Discharge

A test remains pending. The summary says "collect report next week". No team has accepted follow-up.

Is the arrangement complete?

State the immediate safety action, the responsible clinical decision-maker and the evidence that should remain in the record.

Answers and reasons

Compare the immediate safety action, responsibility and required record.

1. Verify identity

Use the approved identifiers to match the patient, request and record. Resolve the discrepancy through the authorised process. Record and examine the bed-change error.

2. Assess the transfer

The clinical team must assess urgency, destination and the support needed in transit. Arrange appropriate transport and receiving care. A relative's offer does not establish suitability.

3. Assign follow-up

The team must name who will track and review the result, contact the patient and arrange further care. Record a backup and escalation route for delay or failed contact.

These answers explain a safety process. The treating team applies the patient-specific clinical decisions and applicable local requirements.

Sources: **W2**: patient identity | **P1**: referral and transport | **W10**: result follow-up

Review one patient pathway

Use a non-confidential real case or the invented examples in this lecture.

Map the pathway

Choose admission, a procedure or discharge. List each department and change of responsibility.

Find the gaps

Check five records and observe care. Distinguish a missing document from an observed care failure.

Prepare the action sheet

Record each risk, interim protection, owner, action, due date and evidence of improvement.

Review with the clinical lead and quality team. Apply the correct PHC standard and approved hospital procedure to the selected pathway.

Next: Lecture 31 - Infection Prevention and a Safe Care Environment.

Sources and continued use | 1

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

P2

Minimum Service Delivery Standards for Hospitals

PHC manual with 2024 cover, document code CG-01MS-Ed2-01092023. Selected references: critical results (indicator 5), consent (74-75) and credentialing (142-143). Check the edition applicable to the hospital.

Punjab Healthcare Commission | [Official source](#)

P1

Guidelines for Referral / Transport of Critically Ill / Injured Patients

PHC, Edition 1, document CG-22GLRT-ED1-120122 (2022). This lecture uses the referral, transport, records and receiving-hospital safeguards. Read with current applicable PHC instruments.

Punjab Healthcare Commission | [Official source](#)

W1

Interagency Integrated Triage Tool

WHO, ICRC and MSF. Official tool and accompanying resources. Triage prioritises care by urgency. The hospital must adopt an appropriate system and train staff to use it.

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 | 2

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

W2

Patient Identification

Patient Safety Solutions, volume 1, solution 2, May 2007. Two identifiers, identification exceptions, specimens and patient participation. WHO guidance, not a Punjab statutory instrument.

WHO Collaborating Centre for Patient Safety Solutions | [Official source](#)

W3

Patient Safety Assessment Manual

Third edition, 2020. Selected guidance on competent staff, clinical deterioration, risk assessment and equipment. Its assessment criteria are WHO framework criteria, not PHC indicator numbers.

WHO Regional Office for the Eastern Mediterranean | [Official source](#)

W4

Patient Safety Rights Charter

2024. International guidance on safe care, competent staff, dignity, confidentiality, information, supported decisions and patient engagement. It does not replace applicable Pakistan law.

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 | 3

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

W5

Medication Safety in Transitions of Care

2019 technical report, WHO/UHC/SDS/2019.9. Structured medication processes, information quality and patient participation when care settings change.

World Health Organization | [Official source](#)

W6

Medication Safety in High-Risk Situations

2019 technical report, WHO/UHC/SDS/2019.10. Risks arise from the medicine, the patient or provider, and the work system. Select safeguards through clinical and pharmacy governance.

World Health Organization | [Official source](#)

W7

Look-Alike, Sound-Alike Medication Names

Patient Safety Solutions, volume 1, solution 1, May 2007. Clear orders, label reading, storage separation and risk review for confusing medicine names.

WHO Collaborating Centre for Patient Safety Solutions | [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.

W8

WHO Surgical Safety Checklist and Implementation Manual

2009. The checklist uses checks before anaesthesia, before incision and before leaving theatre. This lecture summarises the purpose and does not reproduce a complete operating checklist.

World Health Organization | [Official source](#) | [Official checklist](#)

W9

Clinical Transfusion Process and Patient Safety

2010 aide-memoire for national authorities and hospital management, WHO/EHT/10.05. Safe transfusion covers the entire process, including identification, monitoring and adverse-event management.

World Health Organization | [Official source](#)

W10

World Patient Safety Day 2024: Practical Advice for Stakeholders

Official diagnostic-safety guidance for patients, health workers and hospital leaders. Covers communication, follow-up, referral systems and patient participation.

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 | 5

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

W11 Communication During Patient Hand-Overs

Patient Safety Solutions, volume 1, solution 3, May 2007. Structured handover, opportunities for questions, read-back, discharge information and checking patient understanding.

WHO Collaborating Centre for Patient Safety Solutions | [Official source](#)

Keep the current PHC manual and approved clinical procedures accessible to staff. Review changes through the hospital's authorised clinical governance process.

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