

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

Patient Safety Incidents, Complaints and Learning

Practical hospital governance in Punjab, Pakistan

Respond to harm, establish what happened and check that the service becomes safer.

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LECTURE

Turn a safety concern into a completed improvement

The institutional head must manage the patient, the evidence, the response and the follow-up.

- Respond to incidents without delaying care or losing reliable evidence.
- Review events fairly and convert findings into practical changes.
- Use the Punjab Healthcare Commission (PHC) complaint process correctly.

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

An incident review file with a patient communication record and a tested action plan.

Module 7 | Presentation 4 of 5. Allow 45-60 minutes with exercises. All explanations are on the pages; check the cited sources before live use.

The wrong file reaches the procedure room

Invented hospital example. Two patients have similar names.

1

The event

Patient A's file reaches the team preparing Patient B. The final check detects the mismatch.

2

The first response

Pause preparation. Confirm both patients and restore the correct files before continuing safely.

3

The review

Why did earlier checks fail, what stopped the error, and could it happen on another shift?

A near miss can expose a serious weakness. The absence of injury does not remove the need to learn.

Name the event accurately

Use the same definitions across the hospital so reports can be compared.

Term	Plain meaning	Invented example
Hazard	A condition that could cause harm.	Similar patient labels are left together without separation.
Near miss	The incident is stopped before reaching the patient.	A wrong medicine is found before administration.
No-harm incident	The incident reaches the patient, with no harm detected.	An incorrect dose is given; assessment finds no harm.
Harmful incident	The incident causes patient harm.	A patient is injured after a preventable fall.

Actual harm and possible harm are different. Record both; use clinical assessment to update the outcome.

Sources: [11](#): definitions framework

Provide care and prevent further exposure

The bedside team manages the clinical emergency. The administrator secures the support it needs.

Immediate clinical response

- Call the appropriate clinical lead and emergency response service.
- Assess the affected patient and arrange treatment, monitoring or transfer as required.
- Record the patient's condition, actions and responsible treating team.

Immediate service response

- Stop the unsafe activity or isolate the suspected item where necessary.
- Arrange safe cover or an alternative service if the affected service must pause.
- Check whether other patients, wards or batches may be exposed to the same risk.

Do not wait for a completed form, committee meeting or final cause before taking a necessary safety action.

Record enough to start a safe response

Use a short first report. Add verified information later without replacing the original account.

01 Identity

Case reference, restricted patient identifier and available reporter contact.

02 Time and place

Event time, discovery time, report time, ward and service.

03 What happened

A factual account of the sequence; identify what remains uncertain.

04 Patient effect

Known injury, current condition and possible wider exposure.

05 Action taken

Care given, risk controls, people informed and outstanding urgent needs.

06 Evidence

Relevant records, equipment, witnesses and the person preserving them.

The safety form supports learning. It does not replace the clinical record or a required external notification.

Preserve the original record and its history

The quality of a later review depends on what is retained now.

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|---|------------------------|---|
| 1 | Protect records | Secure the original chart and relevant electronic logs through authorised custodians. |
| 2 | Identify items | Retain a relevant label, device, package or batch record safely, with location and custodian. |
| 3 | Record movement | Log who obtains, copies, tests or transfers an item. Preserve context and system timestamps. |
| 4 | Correct openly | Use the approved correction process. Mark a late entry with its actual entry date, author and reason. |

Never backdate, erase an original entry or ask staff to rewrite their accounts into one agreed version.

Speak honestly with the patient and family

Use a senior clinician who understands the event and a named contact for follow-up.

The first conversation

- Explain the known facts and current treatment in language the patient understands.
- Acknowledge the distress and express sincere regret or apology for what has happened.
- Explain what is still being checked. Give a contact and a realistic time for an update.

Continuing communication

- Listen to the patient's account and questions; include them in the review.
- Respect consent, privacy and the patient's choice of who is involved.
- Keep a dated record and correct earlier information when new facts are established.

Explain uncertainty. Do not speculate about guilt, promise compensation without authority or promise legal protection.

Sources: **I3**: open disclosure and patient engagement

Choose the response by the risk

This is a proposed hospital triage method, not a statutory grading scheme.

Situation	Management response	Review ownership
Immediate danger	Urgent clinical and executive escalation; control continuing exposure.	Named senior clinical lead and administrator.
Serious harm or major potential harm	Prompt senior review of scope, evidence and the investigation needed.	Authorised review lead with relevant expertise.
Repeated low-harm events	Review the group for a common service weakness.	Process owner and quality team.
Isolated lower-risk concern	Resolve and record the issue; check for a wider pattern.	Responsible unit lead with oversight.

Near misses may have high potential harm. Follow applicable mandatory escalation rules even if actual harm is low.

WORKING METHOD | Illustrative material is identified in the text.

Include the event categories specified by PHC

The 2024 Minimum Service Delivery Standards (MSDS), indicator 106, set out the minimum sentinel-event list.

01 Deaths

Unexpected deaths, including infants, mothers and suicide.

02 Serious events

Wrong patient, site or procedure; medication errors causing or risking harm.

03 Repeat procedure

Return to the operating room within 24 hours is included in the stated list.

04 Readmission

Readmission within 24 hours is also included in the stated list.

05 Violence

Violence against patients and patient violence against staff.

06 Infant safety

Infant abduction and switching of babies.

Use these as review triggers, not automatic findings of negligence. The manual also supports learning from near misses.

Sources: **I6**: indicator 106, survey process

Define sentinel events and analyse them properly

The MSDS describes sentinel events as causing death, permanent harm or severe temporary harm; it also specifies events to list.

Indicator 106: definition and list

- Use the manual's required event categories when preparing the hospital list.
- Make the list available in patient care areas and ensure staff know their responsibilities.
- The manual also supports including near misses as good practice.

Indicator 107: intensive analysis

- Keep evidence of analysis and corrective action when an event occurs.
- A review limited to blaming an individual does not meet the stated assessment requirement.
- If no event is reported, demonstrate a functioning system and retain the required zero report.

Standard 18, Continuous Quality Improvement (CQI-3): identify, review and learn from these events.

Sources: **I6**: Standard 18; indicators 106-107

Check each required reporting route separately

Do not assume that one internal report satisfies every regulatory requirement.

01 Event type

Identify the regulated area, such as medicines, devices, infection, blood or radiation.

02 Legal source

Find the applicable Act, rule, licence condition, PHC standard or official direction.

03 Recipient

Confirm which regulator, department or other authority must receive it.

04 Deadline

Record the actual legal trigger and period. Do not invent one universal deadline.

05 Accountability

Name the authorised officer, backup and route for urgent escalation.

06 Proof

Keep the submitted version, supporting record, receipt and further directions.

This lecture does not prescribe one reporting period for all incidents. Build a verified notification register for the hospital.

Make it safe to report and fair to review

A learning system needs honest information and clear responsibility.

Encourage useful reporting

- Thank staff who identify a risk and make the reporting route easy to use.
- Assess an anonymous internal safety concern for the risk it identifies.
- Give feedback on action taken so reporting has a visible purpose.

Retain proper accountability

- Check individual decisions in the conditions that existed at the time.
- Refer possible misconduct through the applicable authority and lawful procedure.
- Do not use a learning meeting to impose an unauthorised disciplinary penalty.

Confidential handling does not create legal immunity. Lectures 26-28 explain the separate disciplinary process.

Give the review a clear written scope

Match the depth of the review to the risk, recurrence and questions that need answers.

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| 1 | Set questions | State the event, the period examined and the patient-safety questions to answer. |
| 2 | Choose the team | Include relevant clinical and operational expertise; address conflicts of interest. |
| 3 | Plan the work | List records, people to hear, evidence gaps and realistic review dates. |
| 4 | Define outputs | Require verified findings, unresolved questions, actions and a route for executive decisions. |

The team needs access, time and support. A committee notification alone does not produce a reliable review.

WORKING METHOD | Illustrative material is identified in the text.

Reconstruct what was known at each point

Invented example: a critical test result was not acted on promptly.

Time	Evidence available	Question to resolve
09:10	The laboratory system records verification of a critical result.	Which alert route applied and did it operate?
09:18	A call log records an attempted contact.	Who was called and was the result acknowledged?
10:05	The next documented clinical review occurs.	Was the result known; what decision was made?
Uncertain	A witness recalls a further call without a recorded time.	Can another source confirm the time and content?

Separate documented facts, witness recollection and inference. A missing entry is a gap to investigate, not proof of every allegation.

Ask for an account before offering an explanation

Interview relevant people individually and preserve the meaning of what they say.

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| 1 | Start openly | Ask what happened, what information was available and what action the person took. |
| 2 | Clarify conditions | Ask about workload, equipment, instructions, handover and access to senior help. |
| 3 | Test differences | Compare accounts with records. Ask about contradictions without demanding agreement. |
| 4 | Confirm accuracy | Check that the written account reflects the person's meaning. Mark unresolved differences. |

Do not promise absolute secrecy or coach witnesses. Obtain additional clinical expertise where the facts require it.

Look beyond the final person in the chain

Use these questions to guide evidence collection. A possible factor is not yet a proved cause.

01 Task

Was the task clear, practical and supported by an approved process?

02 Team

Was responsibility understood across shifts and professions?

03 Information

Did the right person receive the right information in time?

04 Equipment

Was equipment suitable, available and working as intended?

05 Environment

Did interruptions, layout, fatigue or workload affect the task?

06 Management

Were known risks, staffing gaps and previous actions addressed?

Record how each supported factor contributed. Also identify the checks or staff actions that successfully prevented harm.

Sources: **I2**: RCA contributing factors

A cause must be supported by evidence

Root cause analysis, or RCA, is a structured review of how an event developed.

Build a defensible explanation

- Describe the gap, its evidence and its link to the event.
- Test more than one explanation and seek contradictory evidence.
- Allow several interacting causes. Identify what remains unknown.

Avoid shortcuts in reasoning

- Five Whys is a questioning aid; five answers do not prove a causal chain.
- A fishbone diagram groups ideas. Each important idea still needs evidence.
- Do not stop at carelessness, poor attitude or lack of training without examining the actual task.

Judge decisions using the information available at the time, not only the outcome now known.

Turn a vague conclusion into a testable finding

Invented example: a critical-result alert was sent but not acknowledged.

Weak conclusion	Staff communication was poor. Everyone must be more careful.
Verified gap	The alert procedure had no named backup if the first recipient did not answer.
Evidence	The procedure, call records and interviews show repeated unanswered calls without a defined next contact.
Contributing role	The gap allowed an urgent result to remain unacknowledged. The clinical effect needs separate expert assessment.
Proposed response	Introduce a named backup and escalation route; test it on day and night shifts and retain response evidence.

A review may establish a process failure without proving that it caused every part of the patient's outcome.

Change the work so the safer action is easier

These examples compare reliance on memory. Every change still needs risk assessment and testing.

Type of action	Example	Main limitation to check
Remove or redesign the hazard	Separate confusing stock or redesign an unsafe request process.	Check availability, workflow and unintended new risks.
Build a reliable control	Add a tested acknowledgement and escalation function to an urgent alert.	Check downtime, overrides and who receives the alert.
Standardise the task	Use one agreed form, named responsibility and a clear handover.	Check that the form is usable and used in real work.
Support knowledge and memory	Train staff, issue reminders and give feedback.	Attendance at training does not prove sustained safe practice.

Use training where needed. Do not make reminders the only response to a persistent design or resource failure.

WORKING METHOD | Illustrative material is identified in the text.

An action needs six parts

A recommendation is incomplete until implementation and effectiveness can be checked.

01 Change State exactly what will be changed and which risk it addresses.	02 Owner Name one accountable person with the authority to deliver it.	03 Resources Identify staff, equipment, system changes and approval needed.
04 Due date Give a realistic completion date and any interim safety control.	05 Evidence Specify the document or observation that proves implementation.	06 Effectiveness State what will be measured, when and by whom to test whether risk fell.

If the owner cannot obtain the resources or authority, escalate the decision and keep the unresolved risk visible.

WORKING METHOD | Illustrative material is identified in the text.

Check that the change works across shifts

Invented example: a hospital tests its new critical-result contact route.

Action completed	The contact list is issued, the alert route is configured and relevant staff are briefed.
Test design	Review the next 20 eligible alerts across day and night shifts against the hospital's approved response target.
Result	18 alerts meet the target; 2 have no recorded acknowledgement. Do not call this complete success.
Next step	Check whether the two alerts were acknowledged, why evidence is missing and whether the target was met. Correct verified gaps and repeat the test.
Closure decision	Close only when the agreed evidence supports effectiveness. Record the decision and future monitoring plan.

The number 20 is an invented learning example, not a PHC sample-size requirement or proof that all future alerts will succeed.

Use clinical case review to improve the service

Morbidity and mortality review, or M&M, examines important complications and deaths for learning.

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| 1 | Select the cases | Use an agreed scope: unexpected outcomes, recurring problems and useful learning questions. |
| 2 | Prepare the facts | Provide a clear timeline, relevant clinical standards and an account of working conditions. |
| 3 | Discuss the gaps | Invite relevant professions. Test decisions fairly and separate avoidability from certainty. |
| 4 | Record the response | Assign actions, an owner and review date. Bring progress back to the next meeting. |

An M&M discussion does not replace urgent safety action, statutory reporting, a PHC case or a required disciplinary process.

WORKING METHOD | Illustrative material is identified in the text.

Support people without concealing the event

The patient remains central. Staff involved may also need practical and psychological support.

Patient and family support

- Identify current care needs, communication needs and a named contact.
- Offer appropriate support and explain the complaint route without pressure.
- Provide agreed updates even when the review is still incomplete.

Staff support and records

- Assess whether the person can continue duties safely and arrange cover when needed.
- Offer suitable peer or professional support while preserving an independent review.
- Restrict identifiable records to authorised access and use de-identified learning summaries.

Do not label meeting minutes legally privileged without a proper basis. Retain records under the applicable policy and legal requirements.

Make it possible to raise a concern

A complaint may concern harm, communication, access, delay, dignity or another service problem.

A usable hospital route

- Display where and how to complain in language patients can understand.
- Provide help for people who cannot easily write, read or use an online form.
- Check immediate clinical risk at receipt; do not wait for the complaint investigation.

A fair response

- Record the complaint accurately and acknowledge it through the approved process.
- Explain the next step, contact person and expected update date.
- Do not reduce appropriate care or pressure a patient to withdraw a complaint.

Link the complaint to the safety system when it reveals a risk. Keep each process and its required records identifiable.

Give patients updates during complaint handling

Standard 13, Patient Rights and Education (PRE-3), requires a fair complaint process and use of findings for improvement.

Stage	Indicator 82 in the 2024 hospital MSDS
Receipt	Provide acknowledgement, tracking number, contact person and next step; preferably within 24 hours.
Investigation	Convey the outcome preferably within 5-7 working days, or explain the delay and estimated completion time.
Outcome and review	Communicate the outcome and explain the right to appeal within 15 days in the hospital complaint process.

These are hospital complaint standards. Keep the PHC statutory filing and appeal periods separate.

Sources: **I6**: Standard 13; indicators 80-83, especially 82

Track the case from receipt to response

Use a restricted register, with access based on responsibility.

01 Reference

Unique number, receipt date, source and patient or representative details.

02 Concern

Issues raised, relevant dates and the outcome the complainant seeks.

03 Risk

Immediate safety concerns and action already taken.

04 Review

Named reviewer, conflict check, records requested and evidence received.

05 Communication

Acknowledgement, promised updates, meetings and correspondence.

06 Completion

Findings, authorised response, remedy route and linked improvement actions.

Do not mark a case resolved merely because a reply was sent. Record whether concerns and required actions remain open.

Answer each issue raised

The response should show what was examined and how the conclusion was reached.

1	Clarify the issues	Confirm the concern and desired outcome without changing the complainant's meaning.
2	Review independently	Use a suitable reviewer, relevant records and a fair opportunity for staff to respond.
3	Decide with reasons	State what is supported, what is not established and what remains uncertain.
4	Respond and follow up	Explain the findings, appropriate actions and applicable further review route in clear language.

A finding that one allegation is not established does not make the entire complaint false or remove other service problems.

WORKING METHOD | Illustrative material is identified in the text.

Distinguish a hospital concern from a PHC complaint

PHC is the Punjab Healthcare Commission. Its legal complaint procedure has specific requirements.

Initial route and filing

- For patient complaints, PHC guidance requires a written hospital complaint first; if not redressed, the PHC route may be used.
- Direct PHC approach is allowed if no hospital mechanism exists; aggrieved healthcare providers may also complain directly.
- Section 23(2) requires a written complaint supported by an affidavit within 60 days of knowledge of the cause of action.

Identity and privacy

- Section 23(3) excludes anonymous and pseudonymous PHC complaints.
- PHC guidance explains that the hospital receives the complainant's name and the nature of the complaint.
- An anonymous internal safety report is different: management can still check the risk it identifies.

Check current regulations before filing. Do not assume the hospital review stops or restarts the statutory filing clock.

Sources: **I4**: s.23(2)-(3) | **I5**: filing route and confidentiality

Prepare a complete and truthful institutional response

Once a notice arrives, work from its actual requirements and dates.

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|---|-----------------------------|--|
| 1 | Register the notice | Record receipt, the case number, required response date and responsible officer. |
| 2 | Preserve and collect | Secure the relevant clinical and administrative records, including material that may weaken the hospital's position. |
| 3 | Prepare the answer | Respond point by point, index the supporting records and obtain clinical and legal review where needed. |
| 4 | Submit and follow | Use the authorised signatory and channel. Keep proof of submission, attend as required and track every direction. |

Do not delay the patient's care while preparing the response. Seek an extension through the proper route if genuinely needed.

WORKING METHOD | Illustrative material is identified in the text.

Check the actual order before selecting a remedy

A complaint outcome, an employee penalty and a regulatory order are different decisions.

PHC appeal provision

- Section 31(1) provides an appeal to the District and Sessions Judge for the orders specified in that section.
- The listed categories include certain licensing, closure or improvement, equipment and fine orders.
- The statutory period is 30 days from communication of the order. Check applicability and date calculation promptly.

Institutional follow-up

- Obtain case-specific advice; do not assume every complaint outcome has the same appeal route.
- Track compliance with directions and any actual stay or further order.
- Keep safety actions running while lawful challenges are pursued, unless a controlling order requires otherwise.

The PHC route does not replace employment remedies. Use the correct law and decision-maker for each matter.

Sources: **I4**: s.31(1)

Do not mistake report counts for harm rates

Incident reports are signals influenced by willingness, access and local reporting practice.

Measure	What it helps show	What it cannot show alone
Reports received	Which concerns staff and patients are reporting.	The true number of harmful events.
Recurring event types	Patterns that need a focused service review.	Which person or unit is necessarily at fault.
Overdue actions	Where agreed risk reduction is delayed.	Whether completed actions actually work.
Checked outcomes	Whether a defined problem improves using consistent data.	That the intervention alone caused the change.

Use incident data alongside audit, complaints, clinical outcomes and direct observation. Lecture 33 explains measurement.

Sources: [11](#): uses and limitations of incident data

Ask for evidence of learning at each review

Use a regular meeting with clear responsibility for decisions and follow-up.

01 Current danger

Which risks still threaten patients today, and what interim control is in place?

02 Review progress

Which serious events remain unreviewed, and why?

03 Patient contact

Have patients and families received promised information and support?

04 Repeated failure

Which problem has returned after a previous action was called complete?

05 Decision needed

Which staffing, equipment, funding or authority issue needs escalation?

06 Verified effect

Which change has evidence of safer practice, across the relevant shifts?

Keep a decision record with owners and dates. Share practical learning without circulating unnecessary patient or staff identifiers.

Three decisions for the institutional head

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

1. The near miss

A wrong patient label is found before a sample is taken. Nobody is injured. The unit proposes no further action.

What should the MS require?

2. More reports

Reports rise from 12 to 35 after staff are taught the reporting route. The Board is told harm has almost tripled.

Is that conclusion supported?

3. The PHC clock

A hospital says a complainant must wait until the internal investigation is complete before considering PHC.

What is the problem with that advice?

All three situations are invented. Use the process and the evidence, not an assumption about fault.

Answers and reasons

Use the evidence, the calculation and the cited source.

1. Review the risk and the successful check

Record the near miss, confirm patients are safe and assess how the label error arose. Use a proportionate review and test any corrective action.

2. Reporting has increased; the harm rate is not established

Better access or confidence may increase reports. Examine severity, activity, reporting changes and other evidence before drawing a conclusion about harm.

3. Internal review does not establish a new statutory deadline

The PHC Act uses a 60-day knowledge trigger. Check the current complaint requirements promptly and do not assume that internal handling pauses that clock.

A safe conclusion states what the evidence supports and what still needs checking.

Sources: **I1**: incident data limitations | **I4**: s.23(2) | **I5**: complaint route

Prepare one complete incident learning file

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

1. Event record

Use an invented case. Write the facts, immediate controls, evidence log and patient communication plan.

2. Review and action

Identify supported factors. Set three actions with owners, dates, resources and an effectiveness check.

3. Follow-up brief

Show open risks, required decisions, complaint or reporting routes and what would justify closure.

Review question: could another administrator understand what happened, what changed and how effectiveness will be checked?

Next: Lecture 33 | Measuring Quality, Clinical Audit and Improvement.

Sources and continued use | 1

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

I1 Incident reporting guidance and patient safety definitions

WHO reporting guidance, 2020, sections 4-5; WHO/IER/PSP/2010.2 for incident definitions. International guidance, not a Punjab statute. Examples are invented.

World Health Organization | [Official source](#) | [Definitions framework](#)

I2 Root cause analysis and learning from error

WHO curriculum handouts, published online in 2021. Structured review of contributing factors and actions. This lecture supplies original hospital working formats.

World Health Organization | [Official source](#) | [Learning from error](#)

I3 Engaging with patients and carers

WHO curriculum handout, published online in 2021. Patient involvement and honest communication after harm. Apply with the hospital policy and applicable local 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 | 2

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

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Punjab Healthcare Commission Act 2010

Act XVI of 2010. Sections 23 and 31: complaints, investigation and specified appealable orders. Check current amendments and regulations before a live legal decision.

Punjab Healthcare Commission | Official Act | [Official source](#)

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PHC complaints: official public guidance

Official FAQs: initial hospital complaint, exceptions, identity and confidentiality. Read with the 2014 Complaint Management Regulations, especially regulations 3-4.

Punjab Healthcare Commission | [Official source](#) | [Complaint regulations](#)

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Hospital MSDS, 2024 edition

Category I; CG-01MS-Ed2-01092023. PRE-3, indicators 80-83, pp.92-95; CQI-3, indicators 106-107, pp.119-120. Use the applicable official manual.

Punjab Healthcare Commission | [Official source](#)

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