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Case Study Analysis Report

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1. Introduction

1.1 Background of the Wrong Patient Surgery Case

According to reports, the Indian hospital, Kota Medical College, was found to be accidentally involved in a mistaken patient identity, which caused unintended harm to an elderly man (SCMP, 2025). The man was wait waiting for his son, who was undergoing a surgical procedure; however, when a similar patient name, as that of the elderly man waiting in the lobby for his son, was called for a surgical procedure, he mistakenly raised his hand, which made the hospital staff consider him as the patient, and without further identity verification, the elderly man was prepared for the surgical procedure as well (SCMP, 2025).

1.2 Purpose of the Report

Against the backdrop of the mistaken patient identity, the purpose of this report is to critically analyse clinical governance, patient safety, leadership, and risk management failures within the case.

1.3 Clinical Governance in Healthcare

In terms of healthcare, clinical governance can be viewed from two different converging perspectives. While Ghavamabad *et al.* (2021) hold the mechanisms of clinical governance as a way to ensure accountability for performance and quality improvement, Fitriani, Antonio and Wuisan (2024) argued that clinical governance emphasises work methods to remain compliant with regulatory requirements, which can also ensure an organisational culture of patient safety. Hence, the synthesis of this information helps to understand the fact that within healthcare organisations, clinical governance is an important factor, helping with maintaining care quality, professional accountability, and developing a patient safety culture also.

1.4 Centralisation vs Decentralisation

With regard to the prior discussion on clinical governance influencing patient safety, it is important to note that organisational structures influence clinical governance, communication, and accountability as well. In this context, it is worthwhile discussing the fact that, in a decentralised organisation, the local staff can make decisions utilising their knowledge and experience, which allows better adaptability and flexibility; however, centralised organisations are better at developing uniform standard operating procedures, facilitating better coordination and accountability, while ensuring predictable outcomes as well (Shishkin *et al.*, 2025). Therefore, the discussion here helps to perceive the important differing attributes of two different organisational structures, influencing healthcare delivery.

1.5 Leadership and Patient Safety

In the context of patient safety here, three different leadership theories are discussed below, which include transformational, authentic, and situational leadership. Additionally, their importance in creating a safe healthcare environment has also been explained here in this research.

2. Main Analysis

2.1 Identifying the Problem and System Context

2.1.1 Overview of the Wrong Patient Surgery

While an elderly man was waiting as his son was undergoing surgical procedures at Kota Medical College, staff called out the name of another patient, scheduled for another surgical procedure, who also had the same name as the elderly man, waiting outside his son's operating area (SCMP, 2025). Upon mistakenly raising his hand when he heard his name, the elderly man was taken to the operating theatre, without any further identity verification, for the surgical procedure scheduled for another patient (SCMP, 2025). There were different obvious organisational and clinical causes. For example, despite not wearing a patient gown and evidently not undergoing any pre-operative procedures, when the wrong patient was considered for surgery, it highlights flaws in the patient identification procedure and pre-operative checklists (SCMP, 2025). Disregarding the elderly man's inability to speak points to a disregard for the clinical procedure of obtaining mandatory patient consent (SCMP, 2025).

2.1.2 Global Burden of Patient Safety Incidents (WHO)

Patient safety incidents, arising from surgical errors, are on the rise globally. According to recent observations made by the WHO, out of more than 300 million surgical procedures globally, 10% of preventable patient harm is caused by surgical errors (WHO, 2023). One of the common sources of patient harm is patient misidentification. Referring to 3,326 incidents of patient harm that took place between 2014 and 2017, the WHO mentioned that 409 incidents were related to misidentification of patients (WHO, 2023). The statistical information here highlights the noticeable prevalence of patient safety incidents in surgical procedures, stemming from patient misidentification. It has been noted that varying causes are responsible for such instances, such as lack of policies, inadequate processes, disrupted workflow, staffing issues, and communication breakdown among healthcare workers (WHO, 2023). Therefore, addressing these challenges in healthcare has become of paramount importance.

2.1.3 Patient Identification and Surgical Safety Statistics

While assessing surgical safety performance, it is important to consider the instances of wrong-patient procedures and patient identification errors. In this context, the findings

presented by Maul and Straub (2022) can be referred to here. The authors, citing the reference of the study involving the Veterans Health Administration, highlighted that there are 31% of reported cases of patient misidentification that led to surgical procedures performed on wrong patients (Maul and Straub, 2022). The clinical error of patient misidentification not only happens internationally and nationally, but there are also several instances in India as well. For example, a trauma centre in Varanasi performed a replacement surgery on a woman, mistaking her for the other patient scheduled to undergo the same surgery, leading to the woman's death (ET, 2025). The discussion here helps to perceive the prevalence and significance of patient identification errors on patient outcomes.

2.1.4 Clinical Governance Failures

One of the factors causing medical errors is weak clinical governance, and its implications are quite critical as well. From the findings presented by Aghighi, Aryankhesal and Raeissi (2022), it is understood that the absence of formal oversight to ensure the implementation of safety protocols and enforcing them as an automatic part of the regular workflow of healthcare workers contributes to medical errors, such as patient misidentification. The evaluation of this information suggests that clinical governance failures, including weak protocols and insufficient oversight, can contribute to the overall clinical governance inadequacy. Consequently, adverse patient outcomes would be more common in healthcare settings as well. The insights gathered from the research done by Anyanwu (2025) reveal that the absence of standard clinical operating procedures and disregarding or a complete lack of past audit reports can also contribute to such institutional failures.

2.1.5 Risk Management Failures

Failing to manage risks before a surgical procedure on a patient is observed to be the other glaring problem factor in the healthcare system context. According to what Romano *et al.* (2021) posit, it can be said that homonymy and disruption to verbal communication are some of the leading causes for incorrect patient identification, particularly in the context of errors in surgical procedures. This was exactly what had happened to the elderly man, who bore the same name as the patient scheduled for surgery, and his speech difficulty was caused by a prior facial paralysis incident (SCMP, 2025). The evaluation of this information indicates that failure to verify the identity of a patient and conducting safety checks of the patient before preparing them for surgical procedures amount to patient safety risk assessment failure, which in turn can jeopardise managing patient risks in healthcare settings.

2.1.6 Rich Picture Analysis

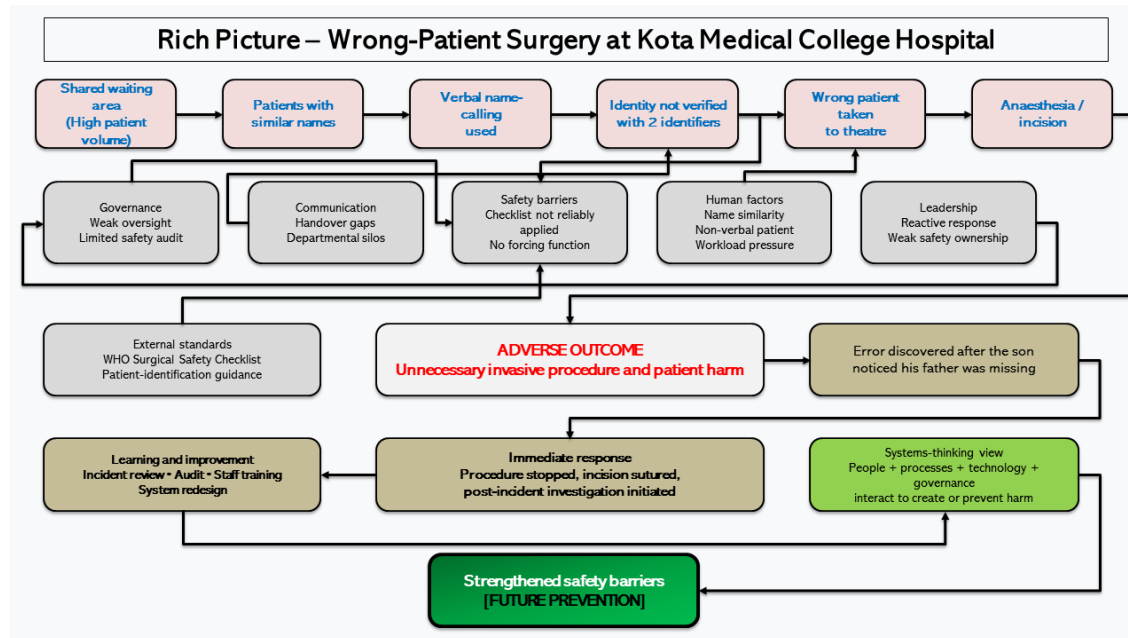


Figure 1: Rich Picture

(Created by Author Using PowerPoint)

The identification of the problem and the system context can be grounded on the analysis of the Donabedian framework. From the research by Tossaint-Schoenmakers *et al.* (2021), it becomes evident that the setting of healthcare service delivery, including the qualification of healthcare workers, and the process of delivering healthcare, involving communication with patients, together have the potential to deliver positive health outcomes. The evaluation of this information helps to understand the fact that a good organisational structure is bound to consist of good healthcare processes, which increases the likelihood of yielding positive healthcare outcomes. However, the case of the elderly man at the Kota Medical College makes it evident that the clinical process of identifying a patient, particularly involving dialogue with the patient, was not followed, pointing to a poor organisational structure that yielded adverse patient outcomes (SCMP, 2025).

2.2 Centralisation and Organisational Decision-Making

2.2.1 Organisational Structure

Based on the patient misidentification, it can be inferred that Kota Medical College has a decentralised organisational structure. While in a decentralised organisation the local staff can make decisions utilising their knowledge and experience, facilitating better adaptability and flexibility, it is also reported that decentralisation causes service fragmentation, as well as a lack of standardisation (Shishkin *et al.*, 2025; Mahmood *et al.*, 2024). The evaluation of this

information helps to uncover that in a decentralised organisational structure, decision-making processes pertaining to patient verification may significantly differ.

Now, when looking back at the case involving the elderly man at Kota Medical College, it becomes clear that decisions made to verify the identity of the patient did not follow any standard protocol, which caused the mix-up, and the wrong patient was considered to be operated on (SCMP, 2025). Had there been a standard operating procedure and a clearly defined patient identification mechanism at the healthcare facility, the incident of patient harm could have easily been avoided. The incident underscores the impact of organisational structure on firm-level decision-making.

2.2.2 Advantages of Centralised Clinical Governance

The discussion above highlights the glaring disadvantage of a decentralised healthcare organisation. As a result, it can be inferred that centralised clinical governance can produce better healthcare outcomes. In support of this claim, the findings presented by Scarffe *et al.* (2022) can be referred to here. The analysis of the findings reveals that through a hierarchical decision-making process, centralised organisational structure prevents local decision-making, which in turn promotes consistency, as well as standardisation in healthcare approach throughout the organisation, contributing to overall patient safety.

From the discussion above, the knowledge gained suggests that because of a decentralised approach at the Kota Medical College, there was no standard operating procedure in place in terms of patient identification. As a consequence, patient safety was significantly compromised at the healthcare facility as well. Further investigation in this regard also highlights the fact that because of the lack of a centralised approach, it was all individual discretion to make decisions pertaining to following patient identification protocols, which led to the negative healthcare outcome as well.

2.2.3 Limitations of Centralised Decision-Making

The discussion on centralised organisational structure may give the impression that such an organisational structure is fail-safe; however, there are also certain limitations in terms of decision-making in centralised organisations. For example, despite the economic efficiency of centralisation, perceived through the standardisation of healthcare resource allocation, being a top-down approach, it actually robs managers of their autonomy in decision-making, which is particularly important in the healthcare sector, especially involving quick decision-making in emergency situations (Krenyacz and Revesz, 2025).

The analysis of this information, discussed above, points to the fact that centralised organisational structure inherently imbibes a bureaucratic approach, which flows from top to

bottom. As a consequence, delays in communication, as well as in making decisions, are more common in such organisations. Thus, it can be said that over-reliance on hierarchical decision-making is particularly problematic in healthcare organisations, because they need to make quick decisions, especially in medical emergency situations. However, it can still be said that a centralised organisational structure at Kota Medical College could have avoided the incident through protocol standardisation.

2.2.4 Accountability within the Surgical Team

The preparation of the wrong patient for the surgical procedure, scheduled for another patient at the medical college, highlights the questionable accountability within the surgical team of the institution. It is important to note that every individual entity, such as surgeons, nurses, anaesthetists and administrators, has their own responsibilities in preventing wrong-patient surgery incidents. For example, surgeons are responsible for preoperative verification of patients by examining their medical records and talking to the patient in order to mark the exact location of surgery.

On the other hand, nurses also play a critical role in preventing wrong patient surgery by following a surgical safety checklist in order to ensure the identification of the correct patient for surgery (Yumna *et al.*, 2025). Anaesthetists are also crucial in terms of preventing wrong patient surgery. For example, anaesthetists have the right to confirm when the patient is awake, particularly regarding their identity. Hospital administrators also have responsibilities, like the surgical team, to prevent wrong-patient surgery by implementing strict patient verification protocols.

2.2.5 Critical Evaluation

The discussion up to this point creates a solid foundation for critically evaluating whether or not a stronger multidisciplinary collaboration and shared accountability could have prevented the error. Multidisciplinary collaboration and shared responsibility create opportunities for the involvement of multiple stakeholders, such as surgeons, nurses, or anaesthetists, which in turn can help in quick identification of the wrong patient. The arrangement is also helpful in terms of creating a multidisciplinary feedback loop, as both anaesthetists and nurses would have the opportunity to confirm the patient identity beforehand.

However, the arrangement of a multidisciplinary collaboration and shared responsibility also does not guarantee the prevention of wrong-patient surgery. The reason for this is the fact that the lack of any standardised protocol, particularly in a decentralised organisational structure, can limit the impact of the collaborative or shared approach. Likewise, relying on multidisciplinary collaboration can also result in the diffusion of accountability in ascertaining

a patient's identity. Multidisciplinary collaboration and shared responsibility invariably would increase workload, managing which, especially in a staff shortage situation, is difficult.

2.3 Leadership Theory Application

2.3.1 Transformational Leadership

Considering the incident at the Kota Medical College, it can be said that transformational leadership at the institute would have been better. In support of this statement, the research findings presented by Althobaiti (2026) can be cited here. From the findings, it can be interpreted that transformational leaders promote organisational learning and teamwork, besides encouraging open communication about errors and sharing non-punishing responses so that the error is not repeated in the future. As a result, this kind of leadership at the healthcare facility would have improved patient safety.

Other than strengthening patient safety culture, transformational leadership at the healthcare facility would have also improved staff engagement, which can also contribute to overall patient safety. Going by the inference made by Linnik, Sepp and Reinhold (2023), it is learned that transformational leaders create a motivating work environment where healthcare workers feel valued, which in turn also creates a positive attitude in them and motivates them to improve their performance and decision quality. As a result, the safety of a patient gets prioritised in such organisations.

2.3.2 Authentic Leadership

This is another leadership style, apart from the already discussed transformational leadership style, in healthcare settings that can address patient safety concerns at the Kota Medical College. The rationale behind this positive outlook is the fact that authentic leadership at the core is a value-based approach, because such leaders promote morality and self-awareness, while emphasising relational transparency (Lazinkaitė *et al.*, 2026). Hence, this kind of leadership at the healthcare facility would have increased the accountability of the healthcare workers to transparently report patient safety issues, driven by their moral perspectives.

However, ethical leadership in such situations is equally effective as well. Ethical leaders prioritise ethical principles to ensure improvement in healthcare delivery to patients by emphasising integrity and patient safety, which they intend to achieve with patient autonomy and their involvement in the care process through open and clear communication (Enahoro *et al.*, 2024). Hence, from the evaluation of this information, it can be inferred that such a leadership style at the healthcare facility would have prevented wrong patient surgery through patient involvement and communication beforehand.

2.3.3 Situational Leadership

Unlike the proactive approach of transformational and ethical leadership in ascertaining patient safety, situational leadership offers a reactive approach, much like the authentic leadership discussed earlier. From the findings presented by Ghallab and Sallam (2026), situational leaders tend to promote responsiveness among their followers through coaching and supporting them according to their competencies. Hence, it becomes clear that once the incident has happened, the situational leader may take up the responsibility to coach or support their followers, including surgeons, nurses, or anaesthetists, to make them learn the ideal future responses.

The incident at Kota Medical College highlighting a wrong patient surgery clearly indicates that the leadership of the organisation did not follow the situational approach at all. The reason for this statement stems from the fact that a similar incident of a wrong surgery on a nine-year-old boy also happened in 2024 (SCMP, 2025). However, had the situational leadership been in place at the healthcare facility, the healthcare workers would have undergone coaching pertaining to the prevention of recurrence of such incidents involving patient safety in the future.

2.3.4 Leadership Effectiveness in Patient Safety

The evaluation of the leadership effectiveness in ensuring patient safety in Kota Medical College can be done with the help of the Swiss Cheese model. When viewed through the framework, it becomes clear that incidents of patient safety happen in healthcare because of either unsafe acts done by a stakeholder, or preconditions of unsafe acts were met, failure in supervision, and lack of organisational protocol (Wiegmann *et al.*, 2022). The analysis of this information helps to reveal how multiple verification failures aligned to permit the wrong-patient surgery at the hospital.

The preconditions of the unsafe act were met in two ways: the homonymy of the elderly man with the patient, and his difficulty in speaking because of a prior facial paralysis. Following this, the unsafe act took place, where neither of the involved stakeholders, such as surgeons, nurses, or anaesthetists, noted the wrong patient preparation for the operation. The incident as a whole shows the lack of concrete organisational protocols for ensuring patient safety, whereas the incident also demonstrated the lack of clinical governance in the healthcare facility as well.

2.3.5 Critical Comparison of Leadership Styles

Considering the achievement of surgical safety in the healthcare facility in the future, when critically comparing the leadership styles elaborated above, their strengths and weaknesses

come to the fore. For example, despite promoting accountability, authentic or ethical leadership relies heavily on the morality of their followers. Moreover, this kind of leadership also proves to be ineffective in addressing organisational weaknesses, such as protocol gaps. On the other hand, flexibility and adaptability are the two key strengths of situational leadership, particularly helpful in sudden emergency healthcare situations.

However, the leadership style is more reactive, as evidenced through the recurrence of similar past incidents. Additionally, the leadership style is also dependent on individual responsiveness. Hence, considering these factors, it can be said that the transformational leadership style would best support surgical safety. Despite being slow to implement due to its resource-heavy nature, such as staff training, the aspects of continuous learning, error reporting, motivating staff to engage in safety protocols proactively, teamwork, and communication can significantly support the development of a patient safety culture in healthcare settings.

2.4 Improvement and Lessons Learned

2.4.1 Strengthening Patient Identification Processes

Based on the lessons learned through the findings presented in this research, it is recommended that Kota Medical College consider improving its existing patient identification process. In order to achieve this recommendation, the healthcare facility may choose to consider focusing on strengthening their existing identity verification procedures, particularly emphasising the implementation of multiple verification checkpoints before undertaking surgical procedures on a patient. Kota Medical College may consider integrating the following measures -

- Involving surgeons, nurses, and anaesthetists.
- Confirming intended surgical procedures, and locating surgical sites on a patient's body.
- Confirming the name and the date of birth prior to obtaining informed consent from the patient for the surgical procedures (Javadnia *et al.*, 2025).

The evaluation of the multiple verification checkpoint strategy recommended for the medical college here helps to understand the fact that either of the stakeholders would get the opportunity to notice any misidentification of a patient, because the whole team would be held accountable for exercising the entire process, which in turn also eliminates any opportunity for the diffusion of responsibility challenge.

2.4.2 Clinical Governance Improvements

It is also an important learning, derived from the findings presented here, which points to the requirement of improving the existing clinical governance practices at the medical college. Hence, the medical college may consider prioritising governance reforms that can strengthen the compliance aspect, particularly with surgical safety standards, while integrating organisational accountability as well. The following ways clinical governance improvements can be achieved -

- Evaluating the current clinical governance practices to identify potential gaps to prepare the ground for governance reforms.
- In order to ensure surgical safety standards, the mental health and overall well-being of every involved stakeholder need to be ensured.
- For compliance, providing evidence-based training to clinical supervisors can enhance organisational accountability towards ensuring patient safety (Martin *et al.*, 2022).

By following these measures, it would be possible for the Kota Medical College to avoid future instances of patient safety issues that otherwise would have been caused by the lack of strong clinical governance. Therefore, the improvement measures, as listed above, are proposed to the organisation to enhance their patient safety culture.

2.4.3 Risk Management Strategies

Considering the patient safety incident faced by the healthcare facility, they need to prioritise developing a robust risk management strategy. It would be necessary that the organisation focuses on proactive risk assessment, incident reporting, and conducting safety audits so that surgical errors can be minimised. One of the proven ways to prevent surgical errors is to implement the practice of surgical time-out, which gives the surgical team an opportunity to focus on the following before the scheduled surgical procedure begins -

- Checklist of the surgical procedure
- Reviewing the patient identity, the consent form, and the surgical procedure to be performed.
- Correct anatomical marking of the patient's skin (Rodziewicz *et al.*, 2024).

The risk management strategy also needs to ensure that every member of a surgical team is present during this procedure, which would give them the opportunity to collectively assess any risks and also to report any identified incidents, which can help in triggering safety audits, preventing the recurrence of similar instances in the future as well. Thus, surgical errors can be significantly reduced.

2.4.4 Safety Culture and Team Communication

The insights gathered from the findings presented in this research helped to learn about the importance of improving the safety culture and team communication aspects of the Kota Medical College. Drawing on the leadership effectiveness of transformational leaders, it is understood that by promoting open communication, teamwork, and offering psychological safety to the healthcare workers, it is possible to prevent similar future incidents. However, it is equally essential to emphasise root cause analysis, going beyond these organisational factors in order to identify the underlying causes.

Building on the discussion on root cause analysis above, the research done by Boussat *et al.* (2021) can be referred to here. From what the authors posited, it can be derived that root cause analysis contributes to the overall increase in awareness regarding any faulty process that may be undermining the efforts of a healthcare facility to ensure patient safety. Hence, the evaluation of this information suggests that root cause analysis can be a great tool to improve the existing patient safety culture of the organisation, backed by evidence.

2.4.5 Lessons for Healthcare Organisations

The research done and the findings presented here have the potential to impart wider lessons that healthcare organisations, as a whole, can learn, specifically regarding patient identification, governance, and continuous quality improvement. For example, healthcare organisations, while prioritising patient identification, may consider implementing multiple verification checkpoints. In addition to this, they may also consider involving all of the associated stakeholders in the process of identity verification in order to reduce potential errors in patient identification, besides adopting the surgical time-out practice.

In a similar manner, healthcare organisations may also consider adopting a centralised approach to clinical governance so that standardised and consistent protocols can be established, giving minimal scope for deviations. In addition to these, audits and compliance checks at regular intervals can also ensure the identification of gaps, resulting in better risk management. As for continuous quality improvement, root cause analysis, facilitating healthcare workers' continuous learning, and ensuring their mental well-being are regarded as effective means for patient safety improvement. Additionally, by adopting transformational leadership and ensuring staff engagement, this objective can also be achieved.

3. Recommendations

3.1 Patient Identification Protocols

It is recommended that Kota Medical College adopt the evidence-based verification process, as laid down in the WHO guidelines (WHO, 2009). The surgical safety checklist makes it

mandatory to identify the patient who will undergo the surgical procedure in the presence of the entire surgical team. In addition to this, the surgical safety checklist prepared by the WHO also makes it mandatory for the surgical team to refer to a patient's wristband to match the patient's name, date of birth, and hospital number that are mentioned on the consent form (NHS, 2022). Therefore, the medical college is also recommended to follow these WHO guidelines in order to ensure patient safety.

3.2 Clinical Governance Strengthening

It is suggested that the medical college focuses on strengthening its clinical governance framework in order to improve its policy compliance, governance oversight, as well as organisational accountability. In order to materialise these recommendations, Kota Medical College needs to establish independent oversight committees, which would be responsible for auditing, investigating, and publishing their findings on patient safety lapses. In addition to these, the medical college may also consider implementing transparent performance metrics, especially linked to patient safety, quality of care, and funding to such institutions (van Elten and van der Kolk, 2024). Moreover, the medical college is also proposed to standardise their existing clinical protocols through uniform operating procedures throughout their departments to eliminate variability and ensure consistency.

3.3 Leadership Development

As a key pillar of clinical governance, Kota Medical College is advised to prioritise developing their existing leadership, so that patient safety, ethical decision-making, and safety culture development can be promoted. In this context, the leadership of the organisation needs to be made familiar with the surgical safety checklist prescribed by the WHO. As a result, familiarity with the documents would transform their knowledge of the requirements for patient safety, with improved focus on risk assessment and error prevention. The organisational leaders are also suggested to undergo ethical decision-making workshops because scenario-based training there can eliminate their dilemma in real-world situations (Wiegmann *et al.* 2022). Additionally, the organisational leaders are also advised to undertake communication and resilience training for better crisis leadership.

3.4 Risk Management Systems

It is also recommended that the medical college consider establishing a multidisciplinary review panel for better risk assessment and root cause analysis. Such a panel involving stakeholders from every section of the hospital management, such as surgeons, nurses, administrators, and anaesthetists, would be assigned tasks for reviewing audit findings pertaining to patient safety lapses and subsequently undertaking root cause analysis as well. In this context, it is suggested that the panel, during the root cause analysis, focuses primarily

on identifying systemic failures, so that existing processes can be improved, facilitating the prevention of the recurrence of similar instances (Alifia and Dhamanti, 2022). The organisation may also consider implementing the practice of continuous feedback on a real-time basis, based on an incident reporting dashboard.

3.5 Continuous Quality Improvement

Based on the findings and the learnings for improvement, Kota Medical College is advised to prioritise continuous quality improvement. The rationale for this suggestion is that the approach can help the firm sustain long-term patient safety improvements. Accordingly, for achieving continuous quality improvement, it is recommended that the organisation deploy a real-time dashboard tracking surgical safety indicators, compliance and incident trends. Furthermore, the medical college is also recommended to consider educating its staff through simulation-based training and WHO surgical safety guidelines. The reason for this recommendation is to ensure correct patient verification procedures, even during crisis situations. Improving the quality of patient safety of the organisation needs to be their priority, which can be achieved through multidisciplinary collaboration.

4. Conclusion

4.1 Summary of Findings

The findings of this study helped to identify the key governance, leadership, patient safety, and risk management issues. For example, the decentralised nature of the Kota Medical College resulted in fragmented healthcare services and inconsistent patient verification, underscoring the governance issue plaguing the organisation. The leadership of the organisation failed to promote open communication, teamwork, and accountability, leading to the gradual development of unsafe practices, affecting patient safety protocols, and resulting in surgical errors as well. While the wrong-patient surgery upholds the patient safety issue of the organisation, absence of safety audits and surgical time-out practices are some of the issues affecting effective risk management.

4.2 Importance of Clinical Governance and Patient Safety

From the discussion above, it can be inferred that effective governance is fundamental to safe surgical practice. The rationale behind this claim is the fact that structured clinical governance prevents the diffusion of patient accountability, while also enforcing compliance. Furthermore, effective clinical governance values continuous improvement, and to attain this, such a governance framework prioritises audits and transparent performance metrics, besides eliminating variability in patients' verification processes before their surgery.

In a similar manner, healthcare leadership is also fundamental in safeguarding patients' well-being. The reason for this statement is the proven fact that effective leadership establishes a non-negotiable priority for patient safety, besides motivating their followers to assume responsibilities to ensure patient safety as well. By promoting multidisciplinary collaboration, healthcare leaders facilitate transparent communication, eliminating any errors that can derive from operational silos, while fostering a learning culture for continuous improvement.

It is also worth mentioning that robust patient identification processes are key elements to surgical safety. Being the first line of defence to patient safety, correct identification of a patient can certainly prevent incidents of wrong-patient surgery. The findings also highlighted that with multiple verification checkpoints involving all stakeholders related to a surgical procedure of a patient, chances of oversight are minimised, while remaining aligned with the WHO recommendations as well.

4.3 Final Conclusion

To conclude, it can be said that strong clinical governance, effective leadership, and a positive safety culture are essential to preventing wrong-patient surgical incidents. By holding stakeholders accountable, prioritising patient safety, and integrating multiple checkpoints into operations, Kota Medical College can overcome its clinical governance failures in patient identification. The findings of this research also hold standardised protocols, patient safety culture, and the WHO guidelines equally important in this context.

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