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Table of Contents

Introduction	3
Main Body and Analysis.....	4
Identification of the Problem and Setting the System Context	4
Centralisation or Decentralisation within the Case Study.....	10
Leadership Theories and Application to the Case Study	13
Improvement and Lessons Learned	16
Recommendation.....	19
Conclusion	21
References.....	22

Introduction

Background and purpose of the Case Study

Patient safety has remained a major concern within the healthcare systems, specifically where failures in communication and medication management occur, resulting in preventable harm. The World Health Organisation (WHO) has estimated that medication errors cause at least one death every day and impact around 1.3 million people annually, while unsafe medication practices cost health systems around US\$42 billion every year (Naserallah et al., 2023). This report will analyse Case Study 2, which has concentrated on an investigation by the HSSIB into the death of Patient X. In this case, the patient's anticoagulant medication (apixaban) was withheld for ten days because of the delays to a planned procedure and was not restarted afterwards, resulting in a fatal stroke. The aim of this report is to critically assess how leadership, governance and organisational structures and systems thinking contributed to this incident and to recognise the evidence-based strategies which could improve patient safety and healthcare quality.

Leadership in health and social care

Leadership in health and social care is the process of influencing individuals and multidisciplinary teams for achieving shared goals while delivering safe, effective and compassionate care (Harris et al., 2022). In Patient X's case, leadership was particularly important because repeated procedural delays required timely assessment of anticoagulant therapy, effective multidisciplinary communication and clear clinical accountability (HSSIB, 2025). In this context, effective leaders can create a shared vision, promote collaboration, encourage accountability and support continuous learning for improving patient outcomes (Schaub et al., 2022). Therefore, the failure to ensure timely review and recommencement of apixaban has demonstrated the significance of leadership in coordinating clinical decisions across the teams.

Centralisation, Decentralisation and Leadership Approaches

Healthcare organisations may adopt either centralised or decentralised governance structures. In centralised systems, strategic decisions are initially made by senior management for ensuring consistency and standardisation, whereas decentralised systems mainly distribute authority for decision-making to the frontline teams, allowing greater flexibility and responsiveness to local clinical requirements (Ohrling, 2026). Patient X's case has involved both approaches; national clinical guidance provided the framework for anticoagulant management, while frontline clinicians were responsible for responding to changes in the patient's treatment pathway (HSSIB, 2025). Transformational, transactional and situational leadership offer different approaches for managing such clinical complexity (Boyar et al., 2023). Therefore, selecting an appropriate leadership

approach is necessary for improving decision-making and responding effectively to the patient safety challenges.

Importance of Leadership

Patient X's case has demonstrated that leadership must connect governance requirements with frontline clinical action. Effective leadership strengthens communication, accountability, escalation, improves patient safety and promotes organisational learning by supporting safer responses to changing clinical risks (Boyar et al., 2023). This report will apply systems for analysing the case, assessing the influence of governance and organisational structure in delivering safer healthcare services.

Main Body and Analysis

Identification of the Problem and Setting the System Context

Overview of the problem

The central problem in Case Study 2 was the failure to safely manage Patient X's apixaban after repeated delays to a planned procedure. The medication was withheld for ten days but was not restarted, resulting in a fatal stroke (HSSIB, 2025). Medication-related harm is identified as one of the leading causes of preventable patient harm worldwide.

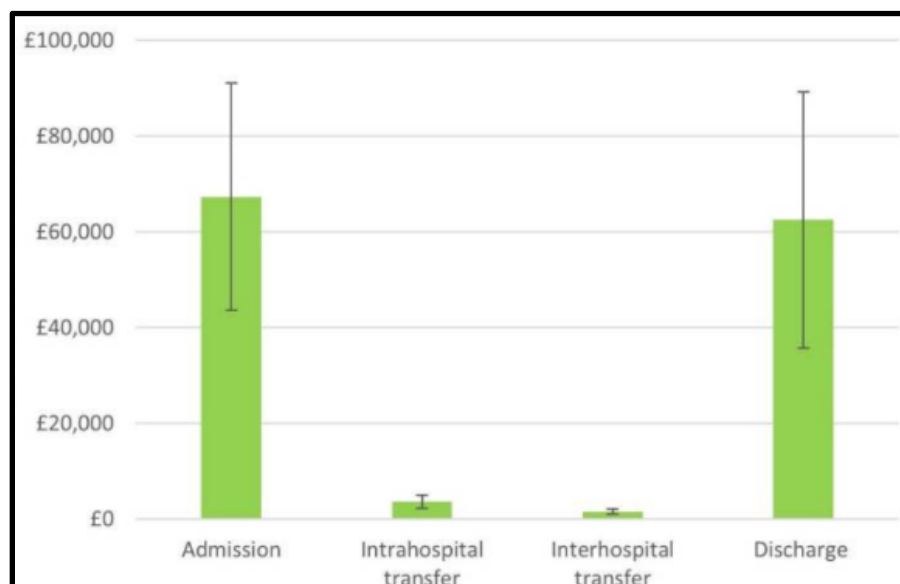


Figure 1: Total Global Cost of Medication

(Source: Ayre et al., 2023)

The WHO has estimated that medication errors result in at least one death every day and affect around 1.3 million people annually, with an estimated global cost of US\$42 billion every year (WHO, 2024).

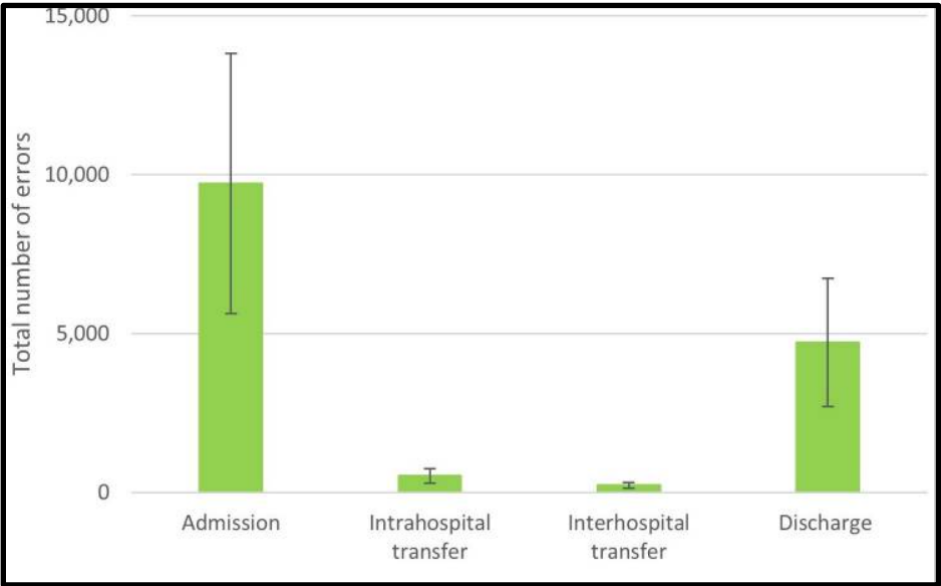


Figure 2: Total Number of medication errors

(Source: Ayre et al., 2023)

Within the NHS, medication safety also has remained a significant concern, with an estimated 237 million medication errors occurring annually worldwide, although many do not result in serious harm (Ayre et al., 2023). Against this wider context, Case Study 2 has concerned the inappropriate interruption and delayed recommencement of Patient X’s anticoagulant therapy, which has ultimately resulted in a preventable fatal stroke. Instead of reflecting a single clinical mistake, the incident has exposed interconnected failures in communication, clinical oversight and governance across multiple healthcare teams. Thus, this case highlights the requirements for assessing the incident utilising systems thinking to understand how the organisational procedures, leadership and governance collectively contributed to the adverse outcome instead of attributing blame to an individual clinician.

Global and National Context

Source	Statistics	Relevance to Patient X Case
WHO (2024)	Medication errors cause at least 1 death every day and affect 1.3 million people	Demonstrated that medication-related harm is a major global patient safety

	annually.	challenge.
WHO (2025)	Stroke is the second leading cause of death worldwide, causing approximately 6.7 million deaths every year.	Highlights the severe consequences of interrupted anticoagulant therapy.
NHS England (2024)	Around 1.6 million people in England live with atrial fibrillation and may require anticoagulants to prevent stroke.	Demonstrates the importance of safe anticoagulant management in NHS hospitals.

Table 1: National and International Data Supporting
(Source: Self-created)

The medication safety issues which have been recognised in Patient X’s case are consistent with broader global and national patient safety challenges.

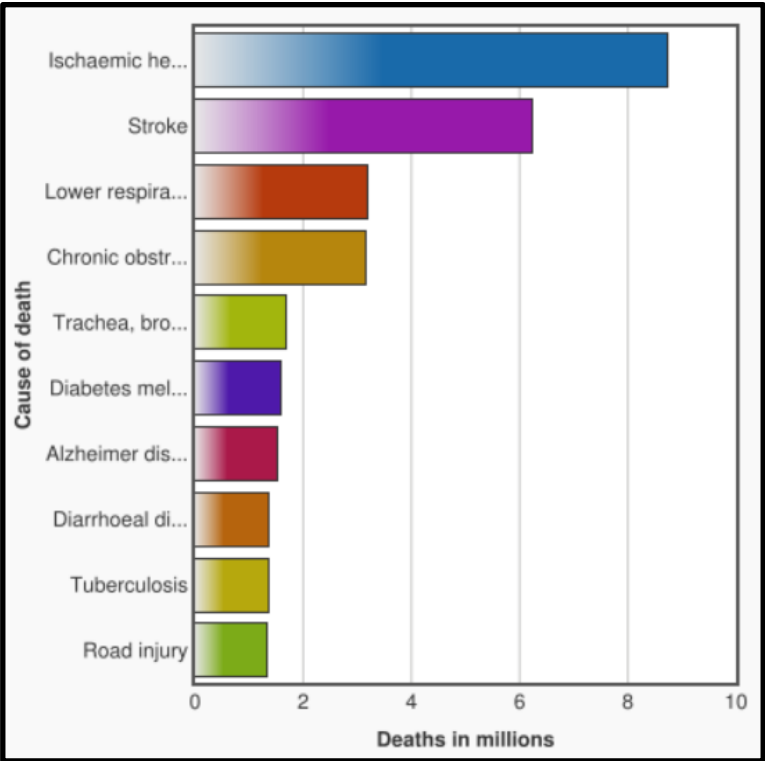


Figure 3: Causes of Death Worldwide
(Source: WHO, 2025)

According to the WHO, stroke is the second leading cause of death worldwide, with an estimated 93.8 million cases, causing approximately 6.7 million deaths annually, while effective anticoagulation has significantly reduced stroke risks in patients with atrial fibrillation (WHO, 2025).

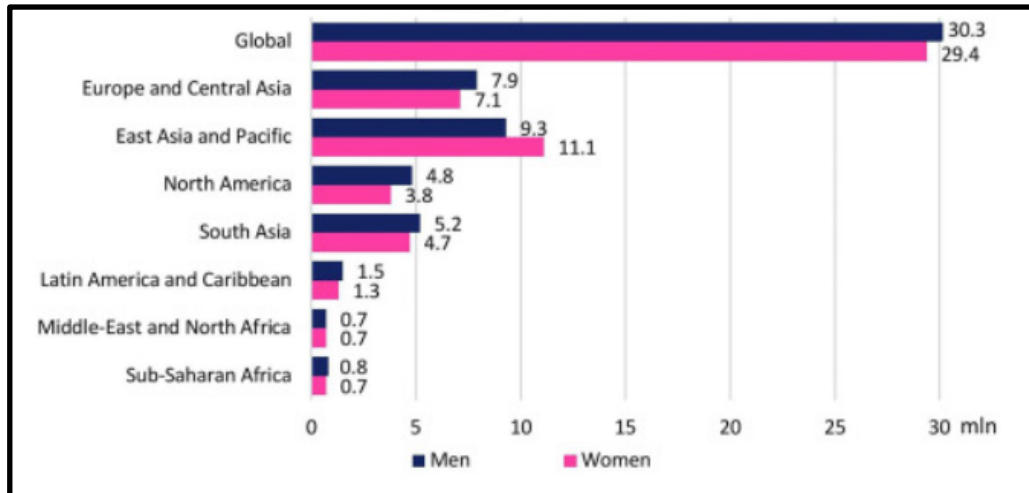


Figure 4: Worldwide people with atrial fibrillation

(Source: NHS England, 2024)

Additionally, in England, an estimated 1.6 million people are living with atrial fibrillation, which is making the safe management of anticoagulant therapy a major patient safety priority (NHS England, 2024). The identified delays in procedures, poor communication between multidisciplinary teams and unclear responsibility for restarting anticoagulants are recurring system issues which increase the risk of preventable harm (Ayre et al., 2023). Therefore, these findings have demonstrated that Patient X's case represents a wider systems issue requiring stronger leadership, governance and coordinated clinical decision-making.

Systems Thinking Analysis

From a systems thinking perspective, Patient X's death was the result of multiple interconnected failures instead of an isolated prescribing error. Systems thinking has identified that adverse events occur when interactions between people, procedures, technology and organisational structures create conditions for failure. In this case, repeated procedural delays, ineffective communication between clinical teams, inadequate documentation and the absence of clear responsibility for restraining apixaban disrupted continuity of care (Cabrera and Cabrera, 2023). As an example, the procedure was delayed, extending the interruption to 10 days, while the medication was not restarted after the procedure. Patient X suffered a stroke two days later and subsequently died (HSSIB, 2025).

A systems thinking approach also highlights the presence of feedback loops, inadequate communication and interdependencies within healthcare delivery. As an example, communication failure has occurred at several points in the care pathway. The changes caused by the procedural delay did not result in an effective reassessment of the medication plan, while documentation and handover did not ensure that the requirement to restart apixaban remained visible to the relevant clinical teams (HSSIB, 2025). The delay also has created a feedback failure because the extended interruption did not trigger sufficiently strong clinical review. These interconnected procedures have reduced the corporation's capability of recognising and responding to the emerging risks (Gadsby and Wilding, 2024).

Hence, systems thinking has recognised the combined effects of procedure management, communication, documentation, staffing and clinical accountability instead of attributing the outcome to one clinician.

Governance and Organisational Challenges

The failures which have been recognised in Patient X's case were mainly influenced by governance challenges at both the local organisational and national healthcare system levels. Locally, the investigation context has recognised bed unavailability in the respiratory ward, linked to high local respiratory need associated with smoking and deprivation, while hospital-level capacity had not been sufficiently increased for meeting this demand, creating a structural constraint (HSSIB, 2025).

Nationally, the NHS has continued to face workforce pressures which impact the safety of the patients.

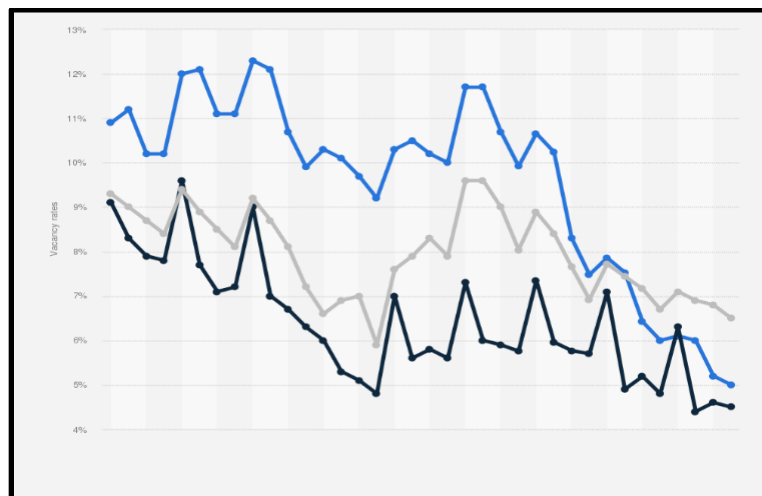


Figure 5: NHS England workforce vacancy

(Source: Mikulic, 2025)

In June 2024, the NHS in England reported over 106,000 vacant posts, leading to increased workload and reduced opportunities for effective clinical communication and medication review (Mikulic, 2025). In the case study context, the 10-day interruption has represented a clear point of workload pressure, as Patient X has remained waiting for a procedure while apixaban continued to be withheld, and the clinical team failed to continuously balance procedural risks, indicating staffing and workload pressures.

From a governance perspective, stronger leadership oversight, standardised medication protocols and regular multidisciplinary safety reviews are necessary for improving responsibility and reducing preventable medication-related harm (Alhabeeb et al., 2024). Therefore, governance failures extended beyond prescribing; insufficient capacity and workload pressures interacted with the fragmented clinical responsibility to delay recognition of the medication risk.

Rich Picture Analysis

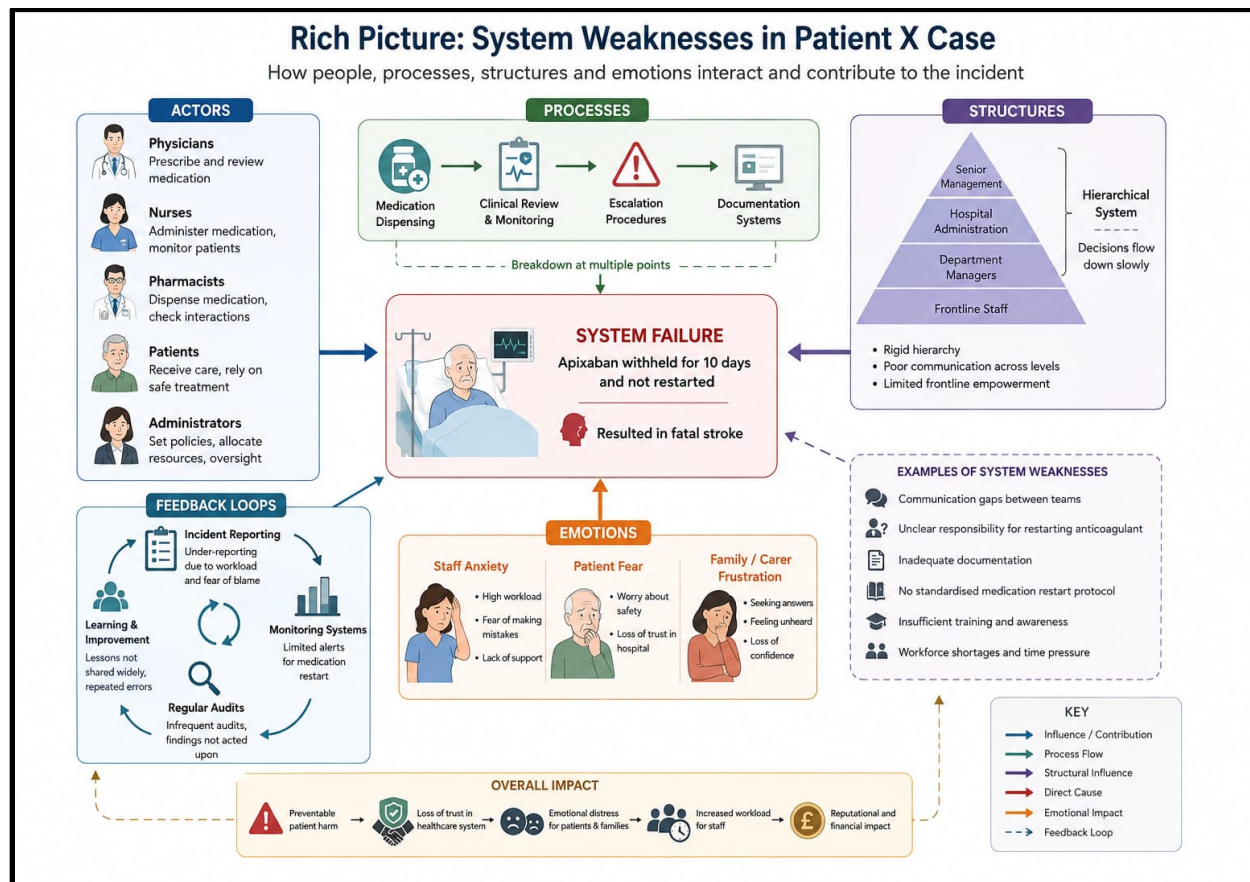


Figure 6: Rich Picture Analysis

(Source: Self-Created)

The Rich Picture has illustrated how Patient X's adverse outcomes resulted from interconnected failures across the healthcare system instead of a single clinical error. It has demonstrated how

delayed processes, fragmented communication, unclear accountability and weak governance have disrupted continuity of care. Thus, clinical audits, staff training and professional development can strengthen patient safety and prevent similar medication-related harm in the future.

Centralisation or Decentralisation within the Case Study

Introduction

Patient X's anticoagulant management has reflected weaknesses in both centralised governance and decentralised clinical decision-making by contributing to delayed medication review and a preventable fatal stroke (HSSIB, 2025). Although national clinical guidance has supported anticoagulant management, ineffective implementation, fragmented responsibility and poor multidisciplinary coordination limited its effectiveness. Therefore, this section will analyse these approaches for providing a better understanding of how organisational structure contributed to the adverse patient outcomes.

Centralised Decision-making in Patient X's case

Patient X's case has demonstrated multiple characteristics of the NHS's centralised healthcare system, particularly through organisational policies, medication governance, digital infrastructure and clinical guidelines. National clinical guidance provided the framework for managing anticoagulant therapy before invasive procedures, while standardised procedures were intended for ensuring consistent medication decisions across clinical teams (HSSIB, 2025). As an example, the planned procedure has resulted in apixaban being withheld according to the established clinical approach; however, when the procedure was repeatedly delayed, the centralised system did not ensure that the medication plan was formally reconsidered. Digital documentation and prescribing infrastructure also have provided opportunities for recording and communicating changes in the treatment plan, but inconsistent documentation weakened their effectiveness (HSSIB, 2025).

Besides that, high-risk medication governance should have provided an additional safeguard through mandatory review of prolonged anticoagulant interruption. Workforce pressures have intensified these governance challenges, with NHS England reporting over 106,000 vacant posts in June 2024, which has reduced the capacity for timely medication review and effective clinical coordination (Mikulic, 2025). Therefore, although centralised governance has promoted standardised anticoagulation policies, insufficient monitoring of policy implementation and limited accountability have contributed to the delayed restart of apixaban, ultimately resulting in a preventable fatal stroke.

Advantages and Limitations of Centralisation

The centralised governance structure has helped Patient X's care by providing nationally standardised guidance for managing anticoagulant therapy before invasive procedures. These evidence-based protocols aiming for reducing variation in prescribing practices and improving patient safety across NHS organisations (NICE, 2020). However, the HSSIP (2025) investigation has shown that despite the existence of national guidance, there were no consistent organisational procedures for reassessing anticoagulant therapy when Patient X's procedure was repeatedly delayed. Thus, responsibility for restarting apixaban became unclear across the clinical teams. This implementation gap significantly reflects wider medication safety challenges within the NHS, where an estimated 237 million medication errors occur annually, although only a small proportion resulted in serious harm (Ayre et al., 2023). These findings indicated that centralisation has helped in establishing the correct initial treatment framework, but its effectiveness was weakened because local oversight, communication and continuous clinical review contributed to the preventable harm experienced by Patient X.

Decentralised Decision-making in Patient X's case

Patient X's care has depended on decentralised clinical decision-making, as frontline clinicians were responsible for reviewing anticoagulant therapy according to the patient's changing condition throughout the hospital admission. This included clinical autonomy for doctors for assessing bleeding and thromboembolic risks, local decision-making during procedural delays, pharmacy professional judgement regarding medication safety and, where relevant, GP independence in coordinating medication management after transitions of care. Although the decision for primarily withholding apixaban was clinically appropriate, repeated procedural delays have required continuous reassessment and timely communication between medical, nursing and pharmacy teams (HSSIB, 2025). The decentralised approach failed when this professional autonomy was not supported by clear ownership and coordination. Responsibility for reviewing and restarting anticoagulant therapy has become fragmented across different clinical teams, with no individual assuming overall ownership of the medication plan (HSSIB, 2025). In this context, the NICE has recommended that anticoagulant therapy should be restarted promptly once the risk of procedural bleeding has reduced, following individual clinical assessment (NICE, 2020). Thus, decentralisation has provided necessary clinical flexibility but became unsafe when autonomy operated without shared accountability, effective communication and coordinated oversight.

Advantages and Limitations of Decentralisation

The decentralised approach has provided clinicians with the flexibility for making patient-centric decisions according to Patient X's evolving clinical condition, specifically during the time of balancing the risks of bleeding against thromboembolism before and after the planned procedure; this flexibility has allowed for multidisciplinary teams for adapting treatment decisions based on individual clinical assessments instead of depending only on standardised protocols (HSSIB, 2025). However, the investigation has demonstrated that this autonomy was not supported by clear accountability or effective coordination between the healthcare professionals. As Patient X's care was transferred across different teams, responsibility for reviewing and restarting apixaban became unclear, resulting in missed opportunities for preventing harm (HSSIB, 2025). In this context, research has indicated that previous communication failures have contributed to around 70% of serious patient safety incidents in healthcare, outlining the significance of effective multidisciplinary collaboration (Leotin, 2025). Therefore, the key failure was not decentralised decision-making itself, but decentralisation without sufficient accountability and coordination. Although this approach allowed for clinical flexibility, fragmented communication and unclear responsibility weakened its patient-safety benefits and contributed to the preventable adverse outcome.

Critical Analysis

Patient X's case has significantly demonstrated that neither centralised nor decentralised decision-making alone was sufficient for ensuring patient safety. While centralised governance has established evidence-based anticoagulant protocols, ineffective implementation and oversight have restricted their effectiveness.

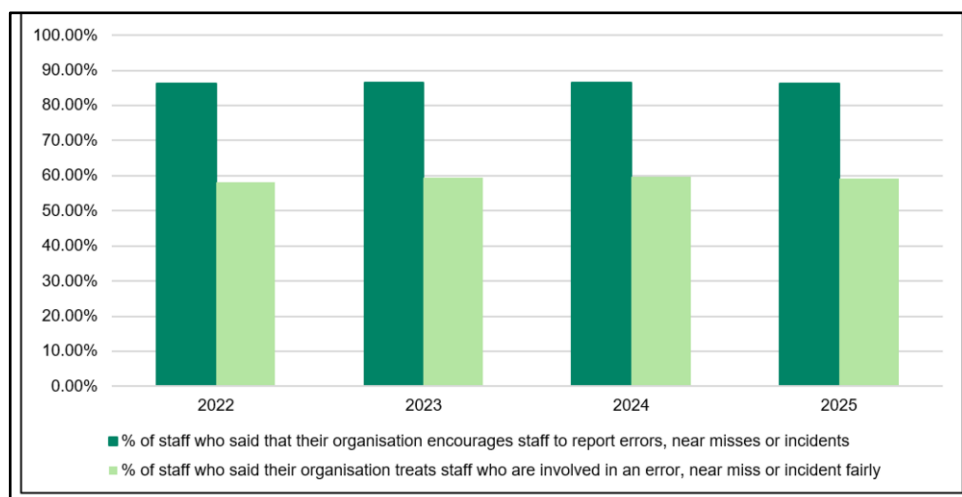


Figure 7: Staff Survey responses on reporting errors

(Source: Hughes, 2025)

This weakness is reflected in the 2024 NHS Staff Survey, where only 56.8% of staff reported that their organisation took positive action after concerns or incidents were raised (Hughes, 2025). Similarly, decentralised clinical self-sufficiency has failed because multidisciplinary teams have lacked in clearing responsibility and synchronised announcement when the patient's disorder had altered (HSSIB, 2025). Thus, it can be interpreted that improvement of medication safety needs balancing consistent ascendancy with authorised frontline decision-making, supported by continuous statement, shared responsibility and regular clinical review for stopping similar adverse proceedings.

Leadership Theories and Application to the Case Study

Introduction

Patient X's avoidable death has reproduced leadership failures which have extended beyond individual clinical decisions to weaknesses in communication, responsibility and multidisciplinary coordination. Thus, this section will critically apply the relevant leadership theories for evaluating leadership effectiveness and recognising evidence-based approaches to recover patient safety and organisational presentation.

Situational Leadership Theory and Application

Patient X's lengthy disruption of anticoagulant treatment has obligatory leadership for adapting clinical decisions as the patient's condition and treatment timeline changed. Although withholding apixaban before the planned procedure was appropriate, repeated procedural delays increased the patient's thromboembolic risk, requiring timely reassessment and coordinated multidisciplinary action (HSSIB, 2025). However, leadership has failed for modifying the management approach in delayed review and failure for restarting anticoagulation after the procedure.

The investigation recognised fragmented communication, unclear clinical responsibility and ineffective coordination between medical, nursing and pharmacy teams, demonstrating that leadership did not respond appropriately to the changing clinical situation (Wang et al., 2024). Rather than anticipating emerging risks, decisions have remained reliant on routine procedures despite significant changes in the Patient X's care pathway. This reactive approach has reduced opportunities for early intervention and increased the likelihood of preventable harm.

Evidence has supported the significance of adaptive leadership during complex clinical situations. According to the reports, adaptive leadership approaches are associated with 15-20% faster recovery from clinical incidents as they allow time for decision-making, collaboration and

responsiveness to the changing risks (Sott and Bender, 2025). Similarly, Robinson et al. (2025) have argued that leadership adaptability strengthens team coordination and clinical judgement during uncertainty. Thus, it can be stated that applying situational leadership through continuous risk assessment, flexible decision-making and shared multidisciplinary accountability could have allowed for earlier recommencement of apixaban and reduced the likelihood of Patient X's preventable fatal stroke.

Transformational Leadership theory and Application

Patient X's case has significantly demonstrated the absence of transformational leadership, as leaders have failed to develop a culture that promoted proactive communication, shared accountability and continuous learning throughout the patient's care pathway. Although repeated procedural delays have increased the clinical risk associated with withholding apixaban, leadership did not encourage the multidisciplinary teams to collaboratively review the medication plan or challenge the existing practices before the harm occurred (HSSIB, 2025). The opportunities for recognising the increasing risk of stroke and restarting anticoagulant therapy were missed.

The investigation has highlighted ineffective communication, fragmented coordination and limited organisational learning following changes in Patient X's clinical condition, indicating that leaders should have concentrated on maintaining routine practice instead of driving quality improvement (HSSIB, 2025). This reactive culture has reduced staff engagement in shared decision-making and weakened patient safety. In this context, Agazu et al. (2025) have found that transformational leadership is associated with 19% better patient safety outcomes and 23% higher staff morale by promoting collaboration, empowerment and open communication. Similarly, Ystaas et al. (2023) have argued that compassionate and inclusive leadership strengthens psychological safety by allowing healthcare professionals for raising concerns and responding effectively to the emerging clinical risks. Thus, it can be stated that adopting transformational leadership could have strengthened multidisciplinary collaboration, encouraged earlier review of anticoagulant therapy and created a safer organisational culture, reducing the probability of Patient X's preventable fatal stroke.

Transactional Leadership Theory and Application

Patient X's anticoagulant management has demonstrated a predominantly Transactional Leadership approach, as clinical teams were concentrated on complying with developed protocols for withholding apixaban before the planned procedure without continuously reassessing the patient's changing clinical condition. Although temporarily withholding apixaban before the planned procedures was clinically appropriate, repeated procedural delays required proactive

leadership for reviewing treatment decisions and ensuring clear accountability to restart the medication (HSSIB, 2025). Instead, responsibility became fragmented across multidisciplinary teams, resulting in delayed clinical action and ultimately a preventable fatal stroke.

The HSSIB (2025) investigation has highlighted inadequate communication, inconsistent documentation and unclear ownership of prescribing decisions, which has indicated that leaders should concentrate more on maintaining procedural compliance than facilitating collaborative decision-making and shared responsibility. In this context, leadership within Patient X's case has remained largely reactive, by responding to clinical events after they occurred instead of anticipating the increasing thromboembolic risk associated with prolonged interruption of anticoagulant therapy (Damanto and Supriyadi, 2022).

Evidence from the 2024 NHS Staff Survey has further supported this critique by reporting that only 56.8% of NHS staff has believed that their organisation has taken effective action for addressing concerns, which have been raised from incidents, demonstrating continuous weaknesses in organisational learning and safety culture (NHS England, 2024). Similarly, Skopak and Hadzaihmetovic (2022) have found that leadership initially concentrates on supervision and compliance associated with lower staff engagement and weaker patient safety outcomes than leadership approaches, which promotes empowerment and collaboration. Thus, it can be interpreted that, although transactional leadership has ensured adherence to the developed clinical procedures, it was insufficient in managing the complexity of Patient X's care, where proactive communication, multidisciplinary collaboration and continuous clinical review were necessary for preventing avoidable harm.

Critical Analysis

Patient X's case demonstrated that no single leadership approach adequately addressed the complexity of the incident. Transactional leadership promoted compliance with clinical protocols but lacked proactive oversight, while situational leadership failed to adapt to repeated procedural delays and increasing clinical risks. A more distributed leadership approach could have assigned shared responsibility for anticoagulant management across physicians, pharmacists and nurses, by allowing frontline professionals for escalating concerns when apixaban remained withheld (HSSIB, 2025). In this context, emotionally intelligent leadership would have encouraged leaders to listen to staff concerns, recognise anxiety or uncertainty and create psychological safety for challenging unsafe decisions (HSSIB, 2025). Thus, combining distributed, emotionally intelligent and transformational leadership could have strengthened shared accountability and allowed for earlier intervention before Patient X experienced preventable harm.

Improvement and Lessons Learned

Introduction

Patient X's preventable fatal stroke resulted from the interaction of ineffective leadership, fragmented governance and weak multidisciplinary coordination instead of an isolated clinical error (HSSIB, 2025). Thus, this section will critically evaluate the missed opportunities which have contributed to the incident and propose evidence-based improvements for strengthening patient safety, accountability and continuous organisational learning across the healthcare services.

Missed Opportunity 1: Weak Communication and Accountability

Patient X's care pathway was disrupted by ineffective communication and unclear accountability across the multidisciplinary teams, preventing timely reassessment and recommencement of apixaban by following repeated procedural delays (HSSIB, 2025). Responsibility for reviewing anticoagulant therapy has become fragmented as the patient moved between clinical teams, resulting in critical information not being communicated or acted upon. Therefore, no clinician has assumed overall ownership of the medication plan, which has allowed the interruption of anticoagulation to continue until the patient experienced a fatal stroke. In this context, the report shows around 10,000 patient-safety incidents associated with hospital discharge were reported to the NRLS between October 2012 and September 2013, with communication during handover accounting for around 33% of these incidents (NHS, 2023). The Joint Commission (2023) also has identified ineffective communication as a leading underlying cause of serious adverse events. Strengthening structured handover processes, such as SBAR, along with clearly defined clinical responsibilities and mandatory multidisciplinary medication reviews, would have improved continuity of care and accountability (NHS England, 2023). However, SBAR can become a procedural tick-box if staff concentrate on completing the format instead of communicating changing clinical risks (NHS England, 2023). Therefore, SBAR should accompany instead of replacing specialised judgement, clinical possession and multidisciplinary answerability.

Missed Opportunity 2: Governance and Medication Safety

Patient X's anticoagulant organisation exposed weaknesses in clinical ascendancy, as repeated procedural delays were not supported by formal suppository reviews or robust monitoring mechanisms (HSSIB, 2025). Although anticoagulation was intentionally withheld before the planned procedure, ascendancy systems failed to ensure reassessment when the patient's treatment pathway changed, subsequent in the omission of resuming apixaban. The investigation also identified unpredictable documentation and inadequate oversight, which has abridged continuity of care and delayed clinical intervention (HSSIB, 2025). According to the reports,

medication errors affect approximately 237 million medication processes annually in England, with many incidents linked to failures in monitoring and communication (Elliott et al., 2021). Introducing electronic prescribing schemes with mechanical medicine alerts, compulsory anticoagulant review checkpoints and regular clinical governance audits would strengthen oversight and reduce medication-related risks (NHS England, 2023). However, excessive electronic alerts can create alert fatigue and reduce attention to clinically important warnings. This could be mitigated by prioritising high-risk anticoagulant alerts and regularly auditing responses (Harsh et al., 2025). Thus, digital organisations should accompany, instead of replace, clinical judgement and clearly assigned answerability.

Missed Opportunity 3: Leadership and Safety Culture

Patient X's case has exposed significant weaknesses in administrative learning, as repeated procedural delays and changes in clinical risk did not prompt leadership to initiate timely medication reviews or multidisciplinary discussions (HSSIB, 2025). Contempt numerous occasions for reassessing the anticoagulation plan, leaders did not create devices that fortified frontline staff for intensifying anxieties or collaboratively encounter existing choices. Therefore, the omission of resuming apixaban remained undetected until the patient experienced a preventable fatal stroke. These findings indicate that management should have concentrated on managing routine procedures instead of promoting incessant learning and quality development following vicissitudes in the patient's disorder.

Evidence from the 2024, NHS Staff Survey has showed that only 56.8% of staff believed their organisation took positive action afterward anxieties or occurrences were reported, suggesting that opportunities for administrative learning and safety development remain incomplete in many healthcare surroundings (NHS England, 2024). Consolidation transformational leadership through regular multidisciplinary safety huddles, organised reflective learning sessions, leadership walk-rounds and a meaningfully harmless speaking-up brashness would inspire earlier certification of medication-related risks (West et al., 2022). However, this method can be unsatisfactory during urgent scientific situations if leader's quintessence heavily on participation instead of immediate culpability and decision-making. This risk could be abridged by combining transformational leadership with situational leadership for permitting rapid escalation when patient risk upsurges (Pimentel, 2021). Thus, leadership would equilibrium staff empowerment with clear clinical responsibility for ensuring that reported anxieties lead to opportune action and computable safety expansions.

Evidence-Based Continuous Improvement

Patient X's case has established that the non-appearance of incessant monitoring and systematic feedback permitted medication-related risks for continuing without timely interference (HSSIB, 2025). Contempt repeated practical delays, no prescribed instrument ensured that anticoagulant therapy was reviewed, importance weaknesses in quality enhancement and performance monitoring. Therefore, disjointed communiqué and unpredictable certification prevented clinicians from classifying the protracted disruption of apixaban before irretrievable harm has happened. Evidence indicates that implementing electronic suggesting systems with clinical decision support significantly reduces medication errors by providing automated alerts for omitted or delayed medicines (AHRQ, 2023). Similarly, the WHO Global Enduring Safety Action Plan 2021–2030 has recommended strengthening incident reporting, regular clinical inspections and organisational learning to improve medicine safety and accountability (WHO, 2020). In Patient X's case, the national governance assembly has limited local ownership, while decentralised clinical decisions were not supported by clear responsibility. A predominantly reactive leadership approach has meant that feedback from procedural delays did not gun trigger timely reassessment. This interaction has created a weak response loop in which risks were neither intensified nor systematically reviewed. Founding medication safety dashboards, mandatory anticoagulant review checkpoints and multidisciplinary audit conferences would strengthen feedback and accountability. Therefore, combining clearer ascendancy, adaptive management and continuous feedback would have allowed earlier intervention and more sustainable patient-safety improvement.

Lessons Learned and Overall Evaluation

Patient X's case demonstrated that the communication between ascendancy structure, leadership and system reply directly biased enduring results. Centralised ascendancy has provided organisational rules for anticoagulant organisation; however, deficient dispersed clinical authority and indistinct accountability overdue medication review when the patient's condition changed (HSSIB, 2025). Leadership has sustained largely sensitive, while disjointed communication and weak response mechanisms banned timely identification of the prolonged interruption of apixaban. Accordingly, system disappointments accrued and resulted in a preventable fatal stroke. Healthcare societies should support multidisciplinary collaboration, communal clinical responsibility and incessant learning instead of contingent only on individual presentation. Regular examination of medication protection data, incident reporting trends and governance audits should inform organisational decision-making, permitting never-ending quality improvement, evidence-based leadership and maintainable patient safety improvements (WHO, 2020). This, participating evidence-based treatment with amenable control and effective

governance, can support sustainable enhancements in medication security and diminution avoidable enduring harm.

Recommendation

Based on the documented leadership, governance and medication-safety faintness, in this section recommendations will be provided by concentrating on practical and maintainable improvements to Patient X's care way.

Leadership for Sustainable Improvement

Patient X's case has demonstrated that contingent only on transformational leadership can encourage staff engagement but also may delay urgent decisions during high-pressure clinical situations if clear accountability is absent. On the other hand, excessive transactional leadership can promote protocol compliance while discouraging staff from questioning unsafe medication decisions (Agazu et al., 2025). As an example, when Patient X's procedure was repeatedly delayed, a situational leader could have required an immediate multidisciplinary review of whether apixaban should remain withheld or be restarted, instead of allowing the original decision for continuing unchanged (HSSIB, 2025). Resistance from senior clinicians accustomed to hierarchical decision-making may limit implementation. This could be mitigated through leadership coaching and simulation exercises using scenarios involving delayed procedures and interrupted anticoagulation. In this context, regular security clusters and leadership walk-rounds should reinforce shared accountability (Boyar et al., 2023). Therefore, the organisation should introduce a baptised clinical lead for high-risk medicine decisions and appraise efficiency through appreciation rates, staff response and medication-safety consequences.

Strengthening Governance, Communication and Systems Integration

Clinical governance should be supported by founding clear responsibility for decoagulant management through the patient's care path. Also, a named clinician should remain answerable for rereading high-risk tablets during charge, procedural interruptions and liberation to diminish fragmented policymaking (HSSIB, 2025). As an example, if a procedure is postponed for more than the originally anticipated period, an electronic trigger could require the responsible clinician to document a fresh assessment of bleeding and thromboembolic risk before the medication plan continues. In this context, SBAR should be mandatory during every clinical handover to improve continuity of care (NHS England, 2023). Although electronic prescribing systems and automated medication alerts can reduce medication omissions, excessive alerts may contribute to alert fatigue and reduce clinician responsiveness. This limitation can be mitigated by prioritising alerts for high-risk medicines, conducting regular governance audits and monitoring compliance through

multidisciplinary governance committees (Bell, 2025). Therefore, the organisation could restrict alerts to clinically important events such as prolonged withholding of anticoagulants, instead of generating alerts for every medication change. Governance committees should subsequently audit whether these alerts resulted in documented clinical reviews.

Enhancing Technical and Allocative Efficiency

Technical efficiency should be improved through phased implementation of electronic prescribing, barcode medication administration and clinical decision-support systems for reducing medication-related errors (WHO, 2020). For example, an electronic prescribing system could flag that apixaban has remained withheld for an extended period and require documented clinical justification before the medication remains suspended. However, introducing these technologies may increase financial pressure, require extensive staff training and temporarily disrupt clinical workflows, particularly in resource-constrained healthcare settings (OECD, 2023). A practical mitigation would be to pilot the system initially within medical wards managing anticoagulated patients, compare medication-error rates before and after implementation, and expand the system only if quantifiable improvement is demonstrated. Specialist drugstore support should also be prioritised for high-risk affected role (NHS England, 2023). For Patient X-type cases, a pharmacist-led review following procedure postponement could provide a supplementary safety barrier before anticoagulation decisions endures (NHS England, 2024). Therefore, this approach would protection that resources are allocated according to quantifiable scientific risk and advantage.

Continuous Learning, Stakeholder Engagement and Co-production

The organisation should implant incessant administrative knowledge by alliance incident reporting, multidisciplinary thoughtful knowledge and simulation-based medicine safety exercise to improve patient safety and administrative pliability (WHO, 2020). As an example, Patient X's case could be rehabilitated into a multidisciplinary imitation scenario in which staff must reply to a postponed procedure, reassess anticoagulation and interconnect the revised plan during handover. However, fear of responsibility may dishearten incident reporting, while greater patient involvement may increase clinical workload (NHS England, 2023). For mitigating these challenges, leaders should foster a psychologically safe philosophy through unidentified reportage systems, leadership walk-rounds, regular response on reported incidents and structured patient education supported by pharmacists and multidisciplinary teams (West et al., 2022). Besides that, unceasing evaluation of audit answers, medication safety pointers and patient feedback should be integrated into ascendancy procedures for recognising emerging risks and guide evidence-based service developments. Thus, compounding continuous learning with

active stakeholder appointment would strengthen responsibility, organisational pliability and sustainable developments in medicine safety.

Conclusion

In conclusion, Patient X's case has established that the fatal medication-related harm resulted from interconnected weaknesses in communication, accountability, governance and clinical coordination as an alternative of a single separate error. Centralised governance has provided standardised anticoagulation guidance, but inadequate local oversight has failed to ensure reassessment when the procedure was repeatedly delayed. Decentralised clinical decision-making has provided professional suppleness, hitherto unclear possession between multidisciplinary sides has prevented opportune recommencement of apixaban. Leadership was also insufficiently proactive in knowing altering risks and encouraging escalation. Therefore, systems thinking has highlighted how these weaknesses have interrelated through fragmented procedures and ineffective feedback mechanisms to produce preventable harm. Effective leadership supported by clear governance responsibilities, multidisciplinary communication, continuous monitoring and organisational learning is necessary for addressing such total failures. Thus, participating governance, leadership and systems thinking can strengthen answerability, improve patient safety and support sustainable health care development.

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