



**PROGRAMME: MSC PUBLIC HEALTH AND SOCIAL CARE IN
PRACTICE**

**MODULE: HEALTH CARE SYSTEM ORGANISATION AND
LEADERSHIP**

MODULE CODE: LCHS7002

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ASSIGNMENT TITLE: CASE STUDY ANALYSIS REPORT

CASE STUDY 4

Executive summary

This report has examined the leadership theories to apply in the case study of Kota Medical College Hospital patient safety issues. The collaborative leadership could be effective to deal patient misidentification. This report carried a critical evaluation of a patient misidentification case that took place at the Kota Medical College Hospital in Rajasthan on 12 April 2025. The case refers to an older patient who underwent the process of anaesthesia intended for a different patient. Utilising the systems thinking technique, Rich Picture and CATWOE analysis, the current report aims to link the case to the global (WHO), national, and organisational level data in order to identify some weaknesses in communication, accountability and governance. Leadership theories related to the situation are critically analysed along with the evidence from safety and engagement perspectives.

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Introduction

Background and purpose of the case study

The case scenario of Jagdish Panchal at Kota Medical College Hospital in Rajasthan, India, presents a critical failure of clinical governance and patient verification. It has been recognised that the 60-year-old speech-impaired man accompanying his injured son was mistakenly called into an operating theatre after responding to a name similar to another patient's (Scmp, 2025). Lack of identity verification and poor hospital staff administered anaesthesia have made a surgical incision on his arm for an unintended arteriovenous fistula procedure. Based on this aspect, the report aims to evaluate the root causes of surgical misidentification and explore the leadership, governance, and systemic reforms required to protect patient safety.

Introducing leadership in health and social care

Leadership in healthcare is considered to be the capacity to motivate, influence and direct multidisciplinary teams toward shared objectives such as delivering safe, high-quality, and ethical patient care (Enahoro et al. 2024). The presence of an effective leadership approach within the healthcare system helps to establish operational norms, fosters psychological safety and enforces strict compliance with clinical standards across complex delivery environments.

Introducing centralisation and decentralisation

A centralised health and social care system is considered to be the decision-making authority that is concentrated at top administrative tiers. On the other hand, a decentralised system influences decision-making power by distributing it to operational teams in terms of enabling rapid local responses. However, risking inconsistent standard enforcement if accountability mechanisms are weak. Apart from this, the need for transformational leadership in health and social care inspires workforce engagement, shared vision and improvement through cultural alignment (Mohajer-Bastami et al. 2023). Apart from this, Situational Leadership in health and social care helps to adapt management behaviour dynamically based on team competence and task complexity.

Importance of leadership

The need for selecting an appropriate leadership style is considered to be essential during organisational change as well as crisis recovery (Al Zeer et al. 2025). It has been recognised that professionals in high-pressure environments such as public hospitals ensure adherence to core surgical safety protocols. The need for effective leadership builds a transformational vision that influences a culture where staff proactively report safety hazards without fear of reprisal.

Report structure

The report aims to evaluate global and national surgical error rates and construct a Rich Picture analysis of communication gaps, governance breakdowns, and resource pressures identified within the Jagdish Panchal case scenario. Additionally, the report also aims to examine how centralised administrative structures contributed to protocol non-compliance in the case scenario. Moreover, the report will assess the role of distributed authority within frontline surgical verification as well as clinical workflow execution.

Main Body and Analysis

a. Identifying the Problem and Setting the System Context- Applying Systems Thinking and the Rich Picture

Global, National, and Organisational Statistical Context

Surgical errors as well as patient misidentifications are recognised as widespread constraints across the global healthcare systems. The World Health Organisation (WHO) has estimated that 1 in every 10 patients across the globe suffers harm while receiving hospital care, and it results in over 3 million annual deaths (WHO, 2026). More than 10% of all preventable patient harm are occurred from the surgical settings. These unsafe surgical procedures often contribute directly to high rates of preventable morbidity in the global context. On the other hand, National Data considers the case scenario and has pioneered the healthcare aspect of India. It has been recognised that India experiences over 5.2 million medical injuries annually because of clinical errors as well as adverse events (Nhsrindia, 2026). It can be translated into the loss of 3 million healthy life years each year. Surgical procedure errors account for roughly 27% of all reported safety incidents in Indian tertiary care centres. The need for improvement is

recognised both at the global and national levels in the healthcare context.

In the case of the operational healthcare context, the institutional figures have highlighted the Joint Commission. The data from the Joint Commission reveal that patient misidentification accounts for 12.3% and tracked sentinel events within the hospital environment (Jointcommission, 2026). Thus, the “Institute for Healthcare Improvement” (IHI) emphasizes on misidentification in the way of perioperative transitions leads directly to wrong-site, wrong-patient surgeries and wrong-procedure.

Explaining how this problem reflects systemic weaknesses

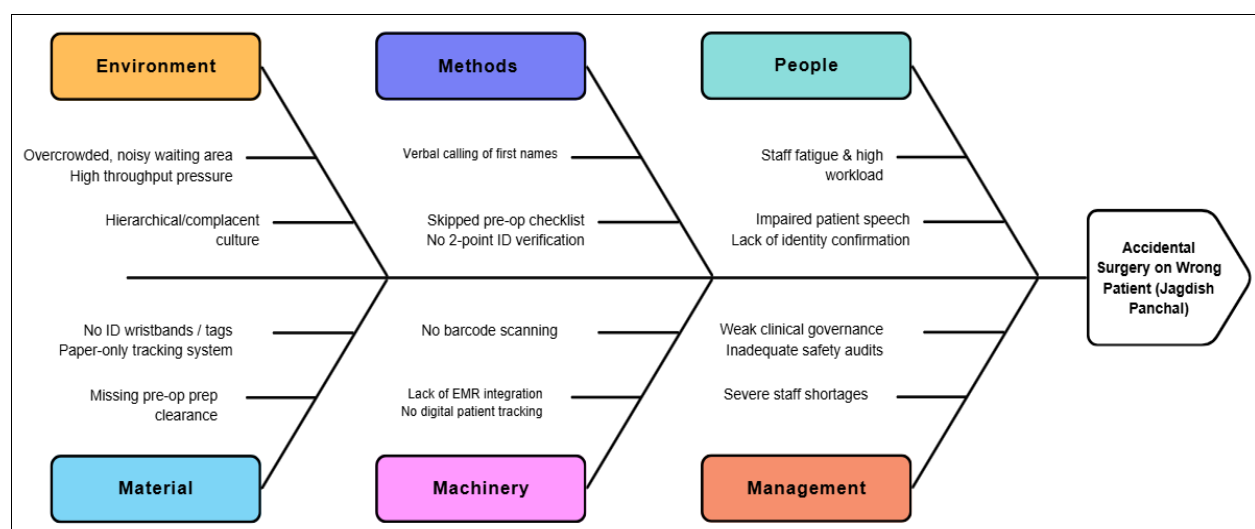


Figure 1: Root Cause Analysis Using Fishbone Diagram

(Source: Self-developed)

The accidental operation on Jagdish Panchal highlights breakdowns across clinical systems that include communication failures and protocol bypassing. As per the opinion of Mogaji et al. (2026), high reliance on verbal announcements in a crowded waiting room creates a single point of failure in health and social care. It has been recognised that Jagdish Panchal's inability to speak due to facial paralysis has prevented him from clarifying his identity. This has exposed the absence of non-verbal, multi-factor identification protocols within the Kota Medical College Hospital in Rajasthan, India. Apart from this, the case scenario also highlights that the basic preoperative safety checks were skipped. Elbahi et al. (2025) have highlighted that lack of

preoperative safety within health and social care systems can lead to severe surgical complications, wrong-site anaesthetic mishaps, higher rates of preventable mortality and prolonged hospital stays. Jagdish Panchal was placed under anaesthesia and operated on while wearing his own clothing, without his arm being shaved or sanitised. This medical practice indicates a major collapse in perioperative checklist enforcement.

Identifying the level of governance that influenced the problem

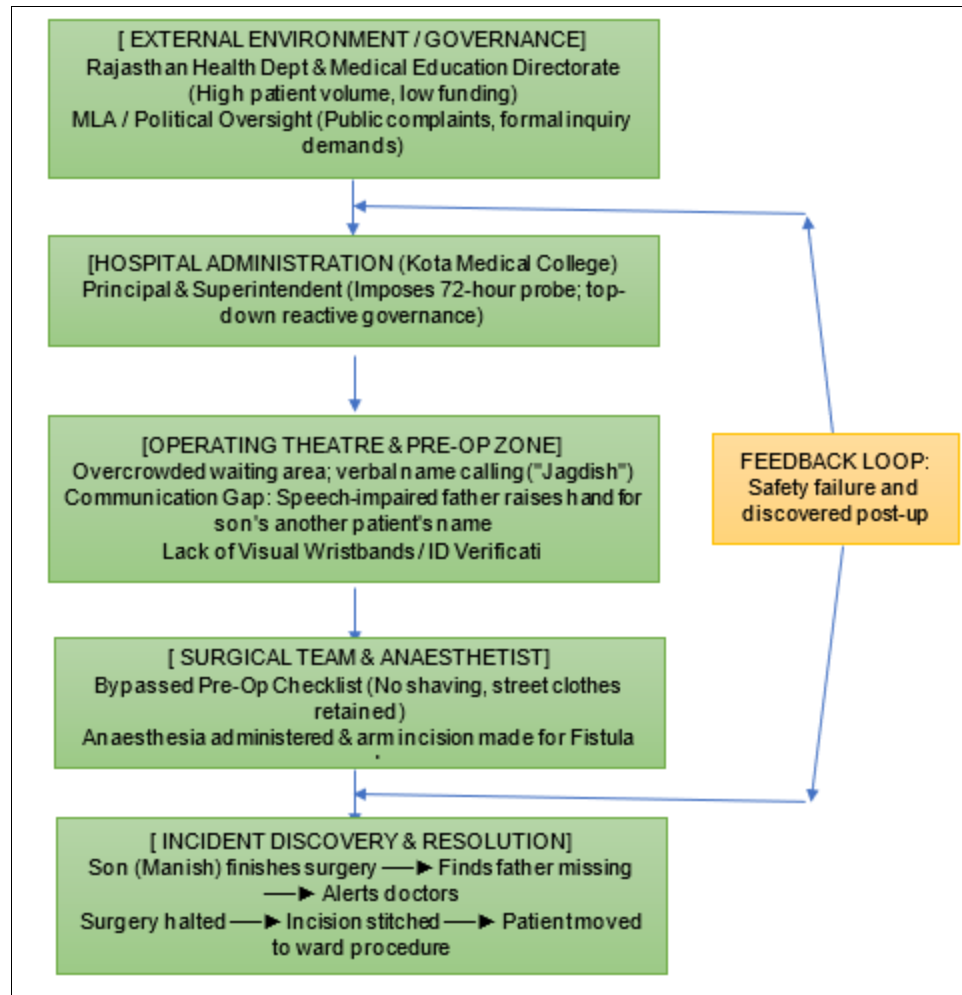


Figure 2: Rich Picture

(Source: Self-developed)

The case scenario reflects failures across multiple governance levels such as local, national and regional levels. For instance, the lack of frontline operational discipline and duty-of-care

oversight by the surgical and nursing staff signifies **local-level governance failure**. As per the analysis of Donisa et al. (2026), lack of frontline operational discipline in health and social care systems leads to compromised patient safety, frequent clinical errors, severe staff burnout and systemic non-compliance with legal or regulatory standards. Apart from this, insufficient state medical college funding, high patient-to-staff ratios as well as reactive administrative oversight signify **regional-level governance failure**. Uchmanowicz et al. (2024) have highlighted that high patient-to-staff ratios in health and social care systems lead to lower care quality, higher patient mortality and more medical errors. Additionally, the inconsistent implementation of NABH safety standards across public tertiary hospitals signifies national-level governance failure.

Provide data on underlying challenges to illustrate underlying challenges

It has been recognised that public tertiary hospitals in India face severe structural constraints such as staff shortage, lack of standardised operations and communication barriers. As per the analysis of Wollitz et al. (2023), high patient volume develops time pressure on nurses as well as surgeons, leading staff to skip standard safety steps. Additionally, private or internationally accredited facilities that mandate two-point patient verification. However, public centres often rely on informal handoffs. The presence of hierarchical communication barriers can lead to an increased risk of medication errors within the health and social care system. Nursing assistants who noticed Panchal in street clothes may have felt hesitant to challenge the attending surgical team. This helps in demonstrating a lack of psychological safety as well as flat communication structures.

b. Centralisation or Decentralisation within the Case Study

Centralised systems

A centralised system within a healthcare system introduces a model where data, administration, as well as resource management are managed and controlled by one main hub (Tariq et al. 2024). It has been recognised that Kota Medical College Hospital operates under a highly centralised administrative structure, commonly found in state-run public medical institutions in India. The strategic decision-making, disciplinary actions, policy creation, and budgetary allocation are concentrated among senior executive leaders in a centralised system. The Medical College Principal, the Hospital Superintendent, and the officials at Kota Medical

College Hospital operate under the guidance of the State Department of Medical Education (Nmc, 2024). Furthermore, the centralised actions taken after the incident included formal corrective measures initiated from the top down. For instance, the Principal, Dr. Sangeeta Saxena, ordered the Hospital Superintendent to establish a three-member investigating committee with a mandate to deliver a findings report within 72 hours (Scmp, 2025). This pointed towards the remedial actions, public statements collection, and policy revisions for management entirely by top management along with external political leaders.

A centralised healthcare system commonly collects the benefits of fewer administrative errors and better resource control (Krenyacz and Revesz, 2025). In other words, decision-making power is centralised in healthcare in a centralised system and internal teams and clinical departments are only responsible for following the guidance described, investing time in making a strategic plan. Similar to this context, Kota Medical College Hospital directs administrative resources immediately toward investigation, ensuring standardised formal inquiries as per regulations. The clear accountability line in the healthcare system establishes a single authority accountable to the legislative assembly, state health department, and the public. Lastly, the policy standardisation in the centralised healthcare system allows leadership to mandate institutional shifts like sweeping wristband protocols across all hospital departments simultaneously (Wollitz et al. 2023). Thus, care quality and medical care flow at Kota Medical College Hospital can be ensured under a centralised healthcare system.

However, the operational rigidity and delays in reporting and decision-making have lowered the effectiveness of the centralized system in healthcare. As per Laha and Dutta (2024), frontline staff are recognised to depend on top-heavy bureaucratic rules despite maintaining local initiative under a centralised system. It can lead to compliance being treated as a dynamic administrative task, and the active safety priority can be ignored in Kota Medical College Hospital. In addition, centralised systems often emphasise punitive measures over research that discourage staff from reporting early (Krenyacz and Revesz, 2025). The present data from India shows that central management structures often experience administrative delays in addressing operational safety gaps. The senior administrators at Kota Hospital set policies without accounting for the daily throughput pressure, such as staffing shortages and communication bottlenecks, experienced by frontline operators. Therefore, the case scenario of Panchal can also be considered as a result of the ineffectiveness of the centralised healthcare

system.

Decentralised systems

It has been recognised that a decentralised healthcare model indicates the distribution of operational authority to healthcare leaders, duty nursing supervisors and surgical unit heads (Birru et al. 2024). The frontline teams within a healthcare system are empowered towards an enforcement of safety checks, halt unsafe procedures, as well as modify unit-level workflows in real time without awaiting executive clearance under a decentralised system. For instance, if Kota Medical College had utilised a decentralised surgical safety framework, the anaesthetist or duty nurse would have the explicit authority to halt the procedure immediately after noticing that Jagdish Panchal was in street clothes and lacked pre-op skin preparation.

Surgical Safety Checklist			World Health Organization	Patient Safety A World Alliance for Safer Health Care
Before induction of anaesthesia (with at least nurse and anaesthetist)	Before skin incision (with nurse, anaesthetist and surgeon)	Before patient leaves operating room (with nurse, anaesthetist and surgeon)		
Has the patient confirmed his/her identity, site, procedure, and consent? ☐ Yes	☐ Confirm all team members have introduced themselves by name and role.	Nurse Verbally Confirms: ☐ The name of the procedure		
Is the site marked? ☐ Yes ☐ Not applicable	☐ Confirm the patient's name, procedure, and where the incision will be made.	☐ Completion of instrument, sponge and needle counts		
Is the anaesthesia machine and medication check complete? ☐ Yes	Has antibiotic prophylaxis been given within the last 60 minutes? ☐ Yes ☐ Not applicable	☐ Specimen labelling (read specimen labels aloud, including patient name)		
Is the pulse oximeter on the patient and functioning? ☐ Yes	Anticipated Critical Events	☐ Whether there are any equipment problems to be addressed		
Does the patient have a:	To Surgeon: ☐ What are the critical or non-routine steps? ☐ How long will the case take? ☐ What is the anticipated blood loss?	To Surgeon, Anaesthetist and Nurse: ☐ What are the key concerns for recovery and management of this patient?		
Known allergy? ☐ No ☐ Yes	To Anaesthetist: ☐ Are there any patient-specific concerns?			
Difficult airway or aspiration risk? ☐ No ☐ Yes, and equipment/assistance available	To Nursing Team: ☐ Has sterility (including indicator results) been confirmed? ☐ Are there equipment issues or any concerns?			
Risk of >500ml blood loss (7ml/kg in children)? ☐ No ☐ Yes, and two IVs/central access and fluids planned	Is essential imaging displayed? ☐ Yes ☐ Not applicable			

Figure 3: WHO's Surgical Safety Checklist

(Source: WHO, 2026)

The decentralized decision-making could enhance patient safety by showing frontline professionals to challenge an incorrect patient-procedure match before harm occurs. In

aligning with this, the examples from WHO's report on 'patient misidentification' as a recognized cause of severe harm including wrong-site surgery, 409 patient-identification sentinel events were reported among 3,326 incidents (12.3%) between 2014-2017 (WHO, 2023). Decentralisation can also encourage shared accountability, multidisciplinary communication and speaking-up behaviours. WHO's 19-item 'Surgical Safety Checklist' specifically promotes team participation, communication and verification before anaesthesia and incision (WHO, 2026). Hence, the staff closest to the patient can respond fast without waiting for senior managerial approval by improving responsiveness in time-critical surgical context.

The disadvantage of a centralised structure observed at Kota Medical College Hospital is associated with the surgical mix-up on 12 April 2025. Initially, the centralised decision-making system provided the power to verify identity onto the hands of less experienced members of the theatre staff without multiple cross-checks. Multiple cross-checking while providing any critical service helps to prevent human error and improve quality of care. According to Abosheisha et al. (2025), wrong-patient incidents continue to occur when the responsibility of verifying falls to one unsupervised person instead of a team. This insight is directly applicable to Kota, where one of the staff called out the name instead of using a wristband or documentation to confirm an identity. Additionally, centralisation slowed down the communication among theatre, ward and administrative levels with the correct patient not being recognised as having gone into surgery until later. Moreover, there was a lack of clear accountability for the confirmation of identity prior to anaesthesia. This is a recurring problem of clinical governance in a hierarchical, top-down approach in the Kota Medical College. Therefore, during a high-risk perioperative process, the hospital's ability to quickly identify errors, empower staff, and make local decisions was limited by centralisation. The disadvantages of centralisation were not only administrative but also they set the conditions in which a preventable identification failure took place.

Critical analysis

It can be stated from the above discussion of centralised and decentralised models in the case of healthcare that neither system is universally superior. Kota Medical Hospital in India can apply a hybrid model combining centralised policy standards with decentralised frontline execution. The excessive top-down centralisation makes real-time decision-making complex

and creates barriers in crisis prevention. The global healthcare system indicates the issues of staff shortage and increased burnout among existing staff (WHO, 2026). The national WHO Surgical Safety Checklist compliance prioritised patient throughput over safety. However, frontline clinicians lacked psychological safety when operational authority remained centralised. This results in internal crisis management failing. Thus, the combined system, decentralising bedside authority, can empower frontline staff to halt operations instantly, and centralisation can ensure baseline quality enforcement.

c. Leadership Theories and Application to the Case Study

Leadership theories to support the case study

- **Transformational leadership**

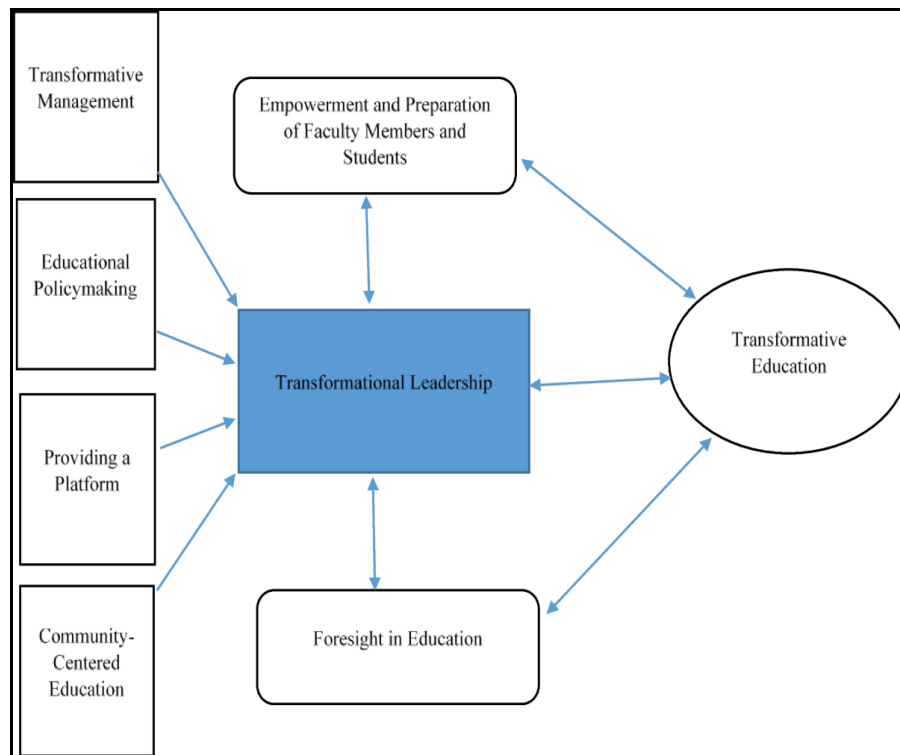


Figure 4: Transformational leadership theory

(Source: Ghorbani et al., 2023)

The transformational leadership focuses vision, shared values, empowerment, motivation and

organisational culture to make it relevant for improving patient-safety (Ystaas et al., 2023). The wrong-patient procedure at Kota Medical College Hospital indicates a failure that involved a breakdown in the safety behaviour expected across the clinical team rather than an individual concern. The patient was called using a similar name, raised his hand and was subsequently taken to theatre without sufficient identity verification. The transformational leadership could have reduced this risk by building patient identification as a non-negotiable organizational value to empower staff for challenging unsafe decision-making (Ghorbani et al., 2023). This is significant as WHO (2023) reported that approximately 1 in 10 patients experienced harm in healthcare, with more than half of harm considered preventable. WHO also finds patients misidentification as a cause of severe events such as 'wrong-site surgery' (WHO, 2023). In this context, Hamdan et al. (2024) stated that transformational leadership positively influenced patient-safety culture through better teamwork, communication, organizational learning and feedback. Thus, transformational leadership would be ensured to prevent recurrence by enhancing culture.

- **Situational leadership**

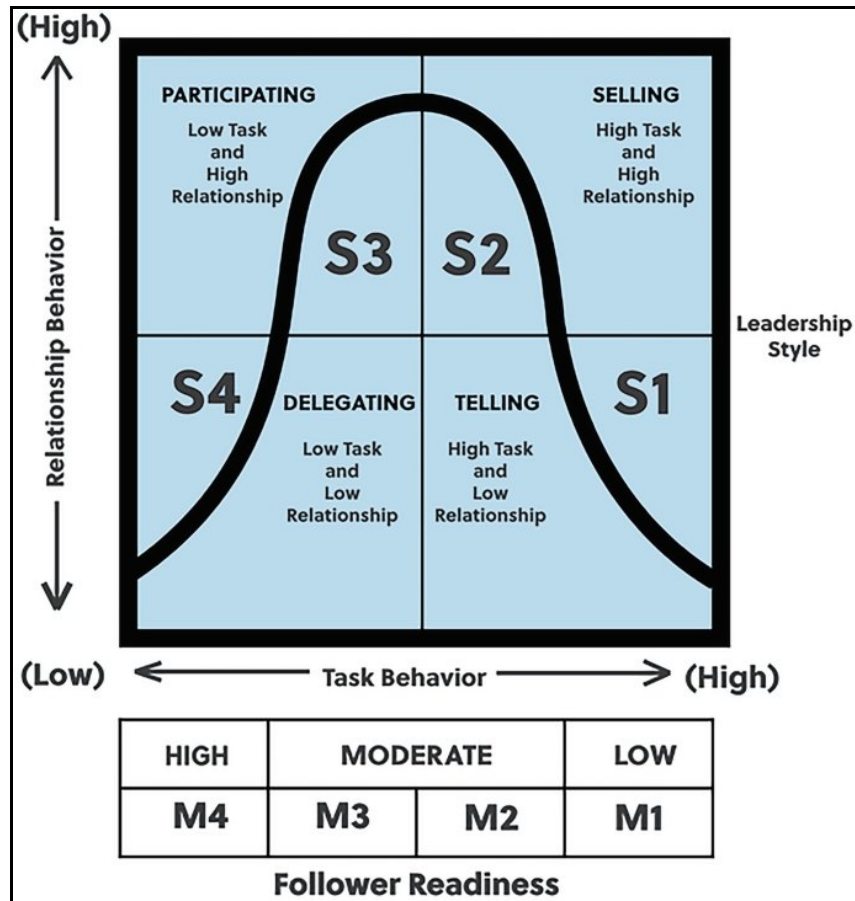


Figure 5: Situational leadership theory

(Source: Zuo, 2023)

The situational leadership proposes that leaders need to adapt their behaviour as per the circumstances, task demands and capability of followers. This theory is applicable as the cases involved a high-risk surgical environment where an apparently routine process became unsafe when patient identity was uncertain. In this regard, Zuo (2023) asserted that the situational leader can identify this issue as a signal to move from routine delegation to a more directive, verification-focused response. Prior anaesthesia and incision, leadership needs to employ confirmation of the patient's identity, intended procedure, clinical records and consent with immediate escalation when discrepancies occur. The scale of surgical risk enhances this argument such as Romaniello et al. (2025) reported that more than 300 million surgical processes occur globally each year and that around 10% of preventable patient harm occurs in surgical settings. Therefore, leaders cannot treat identification as an administrative formality.

The situational leadership could have enabled the theatre team to stop the process when the patient's identity was not established in this case study. However, their effectiveness depends on leaders accurately recognising risk and staff understanding when escalation is needed. This needs clear protocols rather than depending only on the individual decision-making process.

- **Transactional leadership**



Figure 6: Transactional leadership theory

(Source: The Decision Lab, 2025)

The transactional leadership focuses on refined responsibilities, compliance, monitoring and corrective action (Khairy et al., 2023). This is highly relevant to this incident because patient identification needs consistent adherence to established safety procedures instead of discretionary interpretations. The strong transactional controls could have needed staff to document two or more identifiers, reconcile the patient's identity with the operating list to

confirm the procedure before anaesthesia in this case study which are justified because patient misidentifications reports. However, Oswald et al. (2022) claimed that the transactional leadership may show the checklist compliance without making an organisational culture where staff feel confident challenging unsafe practice. Likewise, this leadership style can complement transformational and distributed leadership both to make proper decisions in patient safety. This distinction is significant as procedural compliance can exist without authentic safety awareness.

- **Distributed or Shared leadership**



Figure 7: Distributed or Shared leadership theory

(Source: Bérubé, 2025)

The distributed or shared leadership is highly relevant to the case study as preventing wrong-patient procedures need collective responsibility across the surgical team rather than reliance on one senior decision-maker. The elderly patient was mistakenly taken to theatre after responding to a similar name describing the way multiple opportunities for verification were missed in the incident. The shared leadership would enable nurses, surgeons, anaesthetists

and theatre personnel to participate actively in identity verification and challenge decisions when inconsistencies arise. Regarding this Curşeu et al. (2025), the acute healthcare teams are supportive by indicating high-performing teams demonstrated high shared leadership behaviours. Furthermore, Patil et al. (2023) opined that psychological safety and situational awareness supported safe teamwork as well. Thus, applying shared leadership could make several independent opportunities to identify the identity error before anaesthesia or incision. However, shared leadership needs defined accountability without clear responsibilities and distributed authority may produce ambiguity rather than safety.

Critical evaluation of the preferred approach in application to the case scenario

The distributed leadership is the preferred approach as the Kota Medical College Hospital incident resulted from a failure to challenge an incorrect patient-procedure match. The approach would distribute responsibility for identity verification across the nurses, surgeons, anaesthetists and theatre staff to make multiple opportunities to identify the error before surgery. The evidence supported the application of high-performing acute healthcare teams describing stronger shared-leadership behaviours including situational awareness, psychological safety and shared mental models. However, distributed leadership cannot operate effectively without defined accountability. The case describes that distributing authority may enhance risk when staff assume someone else has completed verification. Thus, the preferred approach needs to combine shared leadership with mandatory identification protocols, clear escalation responsibilities and an empowered speaking-up culture. This would make leadership proactive rather than reactive to reduce reliance on individual assumptions.

d. Improvement and Lessons Learned

Critical Evaluation of the Leadership and Governance Interaction using CATWOE Framework

Element	Application to the Kota Case
Customers	The patient mistakenly operated (Jagdish) on and his son (Manish) and family members are the direct victims of the incident

	Others patients and their family members
Actors	Nurses, anaesthetists, surgeons and ward staff responsible for calling, verifying and preparing patients
Transformation	Converting a scheduled surgical request into a correctly identified, safely consented surgical intervention
Worldview	The assumption that verbal name-calling was a sufficient safeguard for identifying patients before surgery
Owners	The Hospital Principal and Medical Superintendent
Environmental Constrains	- Staff shortages - Absent digital identification infrastructure - Weak state-level governance oversight

Table 1:CATWOE framework

(Source: Self-developed)

The CATWOE framework shown in table 1, reflects how leadership and governance interacted for generating the focused incident at Kota Medical College Hospital. The affected patient who mistakenly operated and his son has been identified as the **customers**. The customers are dependent on the **actors** (Nurses, anaesthetists, surgeons and ward staff) who operate within the **worldview** that verbal identifications are adequate within a critical hospital setting, projecting weak governance oversight. As per Sankaran (2025) soft-systems tend to methodologically demonstrate a mismatched worldview between the frontline actors and system owners, producing a sudden safety failure. This insight relates to the case scenario of Kota Medical College Hospital, where the **owner** or the hospital leadership is not able to enforce independence verification of patients despite knowing the critical risks within a high volume public hospital (India Today, 2025). Additionally, poor **environmental** constraints in the form of

personnel shortage and lack of digitisation made it difficult for the Actors to adhere to the more secure identification processes. In effect, governance structures were not able to match up to the **transformation** process, and as a result, the process relied on individual vigilance rather than a systemic structure. Hence, the CATWOE analysis indicates that the situation arose due to a governance mismatch at the hospitals.

Missed Opportunities and Evidence-based solutions

Several missed opportunities have preceded the focused incident at Kota Medical College Hospital. The problem and improvement opportunities are discussed as follows

Missed opportunity 1

Problem: The absence of technology supported patient identification system and the use of verbal name calling as the only patient verification method

Data: The WHO Global Patient Safety Report 2024 revealed that misidentification is a common adverse event in terms of patient safety. As per the report every year 134 million adverse events occur in the low and middle income countries which contributed to around 2.6 million deaths (WHO, 2024).

Improvement: The implementation of mandatory barcode or wristband scanning linked to electronic records at every stage of the patient movement can critically reduce issues related to patient identification.

Missed opportunity 2:

Problem: Inconsistent and inefficient application of WHO Surgical Safety Checklist sign-in stage, which requires explicit identity confirmation before anaesthesia.

Data: Kamal et al. (2025) revealed an increase in checklist compliance from 58.36% to 78.05% following a specific training programme, even though the checklist was mandatory due to its national implementation under India's Patient Safety Implementation Framework.

Improvement: Conduction of mandatory audit of checklists and training based on simulations for all perioperative team members.

Missed Opportunity 3

Problem: Lack of institutional accountability for verification errors in a hierarchical structure.

Data: There were 12 deaths related to medical negligence reported by the Rajasthan government during 2023-2025, with verification errors at SMS Hospital of Jaipur leading to disciplinary actions against 34 staff members (Medical Dialogues, 2026).

Improvement: Implement a non-punitive reporting system and give autonomy to theatre teams to stop operations in case of uncertainty about patient identification.

Relationships Between Systems Structure, Leadership Style, and Feedback

In the focused case scenario of Kota Medical College Hospital, structure, leadership style, and the system of feedback has been found intricately interconnected. The highly centralised hierarchical structure of the organization hindered free feedback by junior members of the team about the use of verification procedures that were considered unsafe. This led to transactional leadership being practiced in the organisation, which emphasised task completion rather than safety culture, thus encouraging compliance with the procedure without any further inquiry (Rafi and Risky, 2026). This interconnectedness of these factors resulted in the lack of feedback systems, such as incident reporting, until an error was committed.

Lesson Learned from the Case

The case presents several transferable lessons about patient safety in healthcare organisations apart from Kota Medical College Hospital. Apart from this, verbal identification is not enough, especially for vulnerable patients who do not have a chance to express themselves, and has to be substituted with more reliable verification based on technology. According to Abosheisha et al. (2025) wrong-patient and wrong-site errors keep occurring in NHS trusts after years of implementation of national standards. This reflects that only policy formation is not enough rather ground level implementation needs to provide specific emphasis. This relates to Kota, where written protocols existed but were not consistently practised at the frontline.

The use of Evidence and Data to ensure continuous improvement and accountability

It has been recognised that data and evidence is indispensable in promoting continuous

improvement and accountability in health organisations. As per Bowman et al. (2023) hospitals need to systematically collect and analyse data and incidents, like the NHS Never Events reporting process for detecting patterns. Thus, the effective use of evidence and data can ensure the continuous improvement within a healthcare setting, while establishing accountability.

Recommendation

Recommendation for Patient Identification and Verification Technology

One of the biggest challenges at Kota Medical College Hospital is the lack of proper and secure patient identification technology. It has been recognised that the Healthcare Safety Investigation Branch (HSIB) has identified verbal communication as an unreliable identification method for vulnerable or non-verbal patients (HSSIB, 2024). Leeds Teaching Hospitals NHS Trust in the UK has faced similar challenges and deployed GS1-standard barcode wristbands on all patients (GS1 UK, 2023). This initiative helps to minimise identification errors and staff confidence in confirming identities prior to procedures, treatment, and transfers. The mandatory introduction of wristband barcoding for every admitted patient, mainly among those who are unable to communicate by themselves, can be implemented at Kota Medical College Hospital in association with the electronic records. Additionally, scanning needs to be practiced at ward transfer, anaesthetic and surgical sign-in, which need not be only verbal names being called. This solution can directly prevent the April 2025 incident, which was caused by the failure to identify the patient verbally. Therefore, the implementation of barcode verification, based on best practice in the UK, would significantly enhance patient safety and minimise the risk of patient identification error again in the hospital.

Recommendation for Accountability and Incident-Reporting Culture

The second challenge is related to the hospital's centralised structure and the culture of fear that leads to under-reporting of incidents. According to Kumah (2025), punitive reporting environments result in a decrease in staff willingness to report near-miss incidents and concerns about safety. The Civil Aviation Authority (CAA) in the UK supports the principles of a Just Culture by promoting open reporting of safety information without the risk of disproportionate punishment (UKCAA, 2025). UK government has taken this approach of open

reporting of safety information and developed its own Just Culture guide, which aims to strike a balance between individual accountability and learning (NHS England, 2024). Therefore, there is a need for Kota Medical College Hospital to have a formal and non-punitive system of reporting incidents that is backed by a commitment of senior leadership and then reviewed on a regular basis by the governance. Furthermore, staff need to know the difference between system-level failure and the fault of individual employees and therefore need to be trained so that there is fairness and consistency in accountability. The recommendation is given because there is no one responsible with clearly identifiable accountability in this case, when the patient's identity was not disclosed by any responsible party. Altogether, introducing a just culture, as adopted in aviation and in the NHS, would bolster governance, foster transparency, and promote continual enhancement of safety throughout the hospital.

Recommendation for Communication and Team Situation Awareness

A third challenge is associated with a lack of communication and poor situational awareness between theatre staff during handover within the hospital. This challenge is supported by evidence of the significant reduction of technical and informational errors in high-risk transfers with structured communication. Great Ormond Hospital In the UK worked with McLaren Racing to streamline the process of handing over care to patients through structured roles, checklists, and leadership during transfers (YourHeartCheck 2025). The result of this partnership was a significant decrease in the number of errors caused by the handover, highlighting the importance of proper and practiced communication procedures. Therefore, structured handover and sign-in procedures need to be introduced at Kota Medical College Hospital, where the patients' identity need to be clearly confirmed verbally by two separate staff members. Additionally, simulation training need to be implemented to enhance situational awareness of the operating room staff, as used in Great Ormond Street Hospital. This recommendation directly addresses the communication breakdown that enabled an unrelated patient to be taken to theatre without any questions. Therefore, the use of structured, rehearsed communication techniques, based on successful UK models, will significantly minimise the risk of future patient handover identification errors.

Conclusion

In this case study, the patient misidentification incident at Kota Medical College Hospital in

Rajasthan is analysed in detail on 12 April, 2025. The analysis showed that it was due to a mix of poor accountability, lack of identification technology, and a centralized governance system that an elderly patient who was elderly, and didn't speak English and was not verbally adequate and went through an unplanned surgical procedure. This finding supports the systemic issue and without showing an organisational failure, with the Kota incident. The CATWOE analysis also showed a mismatch between the front-line worldview and the hospital ownership responsibilities was a direct cause of the failure to practice safely. Apart from this, Situational Leadership in health and social care helps to adapt management behaviour dynamically based on team competence and task complexity. Apart from this, surgical errors as well as patient misidentifications are recognised as widespread constraints across the global healthcare systems.

The recommendations, such as the use of barcodes for identification, a 'just culture' approach and structured communication between handoffs, are rooted in proven UK practice and academic evidence. Importantly, leadership style emerged as a key element during this analysis, as it discouraged open feedback and delayed error recognition, especially within a transactional and hierarchical structure. Governance arrangements were also strengthened in terms of the ownership of verification processes and safety outcomes. Additionally, the systems thinking approach demonstrated the interdependencies between technology, culture, and communication, and thus, isolated interventions in any of these areas would be unlikely to achieve success if they were not coordinated with organisational change. Hence, sustainable improvement in Kota Medical College Hospital depends on investment in three areas: Leadership, Governance clarity, and evidence-based safety systems. Finally, this case exemplifies the shortcomings of any single individual's responsibility for patient safety in complex healthcare environments. In contrast, leadership and governance need to collaborate in order to design processes that are resilient and can prevent predictable, preventable errors. This holistic approach is essential for healthcare systems in India and the world to ensure that patients receive safe, accurate, and effective care.

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