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1. Introduction

Patient safety incidents at healthcare organisations are often indicative of flaws in leadership, communication, and safety management systems. The following report discusses the safety issue in the form of a patient identification mistake at Kota Medical College Hospital, where an elderly male patient was erroneously admitted to the operating theatre and went through the wrong procedure in response to a person with a similar name being called. This patient safety issue took place when the patient was waiting for his son's operation, and the inability to conduct standard verification procedures resulted in such a patient safety incident (SCMP, 2025).



Figure 1. Kota Medical College

(SCMP, 2025)

Healthcare leadership may be described as the ability to influence, organise, and facilitate healthcare professionals to accomplish safe, quality, and patient-centered outcomes (Miralrio and Tuka, 2025). In other words, healthcare leadership goes further than routine organisational processes in that it fosters accountability, teamwork, ethical decisions, and improvements in healthcare settings. Good leadership is a prerequisite of creating a safety culture where all employees are motivated to adhere to procedures and reduce harm (Bhuyan and Broom, 2025).

Centralisation and decentralisation play crucial roles in decision-making in organisations. Centralisation entails that decisions are made by top-level management and thus can foster

consistency and standardisation. Decentralisation involves sharing of decision-making processes across different levels of management and hence allows for more autonomy of front-line health professionals (Sapkota *et al.*, 2023).

In this report, the situation will be critically analysed using the system thinking approach and the application of transformational, transactional, and situational leadership theories. The transformational leadership theory will be applied in the analysis of the development of patient safety culture, transactional leadership in the implementation of safety protocols while situational leadership will be applied in responding to the critical events as they arise.

2. Main Body

2a. Determining the Problem Using Systems Thinking

2a.1 Description of the Core Patient Safety Problem

The main patient safety problem found in the Kota Medical College Hospital is that there has been a failure in patient identification systems, leading to the wrong patient being admitted in the operating room and having an incorrect surgical procedure done. In this regard, as stated by the South China Morning Post (2025), an elderly man, who was waiting for his son's surgery, answered the call for another person with the same name and was taken in for surgery without going through proper identity verification processes and other pre-surgery processes.

While the initial cause of the problem may seem to be human error, the incident can be explained with a system thinking approach that the problem occurred due to several system failures rather than the actions of just one person. Lack of identity verification, poor communication among healthcare workers, and failure of safety barriers point towards problems with clinical governance and organisational processes. In this regard, the World Health Organization (2023) notes that patient harm usually occurs due to system-related causes, such as poor communication and process design.

2a.2 Evidence of Patient Safety Problem Globally and Nationally

There is a patient safety problem in health care organisations worldwide as the WHO (2023) reports that one in ten patients experience harm during health care delivery and that more than half of these incidents are preventable. Moreover, unsafe care results in more than 3 million deaths each year, illustrating the seriousness of this problem in health care organisations.

Operating theatres are one such hazardous environment because there is a great deal of complexity, a number of different healthcare practitioners involved and fast decision making processes involved. The WHO (2010) illustrated the necessity for structured interventions on the issue by carrying out a global surgical checklist study in which 7,688 patients were involved in 8 countries. After the introduction of the checklist, major surgical complications declined from 11% to 7%, with inpatient deaths following major surgeries declining from 1.5% to 0.8% (WHO, 2010).

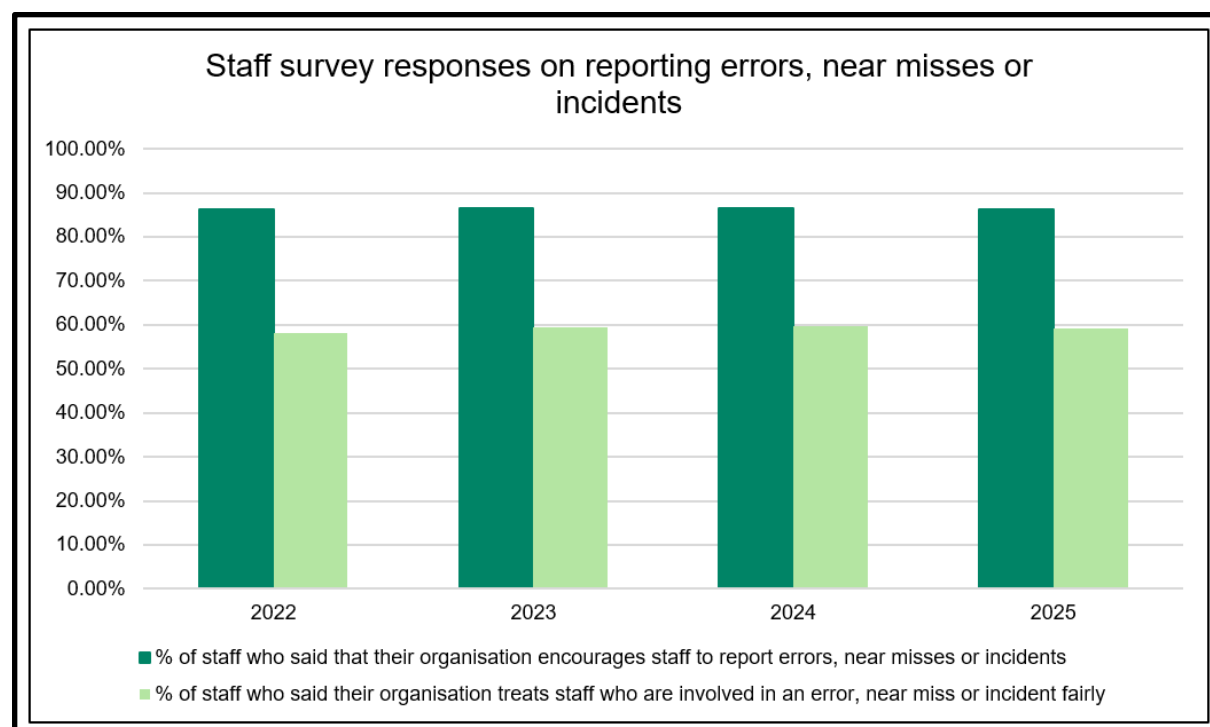


Figure 2. NHS Staff Survey Result

(Source: Patient Safety Learning, 2026)

The workplace environment and communications are among the factors affecting patient safety. The NHS Staff Survey national findings 2025 revealed that 33.71% of NHS staff had seen an error, a near miss or an incident that would have harmed patients or the staff members themselves in the past month (NHS England, 2026). While 86.16% claimed that there was encouragement to report these incidents, only 60.29% felt safe doing so (NHS England, 2026).

Table 1: National and International Evidence Supporting Problem Analysis

Source	Evidence	Relevance to Kota Case

WHO (2023)	1 in 10 patients experience harm during healthcare	Demonstrates the global scale of preventable patient harm
WHO (2023)	Over 3 million deaths annually linked to unsafe care	Highlights urgency of improving healthcare safety systems
WHO (2010)	Surgical checklist reduced complications from 11% to 7% and deaths from 1.5% to 0.8%	Shows effectiveness of structured surgical safety procedures
NHS England (2026)	33.71% of staff witnessed harmful errors, near misses or incidents	Demonstrates continuing safety risks within healthcare organisations
NHS England (2026)	60.29% staff felt safe speaking up about concerns	Indicates challenges with psychological safety and communication
Yadav and Jain (2025)	Indian healthcare faces reporting weaknesses and hierarchical barriers	Provide national relevance to the Kota case

2a.3 Indian Healthcare Context

At the same time, it is important to consider the Kota Medical College Hospital case within the wider framework of the Indian healthcare system, operating in various public and private healthcare settings, characterised by different levels of resource availability, staffing and regulation. While India has increased its healthcare capacity substantially, there persist certain disparities between urban tertiary hospitals and rural healthcare facilities.

As per Chakrabarty (2025), India's doctor-population ratio has risen to one doctor per 811 people, surpassing the World Health Organisation's standard of one doctor per 1,000 people. This national average is indicative of geographical disparities, since the rural and tribal areas still suffer from shortages in healthcare professionals, poor infrastructure, and lack of specialists (Chakrabarty, 2025).

Patient safety concerns in India have also been linked with issues of governance and reporting. According to Yadav and Jain (2025), healthcare safety developments have been hindered by the fragmentation of the regulatory framework, lack of adverse-event reporting and hierarchy that could be discouraging the staff from speaking up about unsafe practices. These are some of the concerns relevant to the Kota case where the front-line healthcare staff failed to disrupt an incorrect patient pathway without the presence of any preparations for surgery.

2a.4 System Weaknesses Identified Through Systems Thinking

Communication Failure

There were significant problems in the communication between the healthcare providers. The patient entered the theatre based on a similar-sounding name which means that verbal confirmation was used as the only method of patient identification. Instead, other approaches could have been used, such as checking a patient's date of birth or identity bracelet. Communication failure is dangerous especially in high-risk environments like operating theatres.

The significance of communication and psychological safety has been shown at NHS England (2026) where 60.29% of healthcare staff members felt safe in reporting their concerns. It means that while reporting mechanisms can be present, some employees in healthcare facilities could feel uneasy reporting on the decisions made by their seniors.

Weaknesses in Clinical Governance and Accountability

The case study reflects the presence of weaknesses in clinical governance since necessary safety procedures were not monitored and controlled properly. According to hospital accreditation standards, safe healthcare practice is characterised by standard operating procedures, auditing, competencies of the staff, and leaders' accountability (Ramayanti Institute of Health Sciences, 2026). The lack of proper monitoring resulted in an easy to detect mistake becoming the cause of serious consequences for the patient.

Training and Competencies of Staff

Continuous education and training of healthcare professionals are needed not only in performing technical aspects of work but also in non-technical skills such as team work, communication, and situational awareness. Employees in this case should have realised warning signs, including the lack of scheduling of the surgery and no pre-surgical preparation of the patient.

2a.5 Description of the Rich Picture

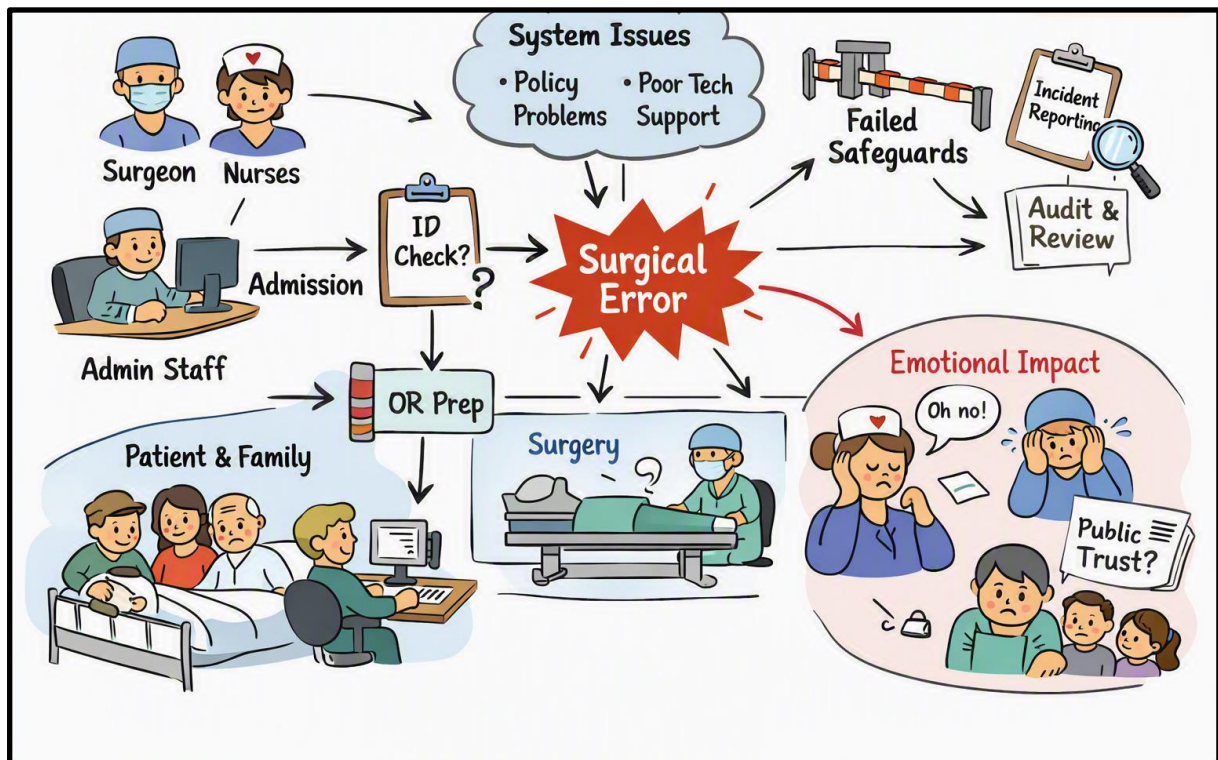


Figure 3. Systemic Factors in Surgical Error

(Source: Self-developed)

The rich picture created for this scenario shows the relationship between the healthcare professionals, organisational structures and safety processes that led to the medical error during surgery. The chart does not point to one individual as being the cause, but rather shows the failure that resulted from the interaction of the elements within the healthcare process.

The main players within the scenario include the surgeons, nurses, administrative staff, the patient and the family members. Each player is an essential part in the surgical chain of events from the patient entering the hospital to the identification and preparation before conducting the operation. Yet, the failure of all these players to validate patient identification together created a failure in safety protection.

Some of the processes involved in this rich picture are the admission process, identity verification process, surgical preparation process and the operating theatre process. All these processes have a role as safety barriers.

Additionally, there are negative emotional impacts such as the fear of patients, stress experienced by health professionals, and reduced public confidence in healthcare services.

Moreover, organisational structures like hierarchical decision making, hospital policies, and lack of technical support also affected staff behavior (Facey *et al.*, 2024).

2b. Analysis of Centralisation and Decentralisation

2b.1 Failure of Centralisation in the Kota Case

Centralisation is a type of organisational structure in which decision-making power is concentrated at higher levels of the organisation, and the responsibility for decision-making is in the hands of senior managers (Facey *et al.*, 2024). The benefits of centralisation are uniformity, because in the field of healthcare, clinical standards should be consistent and used consistently. However, the case of Kota Medical College Hospital shows how excess of hierarchical decision-making can negatively affect the patient's safety when staff members do not feel comfortable criticising.

In this instance, the process of decision-making was extremely reliant on clinical seniors, while the frontline health care staff failed to act despite multiple missed opportunities to ensure safety measures (Sinha *et al.*, 2024). The elderly patient was brought into the operating theater after answering to the same name, without carrying out the basic steps of identification and preoperative checks (South China Morning Post, 2025). In this situation, a stronger decentralised safety culture could have allowed the nurses, technicians and other members of the team to doubt the readiness of the right patient for surgery.

This example represents the authority gradient concept, which implies that the disparities between professionals' statuses prevent the juniors from raising their concerns against seniors. According to Pellegrino *et al.* (2023), the hierarchies existing in surgical settings limit the possibility of open communication and reduce the probability that the safety will be discussed. The presence of the hierarchy in places like operating theaters, where fast communication is critical, may result in continued errors.

The problem, however, was not in centralisation but in the lack of equilibrium between authority and responsibility. Organisations should establish certain safety standards but, in turn, there should be tools that would enable the frontline professional to stop dangerous procedures when they occur (Ebeck, 2022). In the case of Kota, the organisational control was present in the form of the surgery process and expectations of safety but its implementation was ineffective due to the inability of staff to challenge such processes.

2b.2 Benefits and Limitations of Centralisation

There are multiple benefits associated with the use of centralisation in healthcare. They include standardisation of policies, clinical guidelines, safety procedures, among others. For instance, the national and organisational safety protocol for surgical operations enables healthcare providers to have a consistent approach. WHO surgical safety checklist is an example that proves this idea as the international research proved that the implementation of the checklist reduced the rate of major surgical complications from 11% to 7% and reduced inpatient deaths from 1.5% to 0.8% (WHO, 2010).

However, there can be disadvantages associated with centralisation. Firstly, the decision-making process will be slow since the frontline personnel have to seek permission from the higher-ups before doing anything. Secondly, hierarchical organisations discourage autonomy of employees and the fear of questioning authority. This situation poses challenges in patient safety since timely actions are needed to avoid further harm.

2b.3 Decentralisation and Shared Governance

The essence of decentralisation is about sharing decision-making powers between various organisational levels. This way, the frontline personnel will be able to react to the issues emerging in the immediate environment. Decentralised governance allows for shared accountability in the field of health care since nurses, physicians and others take active part in ensuring patient safety instead of being passive listeners of the commands.

In the case of Kota, decentralised decision-making would have helped to avoid the accident since the frontline personnel would be able to intervene in the procedure as soon as the issues emerged. For instance, it could have been asked why the patient was operated on if he was not supposed to be an appropriate surgical candidate, not properly prepared for the operation or underwent identity verification procedures (Ferorelli *et al.*, 2022).

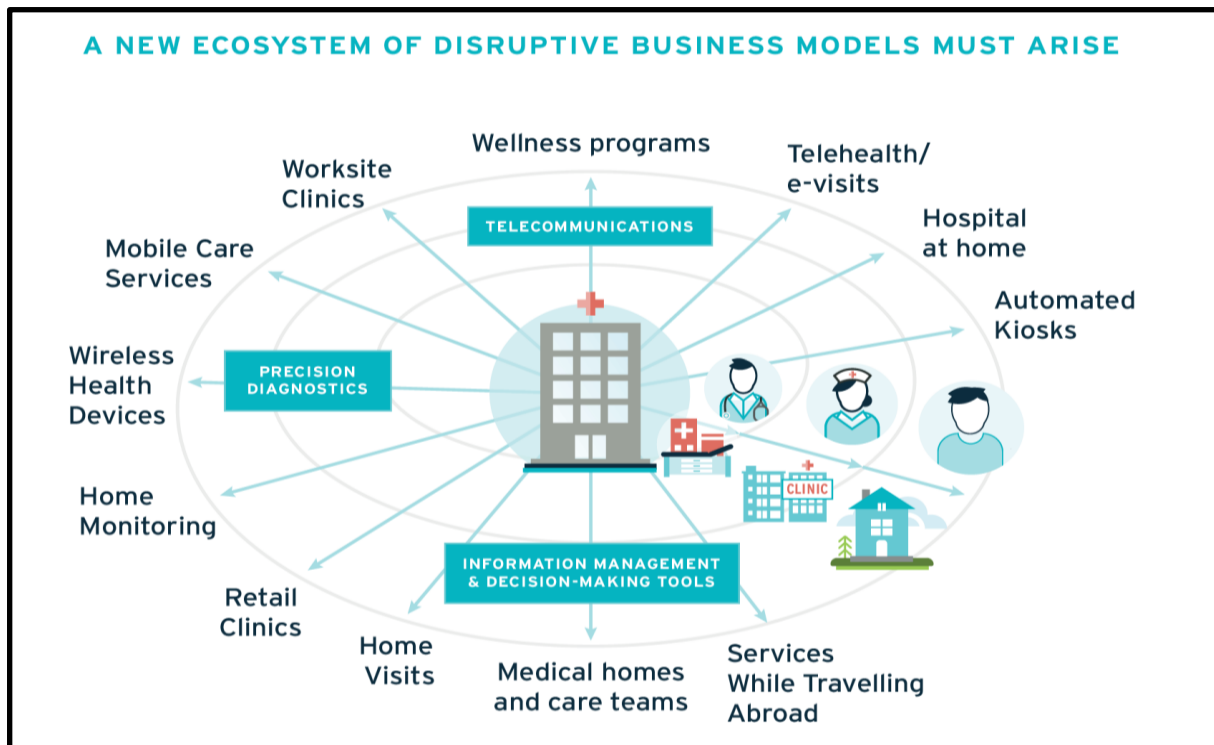


Figure 4. Decentralised Healthcare

(Source: WHO, 2023)

Decentralisation requires, however, the presence of effective leadership, procedures, and psychological safety. Without these elements, decision-making freedom might lead to inconsistency and confusion. NHS England (2026) illustrates this issue in the context of healthcare organisations. Despite the fact that 86.16% of NHS staff confirmed that their organisation encourages error reporting, only 60.29% of them stated that they feel psychologically safe enough to raise concerns. This example shows that organisational policies and practices may differ significantly in healthcare organisations.

2b.4 Balancing Governance: Combination of Centralisation and Decentralisation

The Kota Medical College Hospital case illustrates that a governance model that relies either on total centralisation or decentralisation alone cannot ensure patient safety. To maintain an effective healthcare organisation, it is necessary to implement a governance model that would combine centralised standards and procedures related to patient safety with decentralisation that would empower healthcare professionals. Centralised governance should develop appropriate procedures and monitoring, while decentralised governance is supposed to encourage involvement, professional judgment, and speaking up behavior.

2c. Leadership Theory Application

2c.1 Transformational Leadership

Transformational leadership revolves around the idea of developing a common vision for the organisation and empowering and motivating employees for improvement. Transformational leaders play a critical role in ensuring there is development of a strong culture of patient safety among staff members, whereby employees are aware that the responsibility of patient safety is not personal but a collective one. The type of leadership is very crucial in risky areas such as the operation theaters where teamwork is important (Dougherty *et al.*, 2022).

In the case of Kota Medical College Hospital, there seems to have been a lack of transformational leadership. It is apparent that the organisation was unable to develop a strong patient safety vision whereby patients' safety was the priority in questioning any unsafe practice. Despite having safety policies in place, such policies were not incorporated in the daily behaviors of the organisation. The lack of empowerment made employees feel reluctant to ask whether the right patient had gone to the operation theater (Ohring *et al.*, 2022).

Miralrio and Tuka (2025) emphasise the fact that transformational leadership plays an important role in enhancing the safety culture since it fosters communication, cooperation and engagement of employees. On the other hand, if the level of transformational leadership is poor, there can be a development of a culture within the healthcare organisation wherein employees would just execute orders without really identifying risks. As such, the incident is not only a case of operational deficiency but is also a case of leadership deficiency in fostering an environment where the employees feel psychologically safe to act.

2c.2 Transactional Leadership

Transactional leadership is characterised by structure, compliance, monitoring and the reward or punishment system. There is a great significance of this form of leadership in healthcare because many procedures in healthcare require compliance with procedures including patient identification, surgery checklists and infection control practices (Stroupe, 2022).

Transactional leadership was evident in the Kota case since the health professionals were supposed to conform to the set procedures during surgery. The standardised procedures would ensure that proper identification was carried out before anesthesia and surgery. However, the mistake happened since there was no effective way of enforcing compliance. The staff seemed to be following the operational process of taking a patient to the theatre without wondering if all safety measures had been observed (Yun *et al.*, 2023).

Transactional leadership is important in the maintenance of standard practices but it is not enough when managing health care risks. The patient's safety needs the professionals to identify unforeseen events and address them. In the transactional environment, the staff may just want to complete their task rather than think about the safety implications of their actions.

2c.3 Situational Leadership

Situational leadership is a form of leadership wherein leaders adjust their actions depending on the situation, the complexity of the tasks and the readiness of the team. Situational leadership was clearly absent in the Kota scenario, where leaders apparently failed to understand the riskiness of the surgical setting. A routine approach was done amid many red flags, including the lack of verification and preparation of the patients before the procedure. In such cases, leaders must increase supervision, foster team confirmation and ensure that all safety barriers have been implemented.

Situational leadership in the surgical theatre entails leaders who can quickly evaluate risks, coordinate multidisciplinary teams and use different communication methods depending on how urgent the situation is. Miralrio and Tuka (2025) state that adaptive leadership techniques are necessary in healthcare since clinical settings often entail uncertainties and changes.

2c.4 Behavioral Theory and Tannenbaum-Schmidt Leadership Continuum

Behavioral leadership theories emphasise the activities of leaders instead of the leader's personality. They propose that leadership should combine task-oriented and people-oriented behaviors. Healthcare leaders need to ensure organisational standards and promote communication, teamwork, and engagement of workers (Brennan and Abimbola, 2023).

The Kota scenario demonstrates the extreme task orientation and autocracy on the part of leaders. It seems that the staff concerned more about performing the surgical procedure than discussing the question of whether the right patient is operated on. The Tannenbaum-Schmidt Leadership Continuum assumes that there are different levels of leadership from highly autocratic decision making to the participation of employees in the decision-making process (Hussain *et al.*, 2025).

A shift from the autocratic style to the participative one could positively influence the safety of patients in this case. Participative leaders encourage nurses, doctors, and other healthcare professionals to discuss any problems and make decisions regarding patient safety. Thus, this leadership style ensures psychological safety of workers (Ramirez-GarciaLuna *et al.*, 2022).

The NHS England (2026) Staff Survey illustrates the significance of psychological safety. While 86.16% of NHS staff stated that they work in an organisation that promotes reporting of errors, 60.29% did not feel psychologically safe to raise their concerns.

Table 2: Leadership Theory Application with Examples and Supporting Data

Theory / Model	Application Example	Supporting Data & Critique
Great Man Theory	Senior authority dominated decisions; staff relied on leaders rather than shared responsibility.	Individual leadership cannot replace strong safety systems. WHO (2023) highlights the importance of system-based safety.
Trait Theory	Leaders lacked communication, confidence and safety awareness needed to prevent the error.	Emotional intelligence supports safer teams, but traits alone cannot overcome weak systems.
Behavioural Theory	Leadership focused on completing tasks rather than encouraging teamwork and questioning.	Balanced task and people-focused leadership improves safety and communication (Wong et al., 2018).
Transactional Leadership	Staff followed procedures but failed to verify patient identity effectively.	Rules support consistency but cannot replace proactive problem-solving.
Situational Leadership	Leaders failed to adapt their approach during a high-risk surgical situation.	Adaptive leadership improves coordination and response during healthcare crises (Miralrio and Tuka, 2025).
Tannenbaum-Schmidt Continuum	Leadership remained autocratic with limited staff involvement.	Participative leadership improves psychological safety and speaking-up culture (NHS England, 2026).

Transformational Leadership	No shared safety vision or empowerment of staff existed.	Transformational leadership strengthens safety culture through communication and engagement (Miralrio and Tuka, 2025).
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2d. Critique, Improvements and Lessons Learned

2d.1 Patient Identification Failure

The major issue that took place at the Kota Medical College Hospital was that of patient identification, when the wrong person entered the operating theatre and had an inappropriate procedure performed on him. This can be considered a serious breach of patient safety because the patient identification process is one of the core safety procedures in surgical services. According to South China Morning Post (2025), the elderly patient was operated on because he responded to the similar name being called out in the hospital.



Figure 5. Misidentification of the patient

(Source: South China Morning Post, 2025)

This event proved that the patient's harm was caused by the systemic failures, rather than by any one mistake made by one of the health professionals involved. According to the World

Health Organization (2023), safety problems with patients occur as a result of deficiencies in the health care system including inefficient communication, procedures and the safety culture.

The main strategy for improving situations is the constant application of the WHO Surgical Safety Checklist. As it was found out by the World Health Organization (2010) through the introduction of the list in eight countries the rate of surgical complications was reduced from 11% to 7%, and the rate of in-hospital deaths after surgery fell from 1.5% to 0.8%. Three crucial moments need to be checked in the process: before anesthesia, before incision and before discharge from the operating room (World Health Organization, 2010).

2d.2 Checklist Usage Shortcomings

Even though the checklists have proved to be effective, their effectiveness highly relies on proper implementation (Gul *et al.*, 2022). The Kota case implies that there was negligence on part of healthcare professionals as they neglected or lacked monitoring of all the procedures.

The literature reveals that low team performance, lack of adequate leadership backing and the perception that there is no necessity of using the checklists can decrease compliance (Lim *et al.*, 2023). Thus, it is necessary to implement audits in healthcare organisations to monitor completion of checklists and provide feedback.

Involvement of leadership is crucial since it is much more likely that healthcare professionals will adhere to the safety practices when there is visible commitment shown by the management. Safety culture of an organisation should consider checklists as tools for protecting patients, and not simply formalities (Munthali *et al.*, 2023).

2d.3 Workforce Training and Competency

One more lesson to learn from the incident is the importance of the continuous training of the workforce. In addition to training in technical skills, healthcare professionals should have skills in communication, cooperation and situational awareness.

Simulation training will enable healthcare professionals to prepare for emergencies and make confident decisions regarding tough and potentially unsafe decisions. Training programs need to consider non-technical skills, which include leadership, communication and teamwork (Boroz, 2023).

Yadav and Jain (2025) have noted that the Indian healthcare system is characterised by medical errors, inadequate reporting and hierarchy in workplaces. Thus, along with developing competencies in health care providers, cultural changes that would foster learning culture rather than blame culture should be fostered.

2d.4 Governance and Accreditation Improvement

Effective governance mechanisms are required to ensure that the patient safety standards are constantly upheld (Moyal- Smith *et al.*, 2023). The Kota case study reflects deficiencies in monitoring, accountability and organisational oversight.

Hospital accreditation framework such as NABH considers standard operating procedures, staff competencies, audit and accountability of the leadership as key elements in quality health care (Ramayanti Institute of Health Sciences, 2026). Application of effective accreditation standards may help the hospitals detect weak spots prior to the occurrence of adverse events.

2d.5 Technology Based Interventions

Introducing further safety barriers through technology reduces the dependence on the manual process. For instance, electronic health records, patient identification using barcodes, and verification using digital processes can considerably lower the possibility of procedures done on the wrong patient (Fana and Mokhele, 2025).

Barcoded systems are required to have healthcare professionals verify their patients electronically before administering medications or carrying out surgeries. The clinical teams and staff members can take better decision and determine risks properly due to the utilisation of Artificial intelligence and predictive analytics (Yang *et al.*, 2022). Technology should only supplement professional expertise and skills. Good implementation requires proper training, funding, and leadership.

2d.6 Key Lessons Learned

The critical learning from the Kota case is that the failure of patient safety should never be considered an individual error. As per the system thinking, it is evident that any failure happens as a result of process, communication, and organisational culture weakness (WHO, 2023).

Governance systems need to be built in healthcare organisations, empowering frontline workers, and developing psychologically safe workplaces that ensure employees feel comfortable raising issues. The NHS England (2026) survey shows that even though many organisations promote reporting, fewer members are willing to speak up, which emphasises the need for intervention from leaders.

A safe health care environment requires the combination of a dependable system and motivated workers. By enhancing identification systems, training people, accreditation standards, and communication, health care organisations will be able to decrease preventable errors and cultivate a culture of patient safety (Gong *et al.*, 2026).

Table 3: Problem–Evidence–Improvement Analysis

Problem Identified	Evidence/Data	Improvement Strategy
Patient misidentification	Wrong patient underwent surgery due to identity failure (South China Morning Post, 2025); WHO checklist reduced surgical complications from 11% to 7% (WHO, 2010)	Two patient identifiers, barcode scanning, mandatory surgical pause and checklist verification
Weak checklist compliance	Poor teamwork and leadership support reduce checklist effectiveness (Lim et al., 2023)	Regular audits, leadership monitoring and staff engagement
Training and competency gaps	Indian healthcare faces medical errors and weak safety reporting cultures (Yadav and Jain, 2025)	Simulation training, communication development and competency assessments
Governance failure	Accreditation requires SOPs, audits and leadership accountability (Ramya Institute of Health Sciences, 2026)	Strengthen incident reporting, audits and accountability systems
Limited technology support	Manual identification increases risk of human error	Implement electronic records, barcode identification and AI-supported risk monitoring

3. Recommendations

3.1 Leadership Recommendations

From the analysis, the case underscores the need to move away from hierarchical leadership and command and control leadership towards transformational and situational leadership style. With transformational leadership, developing a patient safety vision can be enhanced

through empowering the employees, accountability and a culture that encourages employees to speak up about issues related to patients' safety (Neuendorf, 2025). Situational leadership allows the leader to adjust his/her leadership style depending on the risk levels, skills of the employees and urgency of the situation. Combining both transformational and situational leadership will ensure improved responsiveness and safety (Miralrio and Tuka, 2025).

Healthcare leaders are advised to foster a psychological safe environment where healthcare professionals including nurses and junior doctors are encouraged to challenge decisions that go against patients' safety without fearing negative repercussions. From the Kota case study, the lack of questioning the process of identifying patients was a result of communication culture and lack of empowerment among the employees (Gómez-Dos-Santos et al., 2023).

3.2 Governance improvements

Effective governance structures must be developed to make sure that policies for patient safety are implemented properly rather than existing solely as a set of procedures. The case study illustrates a lack of accountability, as important procedures like patient identification and preoperative check have not been performed. It is essential for healthcare institutions to establish mandatory compliance audits, clear responsibility frameworks and reviews of clinical practices (Yuanyuan *et al.*, 2023).

High-risk procedures, especially surgeries, require strict compliance with standardised safety procedures. Monitoring should reveal the lack of compliance on time, so that necessary corrections could be done (Ansari and Darvishi, 2024).

3.3 Communication Improvements

A lack of communication was another key factor of the incident; thus, effective communication systems must be put into place. Huddles, briefings and preoperative time-outs can be introduced on a daily basis (Haque et al., 2024). These activities provide an opportunity for staff to share information and to identify potential risks.

Additionally, closed-loop communication and assertiveness training would have to be conducted in order to make sure that all the staff members, irrespective of hierarchy levels, are able to participate in the process of making safety-related decisions (Neuendorf, 2025).

3.4 Technology and Continuous Learning

Healthcare institutions are supposed to utilise more digital patient safety technology, which includes electronic health records and bar code-based patient identification to mitigate risks related to human errors (Khodavandi et al., 2022). Moreover, artificial intelligence tools could

aid in identifying perioperative risks and supporting the clinical decision-making process in advance (Yang et al., 2022).

Lastly, continuous learning has to be promoted as an essential part of patient safety strategy using such approaches as simulation training, competency assessment, and learning from adverse events.

4. Conclusion

In summary, the evaluation of the Kota Medical College Hospital case revealed that the wrong patient procedure is caused by multiple system failures and not just an individual error. The incident highlights issues with patient identification, communication, safety procedures and organisational oversight, and there is a need for more system-wide improvements to increase patient safety and avoid similar patient safety incidents. From this evaluation, gaps were noted in the areas of leadership, governance, communication process, and the safety culture. In this case, there was a very hierarchical environment that did not empower employees, while poor verification procedures made critical safety barriers fail.

From the systems theory, one learns that patient harm happens due to the interplay between people, processes, and organisational structures. As part of a systems theory approach, one learns that health care failures are rarely due to individual incidents, but are instead due to failures in processes, communications, technology, and human factors that are interconnected. This underscores the need to overcome system weaknesses and enhance patient safety and prevent future incidents. Consequently, the only way for continuous improvement is not to blame individuals after any mistakes have happened. This implies that health institutions should work on strengthening their transformational leadership, governance, communicate effectively, and adopt technological safety solutions.

References

- Ansari, M. and Darvishi, A., 2024. A review of the current state of natural biomaterials in wound healing applications. *Frontiers in bioengineering and biotechnology*, 12, p.1309541. <https://www.frontiersin.org/journals/bioengineering-and-biotechnology/articles/10.3389/fbioe.2024.1309541/full>
- Bhuyan, S.S. and Broom, K.D. eds., 2025. *Fundamentals of Healthcare Management: Theory and Practice*. Springer Publishing.
- Boroz, S.L., 2023. *Music Listening as an Intervention to Reduce Patient-Perceived Anxiety and Pain During an Outpatient Wound Dressing Change*. William Carey University.
- Brennan, E. and Abimbola, S., 2023. The impact of decentralisation on health systems in fragile and post-conflict countries: a narrative synthesis of six case studies in the Indo-Pacific. *Conflict and Health*, 17(1), p.31. <https://link.springer.com/article/10.1186/s13031-023-00528-7>
- Chakrabarty, R. (2025) 'India's 1:811 doctor ratio is great on paper. But rural reality is another story', *India Today*, 4 December. Available at: <https://www.indiatoday.in> (Accessed on 04.08.26).
- Dougherty, S., Lorenzoni, L., Marino, A. and Murtin, F., 2022. The impact of decentralisation on the performance of health care systems: a non-linear relationship. *The European Journal of Health Economics*, 23(4), pp.705-715. <https://link.springer.com/article/10.1007/s10198-021-01390-1>
- Ebeck, L., 2022. Surgical safety checklists from concept to implementation. *The Veterinary Nurse*, 13(2), pp.83-88. <https://www.magonlinelibrary.com/doi/abs/10.12968/vetn.2022.13.2.83>
- Facey, M., Baxter, N., Hammond Mobilio, M., Peter, E., Moulton, C.A. and Paradis, E., 2024. Surgical safety checklist compliance process as a moral hazard: An institutional ethnography. *Plos one*, 19(2), p.e0298224. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0298224>
- Fana, T. and Mokhele, M.O., 2025. Centralisation of financial decision-making on public hospitals in the Eastern Cape province. *Africa's Public Service Delivery and Performance Review*, 13(1), p.827. <https://journals.co.za/doi/abs/10.4102/apsdpr.v13i1.827>

Ferorelli, D., Benevento, M., Vimercati, L., Spagnolo, L., De Maria, L., Caputi, A., Zotti, F., Mandarelli, G., Dell'Erba, A. and Solarino, B., 2022. Improving healthcare workers' adherence to surgical safety checklist: the impact of a short training. *Frontiers in Public Health*, 9, p.732707.

<https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2021.732707/full>

Gómez-Dos-Santos, V., López-Plaza, J.A., Molina-Villar, J.M., Blázquez-Hernando, L., Díez-Nicolás, V., Jiménez-Cidre, M., Porrero-Guerrero, B., Rodríguez-Patrón, R., Arias-Fúnez, F., Muriel-García, A. and Fernández-Cebrián, J.M., 2023. Prevention of incisional hernia after kidney transplantation: study protocol for a randomized controlled trial. *Trials*, 24(1), p.528.

<https://link.springer.com/article/10.1186/s13063-023-07545-0>

Gong, Q., Zhang, Y. and Wang, J., 2026. The Application of Risk Care in the Treatment of Complex Renal Calculi with Minimally Invasive Surgery. *International Journal of Clinical and Experimental Medicine Research*, 10(1). <https://www.hillpublisher.com/ArticleDetails/6119>

Gul, F., Nazir, M., Abbas, K., Khan, A.A., Malick, D.S., Khan, H., Kazmi, S.N.H. and Naseem, A.O., 2022. Surgical safety checklist compliance: The clinical audit. *Annals of Medicine and Surgery*, 81, p.104397.

<https://www.sciencedirect.com/science/article/pii/S2049080122011578>

Haque, M.A., Begum, M.M.M., Rahman, M.S. and Hasan, H., 2024. Complications of Arteriovenous Fistula Surgery: A Comprehensive Study in Bangladesh. *TAJ: Journal of Teachers Association*, 37(2), pp.87-97. <https://tajrmc.com/taj/article/view/115>

Hussain, Z., Ambareen, A., Rashid, N.U.A., Raza, A., Anwar, S., Minhas, M., Qureshi, S., Sana, M. and Zara, K., 2025. Insights Into the Assessment of WHO-Recommended Practices Based on Surgical Operations in Tertiary Healthcare Settings. *Cureus*, 17(4). https://assets.cureus.com/uploads/original_article/pdf/363613/20250529-60030-nvqey.pdf

Khodavandi, M., Kakemam, E., Ghasemyani, S. and Khodayari-Zarnaq, R., 2022. Barriers and facilitators of implementing WHO safe surgery checklist: a cross-sectional study in public hospitals of Iran. <https://www.sid.ir/paper/1002614/en>

Lim, P.J.H., Chen, L., Siow, S. and Lim, S.H., 2023. Facilitators and barriers to the implementation of surgical safety checklist: an integrative review. *International Journal for*

Quality in Health Care, 35(4), p.mzad086.
<https://academic.oup.com/intqhc/article/35/4/mzad086/7319718>

Miralrio, H. and Tuka, K., 2025. Leadership Strategies for Robotic Surgery Adoption: A Case Study of Oslo University Hospital.

Moyal-Smith, R., Etheridge, J.C., Lim, S.R., Sonnay, Y., Tan, H.K., Yong, T.T., Havens, J.M. and Brindle, M.E., 2023. Creating a high-performance surgical safety checklist: A multimodal evaluation plan to reinvigorate the checklist. *Journal of Evaluation in Clinical Practice*, 29(2), pp.341-350. <https://onlinelibrary.wiley.com/doi/abs/10.1111/jep.13778>

Munthali, J., Pittalis, C., Bijlmakers, L., Kachimba, J., Cheelo, M., Brugha, R. and Gajewski, J., 2022. Barriers and enablers to utilisation of the WHO surgical safety checklist at the university teaching hospital in Lusaka, Zambia: a qualitative study. *BMC health services research*, 22(1), p.894. <https://link.springer.com/article/10.1186/s12913-022-08257-y>

Neuendorf, K.D., 2025. Ultrasound Guided Cannulation in Hemodialysis Patients for Difficult Intravenous (Doctoral dissertation, Grand Canyon University). <https://www.proquest.com/openview/e9e04f57399ca69622f4d28b0596f3b6/1?pq-origsite=gscholar&cbl=18750&diss=y>

NHS England (2026) *NHS Staff Survey national results 2025*. 12 March. Available at: <https://www.nhsstaffsurveys.com/results/national-results/> (Accessed on 04.08.2026).

Ohrling, M., Tolf, S., Solberg-Carlsson, K. and Brommels, M., 2022. Managers do it their way: How managers act in a decentralised healthcare services provider organisation—a mixed methods study. *Health Services Management Research*, 35(4), pp.215-228. <https://journals.sagepub.com/doi/abs/10.1177/09514848211065467>

Patient Safety Learning (2026) *Our response to the NHS Staff Survey Results 2025*. Available at: <https://www.patientsafetylearning.org/blog/our-response-to-the-nhs-staff-survey-results-2025> (Accessed on 04.08.26).

Pellegrino, A.A., Chen, G., Morgantini, L., Calvo, R.S. and Crivellaro, S., 2023. Simplifying retroperitoneal robotic single-port surgery: novel supine anterior retroperitoneal access. *European Urology*, 84(2), pp.223-228. <https://www.sciencedirect.com/science/article/abs/pii/S0302283823028117>

Ramirez-GarciaLuna, J.L., Bartlett, R., Arriaga-Caballero, J.E., Fraser, R.D. and Saiko, G., 2022. Infrared thermography in wound care, surgery, and sports medicine: a review. *Frontiers in physiology*, 13, p.838528.

<https://www.frontiersin.org/journals/physiology/articles/10.3389/fphys.2022.838528/full>

Ramsay, A.I., Ramsay, A., Tomini, S.M., Tomini, S., Gandhi, S., Fulop, N.J., Fulop, N. and Morris, S., 2025. Centralisation of specialised healthcare services: a scoping review of definitions, types, and impact on outcomes. *Health and Social Care Delivery Research*, (43), pp.1-70. <https://journalslibrary.nihr.ac.uk/hsdr/published-articles/REMD6648>

Ramyanti Institute of Health Sciences (2026) *Hospital Accreditation and Quality Standards in India*. Available at: <https://rihsedu.com/hospital-accreditation-and-quality-standards-in-india/> (Accessed on 04.08.26).

Sapkota, S., Dhakal, A., Rushton, S., van Teijlingen, E., Marahatta, S.B., Balen, J. and Lee, A.C., 2023. The impact of decentralisation on health systems: a systematic review of reviews. *BMJ Global Health*, 8(12). <https://gh.bmj.com/content/8/12/e013317>

Sinha, S.D., Sriramadasu, S.C., Raphael, R. and Roy, S., 2024. Decentralisation in clinical trials and patient centricity: benefits and challenges. *Pharmaceutical Medicine*, 38(2), pp.109-120. <https://link.springer.com/article/10.1007/s40290-024-00518-x>

South China Morning Post (2025) Indian hospital probed after man mistakenly operated on while waiting on son's surgery. Available at: <https://www.scmp.com/week-asia/health-environment/article/3307457/indian-hospital-probed-after-man-mistakenly-operated-while-waiting-sons-surgery> [Accessed on 04.08.26].

Stroupe, J., 2022. Prevention of Infection During Hemodialysis Treatment Initiation. <https://digitalcommons.gardner-webb.edu/nursing-msn/50/>

World Health Organization (2010) *Checklist helps reduce surgical complications, deaths*. 11 December. Available at: <https://www.who.int/news/item/11-12-2010-checklist-helps-reduce-surgical-complications-deaths> (Accessed on 04.08.26).

World Health Organization (2023) Patient safety. Available at: <https://www.who.int/news-room/fact-sheets/detail/patient-safety> (Accessed on 04.08.26).

Yadav, A.K. and Jain, A. (2025) 'Review on Patient Safety in Healthcare Sector in India', *International Journal for Multidisciplinary Research (IJFMR)*, 7(4), pp. 1–3. Available at: <https://www.ijfmr.com> (Accessed on 04.08.26).

Yang, B., Gao, L., Wang, X., Wei, J., Xia, B., Liu, X. and Zheng, P., 2022. Application of supervised machine learning algorithms to predict the risk of hidden blood loss during the perioperative period in thoracolumbar burst fracture patients complicated with neurological compromise. *Frontiers in Public Health*, 10, p.969919. <https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2022.969919/full>

Yuanyuan, Z., Xiaohe, W., Zhen, L. and Guocun, H., 2022. Creating radio-cephalic arteriovenous fistula in the forearm with a modified no-touch technique. *JoVE (Journal of Visualized Experiments)*, (182), p.e62784. <https://www.jove.com/t/62784/creating-radio-cephalic-arteriovenous-fistula-forearm-with-modified>

Yun, S.S., Mok, S., Park, S.C., Park, Y.J. and Kim, J.Y., 2023. Efficacy of blood flow measurement using intraoperative color flow Doppler ultrasound as a predictor of autologous arteriovenous fistula maturation. *Therapeutic Apheresis and Dialysis*, 27(1), pp.50-58. <https://onlinelibrary.wiley.com/doi/abs/10.1111/1744-9987.13855>