



Case study analysis Report

Case study Number 3: At Kota Medical College Hospital
(Rajasthan, India)

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Student Name – Noman Vajoddin Malek

Student id - 2522651

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1 Introduction

At Kota Medical College Hospital (Rajasthan, India) on 12 April 2025, an elderly man awaiting his son's surgery was mistakenly taken to the operating theatre, anaesthetized and given an incision for a dialysis fistula procedure intended for another patient. Surgical errors, particularly wrong-patient, wrong-site, and wrong-procedure incidents, are among the most serious and preventable mistakes in healthcare. These "never events" have profound consequences for patients, healthcare providers, and the institutions where they occur. The incident at Kota Medical College Hospital in Rajasthan, India, on April 12, 2025, provides a sobering example of how systemic failures can result in catastrophic outcomes. In this case, an elderly man was mistakenly taken to the operating theatre and anaesthetized for a dialysis fistula procedure intended for another patient. The error was only identified when the son of the elderly patient, who was undergoing a different surgery, found his father missing from the waiting area. This mix-up occurred due to a failure in patient identification protocols, which allowed for a confusion based on similar-sounding names and led to the elderly man undergoing a surgery he did not need.

Patient identification errors are well-documented in medical literature as a leading cause of wrong-patient incidents (Alvarado et al., 2019). Healthcare systems, particularly in high-pressure environments like busy hospitals, face the risk of these errors when patient verification is done hastily or inadequately. The failure to use multiple identifiers such as name, date of birth, and hospital ID number in conjunction with other safety checks, including the WHO Surgical Safety Checklist, can increase the likelihood of such incidents (Haynes et al., 2009). Moreover, a lack of robust communication between medical staff and patients further exacerbates the risk of misidentification.

The consequences of this mistake extend far beyond the physical harm caused to the patient. The psychological trauma for both the patient and their family, coupled with the legal ramifications for the healthcare institution, is significant. Such errors can erode public trust in healthcare systems, especially when institutions fail to demonstrate accountability and transparency (Mendelson et al., 2016). In this case, the error not only harmed the patient but also risked undermining the reputation of Kota Medical College Hospital, which could face legal consequences for failing to adhere to safety protocols.

Several factors contributed to this incident, including high patient volume, potential staff oversight, and inadequate enforcement of safety procedures. Research has shown that institutions with a culture of safety, where all healthcare workers are trained and encouraged to follow standard safety protocols, experience fewer adverse events (Pronovost et al., 2006). This highlights the importance of improving institutional processes, from staff training and communication to technological interventions like barcode scanning for patient identification, which can prevent such errors from occurring.

This case study will analyze the incident at Kota Medical College Hospital, exploring the systemic issues that led to the error, its impact on patient safety, and the steps that could have been taken to prevent it. Through this analysis, the paper aims to underscore the importance of robust patient safety systems in reducing the occurrence of wrong-patient surgical errors.

2 Main Body and Analysis

2.1 Identifying the Problem and Setting the System

The central problem in this case study is a **wrong-patient surgical procedure** at Kota Medical College Hospital on 12 April 2025. An elderly man who was accompanying his son to hospital was mistakenly taken into the operating theatre, anaesthetized, and given an incision intended for another patient. The incident was only identified when the son finished his own surgery and discovered that his father was missing. This is a serious patient safety failure and can be classified as a preventable “never event” because the error should have been stopped by routine verification processes.

Although the event appears local, it reflects a broader systems issue in healthcare. Wrong-patient and wrong-procedure events remain a recognized global safety problem, particularly where similar names, patient transfers, and weak verification processes are present. Patient identification errors can lead to major harm in surgery, medication, testing, and treatment pathways, showing that this type of incident is not an isolated event but part of a wider patient safety challenge. In this case, the mistake occurred because the patient responded to a similar name and was moved without proper identity confirmation, showing how easily a breakdown at one point in the pathway can escalate into serious harm.

From a systems thinking perspective, the event was caused by several interacting failures rather than a single individual mistake. The first failure was weak patient identification. The second was poor communication between staff during transfer and preoperative preparation. The third was non-compliance with standard safety procedures, including preoperative checks and the time-out process designed to verify the correct patient and procedure before incision. These weaknesses were probably reinforced by contextual pressures such as workload, time pressure, and reliance on assumptions. Patient identification errors are more likely when staff depend on memory, visual recognition, or verbal confirmation instead of structured checks.

The broader healthcare system context also matters. Surgical safety literature shows that wrong-site, wrong-procedure, and wrong-patient events are preventable when organizations use layered safeguards such as preprocedural verification, site marking, and a final team time-out. The WHO Surgical Safety Checklist was introduced to reduce exactly these kinds of failures, yet implementation is often inconsistent when staff are rushed, poorly trained, or unsupported by management. In other words, the existence of a policy does not guarantee safe practice unless the system is designed to make compliance reliable.

A rich picture of this case would show the connected roles and pressures across the hospital system. It would include the patient, his son, nurses, surgeons, anesthetists, ward staff, theatre staff, and managers. It would also map the processes of admission, identity verification, transfer, theatre preparation, anesthesia, and surgery. Around these would sit the organizational structures: protocols, supervision, communication channels, training, and reporting systems. External pressures such as staff shortages, workload, and resource constraints would also be shown because they increase the chance that staff will skip steps or make assumptions. The rich picture would therefore reveal that the incident was not only a clinical mistake but also a breakdown in the flow of information, accountability, and control.

This case can also be understood through the idea of system resilience. A resilient system should be able to absorb human error before it causes harm, using multiple barriers to catch mistakes early. Here, those barriers failed. The wrong patient passed through several stages without being stopped, which suggests that there were too few checks, weak oversight, and insufficient authority for staff to challenge the process. That is why this event should be framed as a system-wide failure rather than an isolated lapse in individual performance.

Governance is another important part of the system context. Effective governance should ensure that national standards are translated into local practice through training, monitoring, and accountability. In this case, the gap between what should have happened and what actually happened suggests weak governance at the hospital level. Even when policies exist, they are ineffective if staff are not trained, supervisors do not check compliance, and there is no strong safety culture encouraging people to speak up. This is consistent with research showing that successful checklist implementation depends on leadership, education, local champions, and audit and feedback systems.

Overall, the incident should be understood as the result of a fragile system in which several small weaknesses aligned to produce a major failure. Poor identity checks, weak communication, inconsistent checklist use, and inadequate governance combined to allow the wrong patient to enter surgery. A systems thinking approach is essential because it shifts the focus from blaming one person to improving the design, reliability, and coordination of the whole healthcare process.

Rich Picture and Systems Thinking

Surgical Safety Checklist



Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?

☐ Yes

Is the site marked?

☐ Yes

☐ Not applicable

Is the anaesthesia machine and medication check complete?

☐ Yes

Is the pulse oximeter on the patient and functioning?

☐ Yes

Does the patient have a:

Known allergy?

☐ No

☐ Yes

Difficult airway or aspiration risk?

☐ No

☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?

☐ No

☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

☐ **Confirm all team members have introduced themselves by name and role.**

☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?

☐ Yes

☐ Not applicable

Anticipated Critical Events

To Surgeon:

☐ What are the critical or non-routine steps?

☐ How long will the case take?

☐ What is the anticipated blood loss?

To Anaesthetist:

☐ Are there any patient-specific concerns?

To Nursing Team:

☐ Has sterility (including indicator results) been confirmed?

☐ Are there equipment issues or any concerns?

Is essential imaging displayed?

☐ Yes

☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:

☐ The name of the procedure

☐ Completion of instrument, sponge and needle counts

☐ Specimen labelling (read specimen labels aloud, including patient name)

☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:

☐ What are the key concerns for recovery and management of this patient?

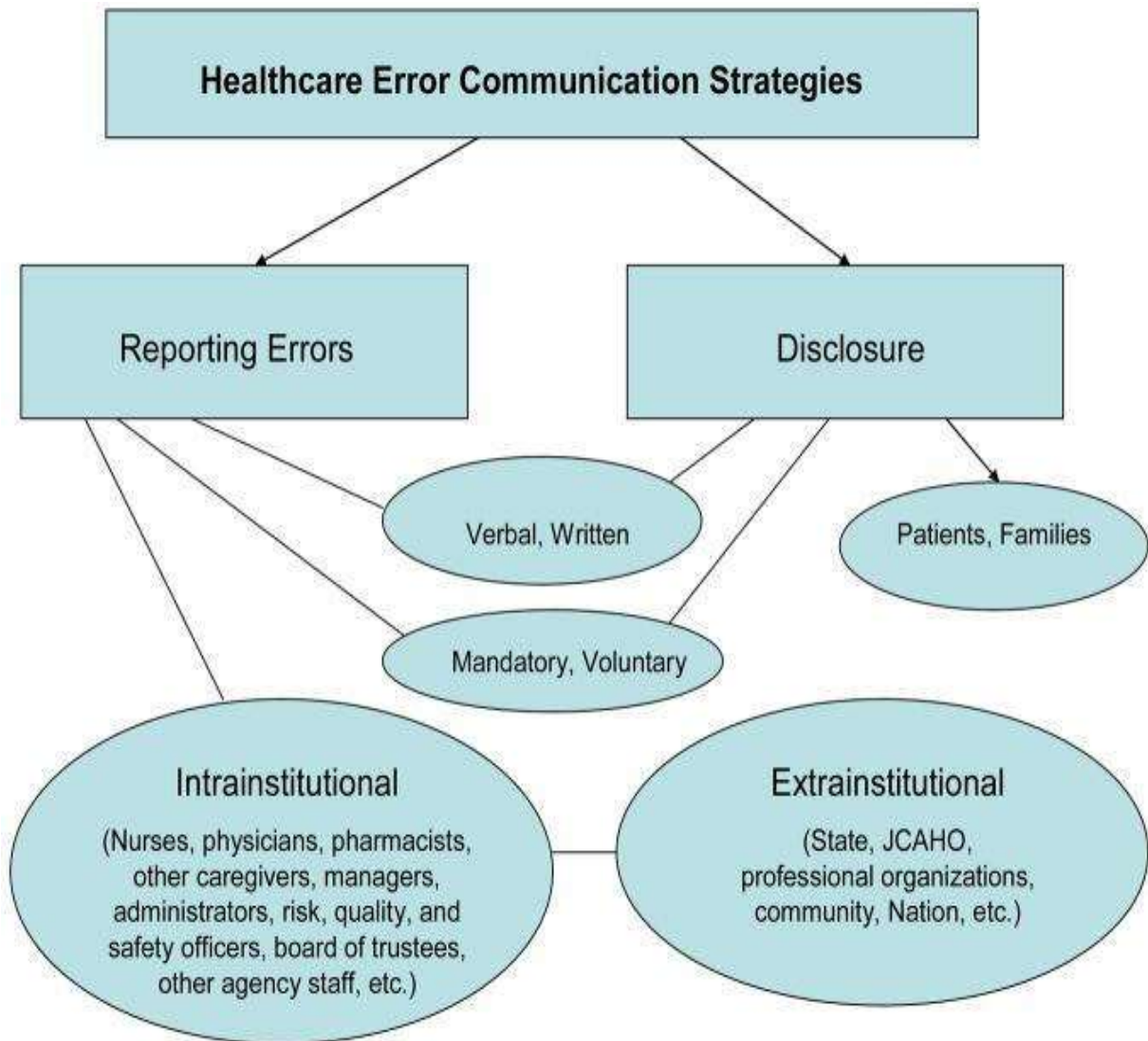
This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

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Communication in Healthcare





5 strategies for patient safety improvement



Nurture a patient
safety culture



Identify and work on
mistakes



Reduce chances for
human error



Ensure a clean
hospital environment



Ensure accurate
patient identification

RightPatient



- **Actors:** Patients, nurses, surgeons, administrative staff, hospital management.
- **Processes:** Admission, identification, surgical preparation, operation.
- **Structures:** Organizational hierarchy, safety protocols, governance systems.
- **External pressures:** Staffing shortages, resource limitations, high demand.

The analysis highlights key issues such as feedback loops (workload leading to errors), communication gaps, and interdependencies between roles. This demonstrates that the incident was not an isolated mistake but a system-wide failure, reinforcing the importance of systems thinking in healthcare improvement.

3 Centralization or Decentralization

The healthcare system in this case study is best understood as a hybrid model, combining centralized policy-making with decentralized day-to-day clinical decision-making. At the national level, health policy and patient safety standards are shaped through central authorities, while at hospital level, staff are responsible for implementing those standards in practice. This mix is common in health systems because it allows governments to set minimum standards while hospitals adapt operations to local needs. In this case, however, the balance between central control and local autonomy appears to have broken down, allowing a preventable wrong-patient surgery to occur.

A centralized system has clear advantages in patient safety because it creates standardization, clear rules, and accountability. WHO describes Decentralization and centralization as governance choices that determine where decision-making authority sits, and notes that centralization can help with coordination and consistency when common standards are needed. In a surgical setting, centralized policies are valuable because they ensure that all staff follow the same minimum requirements for verification, consent, checklist completion, and theatre safety. In principle, this should reduce variation and limit the chance that one team develops unsafe habits. The existence of formal safety protocols is therefore a strength of centralization, but only if the rules are actually implemented at ground level.

At the same time, centralization has limitations. A heavily centralized system can become too rigid, slow to respond, and disconnected from local realities. Hospitals often face unpredictable workloads, different staffing patterns, and varying patient complexity, which means local managers need some discretion to organize care effectively. In this case, however, the central

structure seems to have been insufficiently translated into reliable local practice. If the hospital had stronger central oversight of identity checks, checklist use, and theatre transfers, the error may have been caught earlier. Instead, the policy framework appears to have existed without enough operational enforcement.

Decentralization, on the other hand, gives frontline teams more flexibility and can improve responsiveness. The literature shows that decentralized governance can increase technical efficiency, empower local staff, and improve quality when local leaders understand the immediate context better than distant managers. In healthcare, this can be useful because theatre teams need to respond quickly to changes in patient condition, staffing, and scheduling. However, Decentralization also carries risks. If local units have too much autonomy without strong supervision, practice becomes variable and accountability becomes weaker. That is particularly dangerous in high-risk areas such as surgery, where small deviations from protocol can have severe consequences.

In this case study, decentralized operational control appears to have contributed to inconsistent patient verification. Frontline staff made transfer and theatre decisions without sufficient structured checks, which suggests that local autonomy was not balanced by effective controls. The patient was moved because he responded to a similar name, showing that informal judgement overrode formal verification. This is exactly the kind of failure that Decentralization can produce when staff have discretion but not enough training, monitoring, or escalation support. Research on decentralized health systems shows that autonomy only improves outcomes when there are strong accountability mechanisms, adequate resources, and clear roles.

The case therefore illustrates a mismatch between centralized standards and decentralized implementation. Central policies likely existed, but local practice did not consistently follow them. This is a common problem in healthcare governance, where good policy can fail if hospitals lack staff training, audit systems, or leadership commitment. In other words, the issue was not simply centralization versus Decentralization, but whether the two were aligned. A well-designed hybrid system would set non-negotiable safety standards centrally while allowing local teams flexibility only within those standards.

From a systems perspective, the ideal structure for this type of hospital should be centralized for safety-critical processes and decentralized for operational flexibility. Patient identification,

consent verification, surgical time-outs, and incident reporting should be tightly standardized. By contrast, staffing rosters, workflow adjustments, and local problem-solving can be handled at unit level. This approach is supported by evidence showing that Decentralization can improve responsiveness, but only when there are strong “back-up mechanisms” and accountability links across levels of the system. For this case, the absence of such mechanisms allowed the wrong patient to be processed through the surgical pathway.

Governance is also important. Central authorities can create standards, but hospital leaders must make sure they are followed through training, supervision, and audit. The literature on checklist implementation shows that success depends not just on the checklist itself, but on leadership, local ownership, and ongoing monitoring. If a hospital treats the checklist as a formality rather than a safety barrier, decentralized practice will drift away from safe standards. This is why leadership needs to be both enabling and controlling: enabling staff to adapt to local conditions, but controlling the critical steps that must never be skipped.

Overall, this case shows that neither pure centralization nor pure decentralization is sufficient on its own. Centralization provides consistency, while decentralization provides flexibility, but both must be balanced carefully. The wrong-patient surgery happened because the system allowed local discretion without enough safeguards, oversight, and accountability. A safer model would combine centralized patient-safety standards, decentralized clinical responsiveness, and strong local monitoring to ensure that policy becomes reliable practice.

3.1 Leadership Theories and Application to the Case Study

The incident at Kota Medical College Hospital highlights significant leadership failures that contributed to a preventable patient safety event. Leadership plays a critical role in shaping organizational culture, ensuring protocol compliance, and promoting patient safety. To critically analyse this case, three leadership approaches are applied: transactional leadership, transformational leadership, and distributed leadership, supported by evidence and data.

3.2 Transactional Leadership

Transactional leadership focuses on structure, hierarchy, compliance, and performance monitoring, where leaders emphasize rules, procedures, and corrective actions (Burns, 1978). In healthcare, this approach is often used to enforce standard operating procedures such as surgical safety checklists.

In this case, transactional leadership appears to have been weak or inconsistently applied. The failure to follow patient identification protocols suggests a breakdown in monitoring and

accountability systems. For example, the absence of strict verification checks before surgery indicates that compliance mechanisms were either not enforced or inadequately supervised.

Evidence suggests that strong transactional leadership improves safety outcomes when combined with monitoring systems. According to the [Joint Commission](#), adherence to structured safety protocols can significantly reduce wrong-patient errors (Joint Commission, 2023). However, in environments where oversight is limited, transactional leadership becomes ineffective.

Critical evaluation

While transactional leadership is essential for enforcing safety standards, over-reliance on it without proper monitoring leads to “paper compliance”, where protocols exist but are not followed in practice. In this case, leadership failed to ensure accountability, making this approach insufficient on its own.

3.3 Transformational Leadership

Transformational leadership focuses on vision, motivation, and cultural change, encouraging staff to prioritize patient safety and continuous improvement (Bass, 1985). Leaders adopting this approach inspire staff to go beyond routine tasks and actively engage in safe practices.

In the case study, there is little evidence of transformational leadership. A strong safety culture would have encouraged staff to double-check patient identity, question inconsistencies, and prioritize patient wellbeing over routine efficiency. The fact that no staff member challenged the process suggests a lack of psychological safety and shared vision.

Data from the [Institute for Healthcare Improvement](#) shows that organizations with strong safety cultures—often driven by transformational leadership—experience lower rates of adverse events and higher staff engagement (IHI, 2022). Additionally, WHO reports indicate that safety culture improvements can reduce preventable harm by up to 30% (WHO, 2019).

Critical evaluation:

The absence of transformational leadership in this case contributed to a task-oriented culture rather than a patient-centered one. Leaders failed to inspire staff to take ownership of safety practices, resulting in passive compliance rather than active engagement.

3.4 Distributed Leadership

Distributed leadership involves shared responsibility across teams, empowering frontline staff to make decisions and take accountability (Spillane, 2006). In healthcare, this approach is particularly effective in complex environments where multiple professionals interact.

In this case, leadership appears to have been poorly distributed, with frontline staff lacking the authority or confidence to question decisions. For example, nurses and support staff did not verify the patient’s identity independently, suggesting a hierarchical culture where questioning authority may not have been encouraged.

Research indicates that distributed leadership improves communication and reduces errors. According to the [World Health Organization](#), empowering frontline staff to participate in

decision-making enhances patient safety outcomes (WHO, 2019). Furthermore, studies show that hospitals with higher staff engagement report fewer safety incidents and improved compliance with protocols (Braithwaite et al., 2017).

Critical evaluation:

While Decentralization can improve responsiveness, in this case it resulted in lack of coordination and accountability. Distributed leadership was either absent or ineffective, as staff did not actively participate in ensuring patient safety.

3.5 Reactive vs Proactive Leadership

The leadership response in this case appears to have been reactive rather than proactive. The error was only identified after harm had occurred, indicating a lack of preventive systems and foresight.

Proactive leadership would have included:

- Regular audits of patient identification processes
- Continuous staff training on safety protocols
- Implementation of multi-step verification systems

Data from safety studies shows that proactive organizations experience significantly fewer adverse events compared to reactive systems (Reason, 2000).

3.6 Overall Evaluation

The leadership approach in this case was inadequate and poorly integrated. Transactional leadership failed due to weak enforcement, transformational leadership was absent, and distributed leadership was ineffective. A more balanced approach combining strong governance, cultural leadership, and staff empowerment could have prevented the incident.

4 Improvement and Lessons Learned

The incident at Kota Medical College Hospital demonstrates how failures in leadership and governance can interact to produce serious patient safety outcomes. This section critically evaluates these interactions and identifies evidence-based improvements.

4.1 Problem 1: Failure of Patient Identification Systems

Data: The WHO identifies patient misidentification as a major contributor to adverse events, affecting millions of patients globally (WHO, 2019).

Analysis: In this case, reliance on verbal confirmation without structured verification led to the error. This reflects both a governance failure (lack of enforced protocols) and a leadership failure (lack of accountability).

Improvement:

- Implement multi-factor identification systems (e.g., name, date of birth, ID band)
- Introduce digital verification tools, such as barcode scanning
- Enforce mandatory use of the WHO Surgical Safety Checklist

4.2 Problem 2: Weak Leadership and Safety Culture

Data: Organizations with poor safety culture report significantly higher rates of adverse events (IHI, 2022).

Analysis: The absence of transformational leadership resulted in a culture where staff did not feel responsible for patient safety beyond their immediate tasks.

Improvement:

- Develop transformational leadership training programmes
- Promote a just culture, encouraging staff to speak up
- Conduct regular staff engagement and safety climate surveys

4.3 Problem 3: Ineffective Communication and Team Coordination

Data: Communication failures contribute to up to 70% of serious adverse events (Joint Commission, 2023).

Analysis: Lack of structured communication protocols led to incorrect patient transfer and surgical preparation.

Improvement:

- Standardize communication using tools such as SBAR (Situation, Background, Assessment, Recommendation)
- Introduce mandatory team briefings and debriefings in surgical settings
- Strengthen interdisciplinary collaboration

4.4 Problem 4: Decentralized Practice Without Oversight

Data: Variability in protocol compliance is higher in decentralized systems without strong governance (Braithwaite et al., 2017).

Analysis: While decentralization allowed flexibility, it resulted in inconsistent application of safety procedures.

Improvement:

- Strengthen audit and monitoring systems
- Introduce real-time reporting mechanisms
- Balance decentralization with centralized accountability frameworks

Missed Opportunities

Several opportunities to prevent the incident were missed:

- Failure to implement basic identity verification checks
- Lack of preoperative safety checklist compliance
- Absence of staff empowerment to challenge decisions
- Inadequate leadership oversight and monitoring

Integration of System Structure, Leadership, and Feedback

This case demonstrates how system structure, leadership, and feedback loops interact:

- Decentralized systems without strong leadership lead to inconsistent practice
- Weak leadership fails to enforce protocols and promote safety culture
- Poor feedback mechanisms prevent learning from near-misses

These interactions create a system where errors are not only possible but likely.

4.5 Lessons for Healthcare Organizations

Key lessons include:

1. Patient safety must be system-driven, not individual-dependent
2. Leadership must balance control with empowerment
3. Standardized processes reduce variability and error
4. Data and feedback are essential for continuous improvement

Role of Evidence and Data in Continuous Improvement

Data plays a critical role in improving healthcare systems. Organizations should:

- Use incident reporting systems to identify trends
- Conduct regular audits and performance reviews
- Benchmark against international standards such as WHO guidelines
- Use real-time data dashboards to monitor safety outcomes

Evidence-based approaches ensure that improvements are measurable, sustainable, and accountable.

5 Recommendation

The most important recommendation for Kota Medical College Hospital is to redesign the entire preoperative pathway so that patient verification cannot depend on a single verbal confirmation. WHO describes patient safety as an organized set of cultures, processes, procedures, behaviors, technologies, and environments, which means prevention must be built into the system rather than left to individual memory. In practice, this should mean checking at least two identifiers at admission, transfer, pre-anesthesia, and immediately before incision, such as full name, date of birth, hospital number, and wristband details. If any detail is unclear or inconsistent, the patient must not proceed until the discrepancy is resolved. This kind of redundancy is essential because wrong-patient errors often occur when staff assume that earlier checks were sufficient.

A second recommendation is compulsory use of the WHO Surgical Safety Checklist and a protected “time-out” before surgery begins. The WHO checklist is designed to ensure confirmation of the correct patient, procedure, and site, and it is one of the most established tools for reducing surgical harm. However, the checklist only works when it is performed properly and without shortcuts. The hospital should therefore make the checklist mandatory for every case, with completion verified by more than one team member. The surgeon, anesthetist, and theatre nurse should all actively confirm identity and procedure before incision, and any staff member must have the authority to stop the operation if something does not match. This is important because wrong-patient surgery is not prevented by paperwork alone; it is prevented when the whole team pauses and verifies the process together.

Communication across the surgical pathway also needs immediate improvement. The case suggests that the patient was transferred without proper identity verification, which indicates a breakdown in handover and escalation. Structured communication should be introduced using SBAR or a similar standard method so that staff pass on the same information consistently at every stage. The AHRQ PS Net guidance on wrong-patient and wrong-site surgery identifies communication failure as a major cause of these events and stresses the need for reliable, redundant checking systems. In this hospital, staff should be trained to use closed-loop communication, meaning that requests are repeated back and confirmed rather than assumed. This is especially important during theatre transfer and preoperative preparation, where small misunderstandings can have severe consequences. A clear escalation pathway should also exist so that any uncertainty about identity, consent, or procedure triggers immediate review by a senior clinician.

Leadership is another critical area for change. IHI argues that building a culture of safety requires trust, respect, inclusion, and consistency from leaders at every level of the organization. At Kota Medical College Hospital, leadership should move from a reactive approach to a proactive one. Instead of

responding only after an adverse event, managers should hold regular safety briefings, review near-misses, and reinforce the message that safety takes priority over speed or hierarchy. Staff should feel able to question any mismatch without fear of blame or punishment, because a weak safety culture allows errors to progress unchecked. This is particularly important in operating theatre settings, where junior staff may hesitate to challenge senior colleagues even when they notice something wrong.

The hospital should also invest in training and simulation. Staff need regular refreshers on patient identification, theatre safety, escalation procedures, and human factors such as fatigue, distraction, and time pressure. Training should not be limited to new staff; it should include ongoing education for permanent staff, rotating trainees, and agency workers. Simulation-based drills can help teams practice what to do when a patient is misidentified, when paperwork does not match, or when a team member raises a concern. This makes safety procedures more practical and helps staff respond correctly under pressure. In addition, training should support a just culture, where the focus is on learning and system improvement rather than simply blaming individuals.

Finally, governance and monitoring must be strengthened through audit and feedback. WHO and other patient safety bodies emphasize that safety improves when organizations collect data, monitor compliance, and learn from incidents. The hospital should audit checklist completion, patient identification compliance, handover quality, and theatre time-out practice on a regular basis. Results should be reviewed by senior management and shared with clinical teams in an open, non-punitive way. A simple patient safety dashboard can help track trends, identify repeat problems, and show whether interventions are working. Near-miss reporting should also be encouraged, because learning from near misses is often the best way to prevent a future serious event. This creates a feedback loop in which the organization does not just react to harm but learns continuously from its own performance.

Overall, the key recommendation is that wrong-patient surgery must be addressed as a **system failure** rather than a one-off mistake. The hospital should combine stronger identification, mandatory checklist use, structured communication, empowered staff, visible leadership, and continuous audit. If these measures are implemented consistently, they will reduce the risk of another preventable wrong-patient event and strengthen patient safety across the whole surgical pathway.

6 Conclusion

the wrong-patient surgery at Kota Medical College Hospital was not simply the result of one individual mistake, but a clear example of system failure, weak governance, and ineffective leadership. The incident shows how patient harm can occur when identification procedures are

unreliable, communication is poor, and staff are not supported by a strong safety culture. Although the event was preventable, it was allowed to happen because several safeguards failed at the same time. This makes the case a powerful example of why patient safety must be managed as a whole-system issue rather than as an isolated error.

The analysis also shows that both centralized policies and decentralized practice need to work together effectively. National safety guidance is only useful when it is consistently implemented at hospital level. In this case, the gap between policy and practice allowed unsafe habits, weak oversight, and inconsistent compliance to continue. Leadership therefore has a central role in translating standards into daily action. Without active monitoring, staff training, and accountability, even well-designed safety procedures may remain only on paper.

A key lesson from this case is that hospitals must build multiple layers of protection into every stage of care. Patient identification should never depend on a single verbal check. Instead, it should involve several verified identifiers, a mandatory surgical checklist, a formal time-out, and clear escalation procedures when something does not match. Just as importantly, staff must feel empowered to stop a procedure if they notice a concern. This requires a just and open culture in which speaking up is seen as a professional responsibility, not a challenge to authority.

The case also highlights the importance of continuous learning. Hospitals should use audits, incident reporting, and feedback systems to identify weaknesses before they lead to serious harm. Regular training, simulation, and leadership engagement can help staff recognize risks and respond appropriately. In this way, patient safety becomes part of everyday practice rather than a response after harm has occurred.

Overall, this incident demonstrates that preventable surgical errors can only be reduced through a combination of strong governance, effective leadership, reliable systems, and a culture that places patient safety first. If these lessons are acted upon, hospitals can significantly reduce the risk of wrong-patient surgery and improve the quality and safety of care for all patients.

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