

**Module: Health Care System Organisation and
Leadership**

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Kota Hospital Case: System Failure and Leadership

Case Study Number 3

Lecturer: Tonia Babalola

Student Name/ID: Pinkalben Macwan / 2518469

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Introduction

In this report, the critical patient safety event at Kota Medical College Hospital, Rajasthan, has been investigated where an aged man was mistakenly operated because of a system failure (scmp, 2025). Failure to identify patients, communication breakdown, lax governance and accountability, poor leadership oversight, and absence of safety measures are the issue of serious concern in the case. This case study aims to examine how inadequate systemic conditions, leadership styles, and governance systems led to the incident and how it can be improved to ensure safer healthcare delivery.

Health and social care leadership is the power to direct, influence and encourage people or groups to accomplish common objectives, especially in the provision of effective and safe care to patients. It includes decision-making, communication, and accountability to make sure that healthcare professionals cooperate to ensure high standards of safety and quality. Leadership is crucial in multifaceted healthcare systems where coordination and trust are directly related to patient outcomes. Healthcare systems can be centralised (decisions are made at higher organisational levels) or decentralised (authority is spread at local units). The two structures have an impact on the implementation and monitoring of policies. The main leadership theories that apply to the case analysis are transactional leadership which is based on rules, compliance, transformational leadership which promotes vision, motivation, culture of safety, and situational leadership which relates to the need to adapt the leadership style to a particular situation (Blane, 2017). These theories offer a model with which to study the effectiveness of leadership in healthcare settings (Source: Terkamo-Moisio *et al*, 2022).

During organisational change or crisis, it is important to have the right leadership style (Riggio and Newstead, 2023). A good leader is one that makes quick decisions, communicates effectively and follows safety measures hence minimizing chances of mistakes. On the other hand, bad leadership might create confusion, accountability and failure of the system, as experienced in this scenario. Effective leadership is thus needed to control the risks and guarantee patient safety. In this report, the case will be analysed based on a systems thinking approach, leadership theories and governance structures, decision-making processes and systemic weaknesses will be identified. It will also make available evidence-based recommendations and lessons to enhance patient safety, leadership effectiveness, and performance of the healthcare system.

Main Body and Analysis

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

1. The central problem in the case study

The main issue in the case is that a serious medical error has occurred, wrong-patient surgery, due to a critical failure in patient identification (scmp, 2025). The case at Kota Medical College Hospital (on (12 April 2025), an elderly man awaiting his son's surgery was mistakenly taken for another patient, anaesthetised, and incised due to name confusion and lack of identity verification; the error was discovered afterward (scmp, 2025). *System thinking would explain this as not a single human mistake but a system failure in terms of lack of safety protocols and communication breakdown, as well as absent accountability mechanisms.* The situation rich picture would consist of the various interacting factors, i.e., hospital staff, administrative processes, flow of patients, communication channels and the organisational culture, which all led to the breakdown. The lack of redundancy checks (ID verification bands or cross-checking patient records) shows that the healthcare system is rather weak, and one critical point allows causing serious outcomes.

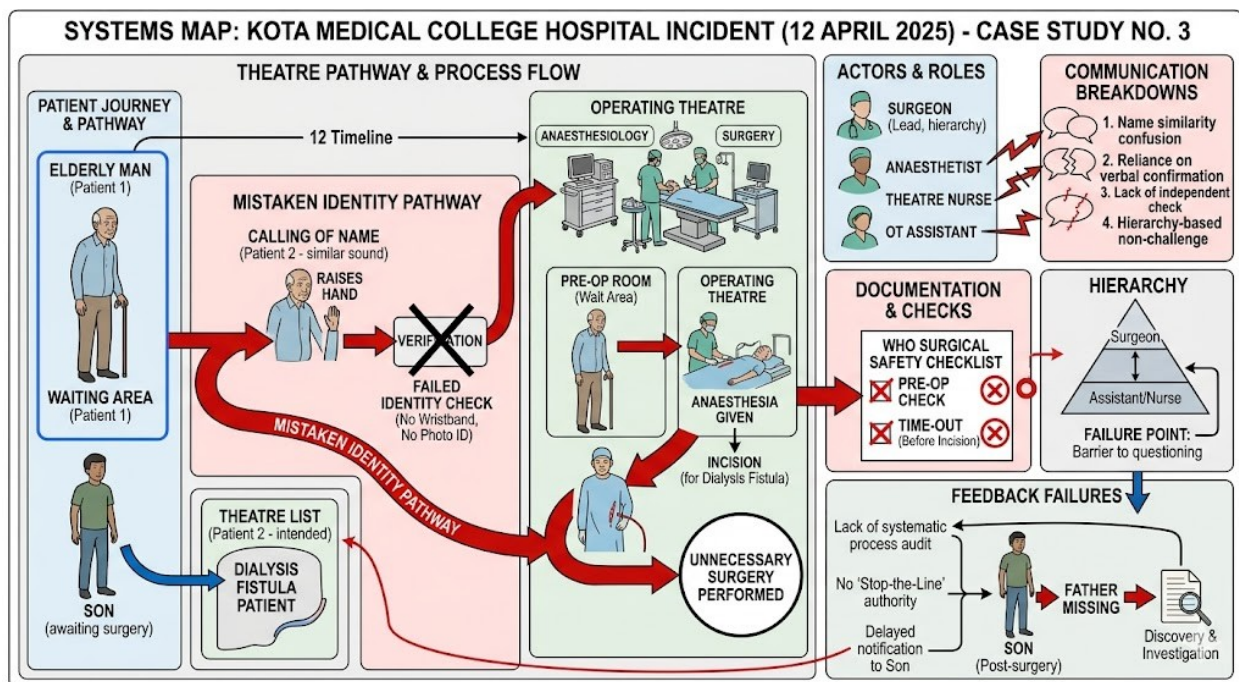


Figure 1: Rich Picture

(Source: Self)

2. Explain what global statistical information reveals about the problem

International statistics show that these events are not isolated but are a subset of a larger patient safety crisis (Restivo *et al*, 2022). The World Health Organization estimates that unsafe medical care in low- and middle-income countries leads to almost 134 million adverse events annually, which cause nearly 2.6 million deaths annually. Also, the WHO has estimated that 1 out of 10 patients are harmed in the course of receiving hospital care in any part of the world and a major percentage of these cases can be avoided. Wrong-site, wrong-procedure or wrong-patient surgical procedures are considered to be never events and should not happen when adequate systems are available. These statistics show that the Kota incident is a part of an international trend of systemic failures, especially in environments that are limited in resources and where the standardised safety measures might not be always enforced (Petersson *et al*, 2022).

3. Explain what national statistical information reveal on the problem

On a national scale, statistics provided by the National Health Service (NHS) gives an understanding of the occurrence of such errors despite the sophistication of healthcare systems. According to NHS reports, there have been hundreds of never events every year, such as wrong-patient or wrong-site operations. As an example, NHS England reported more than 400 never events in one year, and surgical errors constitute a significant subdivision. Although UK safety systems are strong, these statistics indicate that human error coupled with system vulnerability may still result in major accidents (Tsekouropoulos *et al*, 2025). The real number of such events may be underreported as compared to India where the reporting systems are less standardised. Thus, the Kota case would be probably a wider national problem of undocumented patient safety failures, particularly in state hospitals (scmp, 2025).

4. Explain what figures from national organisations reveal on the problem in connection to worldwide presentation.

The problem is further contextualised by the data of worldwide patient safety organisations, i.e., the Institute for Healthcare Improvement (IHI). The IHI emphasizes that almost 70 percent of severe adverse healthcare events, such as surgical errors, are caused by communication failures. In addition, research funded by IHI demonstrates that surgical complications can be

lowered by more than 30 percent by introducing orderly safety measures such as checklists. Comparing these numbers worldwide, it is evident that the lack of organized safety measures and communication guidelines is one of the most common reasons that cause avoidable damages. The Kota incident is not an exception as the mistake was made mainly because of the failures in communication and the absence of verification procedures, which proves that the issue is systemic and is known on the international level (Jain *et al*, 2023).

5. Explain how this problem reflects systemic weaknesses

- **Communication:** The accident underscores a significant breakdown in communication. The patient was only known by his name, but not verified by multiple identifiers like age, ID number, or medical records.
- **Accountability:** Lack of accountability at various levels was evident. Nurses to surgeons, nobody made sure that appropriate verification procedures were adhered to (Pokhariya *et al*, 2026).
- **Leadership:** Failure in leadership can be seen through failure to enforce the standard operating procedures (Verywell Mind, 2024).

The leadership failure and communication failure are not the only ways to evaluate this incident; both are indicative of larger systemic issues with leadership and process functionality. Leadership did not fail simply because protocols were violated but also because there was no active oversight of adherence to those protocols, no means of measuring compliance, and no safety culture that would seem to encourage adherence to those rules. This implies that routine process reliance existed instead of a critical decision-making process. Communication breakdown occurred not only at the point when names were confused but also because no systems existed to provide a structured means of verifying information about vulnerable patient populations and for providing opportunities for adaptive communication. The literature indicates that system failures (poorly designed systems) and failures related to training, as well as failure due to weakness in accountability systems and processes, are the main contributors to most errors within healthcare; therefore, the root cause of these issues is related to organisational design rather than individual actions.

6. Identify the level of governance

The most important level of governance that can affect this issue is local (hospital-level governance). But regional and national governance also contributes as they are the ones who

set standards, follow up on compliance and hold accountability within the public healthcare institutions.

7. Provide data on underlying challenges to illustrate underlying challenges.

- **Staff shortages:** Systemic issues play a major role in causing such errors. The ratio of doctor to patient in India is 1:1500, which is lower than the recommended ratio of 1:1000 as suggested by WHO, which implies staff shortage and overwork (Petersson *et al*, 2022).
- **Budget constraints:** Public hospitals are more prone to overcrowding and lack of resources, which can further enhance the probability of mistakes (Stephenson *et al*, 2022).

b. Centralisation or Decentralisation within the Case Study

1. Analyse whether your case study organisation operates in a centralised or decentralised system

The hospital is a centralised public healthcare system, where government authorities determine the policies and standards followed by Kota Medical College Hospital. Nonetheless, the functioning of the daily operations depends on decentralised decision making by staffs at the hospital. The incident shows a policy-practice disconnect, where non-adherence to patient identification processes took place at the operational level. These show that, despite the stringent central guidelines, the local supervision, communication, and accountability may result in mistakes. The case in general demonstrates that the good implementation requires good local governance in order to make sure that patient safety standards set centrally are adhered to (Jain *et al*, 2023).

An analysis of both centralisation and decentralisation can be clarified through a clearer understanding of system levels. For example, policymakers based in higher-level authorities were responsible for developing safety protocols, but the actual implementation of protocols was the responsibility of employees who worked on the front lines. As a result, there was little or no oversight provided by those at higher levels of authority, so local employees were able to ignore safety protocols, and this lack of cooperation (between central controlling authority and local executing agency) resulted in the incident occurring (Jain *et al*, 2023).

2. Explain how decision-making is concentrated and give a clear example.

Decision-making in Kota Medical College Hospital is centralised at higher administrative and government levels which is a characteristic of a centralised public healthcare system. State health authorities and hospital leadership design and mandate policies regarding patient safety, surgical practices, and hospital policies (Pacific College, 2022). Operational decisions are however implemented by frontline employees. An obvious example, in relation to the case, is the identification of a patient prior to surgery. Although the decision to carry out surgery was not properly verified by higher authorities (assuming that patient identity was verified using multiple identifiers), it was the surgical team that made the decision to carry out surgery. The employees were just given a verbal reply to a name call, and it shows that there is centralised policy with minimal oversight on key decisions. This centralization of policy making and poor oversight resulted in failure in safe decisions.

3. Explain the advantages and disadvantages in connection to your case study.

Advantages: A centralised system assures consistency and standardisation of healthcare practices. This, in theory, minimizes variations in care and enhances patient safety. As an illustration, surgical safety national guidelines (e.g. checklists) are created to reduce the number of errors such as wrong-patient surgery. It is also possible to control the resources efficiently and provide the co-ordinated response to crisis by centralised control (Albert and Pappas, 2024).

Disadvantages: The case however presents some major disadvantages. Centralised systems can also have a disconnect between policy and action with front line staff not necessarily being adherent to the guidelines because of workload or because no one is watching them. Poor supervision and accountability in this incident enabled the staff to circumvent safety measures. Moreover, centralised systems are bureaucratic and slow to react, they are not flexible in responding to real-time problems. The failure was further caused by the lack of empowerment of locals and poor communication (Pokhariya *et al*, 2026)

4. Support this discussion with relevant data.

The way system structure affected the incident is supported by numerical evidence. In India, 1 to 1500 is the doctor to patient ratio, which is lower than the recommended ratio of 1:1000 and this implies that staff are overworked and pressured in time. Research indicates that more than 6070 percent of the medical errors are associated with a breakdown in communication, and this underscores the dangers of bad coordination in decentralised implementation (Dugan *et al*, 2022).

Patient safety statistics show that 1 out of every 10 patients suffers in hospitals all around the globe and wrong-patient surgeries may be rare, but it is considered a never-event. Even with the tight protocols in place, in more formal systems such as the UK, which report more than 400 never events every year, it is evident that even with centralised guidelines, loopholes still exist in compliance.

The centralised system, in this case, did not guarantee effective monitoring and enforcement whereas the execution, which was decentralised, was not accountable. This mix made it difficult to manage the crisis, error detection was delayed and, in the end, a preventable incident took place (Albert and Pappas, 2024).

c. Leadership Theories and Application to the Case Study

1. Leadership theories

Transactional Leadership Theory

Transactional Leadership Theory is structure-oriented, rule-oriented, and compliance-oriented. This is manifested in the strictness of protocols, including patient identification and pre-operative checklists in the healthcare systems. Leadership in the case study seems to be based mostly on a transactional style whereby the rules are in existence but not strictly followed (Baduge *et al*, 2024). Although such a model provides the clarity of roles and responsibilities, its shortcoming is observed when employees are guided by routines carefully without verification. The fact that patient identity was not verified prior to surgery implies that compliance was not proactively pursued but prone to be assumed, which demonstrates ineffective transactional leadership. This criticism is backed by research, indicating that despite organized systems, more than 400 of the so-called never events take place in developed healthcare every year, proving that regulations are not the only factor that ensures safety.

Transformational Leadership Theory

Transformational Leadership Theory focuses on vision, motivation and establishing a safe and accountable culture (Raoush, 2023). Transformational leaders foster an environment whereby staff members are encouraged to value the safety of their patients and report any kind of potential errors in high-risk settings such as hospitals (Stephenson *et al*, 2022). Such leadership is not evidenced much in this case. The employees never raised their concerns about the inconsistencies and neither performed proactive checking. This is indicative of absence of a safety-oriented culture, where employees feel that they are in charge of more than they are supposed to do at their jobs. The transformational leadership approach is important because research shows that the adverse events are reduced by up to 30 percent in hospitals with strong transformational leadership. This lack of this style of leadership led to a passive work environment and this created an environment where the error could take place.

Situational Leadership Theory

According to the Situational Leadership Theory, the leader should change his or her style according to the context and requirements of the situation (Relias, 2023). When working in a high-pressure surgical environment, the leadership must be more directive, but supportive,

making sure that safety standards are followed to the letter, and the communication is clear. Leadership was not able to adapt to the situation in the case study. The fact that the elderly patient had communication challenges necessitated increased vigilance and customized communication, which was not given. This reflects incompatibility of the leadership style with the situation demands at the expense of patient safety. In general, although there were transactional factors, the absence of transformational and situational leadership led to the creation of a strict but poorly implemented system, which led to a systemic failure (Bürkin *et al*, 2024).

2. Was the leadership style chosen appropriate for the situation?

The type of leadership used was not suitable to the situation. Although a transactional approach is needed in clinical settings to promote standardisation, it should be supplemented with transformational and situational factors (Raoush, 2023). Here, leadership was not effective in enforcing the strict protocols and did not create a culture of vigilance. The system lacked proactive monitoring and flexibility and was prone to failure. Thus, the leadership style was inadequate and disproportionate, which resulted in the loss of patient safety.

The reason for the failure of the leadership in the concerned case was the lack of a solid safety culture, limited staff empowerment, and no proactive risk identification due to their absence. A way of preventing the patient identification error and making better decisions overall would have been to create a stronger safety-based culture through more transformational and situational leadership methods that promote verification, accountability, and speaking out.

3. Were leaders reactive (command-driven) or proactive (purpose-driven)?

The leadership here seems more of a reactive (command-based) than a proactive one. Only after the error was found some actions were taken, which means that there are no preventative measures. A responsive leadership style would have seen to it that there are rigorous checks, frequent training of staff and constant compliance checks. Rather, the system was based on the routine practice without the regard of the risks that might occur, which illustrates the lack of prevention of foreseeable errors (Petersson *et al*, 2022).

4. What did data (e.g., staff surveys, safety outcomes) reveal about the leadership's effectiveness?

Indirect evidence of leadership effectiveness is available healthcare data (Bornman and Louw, 2023). Around one out of every 10 patients suffer injury during hospital practice all over the world, and a significant percentage of these events can be avoided. As many as 60-70% of medical errors are due to communication failures, indicating vulnerabilities in the communication systems that are led by leaders. In India, a doctor-to-patient ratio of 1:1500 and large patient loads are some of the issues that imply systemic stress on healthcare personnel. Such circumstances tend to create less adherence to safety measures. Also, the underreporting of adverse events will indicate that there is no open reporting culture which is a major sign of poor leadership. Regarding this case, the wrong-patient surgery, which is a never event, indicates a lack of good safety results and effective leadership control. Such risks would have been minimised by having proper leadership that would have ensured compliance with safety standards (Tsekouropoulos *et al*, 2025).

5. What could have been done differently e.g., more distributed or emotionally intelligent leadership?

The accident would have been avoided when distributed and emotionally intelligent leadership styles are embraced. The Distributed Leadership means distributing responsibility among all the levels of staff and promoting mutual accountability. Assuming that nurses, technicians, and surgeons had the same responsibility to check the identity of a patient, the mistake would have been detected earlier. This will encourage teamwork and eliminate dependence on one decision-maker (Baduge *et al*, 2024). Emotionally Intelligent Leadership is concerned with being aware, empathy, and communication. In the given instance, the fact that the patient was not able to express himself clearly should have led to further verification measures. High emotional intelligence leaders would prompt the staff to be sensitive to patient vulnerabilities and challenge inconsistencies (Bornman and Louw, 2023).

d. Improvement, and Lessons Learned

1. How leadership and governance interacted to produce the outcomes

The Kota Medical College episode should be construed as a failure of the system and not just human mistakes influenced by the interplay between poor governance and poor leadership. The failure can be well classified into five intertwined dimensions namely: *Patient identification failure, communication failure, weak governance and accountability, poor leadership control, and absence of safety measures* (Ledlow et al, 2023).

State and institutional governance structures play the role of putting up patient safety frameworks such as identification protocols and surgical checklists. In this instance, however, governance did not provide a way of ensuring that these standards were put in place and followed. The hospital level leadership failed to impose compliance and culture of prioritising safety protocols (Aromolaran, 2025). Failure to identify the patient was due to lack of governance mechanisms requiring strict multi-step verification systems, or lack of monitoring of such systems. The lack of communication between the patient and the staff also indicates a lack of control over communication standards, particularly of those of vulnerable patients. Also, there were poor accountability mechanisms such that a specific individual or group did not hold anyone accountable to verify.

There was little leadership control because no higher authority would control that protocols were adhered to prior to surgery. This is an indication of a gap in governance-leadership in which policies are in existence but not implemented. The absence of safety measures or their failure to be implemented shows the flaws of the system and not personal apathy. In such a manner, leadership and governance intertwined, which enabled several little failures to come together to form a big negative event (Barr and Dowding, 2022).

2. Missed opportunities and evidence-based solutions and present a discussion highlighting the problems, solutions

The incident identifies a number of missed opportunities on systemic levels.

- First, the lack of a well-developed system of patient identification was a serious void. The use of verbal confirmation alone resulted in the error.
- Second, the communication failure, especially with a patient with speech problems, was not solved using other verification techniques (Cabrera and Cabrera, 2023).

- Third, standard safety measures, including pre-operative checklists, were not put in place.

Evidence-based solutions have a strong effect in dealing with these failures. Studies show that the use of structured surgical safety checklists is able to minimize complications by more than 30 percent, which proves the significance of following the protocols. Likewise, barcode or digital identification systems have proven to greatly minimize patient errors of misidentification. In order to resolve communication failures, research indicates that through enhancement of communication systems, up to 60-70 percent of medical errors can be avoided. This involves adopting various forms of verification, family participation, and having proper documentation. Therefore, leadership supervision should be enhanced by training and supervision. There is evidence that indicates that hospitals that have well-involved leadership in patient safety initiatives realize much better results. These solutions point to the fact that it was not a knowledge gap but the inability to apply known best practices (Terkamo-Moisio *et al*, 2022).

3. How did system structure (centralised/decentralised), leadership style, and system feedback interact?

The interplay of the structure of the system, the leadership style, and feedback mechanisms were critical in this failure. There is a centralised healthcare system, in which the policies are standardised at higher levels. But the implementation is decentralised, and it is based on the locals (Abimbola *et al*, 2019). In this instance, the centralised system did not provide effectiveness in the implementation at the local level. The adopted leadership style was reactive and transactional whereby the routine processes were prioritized instead of active risk management (Stephenson *et al*, 2022). This added to the failure of patient identification and safety measures since the employees were not motivated to doubt or confirm the discrepancies.

There were poor system feedback mechanisms, including incident reporting, and real-time monitoring. Lack of proper feedback loops implied that early indicators, e.g. wrong patient preparation, were not detected. This led to communication failure and lack of accountability that were not corrected. Therefore, a strict centralised organisation, inefficient leadership and lack of efficient feedback systems combined to form a weak healthcare environment, where the weaknesses of the system were not corrected, and eventually caused the incident (Khattak *et al*, 2023).

4. What lessons can other health organisations learn from this case?

Healthcare organisations have critical lessons to learn in this case.

- One, it highlights the fact that patient safety failures are not personal, but rather systemic. Identification processes, communication systems and governance structures are some of the root causes that organisations need to tackle.
- Second, patient identification should be done in several steps such as ID bands, medical records and verification of the patient. This makes the chances of making errors minimal (Aromolaran, 2025).
- Third, the issue of communication breakdowns needs to be addressed. The healthcare providers need to change their communication approach to the needs of the patients, especially vulnerable ones.
- Fourth, organisations need to empower governance and accountability schemes, and safety protocols are not only in place but also under a regular inspection and implementation.
- Fifth, it is essential to have leadership oversight. Leaders should be involved in the active development of a safety culture, compliance, and the willingness to share with the staff about the risks that might occur (Petersson *et al*, 2022).

5. How can evidence and data be used to ensure continuous improvement and accountability?

Systemic failures and their further improvement need evidence and data to address them. Hospitals should gather and examine the data about patient identification mistakes, communication errors and adherence to safety protocols. As an illustration, monitoring misidentification cases can be used to discover trends and improvement opportunities. Statistics indicate that 1 out of 10 patients in the world suffer some damage in health facilities which underscores the necessity of systematic surveillance (Barr and Dowding, 2022).

Organisational performance can be measured on performance metrics, including compliance rates with safety checklists and frequency of incident reporting. Dashboards and real-time data systems can assist leaders in tracking safety outcomes and taking proactive measures.

Recommendation

<i>Priority sequence</i>	<i>Actions to be taken</i>
Immediate (0–3 months)	Patient identification & safety protocols.
Short-term (3–6 months):	Communication systems & leadership alignment
Long-term (6–12 months)	Governance, data systems, and efficiency improvements.

1. Enhancing Patient Identification and Safety measures.

In order to tackle the fundamental system failure, Kota Medical College Hospital should consider the implementation of a solid patient identification system. This involves the mandatory use of various identifiers, which include: patient name, age and unique hospital ID as well as physical aids like wristbands. Standard surgical safety checklists that verify that all procedures have been conducted pre-operative, should be strictly followed and audited. Barcode or digital identification can also be introduced, which will also minimize human error. These actions are directly related to patient identification failure and the absence of safety measures, which were at the centre of the incident (Terkamo-Moisio *et al*, 2022).

2. Implementing Leadership styles that are effective in improving sustainability.

A blend of transformational, distributed and emotionally intelligent leadership is advisable (Raoush, 2023). Transformational leadership will be used to create a culture of safety and accountability that will motivate the staff to promote the well-being of patients. Distributed leadership ensures that there is a decentralization of responsibility at all levels and the leader is not the sole decision-maker (Abimbola *et al*, 2019). Leadership with EI will foster awareness and responsiveness especially in handling vulnerable patients, and the breakdown of communication will decrease, making the overall quality of care better.

3. Enhancing Systems Integration and Communication for improving patient centred care

In order to mitigate the communication failures, the hospital must implement standardised communication procedures, including formalised handovers and multi-step authentication. Effective communication particularly in a high-risk environment such as in an operating theatre

should be the main focus of staff training programs (Tsekouropoulos *et al*, 2025). The electronic health records (EHRs) integration will be able to enhance interdepartmental coordination, and the correct patient data will be available in real-time. This will minimize mistakes due to poor communication and disjointed systems (Khattak *et al*, 2023).

4. Enhancing Governance and Accountability Mechanisms.

Governance should shift away to policy formulation to policy monitoring and enforcement. The hospital must also establish regular audits, compliance check and performance reviews to check compliance with safety protocols. A non-punitive incident reporting system will be put in place to encourage staff to report errors and near misses, enhance transparency and learning. Roles and responsibilities should be clearly defined at each level based on weak governance and accountability problems highlighted in the case.

5. Advocacy of the ongoing Learning and Data-Driven Improvement.

Implementing a data-driven strategy of continuing improvement, the hospital must evaluate key performance indicators like patient safety events, adherence rates of protocols, and response time. Ongoing evaluation will be supported by regular audits, feedback loop and comparison with national and global standards. Promotion of a culture of learning through errors instead of blame will bolster organisational resilience and long-term betterment (Aromolaran, 2025). Stakeholder involvement and co-production through the partnership with the marketing team will be evaluated. Sustainable change involves involving stakeholders. Verification processes should involve patients and their families and provide an additional level of safety. Employees are supposed to be involved in planning and execution of safety programs, which will promote ownership and responsibility. Cooperation with other healthcare organizations and professionals can give new insights and innovativeness (Ledlow *et al*, 2023).

6. Improving Technical and Allocative Efficiency.

Technical efficiency can be improved by optimising the workflows, eliminating repeating of tasks, and minimising errors. The processes should also be streamlined in the hospital so that resources can be utilized efficiently. To achieve allocative efficiency, the investments must be made in high impact areas like patient safety technologies, staff training, and improvement of infrastructure. Staff shortages and workload imbalances will be resolved, leading to less fatigue and time pressure, two major factors that contribute to errors in health care facilities.

Relevance to the case

Recommendations	Responsibility	Success Measure
Enhancing Patient Identification and Safety measures	Hospital administration and surgical safety committee.	100% wristband compliance, reduction in identification errors to zero within 3 months, and audit compliance rate above 95%.
Implementing Leadership styles that are effective in improving sustainability	Senior management and department heads.	Staff satisfaction scores, reduction in reported communication errors, and improved patient safety indicators within 6 months
Enhancing Systems Integration and Communication for improving patient centred care	IT department and clinical operations team.	Reduction in handover errors, 100% EHR usage across departments, and faster response times in critical care settings.
Enhancing Governance and Accountability Mechanisms	Hospital board and quality assurance unit.	Increased incident reporting rates, audit compliance above 90%, and reduced recurrence of similar incidents.
Advocacy of the ongoing Learning and Data-Driven Improvement.	Quality improvement team and department leads .	Monthly KPI tracking, reduction in adverse events, and implementation of at least 2 improvement actions per quarter.
Improving Technical and Allocative Efficiency.	Operations management and HR department.	Reduced patient waiting time, improved staff-to-patient ratio, and decrease in error rates linked to workload. Integration of these recommendations will help in

Conclusion

The Kota Medical College Hospital case study indicates that there was a severe patient safety event that should be interpreted as a system failure and not human error. Key interrelated issues identified in the analysis included: failure in patient identification, breakdown in communication, weak governance and accountability, poor leadership oversight, and absence of safety measures. Such failures were not isolated but had been caused by systematic flaws in a centralised healthcare system, where policies were made but failed to be realised at the working level. Lack of multi-step verification procedures, inadequate communication with a

vulnerable patient, and absence of monitoring led to the development of a preventable so-called never event. Also, high workload and poor supervision, and lack of accountability measures were other factors that increased the possibility of error. On the whole, the results indicate that the accident was the result of several intertwining system malfunctions instead of one error.

The case highlights the importance of leadership, governance, and systems thinking in enhancing healthcare outcomes. A culture of safety and compliance with protocols, as well as accountability among staff, require effective leadership. Effective governance offers the system on which to conduct monitoring, enforce standards and transparency. In the meantime, systems thinking help organisations to observe the interaction and impact of various elements that make up an organisation (communication, processes, and structure). With these components combined, healthcare organisations will be able to make sustainable changes, minimize risks, and provide safer and more reliable patient care.

References

- Abimbola, S., Baatiema, L., Bigdeli, M. 2019. The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence, *Health Policy and Planning*, Volume 34, Issue 8, Pages 605–617. Available at: <https://doi.org/10.1093/heapol/czz055>
- Albert, N.M. and Pappas, S., 2024. *Quantum leadership: Creating sustainable value in health care*. Jones & Bartlett Learning. Available at: https://books.google.co.in/books?hl=en&lr=&id=qOMTEQAAQBAJ&oi=fnd&pg=PP1&dq=system+failure+in+health+care+leadership&ots=zE6gRHw3YV&sig=HUBtWu74s5ywXyWqGVUAszMjRKY&redir_esc=y
- Aromolaran, N., 2025. *Effective Leadership Strategies for the Implementation of Innovative Technologies to Improve Access to Health Facilities* (Doctoral dissertation, Walden University). Available at: <https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=19591&context=dissertations>
- Baduge, M.S.D.S.P., Garth, B., Boyd, L., Ward, K., Joseph, K., Proimos, J. and Teede, H.J., 2024. Barriers to advancing women nurses in healthcare leadership: a systematic review and meta-synthesis. *EClinicalMedicine*, 67. Available at: [https://www.thelancet.com/pdfs/journals/eclinm/PIIS2589-5370\(23\)00531-X.pdf](https://www.thelancet.com/pdfs/journals/eclinm/PIIS2589-5370(23)00531-X.pdf)
- Barr, J. and Dowding, L., 2022. Leadership in health care. <https://www.torrossa.com/gs/resourceProxy?an=5409523&publisher=FZ7200>
- Blane, H. 2017. Principles of transformational leader: Create a mindset of passion, innovation, and growth. Careers Press. Available at: [7-Principles-of-Transformational-Leadership.pdf \(kjfasteners.com\)](https://www.kjfasteners.com/7-Principles-of-Transformational-Leadership.pdf)
- Bornman, J. and Louw, B., 2023. Leadership development strategies in interprofessional healthcare collaboration: a rapid review. *Journal of healthcare leadership*, pp.175-192. Available at: <https://www.tandfonline.com/doi/pdf/10.2147/jhl.s405983>
- Bürkin, B. M., Czabanowska, K., Babich, S., Casamitjana, N., et al. 2024. Competencies for Transformational Leadership in Public Health-An International Delphi Consensus Study. *Int J Public Health*. 23;69:1606267. doi: 10.3389/ijph.2024.1606267.

Cabrera, D. and Cabrera, L., 2023. What is systems thinking?. In *Learning, design, and technology: An international compendium of theory, research, practice, and policy* (pp. 1495-1522). Cham: Springer International Publishing. Available at:<https://ecommons.cornell.edu/bitstream/handle/1813/2860/DerekCabreraDissertation.pdf>

Demssie, Y.N., Biemans, H.J., Wesselink, R. and Mulder, M., 2023. Fostering students' systems thinking competence for sustainability by using multiple real-world learning approaches. *Environmental Education Research*, 29(2), pp.261-286. Available at:<https://www.tandfonline.com/doi/pdf/10.1080/13504622.2022.2141692>

Dugan, K.E., Mosyjowski, E.A., Daly, S.R. and Lattuca, L.R., 2022. Systems thinking assessments in engineering: A systematic literature review. *Systems research and behavioral science*, 39(4), pp.840-866. Available at:<https://onlinelibrary.wiley.com/doi/pdf/10.1002/sres.2808>

Jain, P., Singh, K., Piplani, S., Gulati, S. and Kour, H., 2023. Beyond scrubs: understanding the root causes of violence against doctors. *Cureus*, 15(5), p.e39559. Available at:<https://www.cureus.com/articles/151409>

Khattak, A.F., Rahman, A.U., Khattak, M., Qazi, M., Gilani, H., Khan, A. and Rahman, A., 2023. Toward sustainable healthcare systems: a low and middle-income Country's case for investing in healthcare reforms. *Cureus*, 15(5). Available at:<https://www.cureus.com/articles/155545-toward-sustainable-healthcare-systems-a-low-and-middle-income-countrys-case-for-investing-in-healthcare-reforms.pdf>

Ledlow, G.J.R., Bosworth, M. and Maryon, T., 2023. *Leadership for health professionals: Theory, skills, and applications*. Jones & Bartlett Learning. Available at:https://books.google.co.in/books?hl=en&lr=&id=SI6kEAAQBAJ&oi=fnd&pg=PP1&dq=strategies+to+imrve+healthcare+services+and+leadersjhip&ots=hXHLkHp2mX&sig=nfwokVtoZVp6-UobbCWA3_1Dt3g&redir_esc=y

Lepez, C.O., 2023. Invisible challenges in healthcare leadership. *Health Leadership and Quality of Life*, 2, p.6. Available at:<https://dialnet.unirioja.es/descarga/articulo/9863730.pdf>

Mintzberg, H. 2017. *Some half-truths of management*. Available at:<https://mintzberg.org/blog/some-half-truths-management>

Pacific College. 2022. *7 Leadership Styles in Nursing*. [online] Available at: <https://www.pacific-college.edu/blog/leadership-styles-nursing>

Petersson, L., Larsson, I., Nygren, J.M., Nilsen, P., Neher, M., Reed, J.E., Tyskbo, D. and Svedberg, P., 2022. Challenges to implementing artificial intelligence in healthcare: a qualitative interview study with healthcare leaders in Sweden. *BMC health services research*, 22(1), p.850. Available at: <https://link.springer.com/content/pdf/10.1186/s12913-022-08215-8.pdf>

Pokhariyal, P., Patel, A., Nautiyal, N.S. and Mishra, A.K. eds., 2026. *Emerging Technology and the Law: Bridging the Gap Between Innovation and Regulation*. Taylor & Francis. Available at: https://books.google.co.in/books?hl=en&lr=&id=pGvIEQAAQBAJ&oi=fnd&pg=PT13&dq=Kota+Medical+College+Hospital,+Rajasthan,+has+been+investigated+where+an+aged+man+was+mistakenly+operated+because+of+a+system+failure+12+April+2025&ots=VKOjCbHvZo&sig=2Gmlt9yGVctfxAXaz0fWHnRcrKU&redir_esc=y#v=onepage&q&f=false

Raoush, A. 2023. Transformational leadership impact on innovative behaviour as perceived by healthcare workers in private hospitals in Jordan. *Cogent Business & Management*, 10(3).

Relias. 2023. *7 Leadership Styles in Nursing — Which Is Yours?*. [online] Available at: <https://www.relias.com/blog/7-leadership-styles-in-nursing>

Restivo, V., Minutolo, G., Battaglini, A., Carli, A., Capraro, M., Gaeta, M., Odone, A., Trucchi, C., Favaretti, C., Vitale, F. and Casuccio, A., 2022. Leadership effectiveness in healthcare settings: a systematic review and meta-analysis of cross-sectional and before–after studies. *International journal of environmental research and public health*, 19(17), p.10995. Available at: <https://www.mdpi.com/1660-4601/19/17/10995>

Riggio, R.E. and Newstead, T., 2023. Crisis leadership. *Annual review of organizational psychology and organizational behavior*, 10(1), pp.201-224. Available at: <https://www.annualreviews.org/content/journals/10.1146/annurev-orgpsych-120920-044838?crawler=true&mimetype=application/pdf>

Salmon, P.M., Stanton, N.A., Walker, G.H., Hulme, A., Goode, N., Thompson, J. and Read, G.J., 2023. *Handbook of systems thinking methods*. CRC Press. Available

at:<https://api.taylorfrancis.com/content/books/mono/download?identifierName=doi&identifierValue=10.1201/9780429281624&type=googlepdf>

scmp, 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?utm_source=chatgpt.com

Shin, N., Bowers, J., Roderick, S., McIntyre, C., Stephens, A.L., Eidin, E., Krajcik, J. and Damelin, D., 2022. A framework for supporting systems thinking and computational thinking through constructing models. *Instructional Science*, 50(6), pp.933-960. Available at:<https://link.springer.com/content/pdf/10.1007/s11251-022-09590-9.pdf>

Stephenson, A.L., Sullivan, E.E. and Hoffman, A.R., 2022. Primary care physician leaders' perspectives on opportunities and challenges in healthcare leadership: a qualitative study. *BMJ leader*, pp.leader-2022. Available at:<https://bmjleader.bmj.com/content/leader/early/2022/05/19/leader-2022-000591.full.pdf>

Terkamo-Moisio, A., Karki, S., Kangasniemi, M., Lammintakanen, J. and Häggman-Laitila, A., 2022. Towards remote leadership in health care: Lessons learned from an integrative review. *Journal of advanced nursing*, 78(3), pp.595-608. Available at:https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/jan.15028?utm_source=consensus

Tsekouropoulos, G., Vasileiou, A., Hoxha, G., Theocharis, D., Theodoridou, E. and Grigoriadis, T., 2025. Leadership 4.0: navigating the challenges of the digital transformation in healthcare and beyond. *Administrative sciences*, 15(6), p.194. Available at:<https://www.mdpi.com/2076-3387/15/6/194>

Verywell Mind, 2024. *Laissez-Faire Leadership: Examples and Advantages*. [online] Available at: <https://www.verywellmind.com/what-is-laissez-faire-leadership-2795316>