

Karin Pukk-HÃ¸renstam

List of Publications by Year in descending order

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Version: 2024-02-01

29
papers

748
citations

840119

11
h-index

525886

27
g-index

35
all docs

35
docs citations

35
times ranked

955
citing authors

#	ARTICLE	IF	CITATIONS
1	Application of statistical process control in healthcare improvement: systematic review. <i>Quality and Safety in Health Care</i> , 2007, 16, 387-399.	2.5	298
2	Psychometric properties of the hospital survey on patient safety culture, HSOPSC, applied on a large Swedish health care sample. <i>BMC Health Services Research</i> , 2013, 13, 332.	0.9	55
3	Is detection of adverse events affected by record review methodology? an evaluation of the "Harvard Medical Practice Study" method and the "Global Trigger Tool". <i>Patient Safety in Surgery</i> , 2013, 7, 10.	1.1	54
4	Validation of triggers and development of a pediatric trigger tool to identify adverse events. <i>BMC Health Services Research</i> , 2014, 14, 655.	0.9	54
5	Tasks, multitasking and interruptions among the surgical team in an operating room: a prospective observational study. <i>BMJ Open</i> , 2019, 9, e026410.	0.8	41
6	A systematic literature review of simulation models for non-technical skill training in healthcare logistics. <i>Advances in Simulation</i> , 2018, 3, 15.	1.0	38
7	Diagnostic errors reported in primary healthcare and emergency departments: A retrospective and descriptive cohort study of 4830 reported cases of preventable harm in Sweden. <i>European Journal of General Practice</i> , 2019, 25, 128-135.	0.9	29
8	Safer paediatric surgical teams: A 5-year evaluation of crew resource management implementation and outcomes. <i>International Journal for Quality in Health Care</i> , 2017, 29, 853-860.	0.9	27
9	A novel approach to explore Safety-I and Safety-II perspectives in in situ simulations"the structured what if functional resonance analysis methodology. <i>Advances in Simulation</i> , 2021, 6, 21.	1.0	19
10	Healthcare processes must be improved to reduce the occurrence of orthopaedic adverse events. <i>Scandinavian Journal of Caring Sciences</i> , 2010, 24, 671-677.	1.0	16
11	Design, application and impact of quality improvement "theme months"™ in orthopaedic nursing: A mixed method case study on pressure ulcer prevention. <i>International Journal of Nursing Studies</i> , 2013, 50, 527-535.	2.5	13
12	Results from the National Perinatal Patient Safety Program in Sweden: the challenge of evaluation. <i>Acta Obstetrica Et Gynecologica Scandinavica</i> , 2016, 95, 596-603.	1.3	12
13	A First-line management team's strategies for sustaining resilience in a specialised intensive care unit"a qualitative observational study. <i>BMJ Open</i> , 2021, 11, e040358.	0.8	10
14	Patient safety as perceived by Swedish leaders. <i>International Journal of Health Care Quality Assurance</i> , 2009, 22, 168-182.	0.2	9
15	Retrospective record review in proactive patient safety work " identification of no-harm incidents. <i>BMC Health Services Research</i> , 2013, 13, 282.	0.9	9
16	Patient and provider perspectives on reducing risk of harm in primary health care: a qualitative questionnaire study in Sweden. <i>Scandinavian Journal of Primary Health Care</i> , 2020, 38, 66-74.	0.6	9
17	Drug Use and Type of Adverse Drug Events Identified by a Trigger Tool in Different Units in a Swedish Pediatric Hospital. <i>Drug, Healthcare and Patient Safety</i> , 2020, Volume 12, 31-40.	1.0	8
18	Patient-related factors associated with an increased risk of being a reported case of preventable harm in first-line health care: a case-control study. <i>BMC Family Practice</i> , 2020, 21, 20.	2.9	7

#	ARTICLE	IF	CITATIONS
19	Acting between guidelines and reality- an interview study exploring the strategies of first line managers in patient safety work. BMC Health Services Research, 2021, 21, 48.	0.9	7
20	The work of having a chronic condition: development and psychometric evaluation of the distribution of co-care activities (DoCCA) scale. BMC Health Services Research, 2021, 21, 480.	0.9	6
21	Adaptations to practice and resilience in a paediatric major trauma centre during a mass casualty incident. British Journal of Anaesthesia, 2022, 128, e120-e126.	1.5	6
22	What's the Name of the Game? The Impact of eHealth on Productive Interactions in Chronic Care Management. Sustainability, 2021, 13, 5221.	1.6	5
23	Game Experience and Learning Effects of a Scoring-Based Mechanic for Logistical Aspects of Pediatric Emergency Medicine: Development and Feasibility Study. JMIR Serious Games, 2021, 9, e21988.	1.7	4
24	Mapping registered nurse anaesthetists' intraoperative work: tasks, multitasking, interruptions and their causes, and interactions: a prospective observational study. BMJ Open, 2022, 12, e052283.	0.8	4
25	The DNA damage response and patient safety: engaging our molecular biology-oriented colleagues. International Journal for Quality in Health Care, 2005, 17, 363-367.	0.9	3
26	Validation and initial results of surveys exploring perspectives on risks and solutions for diagnostic and medication errors in primary care in Sweden. Scandinavian Journal of Primary Health Care, 2020, 38, 381-390.	0.6	2
27	Defining and measuring quality in acute paediatric trauma stabilisation: a phenomenographic study. Advances in Simulation, 2019, 4, 4.	1.0	1
28	A Serious Logistical Game of Paediatric Emergency Medicine: Proposed Scoring Mechanism and Pilot Test. Lecture Notes in Computer Science, 2019, , 468-478.	1.0	1
29	Structuring Game Design with Active Learning Benefits: Insights from Logistical Skills Training in Managing an Emergency Department. Lecture Notes in Computer Science, 2021, , 35-49.	1.0	0