Charles A Vincent

List of Publications by Year
in descending order

287 papers	19,225 citations	13068 68 h-index	14702 127 g-index
305 all docs	305 docs citations	305 times ranked	15060 citing authors

#	Article	IF	Citations
1	Adverse events in British hospitals: preliminary retrospective record review. BMJ: British Medical Journal, 2001, 322, 517-519.	2.4	1,517
2	Framework for analysing risk and safety in clinical medicine. BMJ: British Medical Journal, 1998, 316, 1154-1157.	2.4	692
3	Causes of prescribing errors in hospital inpatients: a prospective study. Lancet, The, 2002, 359, 1373-1378.	6.3	530
4	Understanding and Responding to Adverse Events. New England Journal of Medicine, 2003, 348, 1051-1056.	13.9	408
5	Systems Approaches to Surgical Quality and Safety. Annals of Surgery, 2004, 239, 475-482.	2.1	395
6	How to investigate and analyse clinical incidents: Clinical Risk Unit and Association of Litigation and Risk Management protocol. BMJ: British Medical Journal, 2000, 320, 777-781.	2.4	382
7	Why do patients turn to complementary medicine? An empirical study. British Journal of Clinical Psychology, 1996, 35, 37-48.	1.7	367
8	Quality of Care Management Decisions by Multidisciplinary Cancer Teams: A Systematic Review. Annals of Surgical Oncology, 2011, 18, 2116-2125.	0.7	344
9	Patient involvement in patient safety: what factors influence patient participation and engagement?. Health Expectations, 2007, 10, 259-267.	1.1	326
10	Factors underlying parental decisions about combination childhood vaccinations including MMR: A systematic review. Vaccine, 2010, 28, 4235-4248.	1.7	318
11	Technologies for global health. Lancet, The, 2012, 380, 507-535.	6.3	311
12	The Impact of Nontechnical Skills on Technical Performance in Surgery: A Systematic Review. Journal of the American College of Surgeons, 2012, 214, 214-230.	0.2	302
13	Reasons for not reporting adverse incidents: an empirical study. Journal of Evaluation in Clinical Practice, 1999, 5, 13-21.	0.9	295
14	Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. BMJ Quality and Safety, 2012, 21, 737-745.	1.8	275
15	The Inflammatory Response to Cardiopulmonary Bypass: Part 1â€"Mechanisms of Pathogenesis. Journal of Cardiothoracic and Vascular Anesthesia, 2009, 23, 223-231.	0.6	272
16	Do Safety Checklists Improve Teamwork and Communication in the Operating Room? A Systematic Review. Annals of Surgery, 2013, 258, 856-871.	2.1	260
17	Patient safety in developing countries: retrospective estimation of scale and nature of harm to patients in hospital. BMJ: British Medical Journal, 2012, 344, e832-e832.	2.4	222
18	Exploring the Causes of Adverse Events in NHS Hospital Practice. Journal of the Royal Society of Medicine, 2001, 94, 322-330.	1.1	217

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19	Multidisciplinary Crisis Simulations: The Way Forward for Training Surgical Teams. World Journal of Surgery, 2007, 31, 1843-1853.	0.8	199
20	Reliability of a revised NOTECHS scale for use in surgical teams. American Journal of Surgery, 2008, 196, 184-190.	0.9	196
21	A Qualitative Evaluation of the Barriers and Facilitators Toward Implementation of the WHO Surgical Safety Checklist Across Hospitals in England. Annals of Surgery, 2015, 261, 81-91.	2.1	196
22	Patient Reports of Preventable Problems and Harms in Primary Health Care. Annals of Family Medicine, 2004, 2, 333-340.	0.9	184
23	Teamwork in the operating theatre: cohesion or confusion?. Journal of Evaluation in Clinical Practice, 2006, 12, 182-189.	0.9	183
24	Surgical adverse events: a systematic review. American Journal of Surgery, 2013, 206, 253-262.	0.9	182
25	The Impact of Operating Room Distractions on Stress, Workload, and Teamwork. Annals of Surgery, 2015, 261, 1079-1084.	2.1	181
26	Observational Teamwork Assessment for Surgery (OTAS): Refinement and Application in Urological Surgery. World Journal of Surgery, 2007, 31, 1373-1381.	0.8	176
27	The Human Face of Simulation: Patient-Focused Simulation Training. Academic Medicine, 2006, 81, 919-924.	0.8	174
28	Information Transfer and Communication in Surgery. Annals of Surgery, 2010, 252, 225-239.	2.1	173
29	Safer Healthcare. , 2016, , .		167
30	Hospital staff should use more than one method to detect adverse events and potential adverse events: incident reporting, pharmacist surveillance and local real-time record review may all have a place. Quality and Safety in Health Care, 2007, 16, 40-44.	2.5	163
31	An evaluation of adverse incident reporting. Journal of Evaluation in Clinical Practice, 1999, 5, 5-12.	0.9	160
32	The association of workflow interruptions and hospital doctors' workload: a prospective observational study. BMJ Quality and Safety, 2012, 21, 399-407.	1.8	156
33	The role of hospital managers in quality and patient safety: a systematic review. BMJ Open, 2014, 4, e005055-e005055.	0.8	154
34	Safety measurement and monitoring in healthcare: a framework to guide clinical teams and healthcare organisations in maintaining safety. BMJ Quality and Safety, 2014, 23, 670-677.	1.8	148
35	Is health care getting safer?. BMJ: British Medical Journal, 2008, 337, a2426-a2426.	2.4	145
36	Measuring Variation in Use of the WHO Surgical Safety Checklist in the Operating Room: A Multicenter Prospective Cross-Sectional Study. Journal of the American College of Surgeons, 2015, 220, 1-11e4.	0.2	143

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37	Systems analysis of clinical incidents: the London protocol. Clinical Risk, 2004, 10, 211-220.	0.1	138
38	Surgical Crisis Management Skills Training and Assessment. Annals of Surgery, 2006, 244, 139-147.	2.1	137
39	Observational Assessment of Surgical Teamwork: A Feasibility Study. World Journal of Surgery, 2006, 30, 1774-1783.	0.8	133
40	Observational Teamwork Assessment for Surgery. Annals of Surgery, 2009, 249, 1047-1051.	2.1	133
41	Surgical complications and their impact on patientsâ€™ psychosocial well-being: a systematic review and meta-analysis. BMJ Open, 2016, 6, e007224.	0.8	132
42	Incident reporting and patient safety. BMJ: British Medical Journal, 2007, 334, 51-51.	2.4	129
43	Postoperative Handover. Annals of Surgery, 2010, 252, 171-176.	2.1	122
44	Surgical Checklist Implementation Project. Annals of Surgery, 2016, 263, 58-63.	2.1	118
45	Distracting communications in the operating theatre. Journal of Evaluation in Clinical Practice, 2007, 13, 390-394.	0.9	116
46	Improving Decision Making in Multidisciplinary Tumor Boards: Prospective Longitudinal Evaluation of a Multicomponent Intervention for 1,421 Patients. Journal of the American College of Surgeons, 2013, 217, 412-420.	0.2	111
47	Annoyances, Disruptions, and Interruptions in Surgery: The Disruptions in Surgery Index (DiSI). World Journal of Surgery, 2008, 32, 1643-1650.	0.8	110
48	Failures in communication and information transfer across the surgical care pathway: interview study. BMJ Quality and Safety, 2012, 21, 843-849.	1.8	110
49	The Incidence of Prescribing Errors in Hospital Inpatients. Drug Safety, 2005, 28, 891-900.	1.4	109
50	Communication Patterns in a UK Emergency Department. Annals of Emergency Medicine, 2007, 50, 407-413.	0.3	105
51	What is known about adverse events in older medical hospital inpatients? A systematic review of the literature. International Journal for Quality in Health Care, 2013, 25, 542-554.	0.9	103
52	Facilitators and Barriers to Teamworking and Patient Centeredness in Multidisciplinary Cancer Teams: Findings of a National Study. Annals of Surgical Oncology, 2013, 20, 1408-1416.	0.7	101
53	Operation Debrief. Annals of Surgery, 2013, 258, 958-963.	2.1	101
54	Teamwork and team performance in multidisciplinary cancer teams: development and evaluation of an observational assessment tool. BMJ Quality and Safety, 2011, 20, 849-856.	1.8	99

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55	UK parentsâ€™ decision-making about measlesâ€“mumpsâ€“rubella (MMR) vaccine 10 years after the MMR-autism controversy: A qualitative analysis. Vaccine, 2012, 30, 1855-1864.	1.7	99
56	Evaluation of Postoperative Handover Using a Tool to Assess Information Transfer and Teamwork. Annals of Surgery, 2011, 253, 831-837.	2.1	98
57	Quality Improvement in Multidisciplinary Cancer Teams: An Investigation of Teamwork and Clinical Decision-Making and Cross-Validation of Assessments. Annals of Surgical Oncology, 2011, 18, 3535-3543.	0.7	97
58	Breaking the rules: understanding non-compliance with policies and guidelines. BMJ: British Medical Journal, 2011, 343, d5283-d5283.	2.4	96
59	Teamwork and Team Decisionâ€making at Multidisciplinary Cancer Conferences: Barriers, Facilitators, and Opportunities for Improvement. World Journal of Surgery, 2011, 35, 1970-1976.	0.8	95
60	The outcomes of recent patient safety education interventions for trainee physicians and medical students: a systematic review. BMJ Open, 2015, 5, e007705-e007705.	0.8	95
61	Dying for the Weekend. Archives of Neurology, 2012, 69, 1296-302.	4.9	91
62	An Evaluation of Information Transfer Through the Continuum of Surgical Care. Annals of Surgery, 2010, 252, 402-407.	2.1	88
63	Transforming concepts in patient safety: a progress report. BMJ Quality and Safety, 2018, 27, 1019-1026.	1.8	85
64	Studying large-scale programmes to improve patient safety in whole care systems: Challenges for research. Social Science and Medicine, 2009, 69, 1767-1776.	1.8	84
65	How can we keep patients with dementia safe in our acute hospitals? A review of challenges and solutions. Journal of the Royal Society of Medicine, 2013, 106, 355-361.	1.1	83
66	Surgical technology and operating-room safety failures: a systematic review of quantitative studies. BMJ Quality and Safety, 2013, 22, 710-718.	1.8	79
67	Training Faculty in Nontechnical Skill Assessment. Annals of Surgery, 2013, 258, 370-375.	2.1	79
68	A Systematic Quantitative Assessment of Risks Associated With Poor Communication in Surgical Care. Archives of Surgery, 2010, 145, 582.	2.3	78
69	Omission bias and vaccine rejection by parents of healthy children: Implications for the influenza A/H1N1 vaccination programme. Vaccine, 2010, 28, 4181-4185.	1.7	78
70	The Inflammatory Response to Cardiopulmonary Bypass: Part 2â€”Anti-Inflammatory Therapeutic Strategies. Journal of Cardiothoracic and Vascular Anesthesia, 2009, 23, 384-393.	0.6	75
71	Multidisciplinary team working across different tumour types: analysis of a national survey. Annals of Oncology, 2012, 23, 1293-1300.	0.6	72
72	Measurement of patient safety: a systematic review of the reliability and validity of adverse event detection with record review. BMJ Open, 2016, 6, e011078.	0.8	70

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73	Development and Evaluation of a Checklist to Support Decision Making in Cancer Multidisciplinary Team Meetings: MDT-QuIC. Annals of Surgical Oncology, 2012, 19, 1759-1765.	0.7	69
74	Multidisciplinary Cancer Team Meeting Structure and Treatment Decisions: A Prospective Correlational Study. Annals of Surgical Oncology, 2013, 20, 715-722.	0.7	68
75	Safety in healthcare is a moving target. BMJ Quality and Safety, 2015, 24, 539-540.	1.8	68
76	Observational Teamwork Assessment for Surgery. Annals of Surgery, 2012, 255, 804-809.	2.1	65
77	Constructing hierarchical task analysis in surgery. Surgical Endoscopy and Other Interventional Techniques, 2008, 22, 107-111.	1.3	64
78	Improving postoperative handover: a prospective observational study. American Journal of Surgery, 2013, 206, 494-501.	0.9	64
79	Teams under pressure in the emergency department: an interview study. Emergency Medicine Journal, 2012, 29, e2-e2.	0.4	63
80	Factors influencing stigma. Social Psychiatry and Psychiatric Epidemiology, 2002, 37, 430-434.	1.6	61
81	Development and Validation of a Tool to Assess Emergency Physicians' Nontechnical Skills. Annals of Emergency Medicine, 2012, 59, 376-385.e4.	0.3	59
82	Identifying Nontechnical Skills Associated With Safety in the Emergency Department: A Scoping Review of the Literature. Annals of Emergency Medicine, 2012, 59, 386-394.	0.3	58
83	Unannounced in situ simulations: integrating training and clinical practice. BMJ Quality and Safety, 2013, 22, 453-458.	1.8	58
84	COVID-19: patient safety and quality improvement skills to deploy during the surge. International Journal for Quality in Health Care, 2021, 33, .	0.9	58
85	Delivering clinical decision support services: There is nothing as practical as a good theory. Journal of Biomedical Informatics, 2010, 43, 831-843.	2.5	57
86	Strategies to improve the efficiency and utility of multidisciplinary team meetings in urology cancer care: a survey study. BMC Health Services Research, 2014, 14, 377.	0.9	56
87	The Health Beliefs and Behaviors of Three Groups of Complementary Medicine and a General Practice Group of Patients. Journal of Alternative and Complementary Medicine, 1995, 1, 347-359.	2.1	55
88	On the Evaluation of the Clinical Effects of Acupuncture: A Problem Reassessed and a Framework for Future Research. Journal of Alternative and Complementary Medicine, 1996, 2, 79-90.	2.1	55
89	Patients and families as safety experts. Cmaj, 2012, 184, 15-16.	0.9	54
90	Errors in surgery. International Journal of Surgery, 2005, 3, 75-81.	1.1	53

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91	The challenges of caring for children who require complex medical care at home: â€˜The go between for everyone is the parent and as the parent thatâ€™s an awful lot of responsibilityâ€™. Health Expectations, 2020, 23, 1144-1154.	1.1	53
92	Team performance in resuscitation teams: Comparison and critique of two recently developed scoring tools. Resuscitation, 2012, 83, 1478-1483.	1.3	52
93	An Examination of Opportunities for the Active Patient in Improving Patient Safety. Journal of Patient Safety, 2012, 8, 36-43.	0.7	51
94	Organisational readiness: exploring the preconditions for success in organisation-wide patient safety improvement programmes. Quality and Safety in Health Care, 2010, 19, 313-317.	2.5	50
95	Development of assessing generic and specific technical skills in laparoscopic surgery. American Journal of Surgery, 2006, 191, 238-244.	0.9	49
96	Strategies for sustaining a quality improvement collaborative and its patient safety gains. International Journal for Quality in Health Care, 2012, 24, 380-390.	0.9	49
97	An Observational Study of the Frequency, Severity, and Etiology of Failures in Postoperative Care After Major Elective General Surgery. Annals of Surgery, 2013, 257, 1-5.	2.1	49
98	Learning from litigation. The role of claims analysis in patient safety. Journal of Evaluation in Clinical Practice, 2006, 12, 665-674.	0.9	48
99	The perceived efficacy of complementary and orthodox medicine in complementary and general practice patients. Health Education Research, 1995, 10, 395-405.	1.0	47
100	Identifying vulnerabilities in communication in the emergency department. Emergency Medicine Journal, 2009, 26, 653-657.	0.4	47
101	Socio-Psychological Factors Driving Adult Vaccination: A Qualitative Study. PLoS ONE, 2014, 9, e113503.	1.1	47
102	Patientsâ€™ attitudes towards patient involvement in safety interventions: results of two exploratory studies. Health Expectations, 2013, 16, e164-76.	1.1	44
103	Actual vs perceived performance debriefing in surgery: practice far from perfect. American Journal of Surgery, 2013, 205, 434-440.	0.9	44
104	Surgery, Complications, and Quality of Life. Annals of Surgery, 2019, 270, 95-101.	2.1	44
105	Incident reporting in one UK accident and emergency department. International Emergency Nursing, 2006, 14, 27-37.	0.7	43
106	Learning from failure: the need for independent safety investigation in healthcare. Journal of the Royal Society of Medicine, 2014, 107, 439-443.	1.1	43
107	Single measures of performance do not reflect overall institutional quality in colorectal cancer surgery. Gut, 2013, 62, 423-429.	6.1	42
108	Evidence-based interventions to reduce adverse events in hospitals: a systematic review of systematic reviews. BMJ Open, 2016, 6, e012555.	0.8	42

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109	Mapping surgical practice decision making: an interview study to evaluate decisions in surgical care. American Journal of Surgery, 2008, 195, 689-696.	0.9	41
110	A longitudinal, multi-level comparative study of quality and safety in European hospitals: the QUASER study protocol. BMC Health Services Research, 2011, 11, 285.	0.9	41
111	Safety analysis over time: seven major changes to adverse event investigation. Implementation Science, 2017, 12, 151.	2.5	41
112	The complexity of measuring interprofessional teamwork in the operating theatre. Journal of Interprofessional Care, 2006, 20, 485-495.	0.8	40
113	Reflective analysis of safety research in the hospital accident & emergency departments. Applied Ergonomics, 2010, 41, 695-700.	1.7	40
114	Acute traumatic stress among surgeons after major surgical complications. American Journal of Surgery, 2014, 208, 642-647.	0.9	40
115	Perceptions of the impact of a largeâ€scale collaborative improvement programme: experience in the UK Safer Patients Initiative. Journal of Evaluation in Clinical Practice, 2009, 15, 524-540.	0.9	39
116	Quantitative analysis of intraoperative communication in open and laparoscopic surgery. Surgical Endoscopy and Other Interventional Techniques, 2012, 26, 2931-2938.	1.3	39
117	Managing risk in hazardous conditions: improvisation is not enough. BMJ Quality and Safety, 2020, 29, 60-63.	1.8	39
118	Missing Clinical Information in NHS hospital outpatient clinics: prevalence, causes and effects on patient care. BMC Health Services Research, 2011, 11, 114.	0.9	38
119	The ABC of handover: a qualitative study to develop a new tool for handover in the emergency department. Emergency Medicine Journal, 2012, 29, 941-946.	0.4	38
120	Variation in the prevalence of urinary catheters: a profile of National Health Service patients in England. BMJ Open, 2017, 7, e013842.	0.8	38
121	Observer-based tools for non-technical skills assessment in simulated and real clinical environments in healthcare: a systematic review. BMJ Quality and Safety, 2019, 28, 672-686.	1.8	38
122	Diagnostic error in a national incident reporting system in the UK. Journal of Evaluation in Clinical Practice, 2010, 16, 1276-1281.	0.9	37
123	Failure to Rescue Patients After Reintervention in Gastroesophageal Cancer Surgery in England. JAMA Surgery, 2013, 148, 272.	2.2	37
124	Applying human factors methods to clinical risk management in obstetrics. BJOG: an International Journal of Obstetrics and Gynaecology, 1997, 104, 1225-1232.	1.1	36
125	Complementary medicine: state of the evidence. Journal of the Royal Society of Medicine, 1999, 92, 170-177.	1.1	36
126	Attitudinal and Demographic Predictors of Measles-Mumps-Rubella Vaccine (MMR) Uptake during the UK Catch-Up Campaign 2008â€“09: Cross-Sectional Survey. PLoS ONE, 2011, 6, e19381.	1.1	36

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127	Attitudinal and demographic predictors of measles, mumps and rubella (MMR) vaccine acceptance: Development and validation of an evidence-based measurement instrument. Vaccine, 2011, 29, 1700-1709.	1.7	34
128	Hospital patients' reports of medical errors and undesirable events in their health care. Journal of Evaluation in Clinical Practice, 2013, 19, 875-881.	0.9	34
129	Blood Transfusion Safety: The Potential Role of the Patient. Transfusion Medicine Reviews, 2011, 25, 12-23.	0.9	33
130	Using institutional theory to analyse hospital responses to external demands for finance and quality in five European countries. Journal of Health Services Research and Policy, 2016, 21, 109-117.	0.8	33
131	Carers' Medication Administration Errors in the Domiciliary Setting: A Systematic Review. PLoS ONE, 2016, 11, e0167204.	1.1	33
132	Communication in the emergency department: separating the signal from the noise. Medical Journal of Australia, 2002, 176, 409-410.	0.8	32
133	Improving patient safety incident reporting systems by focusing upon feedback â€“ lessons from English and Welsh trusts. Health Services Management Research, 2009, 22, 129-135.	1.0	32
134	The disparity of frontline clinical staff and managers' perceptions of a quality and patient safety initiative. Journal of Evaluation in Clinical Practice, 2011, 17, 1184-1190.	0.9	32
135	Patient Involvement in Patient Safety. Journal of Patient Safety, 2012, 8, 182-188.	0.7	32
136	Reducing Error and Improving Efficiency during Vascular Interventional Radiology: Implementation of a Preprocedural Team Rehearsal. Radiology, 2012, 264, 473-483.	3.6	32
137	Safety skills training for surgeons: AÂhalf-day intervention improves knowledge, attitudes and awareness of patient safety. Surgery, 2012, 152, 26-31.	1.0	32
138	Prospects for comparing European hospitals in terms of quality and safety: lessons from a comparative study in five countries. International Journal for Quality in Health Care, 2013, 25, 1-7.	0.9	32
139	Influence of doctor-patient conversations on behaviours of patients presenting to primary care with new or persistent symptoms: a video observation study. BMJ Quality and Safety, 2020, 29, 198-208.	1.8	32
140	Patients' and health care professionals' attitudes towards the PINK patient safety video. Journal of Evaluation in Clinical Practice, 2012, 18, 848-853.	0.9	31
141	The perceived efficacy of complementary and orthodox medicine: preliminary findings and the development of a questionnaire. Complementary Therapies in Medicine, 1994, 2, 128-134.	1.3	30
142	Factors predicting change in hospital safety climate and capability in a multi-site patient safety collaborative: a longitudinal survey study. BMJ Quality and Safety, 2012, 21, 559-568.	1.8	30
143	A Systematic Proactive Risk Assessment of Hazards in Surgical Wards. Annals of Surgery, 2012, 255, 1086-1092.	2.1	30
144	Building capacity and capability for patient safety education: a train-the-trainers programme for senior doctors. BMJ Quality and Safety, 2013, 22, 618-625.	1.8	30

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145	Development, initial reliability and validity testing of an observational tool for assessing technical skills of operating room nurses. International Journal of Nursing Studies, 2009, 46, 1187-1193.	2.5	29
146	How do we approach a major change program using the example of the development, evaluation, and implementation of an electronic transfusion management system. Transfusion, 2009, 49, 829-837.	0.8	29
147	How reliable are clinical systems in the UK NHS? A study of seven NHS organisations. BMJ Quality and Safety, 2012, 21, 466-472.	1.8	28
148	Building a safer foundation: the Lessons Learnt patient safety training programme. BMJ Quality and Safety, 2014, 23, 78-86.	1.8	28
149	Evaluating the importance of policy amenable factors in explaining influenza vaccination: a cross-sectional multinational study. BMJ Open, 2017, 7, e014668.	0.8	28
150	Judgment analysis: a method for quantitative evaluation of trainee surgeonsâ€™ judgments of surgical risk. American Journal of Surgery, 2008, 195, 183-188.	0.9	26
151	Exploring the care experience of patients undergoing spinal surgery: a qualitative study. Journal of Evaluation in Clinical Practice, 2013, 19, 132-138.	0.9	26
152	The natural lifespan of a safety policy: violations and system migration in anaesthesia. Quality and Safety in Health Care, 2010, 19, 327-331.	2.5	25
153	A multicentre observational study to evaluate a new tool to assess emergency physicians' non-technical skills. Emergency Medicine Journal, 2013, 30, 437-443.	0.4	25
154	The WHO surgical safety checklist: survey of patientsâ€™ views. BMJ Quality and Safety, 2014, 23, 939-946.	1.8	25
155	Towards the Next Frontier for Simulation-Based Training. Annals of Surgery, 2014, 260, 252-258.	2.1	25
156	The role of oncologists in multidisciplinary cancer teams in the UK: an untapped resource for team leadership?. Journal of Evaluation in Clinical Practice, 2011, 17, 1200-1206.	0.9	24
157	Predictors of hospitalized patientsâ€™ intentions to prevent healthcare harm: A cross sectional survey. International Journal of Nursing Studies, 2012, 49, 407-415.	2.5	23
158	Identifying systems failures in the pathway to a catastrophic event: an analysis of national incident report data relating to vinca alkaloids. BMJ Quality and Safety, 2014, 23, 765-772.	1.8	23
159	Improving communication in the emergency department. Emergency Medicine Journal, 2009, 26, 658-661.	0.4	22
160	Medical engagement in organisation-wide safety and quality-improvement programmes: experience in the UK Safer Patients Initiative. BMJ Quality and Safety, 2010, 19, e44-e44.	1.8	22
161	Multidisciplinary centres for safety and quality improvement: learning from climate change science. BMJ Quality and Safety, 2011, 20, i73-i78.	1.8	22
162	The role of chief executive officers in a quality improvement initiative: a qualitative study. BMJ Open, 2013, 3, e001731.	0.8	22

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163	A qualitative exploration of patients' attitudes towards the 'Participate Inform Notice Know' (PINK) patient safety video. International Journal for Quality in Health Care, 2013, 25, 29-34.	0.9	22
164	Reducing urinary tract infections in care homes by improving hydration. BMJ Open Quality, 2019, 8, e000563.	0.4	22
165	The problem of engaging hospital doctors in promoting safety and quality in clinical care. Perspectives in Public Health, 2007, 127, 87-94.	0.5	21
166	High reliability in health care. BMJ: British Medical Journal, 2010, 340, c84-c84.	2.4	21
167	The role of the urology clinical nurse specialist in the multidisciplinary team meeting. International Journal of Urological Nursing, 2011, 5, 59-64.	0.1	21
168	Communication strategies in acute health care: evaluation within the context of infection prevention and control. Journal of Hospital Infection, 2012, 82, 25-29.	1.4	21
169	Consent to transfusion: patients' and healthcare professionals' attitudes towards the provision of blood transfusion information. Transfusion Medicine, 2012, 22, 167-172.	0.5	21
170	Preventing delayed diagnosis of cancer: cliniciansâ€™ views on main problems and solutions. Journal of Global Health, 2016, 6, 020901.	1.2	21
171	Social scientists and patient safety: Critics or contributors?. Social Science and Medicine, 2009, 69, 1777-1779.	1.8	20
172	Measuring Safety and Efficiency in the Operating Room: Development and Validation of a Metric for Evaluating Task Execution in the Operating Room. Journal of the American College of Surgeons, 2013, 216, 472-481.	0.2	20
173	Identification of priorities for improvement of medication safety in primary care: a PRIORITIZE study. BMC Family Practice, 2016, 17, 160.	2.9	20
174	Is team training in briefings for surgical teams feasible in simulation?. Cognition, Technology and Work, 2007, 10, 275.	1.7	19
175	Systemic Leukofiltration Does Not Attenuate Pulmonary Injury after Cardiopulmonary Bypass. ASAIO Journal, 2008, 54, 78-88.	0.9	19
176	Variations in the Application of Various Perfusion Technologies in Great Britain and Irelandâ€”A National Survey. Artificial Organs, 2010, 34, 200-205.	1.0	19
177	The ABC of handover: impact on shift handover in the emergency department. Emergency Medicine Journal, 2012, 29, 947-953.	0.4	19
178	Coping with more people with more illness. Part 1: the nature of the challenge and the implications for safety and quality. International Journal for Quality in Health Care, 2019, 31, 154-158.	0.9	19
179	Patient safety regulation in the NHS: mapping the regulatory landscape of healthcare. BMJ Open, 2019, 9, e028663.	0.8	19
180	Defining and measuring suspicion of sepsis: an analysis of routine data. BMJ Open, 2017, 7, e014885.	0.8	18

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181	Establishing quality in colorectal surgery. Colorectal Disease, 2011, 13, 961-973.	0.7	17
182	Improving reliability of clinical care practices for ventilated patients in the context of a patient safety improvement initiative. Journal of Evaluation in Clinical Practice, 2011, 17, 180-187.	0.9	17
183	The Effects of Medical Accidents and Litigation on Doctors and Patients*. Law and Policy, 1994, 16, 97-121.	0.3	16
184	An observational study of teamwork skills in shift handover. International Journal of Surgery, 2012, 10, 355-359.	1.1	16
185	Clinician-identified problems and solutions for delayed diagnosis in primary care: a PRIORITIZE study. BMC Family Practice, 2016, 17, 131.	2.9	16
186	Measurement and monitoring of safety: impact and challenges of putting a conceptual framework into practice. BMJ Quality and Safety, 2018, 27, 818-826.	1.8	16
187	Coping with more people with more illness. Part 2: new generation of standards for enabling healthcare system transformation and sustainability. International Journal for Quality in Health Care, 2019, 31, 159-163.	0.9	16
188	Hidden hazards of SARSâ€CoVâ€2 transmission in hospitals: A systematic review. Indoor Air, 2022, 32, .	2.0	16
189	The human element of adverse events. Medical Journal of Australia, 1999, 170, 404-405.	0.8	15
190	A decision-making learning and assessment tool in laparoscopic cholecystectomy. Surgical Endoscopy and Other Interventional Techniques, 2009, 23, 197-203.	1.3	15
191	Building global capacity for patient safety: A training program for surgical safety research in developing and transitional countries. International Journal of Surgery, 2012, 10, 493-499.	1.1	15
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