Charles A Vincent

List of Publications by Year
in descending order

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287	19,225	13099	14759
papers	citations	68 h-index	127 g-index

305	305	305	15060
all docs	docs citations	times ranked	citing authors

#	Article	IF	Citations
1	Coproducing a library of videos to support families caring for children with gastrostomies: A mixedâ€methods evaluation with family carers and clinicians. Health Expectations, 2022, 25, 1038-1047.	2.6	2
2	Embracing multiple aims in healthcare improvement and innovation. International Journal for Quality in Health Care, 2022, 34, .	1.8	1
3	Action on patient safety can reduce health inequalities. BMJ, The, 2022, 376, e067090.	6.0	8
4	Hidden hazards of SARSâ€CoVâ€2 transmission in hospitals: A systematic review. Indoor Air, 2022, 32, .	4.3	16
5	Designing clinical indicators for common residential aged care conditions and processes of care: the CareTrack Aged development and validation study. International Journal for Quality in Health Care, 2022, 34, .	1.8	5
6	Environmental changes to reduce self-harm on an adolescent inpatient psychiatric ward: an interrupted time series analysis. European Child and Adolescent Psychiatry, 2021, 30, 1173-1186.	4.7	4
7	COVID-19: patient safety and quality improvement skills to deploy during the surge. International Journal for Quality in Health Care, 2021, 33, .	1.8	58
8	A Protocol is not Enough: Enhanced Recovery Programâ€Based Care and Clinician Adherence Associated with Shorter Stay After Colorectal Surgery. World Journal of Surgery, 2021, 45, 347-355.	1.6	10
9	How to do no harm: empowering local leaders to make care safer in low-resource settings. Archives of Disease in Childhood, 2021, 106, 333-337.	1.9	6
10	Moving beyond the weekend effect: how can we best target interventions to improve patient care?. BMJ Quality and Safety, 2021, 30, 525-528.	3.7	4
11	Interventions to reduce self-harm on in-patient wards: systematic review. BJPsych Open, 2021, 7, e80.	0.7	14
12	Training and support for caring for a childâ€™s gastrostomy: a survey with family carers. BMJ Paediatrics Open, 2021, 5, e001068.	1.4	4
13	First do no harm: practitionersâ€™ ability to â€˜diagnoseâ€™ system weaknesses and improve safety is a critical initial step in improving care quality. Archives of Disease in Childhood, 2021, 106, 326-332.	1.9	10
14	Human Error and Patient Safety. , 2021, , 29-44.		2
15	How do National Health Service (NHS) organisations respond to patient concerns? A qualitative interview study of the Patient Advice and Liaison Service (PALS). BMJ Open, 2021, 11, e053239.	1.9	1
16	What is the relationship between mortality alerts and other indicators of quality of care? A national cross-sectional study. Journal of Health Services Research and Policy, 2020, 25, 13-21.	1.7	7
17	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.	3.7	32
18	Impact of the Norwegian National Patient Safety Program on implementation of the WHO Surgical Safety Checklist and on perioperative safety culture. BMJ Open Quality, 2020, 9, e000966.	1.1	7

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19	Transformational improvement in quality care and health systems: the next decade. BMC Medicine, 2020, 18, 340.	5.5	14
20	Building improvement capacity in mental healthÂservices. BJPsych International, 2020, 17, 75-76.	1.4	1
21	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.	2.6	53
22	Systematic review of interventions to improve constant observation on adult inpatient psychiatric wards. International Journal of Mental Health Nursing, 2020, 29, 372-386.	3.8	11
23	Validation of the Partners at Care Transitions Measure (PACT-M): assessing the quality and safety of care transitions for older people in the UK. BMC Health Services Research, 2020, 20, 608.	2.2	7
24	Managing risk in hazardous conditions: improvisation is not enough. BMJ Quality and Safety, 2020, 29, 60-63.	3.7	39
25	Analysis of paediatric long-term ventilation incidents in the community. Archives of Disease in Childhood, 2020, 105, 446-451.	1.9	7
26	Redesigning safety regulation in the NHS. BMJ, The, 2020, 368, m760.	6.0	4
27	From incident reporting to the analysis of the patient journey. BMJ Quality and Safety, 2019, 28, 169-171.	3.7	13
28	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.	3.7	38
29	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.	1.8	16
30	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.	1.8	19
31	Patient safety regulation in the NHS: mapping the regulatory landscape of healthcare. BMJ Open, 2019, 9, e028663.	1.9	19
32	Reducing urinary tract infections in care homes by improving hydration. BMJ Open Quality, 2019, 8, e000563.	1.1	22
33	Paediatric enteral feeding at home: an analysis of patient safety incidents. Archives of Disease in Childhood, 2019, 104, 1174-1180.	1.9	13
34	Surgery, Complications, and Quality of Life. Annals of Surgery, 2019, 270, 95-101.	4.2	44
35	Improving communication at handover and transfer reduces retained swabs in maternity services. European Journal of Obstetrics, Gynecology and Reproductive Biology, 2018, 220, 50-56.	1.1	6
36	Measurement and monitoring of safety: impact and challenges of putting a conceptual framework into practice. BMJ Quality and Safety, 2018, 27, 818-826.	3.7	16

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37	National hospital mortality surveillance system: a descriptive analysis. BMJ Quality and Safety, 2018, 27, 974-981.	3.7	8
38	Investigating the association of alerts from a national mortality surveillance system with subsequent hospital mortality in England: an interrupted time series analysis. BMJ Quality and Safety, 2018, 27, 965-973.	3.7	8
39	Transforming concepts in patient safety: a progress report. BMJ Quality and Safety, 2018, 27, 1019-1026.	3.7	85
40	Evaluation of a national surveillance system for mortality alerts: a mixed-methods study. Health Services and Delivery Research, 2018, 6, 1-314.	1.4	5
41	Predicting clinical deterioration after initial assessment in out-of-hours primary care: a retrospective service evaluation. British Journal of General Practice, 2017, 67, e78-e85.	1.4	11
42	Prioritizing problems in and solutions to homecare safety of people with dementia: supporting carers, streamlining care. BMC Geriatrics, 2017, 17, 26.	2.7	13
43	A new national safety investigator for healthcare: the road ahead. Journal of the Royal Society of Medicine, 2017, 110, 90-92.	2.0	12
44	Defining and measuring suspicion of sepsis: an analysis of routine data. BMJ Open, 2017, 7, e014885.	1.9	18
45	Evaluating the importance of policy amenable factors in explaining influenza vaccination: a cross-sectional multinational study. BMJ Open, 2017, 7, e014668.	1.9	28
46	Surgeons' Perceptions of the Causes of Preventable Harm in Arterial Surgery: A Mixed-Methods Study. European Journal of Vascular and Endovascular Surgery, 2017, 54, 778-786.	1.5	8
47	Variation in the prevalence of urinary catheters: a profile of National Health Service patients in England. BMJ Open, 2017, 7, e013842.	1.9	38
48	Safety analysis over time: seven major changes to adverse event investigation. Implementation Science, 2017, 12, 151.	6.9	41
49	Prioritizing medication safety in care of people with cancer: cliniciansâ€™ views on main problems and solutions. Journal of Global Health, 2017, 7, 011001.	2.7	6
50	Patient safety in community dementia services: what can we learn from the experiences of caregivers and healthcare professionals?. Age and Ageing, 2017, 46, 518-521.	1.6	12
51	Measuring harm and informing quality improvement in the Welsh NHS: the longitudinal Welsh national adverse events study. Health Services and Delivery Research, 2017, 5, 1-190.	1.4	7
52	Preventing delayed diagnosis of cancer: cliniciansâ€™ views on main problems and solutions. Journal of Global Health, 2016, 6, 020901.	2.7	21
53	Surgical Checklist Implementation Project. Annals of Surgery, 2016, 263, 58-63.	4.2	118
54	Measurement of patient safety: a systematic review of the reliability and validity of adverse event detection with record review. BMJ Open, 2016, 6, e011078.	1.9	70

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55	Identification of priorities for improvement of medication safety in primary care: a PRIORITIZE study. BMC Family Practice, 2016, 17, 160.	2.9	20
56	Evidence-based interventions to reduce adverse events in hospitals: a systematic review of systematic reviews. BMJ Open, 2016, 6, e012555.	1.9	42
57	Reliability in the process of care during emergency general surgical admission: A prospective cohort study. International Journal of Surgery, 2016, 32, 143-149.	2.7	6
58	Rethinking medical ward quality. BMJ, The, 2016, 355, i5417.	6.0	8
59	Absconding: reducing failure to return in adult mental health wards. BMJ Quality Improvement Reports, 2016, 5, u209837.w5117.	0.8	8
60	Do patients with gastrointestinal cancer want to decide where they have tests and surgery? A questionnaire study of provider choice. BMJ Quality and Safety, 2016, 25, 696-703.	3.7	4
61	Clinician-identified problems and solutions for delayed diagnosis in primary care: a PRIORITIZE study. BMC Family Practice, 2016, 17, 131.	2.9	16
62	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.	1.7	33
63	Strategies for Safety. , 2016, , 59-72.		2
64	Safety Strategies in Hospitals. , 2016, , 73-91.		9
65	Safer Healthcare. , 2016, , .		167
66	Approaches to Safety: One Size Does Not Fit All. , 2016, , 27-37.		5
67	Surgical complications and their impact on patientsâ€™ psychosocial well-being: a systematic review and meta-analysis. BMJ Open, 2016, 6, e007224.	1.9	132
68	Progress and Challenges for Patient Safety. , 2016, , 1-12.		2
69	New Challenges for Patient Safety. , 2016, , 129-138.		2
70	The Ideal and the Real. , 2016, , 13-25.		3
71	Safety Strategies for Care in the Home. , 2016, , 93-111.		6
72	Carers' Medication Administration Errors in the Domiciliary Setting: A Systematic Review. PLoS ONE, 2016, 11, e0167204.	2.5	33

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73	The Consequences for Incident Analysis. , 2016, , 47-58.		0
74	Predictors of Patientsâ€™ Intentions to Participate in Incident Reporting and Medication Safety. Journal of Patient Safety, 2015, 11, 191-197.	1.7	7
75	The Impact of Operating Room Distractions on Stress, Workload, and Teamwork. Annals of Surgery, 2015, 261, 1079-1084.	4.2	181
76	Making health care safer: What is the contribution of health psychology?. British Journal of Health Psychology, 2015, 20, 681-687.	3.5	3
77	Safety in healthcare is a moving target. BMJ Quality and Safety, 2015, 24, 539-540.	3.7	68
78	Understanding how colorectal units achieve short length of stay: an interview survey among representative hospitals in England. Patient Safety in Surgery, 2015, 9, 2.	2.3	2
79	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.	4.2	196
80	Researching patient safety in primary care: Now and in the future. European Journal of General Practice, 2015, 21, 1-2.	2.0	1
81	The outcomes of recent patient safety education interventions for trainee physicians and medical students: a systematic review. BMJ Open, 2015, 5, e007705-e007705.	1.9	95
82	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.	0.5	143
83	Improving Multidisciplinary Team Working in Pelvic Oncology. , 2015, , 3-12.		0
84	Socio-Psychological Factors Driving Adult Vaccination: A Qualitative Study. PLoS ONE, 2014, 9, e113503.	2.5	47
85	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.	2.2	56
86	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.	3.7	148
87	The role of hospital managers in quality and patient safety: a systematic review. BMJ Open, 2014, 4, e005055-e005055.	1.9	154
88	Relationship between preventable hospital deaths and other measures of safety: an exploratory study. International Journal for Quality in Health Care, 2014, 26, 298-307.	1.8	13
89	Journey to vaccination: a protocol for a multinational qualitative study. BMJ Open, 2014, 4, e004279.	1.9	9
90	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.	3.7	23

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91	Patient safety skills in primary care: a national survey of GP educators. BMC Family Practice, 2014, 15, 206.	2.9	6
92	Outlier Identification in Colorectal Surgery Should Separate Elective and Nonelective Service Components. Diseases of the Colon and Rectum, 2014, 57, 1098-1104.	1.3	3
93	Learning from preventable deaths: exploring case record reviewers' narratives using change analysis. Journal of the Royal Society of Medicine, 2014, 107, 365-375.	2.0	15
94	Building a safer foundation: the Lessons Learnt patient safety training programme. BMJ Quality and Safety, 2014, 23, 78-86.	3.7	28
95	Learning from failure: the need for independent safety investigation in healthcare. Journal of the Royal Society of Medicine, 2014, 107, 439-443.	2.0	43
96	Acute traumatic stress among surgeons after major surgical complications. American Journal of Surgery, 2014, 208, 642-647.	1.8	40
97	The WHO surgical safety checklist: survey of patientsâ€™ views. BMJ Quality and Safety, 2014, 23, 939-946.	3.7	25
98	Towards the Next Frontier for Simulation-Based Training. Annals of Surgery, 2014, 260, 252-258.	4.2	25
99	The medical student as a patient: attitudes towards involvement in the quality and safety of health care. Journal of Evaluation in Clinical Practice, 2013, 19, 812-818.	1.8	4
100	Hospital patients' reports of medical errors and undesirable events in their health care. Journal of Evaluation in Clinical Practice, 2013, 19, 875-881.	1.8	34
101	Patientsâ€™ attitudes towards patient involvement in safety interventions: results of two exploratory studies. Health Expectations, 2013, 16, e164-76.	2.6	44
102	Exploring the care experience of patients undergoing spinal surgery: a qualitative study. Journal of Evaluation in Clinical Practice, 2013, 19, 132-138.	1.8	26
103	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.	1.5	101
104	Improving postoperative handover: a prospective observational study. American Journal of Surgery, 2013, 206, 494-501.	1.8	64
105	Surgical adverse events: a systematic review. American Journal of Surgery, 2013, 206, 253-262.	1.8	182
106	Multidisciplinary Cancer Team Meeting Structure and Treatment Decisions: A Prospective Correlational Study. Annals of Surgical Oncology, 2013, 20, 715-722.	1.5	68
107	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.	0.5	111
108	The effects of resource availability on mortality for emergency general surgical admissions. Journal of the American College of Surgeons, 2013, 217, S109.	0.5	0

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109	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.	0.5	20
110	Actual vs perceived performance debriefing in surgery: practice far from perfect. American Journal of Surgery, 2013, 205, 434-440.	1.8	44
111	Surgical technology and operating-room safety failures: a systematic review of quantitative studies. BMJ Quality and Safety, 2013, 22, 710-718.	3.7	79
112	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.	1.8	103
113	The role of chief executive officers in a quality improvement initiative: a qualitative study. BMJ Open, 2013, 3, e001731.	1.9	22
114	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.	1.8	32
115	Meeting the ambition of measuring the quality of hospitals' stroke care using routinely collected administrative data: a feasibility study. International Journal for Quality in Health Care, 2013, 25, 429-436.	1.8	15
116	Failure to Rescue Patients After Reintervention in Gastroesophageal Cancer Surgery in England. JAMA Surgery, 2013, 148, 272.	4.3	37
117	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.	2.0	83
118	Science and patient safety. Cmaj, 2013, 185, 110-111.	2.0	9
119	A multicentre observational study to evaluate a new tool to assess emergency physicians' non-technical skills. Emergency Medicine Journal, 2013, 30, 437-443.	1.0	25
120	Republished: Managing the after effects of serious patient safety incidents in the NHS: an online survey study. Postgraduate Medical Journal, 2013, 89, 266-273.	1.8	2
121	Do Safety Checklists Improve Teamwork and Communication in the Operating Room? A Systematic Review. Annals of Surgery, 2013, 258, 856-871.	4.2	260
122	Building capacity and capability for patient safety education: a train-the-trainers programme for senior doctors. BMJ Quality and Safety, 2013, 22, 618-625.	3.7	30
123	To what extent are inpatient deaths preventable? The author's reply. BMJ Quality and Safety, 2013, 22, 607.2-608.	3.7	2
124	Single measures of performance do not reflect overall institutional quality in colorectal cancer surgery. Gut, 2013, 62, 423-429.	12.1	42
125	Operation Debrief. Annals of Surgery, 2013, 258, 958-963.	4.2	101
126	Unannounced in situ simulations: integrating training and clinical practice. BMJ Quality and Safety, 2013, 22, 453-458.	3.7	58

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127	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.	1.8	22
128	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.	4.2	49
129	Training Faculty in Nontechnical Skill Assessment. Annals of Surgery, 2013, 258, 370-375.	4.2	79
130	Structured Team Self-Report of Intraoperative Error Can Identify Obstacles to Safe Surgery. Joint Commission Journal on Quality and Patient Safety, 2013, 39, 480.	0.7	2
131	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.	3.7	30
132	Failures in communication and information transfer across the surgical care pathway: interview study. BMJ Quality and Safety, 2012, 21, 843-849.	3.7	110
133	The ABC of handover: impact on shift handover in the emergency department. Emergency Medicine Journal, 2012, 29, 947-953.	1.0	19
134	Managing the after effects of serious patient safety incidents in the NHS: an online survey study. BMJ Quality and Safety, 2012, 21, 1001-1008.	3.7	13
135	Multidisciplinary team working across different tumour types: analysis of a national survey. Annals of Oncology, 2012, 23, 1293-1300.	1.2	72
136	Dying for the Weekend. Archives of Neurology, 2012, 69, 1296-302.	4.5	91
137	An Examination of Opportunities for the Active Patient in Improving Patient Safety. Journal of Patient Safety, 2012, 8, 36-43.	1.7	51
138	Patient Involvement in Patient Safety. Journal of Patient Safety, 2012, 8, 182-188.	1.7	32
139	Teams under pressure in the emergency department: an interview study. Emergency Medicine Journal, 2012, 29, e2-e2.	1.0	63
140	Reducing Error and Improving Efficiency during Vascular Interventional Radiology: Implementation of a Preprocedural Team Rehearsal. Radiology, 2012, 264, 473-483.	7.3	32
141	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.	2.3	222
142	Patients and families as safety experts. Cmaj, 2012, 184, 15-16.	2.0	54
143	The association of workflow interruptions and hospital doctors' workload: a prospective observational study. BMJ Quality and Safety, 2012, 21, 399-407.	3.7	156
144	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.	3.7	275

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145	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.	1.0	38
146	Strategies for sustaining a quality improvement collaborative and its patient safety gains. International Journal for Quality in Health Care, 2012, 24, 380-390.	1.8	49
147	Observational Teamwork Assessment for Surgery. Annals of Surgery, 2012, 255, 804-809.	4.2	65
148	A Matter of Conscience. Anesthesia and Analgesia, 2012, 114, 494-496.	2.2	7
149	How reliable are clinical systems in the UK NHS? A study of seven NHS organisations. BMJ Quality and Safety, 2012, 21, 466-472.	3.7	28
150	A Systematic Proactive Risk Assessment of Hazards in Surgical Wards. Annals of Surgery, 2012, 255, 1086-1092.	4.2	30
151	Technologies for global health. Lancet, The, 2012, 380, 507-535.	13.7	311
152	The Impact of Nontechnical Skills on Technical Performance in Surgery: A Systematic Review. Journal of the American College of Surgeons, 2012, 214, 214-230.	0.5	302
153	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.	2.7	15
154	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.	3.8	99
155	A clinical "near miss" highlights risk management issues surrounding ultrasound-guided and wire-localised breast resections. Patient Safety in Surgery, 2012, 6, 15.	2.3	1
156	The safe insertion of peripheral intravenous catheters: a mixed methods descriptive study of the availability of the equipment needed. Antimicrobial Resistance and Infection Control, 2012, 1, 15.	4.1	10
157	Assessment of blood administration competencies using objective structured clinical examination. Transfusion Medicine, 2012, 22, 409-417.	1.1	6
158	Communication strategies in acute health care: evaluation within the context of infection prevention and control. Journal of Hospital Infection, 2012, 82, 25-29.	2.9	21
159	Team performance in resuscitation teams: Comparison and critique of two recently developed scoring tools. Resuscitation, 2012, 83, 1478-1483.	3.0	52
160	An observational study of teamwork skills in shift handover. International Journal of Surgery, 2012, 10, 355-359.	2.7	16
161	The â€œResus:Stationâ€: The use of clinical simulations in a randomised crossover study to evaluate a novel resuscitation trolley. Resuscitation, 2012, 83, 1374-1380.	3.0	12
162	Quantitative analysis of intraoperative communication in open and laparoscopic surgery. Surgical Endoscopy and Other Interventional Techniques, 2012, 26, 2931-2938.	2.4	39

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163	Caseâ€based Learning for Patient Safety: The Lessons Learnt Program for UK Junior Doctors. World Journal of Surgery, 2012, 36, 956-958.	1.6	4
164	Reviewing methodologically disparate data: a practical guide for the patient safety research field. Journal of Evaluation in Clinical Practice, 2012, 18, 172-181.	1.8	6
165	Identifying Nontechnical Skills Associated With Safety in the Emergency Department: A Scoping Review of the Literature. Annals of Emergency Medicine, 2012, 59, 386-394.	0.6	58
166	Development and Validation of a Tool to Assess Emergency Physicians' Nontechnical Skills. Annals of Emergency Medicine, 2012, 59, 376-385.e4.	0.6	59
167	Predictors of hospitalized patientsâ€™ intentions to prevent healthcare harm: A cross sectional survey. International Journal of Nursing Studies, 2012, 49, 407-415.	5.6	23
168	Patients' and health care professionals' attitudes towards the PINK patient safety video. Journal of Evaluation in Clinical Practice, 2012, 18, 848-853.	1.8	31
169	Safety skills training for surgeons: AÂhalf-day intervention improves knowledge, attitudes and awareness of patient safety. Surgery, 2012, 152, 26-31.	1.9	32
170	Consent to transfusion: patients' and healthcare professionals' attitudes towards the provision of blood transfusion information. Transfusion Medicine, 2012, 22, 167-172.	1.1	21
171	Patient involvement in blood transfusion safety: patients' and healthcare professionals' perspective. Transfusion Medicine, 2012, 22, 251-256.	1.1	10
172	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.	1.5	69
173	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.	3.8	34
174	Multidisciplinary centres for safety and quality improvement: learning from climate change science. BMJ Quality and Safety, 2011, 20, i73-i78.	3.7	22
175	Evaluation of Postoperative Handover Using a Tool to Assess Information Transfer and Teamwork. Annals of Surgery, 2011, 253, 831-837.	4.2	98
176	The role of the urology clinical nurse specialist in the multidisciplinary team meeting. International Journal of Urological Nursing, 2011, 5, 59-64.	0.2	21
177	Breaking the rules: understanding non-compliance with policies and guidelines. BMJ: British Medical Journal, 2011, 343, d5283-d5283.	2.3	96
178	Establishing quality in colorectal surgery. Colorectal Disease, 2011, 13, 961-973.	1.4	17
179	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.	1.8	17
180	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.	1.8	32

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181	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.	1.8	24
182	Blood Transfusion Safety: The Potential Role of the Patient. Transfusion Medicine Reviews, 2011, 25, 12-23.	2.0	33
183	Quality of Care Management Decisions by Multidisciplinary Cancer Teams: A Systematic Review. Annals of Surgical Oncology, 2011, 18, 2116-2125.	1.5	344
184	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.	1.5	97
185	Information needs in operating room teams: what is right, what is wrong, and what is needed?. Surgical Endoscopy and Other Interventional Techniques, 2011, 25, 1913-1920.	2.4	11
186	Engineering the system of communication for safer surgery. Cognition, Technology and Work, 2011, 13, 1-10.	3.0	11
187	Teamwork and Team Decisionâ€making at Multidisciplinary Cancer Conferences: Barriers, Facilitators, and Opportunities for Improvement. World Journal of Surgery, 2011, 35, 1970-1976.	1.6	95
188	Missing Clinical Information in NHS hospital outpatient clinics: prevalence, causes and effects on patient care. BMC Health Services Research, 2011, 11, 114.	2.2	38
189	A longitudinal, multi-level comparative study of quality and safety in European hospitals: the QUASER study protocol. BMC Health Services Research, 2011, 11, 285.	2.2	41
190	Predictors of the perceived impact of a patient safety collaborative: an exploratory study. International Journal for Quality in Health Care, 2011, 23, 173-181.	1.8	10
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