

# Duncan McNab

## List of Publications by Year in descending order

Source: <https://exaly.com/author-pdf/7425907/publications.pdf>

Version: 2024-02-01

12  
papers

241  
citations

1307594

7  
h-index

1199594

12  
g-index

12  
all docs

12  
docs citations

12  
times ranked

365  
citing authors

#	ARTICLE	IF	CITATIONS
1	Systematic review and meta-analysis of the effectiveness of pharmacist-led medication reconciliation in the community after hospital discharge. <i>BMJ Quality and Safety</i> , 2018, 27, 308-320.	3.7	86
2	Participatory design of a preliminary safety checklist for general practice. <i>British Journal of General Practice</i> , 2015, 65, e330-e343.	1.4	34
3	Development and application of "systems thinking" principles for quality improvement. <i>BMJ Open Quality</i> , 2020, 9, e000714.	1.1	34
4	Participatory design of an improvement intervention for the primary care management of possible sepsis using the Functional Resonance Analysis Method. <i>BMC Medicine</i> , 2018, 16, 174.	5.5	27
5	Understanding patient safety performance and educational needs using the "Safety-II" approach for complex systems. <i>Education for Primary Care</i> , 2016, 27, 443-450.	0.6	24
6	Quality improvement and person-centredness: a participatory mixed methods study to develop the 'always event' concept for primary care. <i>BMJ Open</i> , 2015, 5, e006667-e006667.	1.9	13
7	Human factors in general practice "early thoughts on the educational focus for specialty training and beyond. <i>Education for Primary Care</i> , 2016, 27, 162-171.	0.6	7
8	Understanding and responding when things go wrong: key principles for primary care educators. <i>Education for Primary Care</i> , 2016, 27, 258-266.	0.6	5
9	Quality improvement training for core medical and general practice trainees: a pilot study of project participation, completion and journal publication. <i>Scottish Medical Journal</i> , 2015, 60, 208-213.	1.3	3
10	A before and after study of warfarin monitoring in a single region as part of the Scottish patient safety programme in primary care. <i>Scottish Medical Journal</i> , 2015, 60, 196-201.	1.3	3
11	The past, present and future of patient safety education and research in primary care. <i>Education for Primary Care</i> , 2016, 27, 3-9.	0.6	3
12	Is the "never event" concept a useful safety management strategy in complex primary healthcare systems?. <i>International Journal for Quality in Health Care</i> , 2021, 33, 25-30.	1.8	2