

Ken R Catchpole

List of Publications by Citations

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The third column is the impact factor (IF) of the journal, and the fourth column is the number of citations of the article.

124
papers

3,776
citations

31
h-index

59
g-index

151
ext. papers

4,446
ext. citations

3.1
avg, IF

5.55
L-index

| # | Paper | IF | Citations |
|-----|--|------|-----------|
| 124 | Patient handover from surgery to intensive care: using Formula 1 pit-stop and aviation models to improve safety and quality. <i>Paediatric Anaesthesia</i> , 2007 , 17, 470-8 | 1.8 | 374 |
| 123 | The effects of aviation-style non-technical skills training on technical performance and outcome in the operating theatre. <i>Quality and Safety in Health Care</i> , 2009 , 18, 109-15 | | 270 |
| 122 | The Oxford NOTECHS System: reliability and validity of a tool for measuring teamwork behaviour in the operating theatre. <i>Quality and Safety in Health Care</i> , 2009 , 18, 104-8 | | 238 |
| 121 | Teamwork and error in the operating room: analysis of skills and roles. <i>Annals of Surgery</i> , 2008 , 247, 699-706 | 7.86 | 238 |
| 120 | The influence of non-technical performance on technical outcome in laparoscopic cholecystectomy. <i>Surgical Endoscopy and Other Interventional Techniques</i> , 2008 , 22, 68-73 | 5.2 | 202 |
| 119 | Improving patient safety by identifying latent failures in successful operations. <i>Surgery</i> , 2007 , 142, 102-106 | | 181 |
| 118 | Identification of systems failures in successful paediatric cardiac surgery. <i>Ergonomics</i> , 2006 , 49, 567-88 | 2.9 | 140 |
| 117 | Interventions to improve teamwork and communications among healthcare staff. <i>British Journal of Surgery</i> , 2011 , 98, 469-79 | 5.3 | 109 |
| 116 | Compliance and use of the World Health Organization checklist in U.K. operating theatres. <i>British Journal of Surgery</i> , 2013 , 100, 1664-70 | 5.3 | 100 |
| 115 | Oxford NOTECHS II: a modified theatre team non-technical skills scoring system. <i>PLoS ONE</i> , 2014 , 9, e90320 | 3.70 | 87 |
| 114 | The problem with checklists. <i>BMJ Quality and Safety</i> , 2015 , 24, 545-9 | 5.4 | 79 |
| 113 | A multicenter trial of aviation-style training for surgical teams. <i>Journal of Patient Safety</i> , 2010 , 6, 180-6 | 1.9 | 77 |
| 112 | Safety in anaesthesia: a study of 12,606 reported incidents from the UK National Reporting and Learning System. <i>Anaesthesia</i> , 2008 , 63, 340-6 | 6.6 | 73 |
| 111 | Safety, efficiency and learning curves in robotic surgery: a human factors analysis. <i>Surgical Endoscopy and Other Interventional Techniques</i> , 2016 , 30, 3749-61 | 5.2 | 65 |
| 110 | State of science: human factors and ergonomics in healthcare. <i>Ergonomics</i> , 2013 , 56, 1491-503 | 2.9 | 61 |
| 109 | Interventions employed to improve intrahospital handover: a systematic review. <i>BMJ Quality and Safety</i> , 2014 , 23, 600-7 | 5.4 | 60 |
| 108 | Intra-operative disruptions, surgeon mental workload, and technical performance in a full-scale simulated procedure. <i>Surgical Endoscopy and Other Interventional Techniques</i> , 2016 , 30, 559-566 | 5.2 | 55 |

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|-----|--|-----|----|
| 107 | Patient handovers within the hospital: translating knowledge from motor racing to healthcare. <i>Quality and Safety in Health Care</i> , 2010 , 19, 318-22 | | 54 |
| 106 | Integrating human factors research and surgery: a review. <i>Archives of Surgery</i> , 2012 , 147, 1141-6 | | 48 |
| 105 | The effect of teamwork training on team performance and clinical outcome in elective orthopaedic surgery: a controlled interrupted time series study. <i>BMJ Open</i> , 2015 , 5, e006216 | 3 | 45 |
| 104 | Interruptions during drug rounds: an observational study. <i>British Journal of Nursing</i> , 2008 , 17, 1326-30 | 0.7 | 43 |
| 103 | Factors influencing incident reporting in surgical care. <i>Quality and Safety in Health Care</i> , 2009 , 18, 116-20 | | 41 |
| 102 | Human factors in healthcare: welcome progress, but still scratching the surface. <i>BMJ Quality and Safety</i> , 2016 , 25, 480-4 | 5.4 | 38 |
| 101 | A combined teamwork training and work standardisation intervention in operating theatres: controlled interrupted time series study. <i>BMJ Quality and Safety</i> , 2015 , 24, 111-9 | 5.4 | 37 |
| 100 | Effect of a "Lean" intervention to improve safety processes and outcomes on a surgical emergency unit. <i>BMJ, The</i> , 2010 , 341, c5469 | 5.9 | 36 |
| 99 | Localizable auditory warning pulses. <i>Ergonomics</i> , 2004 , 47, 748-71 | 2.9 | 36 |
| 98 | Framework for direct observation of performance and safety in healthcare. <i>BMJ Quality and Safety</i> , 2017 , 26, 1015-1021 | 5.4 | 34 |
| 97 | Human factors and ergonomics and quality improvement science: integrating approaches for safety in healthcare. <i>BMJ Quality and Safety</i> , 2015 , 24, 250-4 | 5.4 | 34 |
| 96 | Combining Systems and Teamwork Approaches to Enhance the Effectiveness of Safety Improvement Interventions in Surgery: The Safer Delivery of Surgical Services (S3) Program. <i>Annals of Surgery</i> , 2017 , 265, 90-96 | 7.8 | 31 |
| 95 | Devising a consensus definition and framework for non-technical skills in healthcare to support educational design: A modified Delphi study. <i>Medical Teacher</i> , 2015 , 37, 572-7 | 3 | 31 |
| 94 | A human factors subsystems approach to trauma care. <i>JAMA Surgery</i> , 2014 , 149, 962-8 | 5.4 | 31 |
| 93 | Flow disruptions during trauma care. <i>World Journal of Surgery</i> , 2014 , 38, 314-21 | 3.3 | 31 |
| 92 | Human factors in robotic assisted surgery: Lessons from studies on the WildQ. <i>Applied Ergonomics</i> , 2019 , 78, 270-276 | 4.2 | 31 |
| 91 | A method for measuring threats and errors in surgery. <i>Cognition, Technology and Work</i> , 2008 , 10, 295-304. | 3.9 | 30 |
| 90 | Capturing intraoperative process deviations using a direct observational approach: the glitch method. <i>BMJ Open</i> , 2013 , 3, e003519 | 3 | 28 |

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|----|--|-----|----|
| 89 | Barriers to efficiency in robotic surgery: the resident effect. <i>Journal of Surgical Research</i> , 2016 , 205, 296-304 | 3.4 | 26 |
| 88 | Strategies for conducting situated studies of technology use in hospitals. <i>Cognition, Technology and Work</i> , 2015 , 17, 489-502 | 2.9 | 24 |
| 87 | Diagnosing barriers to safety and efficiency in robotic surgery. <i>Ergonomics</i> , 2018 , 61, 26-39 | 2.9 | 24 |
| 86 | Flow disruptions in trauma care handoffs. <i>Journal of Surgical Research</i> , 2013 , 184, 586-91 | 2.5 | 23 |
| 85 | Task, team and technology integration in the paediatric cardiac operating room. <i>Progress in Pediatric Cardiology</i> , 2011 , 32, 85-88 | 0.4 | 23 |
| 84 | Associations of Intraoperative Flow Disruptions and Operating Room Teamwork During Robotic-assisted Radical Prostatectomy. <i>Urology</i> , 2018 , 114, 105-113 | 1.6 | 22 |
| 83 | Effects of Flow Disruptions on Mental Workload and Surgical Performance in Robotic-Assisted Surgery. <i>World Journal of Surgery</i> , 2018 , 42, 3599-3607 | 3.3 | 19 |
| 82 | Patient safety: a core value of nursing - so why is achieving it so difficult?. <i>Journal of Research in Nursing</i> , 2011 , 16, 209-223 | 0.9 | 19 |
| 81 | Minor flow disruptions, traffic-related factors and their effect on major flow disruptions in the operating room. <i>BMJ Quality and Safety</i> , 2019 , 28, 276-283 | 5.4 | 19 |
| 80 | Preventing Retained Central Venous Catheter Guidewires: A Randomized Controlled Simulation Study Using a Human Factors Approach. <i>Anesthesiology</i> , 2017 , 127, 658-665 | 4.3 | 18 |
| 79 | Effectiveness of facilitated introduction of a standard operating procedure into routine processes in the operating theatre: a controlled interrupted time series. <i>BMJ Quality and Safety</i> , 2015 , 24, 120-7 | 5.4 | 17 |
| 78 | A three-dimensional model of error and safety in surgical health care microsystems. Rationale, development and initial testing. <i>BMC Surgery</i> , 2011 , 11, 23 | 2.3 | 17 |
| 77 | Reducing Operating Room Turnover Time for Robotic Surgery Using a Motor Racing Pit Stop Model. <i>World Journal of Surgery</i> , 2017 , 41, 1943-1949 | 3.3 | 16 |
| 76 | Barriers to trauma patient care associated with CT scanning. <i>Journal of the American College of Surgeons</i> , 2013 , 217, 135-41; discussion 141-3 | 4.4 | 15 |
| 75 | Human factors perspective on the prescribing behavior of recent medical graduates: implications for educators. <i>Advances in Medical Education and Practice</i> , 2013 , 4, 1-9 | 1.5 | 15 |
| 74 | Bottleneck Analysis to Reduce Surgical Flow Disruptions: Theory and Application. <i>IEEE Transactions on Automation Science and Engineering</i> , 2015 , 12, 127-139 | 4.9 | 14 |
| 73 | A framework for the design of ambulance sirens. <i>Ergonomics</i> , 2007 , 50, 1287-301 | 2.9 | 14 |
| 72 | Who do we blame when it all goes wrong?. <i>Quality and Safety in Health Care</i> , 2009 , 18, 3-4 | | 13 |

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| 71 | Surgical flow disruptions during robotic-assisted radical prostatectomy. <i>Canadian Journal of Urology</i> , 2017 , 24, 8814-8821 | 0.8 | 13 |
| 70 | Human factors in critical care: towards standardized integrated human-centred systems of work. <i>Current Opinion in Critical Care</i> , 2010 , 16, 618-22 | 3.5 | 12 |
| 69 | Quality and safety on an acute surgical ward: an exploratory cohort study of process and outcome. <i>Annals of Surgery</i> , 2009 , 250, 1035-40 | 7.8 | 11 |
| 68 | Associations of workflow disruptions in the operating room with surgical outcomes: a systematic review and narrative synthesis. <i>BMJ Quality and Safety</i> , 2020 , 29, 1033-1045 | 5.4 | 11 |
| 67 | Using a systems approach to evaluate a circulating nurse's work patterns and workflow disruptions. <i>Applied Ergonomics</i> , 2019 , 78, 293-300 | 4.2 | 11 |
| 66 | Toward the modelling of safety violations in healthcare systems. <i>BMJ Quality and Safety</i> , 2013 , 22, 705-95.4 | 5.4 | 10 |
| 65 | Effective prevention of thromboembolic complications in emergency surgery patients using a quality improvement approach. <i>BMJ Quality and Safety</i> , 2013 , 22, 916-22 | 5.4 | 10 |
| 64 | Flow Disruptions in Trauma Surgery: Type, Impact, and Affect. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2012 , 56, 811-815 | 0.4 | 9 |
| 63 | Lean Participative Process Improvement: Outcomes and Obstacles in Trauma Orthopaedics. <i>PLoS ONE</i> , 2016 , 11, e0152360 | 3.7 | 9 |
| 62 | Flow disruptions in robotic-assisted abdominal sacrocolpopexy: does robotic surgery introduce unforeseen challenges for gynecologic surgeons?. <i>International Urogynecology Journal</i> , 2019 , 30, 2177-2182 | 2.8 | 8 |
| 61 | Workflow disruptions and provider situation awareness in acute care: An observational study with emergency department physicians and nurses. <i>Applied Ergonomics</i> , 2020 , 88, 103155 | 4.2 | 8 |
| 60 | A Study of VITOM in Pediatric Surgery and Urology: Evaluation of Technology Acceptance and Usability by Operating Team and Surgeon Musculoskeletal Discomfort. <i>Journal of Laparoendoscopic and Advanced Surgical Techniques - Part A</i> , 2017 , 27, 191-196 | 2.1 | 8 |
| 59 | Errors in the operating theatre--how to spot and stop them. <i>Journal of Health Services Research and Policy</i> , 2010 , 15 Suppl 1, 48-51 | 2.4 | 8 |
| 58 | Work systems analysis of sterile processing: decontamination. <i>BMJ Quality and Safety</i> , 2020 , 29, 320-328.5.4 | 5.4 | 8 |
| 57 | Increased Age Predicts Failure to Rescue. <i>American Surgeon</i> , 2016 , 82, 1073-1079 | 0.8 | 7 |
| 56 | The role of human factors in neonatal patient safety. <i>Seminars in Perinatology</i> , 2019 , 43, 151174 | 3.3 | 7 |
| 55 | Creating a safe, reliable hospital at night handover: a case study in implementation science. <i>BMJ Quality and Safety</i> , 2014 , 23, 465-73 | 5.4 | 7 |
| 54 | Industrial Conceptualization of Health Care Versus the Naturalistic Decision-Making Paradigm: Work as Imagined Versus Work as Done. <i>Journal of Cognitive Engineering and Decision Making</i> , 2018 , 12, 222-226 | 2.5 | 6 |

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| 53 | Nurses' Perceptions of high-alert medication administration safety: A qualitative descriptive study. <i>Journal of Advanced Nursing</i> , 2019 , 75, 3654-3667 | 3.1 | 6 |
| 52 | Flow disruptions during trauma care. <i>Journal of the American College of Surgeons</i> , 2012 , 215, S99-S100 | 4.4 | 5 |
| 51 | Strangers in a strange land: Understanding professional challenges for human factors/ergonomics and healthcare. <i>Applied Ergonomics</i> , 2021 , 94, 103040 | 4.2 | 5 |
| 50 | Highlights from the First Annual Spinal Navigation, Emerging Technologies and Systems Integration Meeting. <i>Annals of Translational Medicine</i> , 2018 , 6, 110 | 3.2 | 5 |
| 49 | Developing a 3D Gestural Interface for Anesthesia-Related Human-Computer Interaction Tasks Using Both Experts and Novices. <i>Human Factors</i> , 2018 , 60, 992-1007 | 3.8 | 5 |
| 48 | Using flow disruptions to understand healthcare system safety: A systematic review of observational studies. <i>Applied Ergonomics</i> , 2022 , 98, 103559 | 4.2 | 5 |
| 47 | Republished: creating a safe, reliable hospital at night handover: a case study in implementation science. <i>Postgraduate Medical Journal</i> , 2014 , 90, 493-501 | 2 | 4 |
| 46 | Barriers to safety and efficiency in robotic surgery docking. <i>Surgical Endoscopy and Other Interventional Techniques</i> , 2021 , 1 | 5.2 | 4 |
| 45 | Increased Age Predicts Failure to Rescue. <i>American Surgeon</i> , 2016 , 82, 1073-1079 | 0.8 | 4 |
| 44 | Impact of flow disruptions in the delivery room. <i>Resuscitation</i> , 2020 , 150, 29-35 | 4 | 3 |
| 43 | Failure to rescue the elderly: a superior quality metric for trauma centers. <i>European Journal of Trauma and Emergency Surgery</i> , 2018 , 44, 377-384 | 2.3 | 3 |
| 42 | A Work Systems Analysis of Sterile Processing: Sterilization and Case Cart Preparation. <i>Advances in Health Care Management</i> , 2019 , 18, | 0.8 | 3 |
| 41 | Observational study of anaesthesia workflow to evaluate physical workspace design and layout. <i>British Journal of Anaesthesia</i> , 2021 , 126, 633-641 | 5.4 | 3 |
| 40 | Work systems analysis of sterile processing: assembly. <i>BMJ Quality and Safety</i> , 2021 , 30, 271-282 | 5.4 | 3 |
| 39 | Work-system interventions in robotic-assisted surgery: a systematic review exploring the gap between challenges and solutions. <i>Surgical Endoscopy and Other Interventional Techniques</i> , 2021 , 35, 1976-1989 | 5.2 | 3 |
| 38 | A Pilot Trial of Online Simulation Training for Ebola Response Education. <i>Health Security</i> , 2018 , 16, 391-401 | 4.1 | 3 |
| 37 | Observing and Categorising Process Deviations in Orthopaedic Surgery. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2011 , 55, 685-689 | 0.4 | 2 |
| 36 | Train-the-trainer: Pilot trial for ebola virus disease simulation training. <i>Education for Health: Change in Learning and Practice</i> , 2020 , 33, 37-45 | 0.4 | 2 |

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| 35 | RAS-NOTECHS: validity and reliability of a tool for measuring non-technical skills in robotic-assisted surgery settings. <i>Surgical Endoscopy and Other Interventional Techniques</i> , 2021 , 1 | 5.2 | 2 |
| 34 | Informatics and interaction: Applying human factors principles to optimize the design of clinical decision support for sepsis. <i>Health Informatics Journal</i> , 2020 , 26, 642-651 | 3 | 2 |
| 33 | Incidents in anaesthesia: past occurrence and future avoidance. <i>Journal of Perioperative Practice</i> , 2009 , 19, 342-7 | 0.4 | 1 |
| 32 | Adapting Ebola training to educate healthcare workers during the SARS-2-CoV pandemic. <i>American Journal of Disaster Medicine</i> , 2020 , 15, 137-140 | 0.6 | 1 |
| 31 | Addressing misconceptions of flow disruption studies in "Is non-stop always better? Examining assumptions behind the concept of flow disruptions in studies of robot-assisted surgery". <i>Journal of Robotic Surgery</i> , 2021 , 1 | 2.9 | 1 |
| 30 | Preliminary evaluation of the impact of TeamSTEPPS [®] training on hospital quality indicators. <i>Journal of Interprofessional Education and Practice</i> , 2020 , 18, 100306 | 0.6 | 1 |
| 29 | Use of Simulation-Based Learning to Teach High-Alert Medication Safety: A Feasibility Study. <i>Clinical Simulation in Nursing</i> , 2020 , 47, 60-64 | 3 | 1 |
| 28 | Understanding the limitations of incident reporting in medication errors. <i>British Journal of Anaesthesia</i> , 2020 , 125, e343-e344 | 5.4 | 1 |
| 27 | A Smartphone Application for Teamwork and Communication in Trauma: Pilot Evaluation "in the Wild". <i>Human Factors</i> , 2021 , 187208211021717 | 3.8 | 1 |
| 26 | Human Factors and Ergonomics in Health Care Systems: Identifying Roles and Strategies for Success. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2019 , 63, 729-732 | 0.4 | 1 |
| 25 | Using Flow Disruptions to Examine System Safety in Robotic-Assisted Surgery: Protocol for a Stepped Wedge Crossover Design. <i>JMIR Research Protocols</i> , 2021 , 10, e25284 | 2 | 1 |
| 24 | Investigating Intraoperative and Intraprofessional Handoffs in Anesthesia. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2018 , 62, 469-473 | 0.4 | 1 |
| 23 | Room Size Influences Flow in Robotic-Assisted Surgery. <i>International Journal of Environmental Research and Public Health</i> , 2021 , 18, | 4.6 | 1 |
| 22 | Prevention of Failure to Rescue in Obstetric Patients: A Realist Review. <i>Worldviews on Evidence-Based Nursing</i> , 2021 , 18, 352-360 | 2.9 | 1 |
| 21 | Human Factors Integration in Robotic Surgery.. <i>Human Factors</i> , 2022 , 187208211068946 | 3.8 | 1 |
| 20 | 4474 READ-TV: Research and Exploratory Analysis Driven Time-data Visualization. <i>Journal of Clinical and Translational Science</i> , 2020 , 4, 51-51 | 0.4 | 0 |
| 19 | Anaesthesia providers' perceptions of system safety and critical incidents in non-operating theatre anaesthesia.. <i>British Journal of Anaesthesia</i> , 2022 , | 5.4 | 0 |
| 18 | Illuminating the decision-making strategies of anesthesia providers in challenging cases. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2020 , 64, 653-657 | 0.4 | 0 |

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|----|---|-----|---|
| 17 | Components of team science. What contributes to success?. <i>Journal of Interprofessional Education and Practice</i> , 2020 , 18, 100298 | 0.6 | 0 |
| 16 | Research and Exploratory Analysis Driven-Time-data Visualization (read-tv) software. <i>JAMIA Open</i> , 2021 , 4, ooab007 | 2.9 | 0 |
| 15 | A pragmatic implementation research study for In Our DNA SC: a protocol to identify multi-level factors that support the implementation of a population-wide genomic screening initiative in diverse populations.. <i>Implementation Science Communications</i> , 2022 , 3, 48 | 2.2 | 0 |
| 14 | 819. <i>Critical Care Medicine</i> , 2014 , 42, A1557 | 1.4 | |
| 13 | Bringing our Toys to your Sandbox: Developing Database-Driven EMR Indifferent Sepsis Alerts. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , 2017 , 6, 57-58 ⁵ | 0.5 | |
| 12 | Learning from other industries. <i>Pediatric Critical Care Medicine</i> , 2012 , 13, 123-4; author reply 124-5 | 3 | |
| 11 | Display and perception of risk: Analysis of decision support system display and its impact on perceived clinical risk of sepsis-induced health deterioration.. <i>Health Informatics Journal</i> , 2022 , 28, 14604582211073075 | 2 | |
| 10 | Surgical Performance and the Working Environment 2020 , 51-61 | | |
| 9 | Reducing Errors in Surgical Care 2008 , 357-362 | | |
| 8 | Process Risks in Perioperative Medication Delivery. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2020 , 64, 1100-1100 | 0.4 | |
| 7 | Robotic Assisted Surgery: The Gap Between Challenges And Solutions. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2020 , 64, 1170-1170 | 0.4 | |
| 6 | Surgery Through a Human Factors and Ergonomics Lens 2017 , 39-50 | | |
| 5 | Chapter 13 Human Factors and Ergonomics Practice in Healthcare 2016 , 181-192 | | |
| 4 | Signaling Sepsis Scenario Development & Validation. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2018 , 62, 615-619 | 0.4 | |
| 3 | Engineering the Future of Sepsis Care: An Application of Fuzzy Logic Cognitive Mapping for Sepsis Diagnosis. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , 2018 , 7, 103-104 | 0.5 | |
| 2 | Author Reply. <i>Urology</i> , 2018 , 114, 112-113 | 1.6 | |
| 1 | Understanding "Work as Done": Using a Structured Video-Based Observational Method to Understand and Model the Role of the Physical Environment in Complex Clinical Work Systems.. <i>Herd</i> , 2022 , 19375867221089271 | 2.4 | |