Ken R Catchpole

List of Publications by Year in Descending Order

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	Display and perception of risk: Analysis of decision support system display and its impact on perceived clinical risk of sepsis-induced health deterioration.. *Health Informatics Journal*, **2022**, 28, 14604582211073075	3	
123	Anaesthesia providersQperceptions of system safety and critical incidents in non-operating theatre anaesthesia.. *British Journal of Anaesthesia*, **2022**,	5.4	0
122	Using flow disruptions to understand healthcare system safety: A systematic review of observational studies. *Applied Ergonomics*, **2022**, 98, 103559	4.2	5
121	Human Factors Integration in Robotic Surgery.. *Human Factors*, **2022**, 187208211068946	3.8	1
120	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.. *Herd*, **2022**, 19375867221089271	2.4	
119	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.. *Implementation Science Communications*, **2022**, 3, 48	2.2	0
118	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". *Journal of Robotic Surgery*, **2021**, 1	2.9	1
117	RAS-NOTECHS: validity and reliability of a tool for measuring non-technical skills in robotic-assisted surgery settings. *Surgical Endoscopy and Other Interventional Techniques*, **2021**, 1	5.2	2
116	A Smartphone Application for Teamwork and Communication in Trauma: Pilot Evaluation "in the Wild". *Human Factors*, **2021**, 187208211021717	3.8	1
115	QStrangers in a strange landQUnderstanding professional challenges for human factors/ergonomics and healthcare. *Applied Ergonomics*, **2021**, 94, 103040	4.2	5
114	Observational study of anaesthesia workflow to evaluate physical workspace design and layout. *British Journal of Anaesthesia*, **2021**, 126, 633-641	5.4	3
113	Work systems analysis of sterile processing: assembly. *BMJ Quality and Safety*, **2021**, 30, 271-282	5.4	3
112	Research and Exploratory Analysis Driven-Time-data Visualization (read-tv) software. *JAMIA Open*, **2021**, 4, ooab007	2.9	0
111	Work-system interventions in robotic-assisted surgery: a systematic review exploring the gap between challenges and solutions. *Surgical Endoscopy and Other Interventional Techniques*, **2021**, 35, 1976-1989	5.2	3
110	Barriers to safety and efficiency in robotic surgery docking. *Surgical Endoscopy and Other Interventional Techniques*, **2021**, 1	5.2	4
109	Using Flow Disruptions to Examine System Safety in Robotic-Assisted Surgery: Protocol for a Stepped Wedge Crossover Design. *JMIR Research Protocols*, **2021**, 10, e25284	2	1
108	Room Size Influences Flow in Robotic-Assisted Surgery. *International Journal of Environmental Research and Public Health*, **2021**, 18,	4.6	1

107	Prevention of Failure to Rescue in Obstetric Patients: A Realist Review. *Worldviews on Evidence-Based Nursing*, **2021**, 18, 352-360	2.9	1
106	4474 READ-TV: Research and Exploratory Analysis Driven Time-data Visualization. *Journal of Clinical and Translational Science*, **2020**, 4, 51-51	0.4	0
105	Workflow disruptions and provider situation awareness in acute care: An observational study with emergency department physicians and nurses. *Applied Ergonomics*, **2020**, 88, 103155	4.2	8
104	Impact of flow disruptions in the delivery room. *Resuscitation*, **2020**, 150, 29-35	4	3
103	Associations of workflow disruptions in the operating room with surgical outcomes: a systematic review and narrative synthesis. *BMJ Quality and Safety*, **2020**, 29, 1033-1045	5.4	11
102	Surgical Performance and the Working Environment **2020**, 51-61		
101	Adapting Ebola training to educate healthcare workers during the SARS-2-CoV pandemic. *American Journal of Disaster Medicine*, **2020**, 15, 137-140	0.6	1
100	Train-the-trainer: Pilot trial for ebola virus disease simulation training. *Education for Health: Change in Learning and Practice*, **2020**, 33, 37-45	0.4	2
99	Process Risks in Perioperative Medication Delivery. *Proceedings of the Human Factors and Ergonomics Society*, **2020**, 64, 1100-1100	0.4	
98	Robotic Assisted Surgery: The Gap Between Challenges And Solutions. *Proceedings of the Human Factors and Ergonomics Society*, **2020**, 64, 1170-1170	0.4	
97	Illuminating the decision-making strategies of anesthesia providers in challenging cases. *Proceedings of the Human Factors and Ergonomics Society*, **2020**, 64, 653-657	0.4	0
96	Components of team science What contributes to success?. *Journal of Interprofessional Education and Practice*, **2020**, 18, 100298	0.6	0
95	Preliminary evaluation of the impact of TeamSTEPPS training on hospital quality indicators. *Journal of Interprofessional Education and Practice*, **2020**, 18, 100306	0.6	1
94	Work systems analysis of sterile processing: decontamination. *BMJ Quality and Safety*, **2020**, 29, 320-328	5.4	8
93	Use of Simulation-Based Learning to Teach High-Alert Medication Safety: A Feasibility Study. *Clinical Simulation in Nursing*, **2020**, 47, 60-64	3	1
92	Understanding the limitations of incident reporting in medication errors. *British Journal of Anaesthesia*, **2020**, 125, e343-e344	5.4	1
91	Informatics and interaction: Applying human factors principles to optimize the design of clinical decision support for sepsis. *Health Informatics Journal*, **2020**, 26, 642-651	3	2
90	Flow disruptions in robotic-assisted abdominal sacrocolpopexy: does robotic surgery introduce unforeseen challenges for gynecologic surgeons?. *International Urogynecology Journal*, **2019**, 30, 2177-2182	2	8

89	Nurses' perceptions of high-alert medication administration safety: A qualitative descriptive study. *Journal of Advanced Nursing*, **2019**, 75, 3654-3667	3.1	6
88	The role of human factors in neonatal patient safety. *Seminars in Perinatology*, **2019**, 43, 151174	3.3	7
87	A Work Systems Analysis of Sterile Processing: Sterilization and Case Cart Preparation. *Advances in Health Care Management*, **2019**, 18,	0.8	3
86	Human Factors and Ergonomics in Health Care Systems: Identifying Roles and Strategies for Success. *Proceedings of the Human Factors and Ergonomics Society*, **2019**, 63, 729-732	0.4	1
85	Minor flow disruptions, traffic-related factors and their effect on major flow disruptions in the operating room. *BMJ Quality and Safety*, **2019**, 28, 276-283	5.4	19
84	Using a systems approach to evaluate a circulating nurse's work patterns and workflow disruptions. *Applied Ergonomics*, **2019**, 78, 293-300	4.2	11
83	Human factors in robotic assisted surgery: Lessons from studies 'in the Wild' *Applied Ergonomics*, **2019**, 78, 270-276	4.2	31
82	Associations of Intraoperative Flow Disruptions and Operating Room Teamwork During Robotic-assisted Radical Prostatectomy. *Urology*, **2018**, 114, 105-113	1.6	22
81	Failure to rescue the elderly: a superior quality metric for trauma centers. *European Journal of Trauma and Emergency Surgery*, **2018**, 44, 377-384	2.3	3
80	Diagnosing barriers to safety and efficiency in robotic surgery. *Ergonomics*, **2018**, 61, 26-39	2.9	24
79	Industrial Conceptualization of Health Care Versus the Naturalistic Decision-Making Paradigm: Work as Imagined Versus Work as Done. *Journal of Cognitive Engineering and Decision Making*, **2018**, 12, 222-226	2.5	6
78	Effects of Flow Disruptions on Mental Workload and Surgical Performance in Robotic-Assisted Surgery. *World Journal of Surgery*, **2018**, 42, 3599-3607	3.3	19
77	Signaling Sepsis Scenario Development & Validation. *Proceedings of the Human Factors and Ergonomics Society*, **2018**, 62, 615-619	0.4	
76	Highlights from the First Annual Spinal Navigation, Emerging Technologies and Systems Integration Meeting. *Annals of Translational Medicine*, **2018**, 6, 110	3.2	5
75	Engineering the Future of Sepsis Care: An Application of Fuzzy Logic Cognitive Mapping for Sepsis Diagnosis. *Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare*, **2018**, 7, 103-104	0.5	
74	A Pilot Trial of Online Simulation Training for Ebola Response Education. *Health Security*, **2018**, 16, 391-401	2.1	3
73	Developing a 3D Gestural Interface for Anesthesia-Related Human-Computer Interaction Tasks Using Both Experts and Novices. *Human Factors*, **2018**, 60, 992-1007	3.8	5
72	Investigating Intraoperative and Intraprofessional Handoffs in Anesthesia. *Proceedings of the Human Factors and Ergonomics Society*, **2018**, 62, 469-473	0.4	1

71	Author Reply. *Urology*, **2018**, 114, 112-113	1.6	
70	Combining Systems and Teamwork Approaches to Enhance the Effectiveness of Safety Improvement Interventions in Surgery: The Safer Delivery of Surgical Services (S3) Program. *Annals of Surgery*, **2017**, 265, 90-96	7.8	31
69	Framework for direct observation of performance and safety in healthcare. *BMJ Quality and Safety*, **2017**, 26, 1015-1021	5.4	34
68	Preventing Retained Central Venous Catheter Guidewires: A Randomized Controlled Simulation Study Using a Human Factors Approach. *Anesthesiology*, **2017**, 127, 658-665	4.3	18
67	Reducing Operating Room Turnover Time for Robotic Surgery Using a Motor Racing Pit Stop Model. *World Journal of Surgery*, **2017**, 41, 1943-1949	3.3	16
66	A Study of VITOM in Pediatric Surgery and Urology: Evaluation of Technology Acceptance and Usability by Operating Team and Surgeon Musculoskeletal Discomfort. *Journal of Laparoendoscopic and Advanced Surgical Techniques - Part A*, **2017**, 27, 191-196	2.1	8
65	Bringing our Toys to your Sandbox: Developing Database-Driven EMR Indifferent Sepsis Alerts. *Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare*, **2017**, 6, 57-58	0.5	
64	Surgery Through a Human Factors and Ergonomics Lens **2017**, 39-50		
63	Surgical flow disruptions during robotic-assisted radical prostatectomy. *Canadian Journal of Urology*, **2017**, 24, 8814-8821	0.8	13
62	Increased Age Predicts Failure to Rescue. *American Surgeon*, **2016**, 82, 1073-1079	0.8	7
61	Intra-operative disruptions, surgeon's mental workload, and technical performance in a full-scale simulated procedure. *Surgical Endoscopy and Other Interventional Techniques*, **2016**, 30, 559-566	5.2	55
60	Safety, efficiency and learning curves in robotic surgery: a human factors analysis. *Surgical Endoscopy and Other Interventional Techniques*, **2016**, 30, 3749-61	5.2	65
59	Lean Participative Process Improvement: Outcomes and Obstacles in Trauma Orthopaedics. *PLoS ONE*, **2016**, 11, e0152360	3.7	9
58	Chapter 13 Human Factors and Ergonomics Practice in Healthcare **2016**, 181-192		
57	Human factors in healthcare: welcome progress, but still scratching the surface. *BMJ Quality and Safety*, **2016**, 25, 480-4	5.4	38
56	Barriers to efficiency in robotic surgery: the resident effect. *Journal of Surgical Research*, **2016**, 205, 296-304	2.1	26
55	Increased Age Predicts Failure to Rescue. *American Surgeon*, **2016**, 82, 1073-1079	0.8	4
54	Strategies for conducting situated studies of technology use in hospitals. *Cognition, Technology and Work*, **2015**, 17, 489-502	2.9	24

53	Effectiveness of facilitated introduction of a standard operating procedure into routine processes in the operating theatre: a controlled interrupted time series. *BMJ Quality and Safety*, **2015**, 24, 120-7	5.4	17
52	Devising a consensus definition and framework for non-technical skills in healthcare to support educational design: A modified Delphi study. *Medical Teacher*, **2015**, 37, 572-7	3	31
51	Human factors and ergonomics and quality improvement science: integrating approaches for safety in healthcare. *BMJ Quality and Safety*, **2015**, 24, 250-4	5.4	34
50	The problem with checklists. *BMJ Quality and Safety*, **2015**, 24, 545-9	5.4	79
49	Bottleneck Analysis to Reduce Surgical Flow Disruptions: Theory and Application. *IEEE Transactions on Automation Science and Engineering*, **2015**, 12, 127-139	4.9	14
48	The effect of teamwork training on team performance and clinical outcome in elective orthopaedic surgery: a controlled interrupted time series study. *BMJ Open*, **2015**, 5, e006216	3	45
47	A combined teamwork training and work standardisation intervention in operating theatres: controlled interrupted time series study. *BMJ Quality and Safety*, **2015**, 24, 111-9	5.4	37
46	819. *Critical Care Medicine*, **2014**, 42, A1557	1.4	
45	Oxford NOTECHS II: a modified theatre team non-technical skills scoring system. *PLoS ONE*, **2014**, 9, e90320	3.7	87
44	Creating a safe, reliable hospital at night handover: a case study in implementation science. *BMJ Quality and Safety*, **2014**, 23, 465-73	5.4	7
43	Republished: creating a safe, reliable hospital at night handover: a case study in implementation science. *Postgraduate Medical Journal*, **2014**, 90, 493-501	2	4
42	Interventions employed to improve intrahospital handover: a systematic review. *BMJ Quality and Safety*, **2014**, 23, 600-7	5.4	60
41	A human factors subsystems approach to trauma care. *JAMA Surgery*, **2014**, 149, 962-8	5.4	31
40	Flow disruptions during trauma care. *World Journal of Surgery*, **2014**, 38, 314-21	3.3	31
39	Barriers to trauma patient care associated with CT scanning. *Journal of the American College of Surgeons*, **2013**, 217, 135-41; discussion 141-3	4.4	15
38	Flow disruptions in trauma care handoffs. *Journal of Surgical Research*, **2013**, 184, 586-91	2.5	23
37	Toward the modelling of safety violations in healthcare systems. *BMJ Quality and Safety*, **2013**, 22, 705-9	5.4	10
36	State of science: human factors and ergonomics in healthcare. *Ergonomics*, **2013**, 56, 1491-503	2.9	61

35	Compliance and use of the World Health Organization checklist in U.K. operating theatres. *British Journal of Surgery*, **2013**, 100, 1664-70	5.3	100
34	Capturing intraoperative process deviations using a direct observational approach: the glitch method. *BMJ Open*, **2013**, 3, e003519	3	28
33	Effective prevention of thromboembolic complications in emergency surgery patients using a quality improvement approach. *BMJ Quality and Safety*, **2013**, 22, 916-22	5.4	10
32	Human factors perspective on the prescribing behavior of recent medical graduates: implications for educators. *Advances in Medical Education and Practice*, **2013**, 4, 1-9	1.5	15
31	Flow disruptions during trauma care. *Journal of the American College of Surgeons*, **2012**, 215, S99-S100	4.4	5
30	Flow Disruptions in Trauma Surgery: Type, Impact, and Affect. *Proceedings of the Human Factors and Ergonomics Society*, **2012**, 56, 811-815	0.4	9
29	Learning from other industries. *Pediatric Critical Care Medicine*, **2012**, 13, 123-4; author reply 124-5	3	
28	Integrating human factors research and surgery: a review. *Archives of Surgery*, **2012**, 147, 1141-6		48
27	Observing and Categorising Process Deviations in Orthopaedic Surgery. *Proceedings of the Human Factors and Ergonomics Society*, **2011**, 55, 685-689	0.4	2
26	Task, team and technology integration in the paediatric cardiac operating room. *Progress in Pediatric Cardiology*, **2011**, 32, 85-88	0.4	23
25	A three-dimensional model of error and safety in surgical health care microsystems. Rationale, development and initial testing. *BMC Surgery*, **2011**, 11, 23	2.3	17
24	Interventions to improve teamwork and communications among healthcare staff. *British Journal of Surgery*, **2011**, 98, 469-79	5.3	109
23	Patient safety: a core value of nursing - so why is achieving it so difficult?. *Journal of Research in Nursing*, **2011**, 16, 209-223	0.9	19
22	Patient handovers within the hospital: translating knowledge from motor racing to healthcare. *Quality and Safety in Health Care*, **2010**, 19, 318-22		54
21	A multicenter trial of aviation-style training for surgical teams. *Journal of Patient Safety*, **2010**, 6, 180-6	1.9	77
20	Errors in the operating theatre--how to spot and stop them. *Journal of Health Services Research and Policy*, **2010**, 15 Suppl 1, 48-51	2.4	8
19	Effect of a "Lean" intervention to improve safety processes and outcomes on a surgical emergency unit. *BMJ, The*, **2010**, 341, c5469	5.9	36
18	Human factors in critical care: towards standardized integrated human-centred systems of work. *Current Opinion in Critical Care*, **2010**, 16, 618-22	3.5	12

17	The Oxford NOTECHS System: reliability and validity of a tool for measuring teamwork behaviour in the operating theatre. *Quality and Safety in Health Care*, **2009**, 18, 104-8		238
16	Factors influencing incident reporting in surgical care. *Quality and Safety in Health Care*, **2009**, 18, 116-20		41
15	The effects of aviation-style non-technical skills training on technical performance and outcome in the operating theatre. *Quality and Safety in Health Care*, **2009**, 18, 109-15		270
14	Who do we blame when it all goes wrong?. *Quality and Safety in Health Care*, **2009**, 18, 3-4		13
13	Quality and safety on an acute surgical ward: an exploratory cohort study of process and outcome. *Annals of Surgery*, **2009**, 250, 1035-40	7.8	11
12	Incidents in anaesthesia: past occurrence and future avoidance. *Journal of Perioperative Practice*, **2009**, 19, 342-7	0.4	1
11	Safety in anaesthesia: a study of 12,606 reported incidents from the UK National Reporting and Learning System. *Anaesthesia*, **2008**, 63, 340-6	6.6	73
10	Interruptions during drug rounds: an observational study. *British Journal of Nursing*, **2008**, 17, 1326-30	0.7	43
9	Teamwork and error in the operating room: analysis of skills and roles. *Annals of Surgery*, **2008**, 247, 699-706	7.8	238
8	A method for measuring threats and errors in surgery. *Cognition, Technology and Work*, **2008**, 10, 295-304	1.9	30
7	The influence of non-technical performance on technical outcome in laparoscopic cholecystectomy. *Surgical Endoscopy and Other Interventional Techniques*, **2008**, 22, 68-73	5.2	202
6	Reducing Errors in Surgical Care **2008**, 357-362		
5	Patient handover from surgery to intensive care: using Formula 1 pit-stop and aviation models to improve safety and quality. *Paediatric Anaesthesia*, **2007**, 17, 470-8	1.8	374
4	Improving patient safety by identifying latent failures in successful operations. *Surgery*, **2007**, 142, 102-10	3.6	181
3	A framework for the design of ambulance sirens. *Ergonomics*, **2007**, 50, 1287-301	2.9	14
2	Identification of systems failures in successful paediatric cardiac surgery. *Ergonomics*, **2006**, 49, 567-88	2.9	140
1	Localizable auditory warning pulses. *Ergonomics*, **2004**, 47, 748-71	2.9	36