# CITATION REPORT List of articles citing

A new, evidence-based estimate of patient harms associated with hospital care

DOI: 10.1097/pts.ob013e3182948a69 Journal of Patient Safety, 2013, 9, 122-8.

Source: https://exaly.com/paper-pdf/56520748/citation-report.pdf

Version: 2024-04-28

This report has been generated based on the citations recorded by exaly.com for the above article. For the latest version of this publication list, visit the link given above.

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

#	Paper I	IF	Citations
912	Disclosure of adverse events in the United States and Canada: an update, and a proposed framework for improvement. <b>2013</b> , 2, e32		57
911	Interprofessional faculty development: integration of oral health into the geriatric diabetes curriculum, from theory to practice. <b>2013</b> , 7, 1-9		7
910	Text prediction on structured data entry in healthcare: a two-group randomized usability study measuring the prediction impact on user performance. <b>2014</b> , 5, 249-63		6
909	Technology innovations in global medical education. <b>2014</b> , 2014,		
908	Current applications of capnography in non-intubated patients. <b>2014</b> , 8, 629-39		6
907	An Evidence-Based Tool for Regulatory Decision Making: The Regulatory Decision Pathway. <b>2014</b> , 5, 5-9		5
906	The cystic fibrosis improvement story: we count our successes in lives. <b>2014</b> , 23, 268-71		5
905	Quality of reporting of studies evaluating time to diagnosis: a systematic review in paediatrics. <b>2014</b> , 99, 244-50		15
904	Improving Patient Safety and Care Quality: A Multiteam System Perspective. <b>2014</b> , 35-60		5
903	Supporting crisis response with dynamic procedure aids. 2014,		17
902	Application of Mobile Cloud Computing in Care pathways. 2014,		2
901	Checklist usage decreases critical task omissions when training residents to separate from simulated cardiopulmonary bypass. <b>2014</b> , 28, 1484-9		8
900	Expert panel evaluation of health information technology effects on adverse events. <b>2014</b> , 20, 375-82		4
899	Patient safety: this is public health. <b>2014</b> , 34, 6-12		10
898	Implementing a predictive system for medication errors. <b>2014</b> , 22, 307-8		1
897	It's safety, not the score, that needs improvement. <b>2014</b> , 9, 274		
896	Safety in education. <b>2014</b> , 45, 8-10		

895	Common Errors in Using Analgesics by Home-Based Nonprofessional Hospice Caregivers. <b>2014</b> , 16, 134-140	9
894	Patient safety begins with me. <b>2014</b> , 260, 971-2	2
893	The role of the anesthesiologist in perioperative patient safety. <b>2014</b> , 27, 649-56	27
892	Importance of nonverbal communication in medical error disclosures. <b>2014</b> , 94, 289-90	2
891	A 100% departmental mortality review improves observed-to-expected mortality ratios and University HealthSystem Consortium rankings. <b>2014</b> , 218, 554-62	13
890	The Active Risk Control (ARC) toolkit: a new approach to designing risk control interventions. <b>2014</b> , 33, 5-14	8
889	Cloud-based data exchange framework for healthcare services. 2014,	4
888	Anesthesia case of the month. Abnormal capnographic waveform caused by dislodged water trap of a capnography sampling line misinterpreted as bronchoconstriction. <b>2014</b> , 245, 183-5	
887	Trust-level risk evaluation and risk control guidance in the NHS East of England. 2014, 34, 1469-81	21
886	When good isn't good enough. <b>2014</b> , 33, 133-5	
886 885	When good isn't good enough. 2014, 33, 133-5  Adverse events in hospitalized paediatric patients: a systematic review and a meta-regression analysis. 2014, 20, 551-8	4
	Adverse events in hospitalized paediatric patients: a systematic review and a meta-regression	4
885	Adverse events in hospitalized paediatric patients: a systematic review and a meta-regression analysis. <b>2014</b> , 20, 551-8	
885	Adverse events in hospitalized paediatric patients: a systematic review and a meta-regression analysis. 2014, 20, 551-8  Breaking Boundaries: Temporality and Worklife Practices in Hospital Organizations. 2014, 78, 441-461	10
885 884 883	Adverse events in hospitalized paediatric patients: a systematic review and a meta-regression analysis. 2014, 20, 551-8  Breaking Boundaries: Temporality and Work[life Practices in Hospital Organizations. 2014, 78, 441-461  Challenges and opportunities in the analysis of risk in healthcare. 2014, 4, 88-104  Proof of Concept: Virtual Reality Simulation of a Pyxis Machine for Medication Administration. 2014	10
885 884 883 882	Adverse events in hospitalized paediatric patients: a systematic review and a meta-regression analysis. 2014, 20, 551-8  Breaking Boundaries: Temporality and Worklife Practices in Hospital Organizations. 2014, 78, 441-461  Challenges and opportunities in the analysis of risk in healthcare. 2014, 4, 88-104  Proof of Concept: Virtual Reality Simulation of a Pyxis Machine for Medication Administration. 2014, 10, e325-e331	10 5 10
885 884 883 882	Adverse events in hospitalized paediatric patients: a systematic review and a meta-regression analysis. 2014, 20, 551-8  Breaking Boundaries: Temporality and Work[life Practices in Hospital Organizations. 2014, 78, 441-461  Challenges and opportunities in the analysis of risk in healthcare. 2014, 4, 88-104  Proof of Concept: Virtual Reality Simulation of a Pyxis Machine for Medication Administration. 2014, 10, e325-e331  Patient safety first a California partnership for health. 2014, 40, 205-11  Management strategies to effect change in intensive care units: lessons from the world of	10 5 10

877	ICU director data: using data to assess value, inform local change, and relate to the external world. <b>2015</b> , 147, 1168-1178	18
876	Development and Evaluation of a Health Information Technology Dashboard of Quality Indicators. <b>2015</b> , 59, 461-465	2
875	Patient safety and healthcare technology management. <b>2015</b> , 49, 60-5	1
874	Unreliable numbers: error and harm induced by bad design can be reduced by better design. <b>2015</b> , 12, 0685	8
873	Investigating Guiding Attributes in Visual Search for Medication Vials. <b>2015</b> , 59, 1006-1010	
872	Current Resources for Evidence-Based Practice, September/October 2015. <b>2015</b> , 60, 618-22	
871	Identifying barriers and benefits of patient safety event reporting toward user-centered design. <b>2015</b> , 1,	12
870	Organizational culture in cardiovascular care in Chinese hospitals: a descriptive cross-sectional study. <b>2015</b> , 15, 569	5
869	Using a Critical Incident Scenario With Virtual Humans to Assess Educational Needs of Nurses in a Postanesthesia Care Unit. <b>2015</b> , 35, 158-65	8
868	Healthcare Performance Excellence: A Comparison of Baldrige Award Recipients and Competitors. <b>2015</b> , 22, 6-22	9
867	Factors in the Path From Lean to Patient Safety: Six Sigma, Goal Specificity and Responsiveness Capability. <b>2015</b> , 22, 37-53	12
866	Cost-Quality Tradeoff in Healthcare: Does it Affect Patient Experience?. <b>2015</b> , 22, 38-45	7
865	Root Cause Analysis Design and Its Application to Pharmacy Education. <b>2015</b> , 79, 99	6
864	Data as a catalyst for change: stories from the frontlines. <b>2015</b> , 34, 18-25	4
863	Current Resources for Evidence-Based Practice, September/October 2015. <b>2015</b> , 44, 624-30	
862	Root cause analysis in infusion nursing: applying quality improvement tools for adverse events. <b>2015</b> , 38, 225-31	1
861	Quality and Safety in Health Care, Part III: To Err is Human. <b>2015</b> , 40, 793-5	7
860	Trust-level risk identification guidance in the NHS East of England. <b>2015</b> , 27, 67-76	13

#### (2015-2015)

859	Successful Implementation of Clinical Information Technology: Seven Key Lessons from CPOE. <b>2015</b> , 6, 698-715	5
858	Improving Teamwork and Communication in the Operating Room Using Teamsteppss. 2015,	
857	Nursing Fatigue: An Evidence-Based Practice Review for Oncology Nurses?. <b>2015</b> , 19, 662-4	1
856	Optimizing Quality of Care and Patient Safety in Malaysia: The Current Global Initiatives, Gaps and Suggested Solutions. <b>2015</b> , 8, 44132	6
855	Bioregulatory systems medicine: an innovative approach to integrating the science of molecular networks, inflammation, and systems biology with the patient's autoregulatory capacity?. <b>2015</b> , 6, 225	21
854	SIMMEON-Prep study: SIMulation of Medication Errors in ONcology: prevention of antineoplastic preparation errors. <b>2015</b> , 40, 55-62	8
853	Encyclopedia of Global Bioethics. <b>2015</b> , 1-8	2
852	Are measurements of patient safety culture and adverse events valid and reliable? Results from a cross sectional study. <b>2015</b> , 15, 186	22
851	The use of a nursing informatics system as an exemplar to investigate business value of IT in healthcare. <b>2015</b> , 5, 25-33	1
850	Providers, Older Adults, and Communication. <b>2015</b> , 1-17	
849	Improving surgeon wellness: The second victim syndrome and quality of care. <b>2015</b> , 24, 315-8	60
848	Value Driven Outcomes (VDO): a pragmatic, modular, and extensible software framework for understanding and improving health care costs and outcomes. <b>2015</b> , 22, 223-35	70
847	New tools for high reliability healthcare. <b>2015</b> , 24, 423-4	5
846	Culture of safety: A foundation for patient care. <b>2015</b> , 24, 283-7	24
845	Fidelity and Validity in Medical Simulation: Effectively engaging new technology raises the training bar. <b>2015</b> , 6, 4-9	1
844	Care of the clinician after an adverse event. <b>2015</b> , 24, 54-63	39
843	Exploring the influence of workplace supports and relationships on safe medication practice: A pilot study of Australian graduate nurses. <b>2015</b> , 35, e21-6	20
842	Preventing errors in laterality. <b>2015</b> , 28, 240-6	6

841	Quality improvement tools and processes. <b>2015</b> , 26, 177-87, viii	12
840	Patient safety across disciplines: radiation oncology incident learning system. <b>2015</b> , 11, 202-3	2
839	Transition to Practice Study in Hospital Settings. <b>2015</b> , 5, 24-38	97
838	What can triumphs and tribulations from drug research in Alzheimer's disease tell us about the development of psychotropic drugs in general?. <b>2015</b> , 2, 756-764	11
837	Faculty development in simulation education. <b>2015</b> , 50, 389-97	15
836	Bpeaking Uplfor Patient Safety in the Pediatric Emergency Department. <b>2015</b> , 16, 83-89	10
835	Validating the Health Communication Assessment Tool' (HCAT). <b>2015</b> , 11, 402-410	13
834	JOURNAL CLUB: Evaluation of Near-Miss Wrong-Patient Events in Radiology Reports. <b>2015</b> , 205, 337-43	11
833	The effect of simulation on skill performance: a need for change in pediatric nursing education. <b>2015</b> , 30, 439-46	16
832	A comparison of the methods used to support risk identification for patient safety in one UK NHS foundation trust. <b>2015</b> , 21, 37-46	11
831	Health information technology in hospitals: current issues and future trends. <b>2015</b> , 2, 50-56	25
830	A trigger tool to detect harm in pediatric inpatient settings. <b>2015</b> , 135, 1036-42	58
829	Pivoting: leveraging opportunities in a turbulent health care environment. <b>2015</b> , 103, 3-13	4
828	Ebola, team communication, and shame: but shame on whom?. <b>2015</b> , 15, 20-5	5
827	The present of presence. <b>2015</b> , 44, 88	
826	Safety culture and care: a program to prevent surgical errors. <b>2015</b> , 101, 404-12; quiz 413-5	15
825	Solving challenges in inter- and trans-disciplinary working teams: Lessons from the surgical technology field. <b>2015</b> , 63, 209-19	13
824	Simulation-based medical education: time for a pedagogical shift. <b>2015</b> , 52, 41-5	23

### (2015-2015)

823	Human factors engineering: its place and potential in OR safety. <b>2015</b> , 101, 571-3	1
822	Morbidity of urologic surgical procedures: an analysis of rates, risk factors, and outcomes. <b>2015</b> , 85, 552-9	68
821	Nutrition and pain. <b>2015</b> , 26, 309-20	70
820	Protection and measurement in radiation therapy. <b>2015</b> , 108, 224-41	11
819	Exemplary leadership: how style and culture predict organizational outcomes. 2015, 46, 47-51	5
818	An electronic checklist improves transfer and retention of critical information at intraoperative handoff of care. <b>2015</b> , 120, 96-104	51
817	An Emerging Science of Improvement in Health Care. <b>2015</b> , 27, 17-34	28
816	Moving From Digitalization to Digitization in Cardiovascular Care: Why Is it Important, and What Could it Mean for Patients and Providers?. <b>2015</b> , 66, 1489-96	35
815	Electronic medication reconciliation and medication errors. <b>2015</b> , 27, 314-9	18
814	The Association Between Sensemaking During Physician Team Rounds and Hospitalized Patients' Outcomes. <b>2015</b> , 30, 1821-7	10
813	A pilot study to test the effectiveness of an innovative interprofessional education assessment strategy. <b>2015</b> , 29, 451-6	12
812	Improvement in Detection of Wrong-Patient Errors When Radiologists Include Patient Photographs in Their Interpretation of Portable Chest Radiographs. <b>2015</b> , 28, 664-70	5
811	Key Concepts of Patient Safety in Radiology. <b>2015</b> , 35, 1677-93	33
810	Making healthcare safer by understanding, designing and buying better IT. <b>2015</b> , 15, 258-62	12
809	Experiences of intermediate care among older people: a phenomenological study. <b>2015</b> , 20, 74-9	10
808	Training in quality and safety: the current landscape. <b>2015</b> , 30, 526-38	13
807	Culture of safety. <b>2015</b> , 50, 139-52	16
806	Errors in neurosurgery. <b>2015</b> , 26, 149-55, vii	21

805	Research on quality and safety: what are we missing?. <b>2015</b> , 91, 17-9	1
804	What health care is learning from the aviation industry. <b>2015</b> , 29, 1-2	5
803	Patient-specific risk factors of adverse drug events in adult inpatients - evidence detected using the Global Trigger Tool method. <b>2015</b> , 24, 582-91	21
802	Standard performance measures for adult stroke patients. <b>2015</b> , 83, 325-7	
801	Navigating Through Chaos: Charge Nurses and Patient Safety. <b>2016</b> , 46, 208-14	5
800	Describing Nurse Leaders' and Direct Care Nurses' Perceptions of a Healthy Work Environment in Acute Care Settings, Part 2. <b>2016</b> , 46, 462-7	22
799	Outcomes-Oriented Medical Training: A Critical Curricular Design Consideration in Developing 21st Century Health Care Professionals. <b>2016</b> , 116, 742-746	
798	The culture of patient safety from the perspective of the pediatric emergency nursing team. <b>2016</b> , 50, 756-762	13
797	Working conditions of interns/residents and patient safety: Painful training might not be authentic. <b>2016</b> , 59, 82	4
796	Human Factors Engineering in Healthcare. <b>2016</b> , 167-182	
795	Faculty Development Directed at Curricular Reforms Designed to Improve Patient Outcomes. <b>2016</b> , 116, 736-741	2
794	Real-Time Reporting of Small Operational Failures in Nursing Care. <b>2016</b> , 2016, 8416158	3
793	Reliability and Patient Safety. <b>2016</b> , 217-244	
792	Clinical Information Systems - From Yesterday to Tomorrow. <b>2016</b> , Suppl 1, S62-75	10
791	A Culture of Safety: It Starts With You. <b>2016</b> , 39, 125-6	
790	Quality, Safety, and Value in Pediatric Orthopaedic Surgery. <b>2016</b> , 36, 549-57	8
789	The Feasibility of the Nationwide Health Information Network. <b>2016</b> , 35, 103-12	5
788	Transformational leadership in nursing: a concept analysis. <b>2016</b> , 72, 2644-2653	49

787	Linking Root Cause Analysis to Practice Using Problem-Based Learning. <b>2016</b> , 41, 225-7	2
786	Quality and Safety in Health Care, Part VI: More on Crossing the Quality Chasm. 2016, 41, 41-3	4
785	The important role of simulation in sedation. <b>2016</b> , 29 Suppl 1, S14-20	9
7 <sup>8</sup> 4	The Impact of a Rigorous Multiple Work Shift Schedule and Day Versus Night Shift Work on Reaction Time and Balance Performance in Female Nurses: A Repeated Measures Study. <b>2016</b> , 58, 737-43	13
783	Care at the point of impact: Insights into the second-victim experience. <b>2016</b> , 35, 6-13	24
782	CURB-65 Performance Among Admitted and Discharged Emergency Department Patients With Community-acquired Pneumonia. <b>2016</b> , 23, 400-5	14
781	The promise of big data: Improving patient safety and nursing practice. <b>2016</b> , 46, 28-34; quiz 34-5	6
780	Medical decision support systems and therapeutics: The role of autopilots. <b>2016</b> , 99, 161-4	17
779	Human factors in the emergency department: Is physician perception of time to intubation and desaturation rate accurate?. <b>2016</b> , 28, 295-9	16
778	Impact of a Collaborative Radiology Utilization Management Program: Does the Specialty of the Referring Provider Matter?. <b>2016</b> , 207, 121-5	2
777	Estimating deaths due to medical error: the ongoing controversy and why it matters. 2017, 26, 423-428	40
776	Is Social Work Evidence-based? Does Saying So Make It So? Ongoing Challenges in Integrating Research, Practice and Policy. <b>2016</b> , 52, S110-S125	6
775	Data that drive: Closing the loop in the learning hospital system. <b>2016</b> , 11 Suppl 1, S11-S17	18
774	Does increasing the size of bi-weekly samples of records influence results when using the Global Trigger Tool? An observational study of retrospective record reviews of two different sample sizes. <b>2016</b> , 6, e010700	3
773	Patient safety education among chinese medical undergraduates: An empirical study. <b>2016</b> , 36, 780-784	4
772	Tools to improve patient safety and adverse events. 95-102	
77 <sup>1</sup>	Severity scoring, improved care?. 124-133	
770	Coronary Computed Tomography Angiography for Low-Risk Chest Pain. <b>2016</b> , 68, 645	2

12

Reporting and Analyzing Patient Safety Incidents. 2016, 25-44 769 Simulation-based training: the missing link to lastingly improved patient safety and health?. 2016, 768 2 92, 309-11 Introducing inter-professional education in curricula of Saudi health science schools: An educational 767 8 projection of Saudi Vision 2030. **2016**, 11, 520-525 Examining pathways to safety and financial performance in hospitals: A study of lean in 766 71 professional service operations. 2016, 42-43, 39-51 The Why and What of Integrative Pain Medicine. 2016, 75-77 765 Developing a Checklist: Consensus Via a Modified Delphi Technique. 2016, 30, 855-8 16 764 Implementation and evaluation of a gravimetric i.v. workflow software system in an oncology 763 21 ambulatory care pharmacy. **2016**, 73, 165-73 Creating Highly Reliable Health Care: How Reliability-Enhancing Work Practices Affect Patient 762 27 Safety in Hospitals. 2016, 69, 911-938 The neonatal preventable harm index: a high reliability tool. 2016, 36, 676-80 761 3 Surgeon-Level Variation in Postoperative Complications. 2016, 20, 1393-9 760 Accuracy of interpreting vital signs in simulation: An empirical study of conformity between 9 759 medical and nursing students. 2016, 3, 9-18 Barriers and facilitators of nurses' use of clinical practice guidelines: An integrative review. 2016, 66 758 60, 54-68 Multicenter Assessment of Gram Stain Error Rates. 2016, 54, 1442-1447 757 41 Implementing a Quality and Safety Agenda in a Children's Hospital Within a Hospital: Challenges 756 and Successes. 2016, 6, 431-3 Nurses' experiences with errors in nursing. 2016, 64, 566-574 755 19 Fresh Ideas to Foster True Innovation in Nursing. **2016**, 14, 238-239 754 Use of a Surgical Safety Checklist to Improve Team Communication. 2016, 104, 206-16 753 15

Improving patient safety reporting with the common formats: Common data representation for

Patient Safety Organizations. 2016, 64, 116-121

752

751	Embedded, In Situ Simulation Improves Ability to Rescue. <b>2016</b> , 12, 522-527	5
75°	Impact of a standardized rapid response system on outcomes in a large healthcare jurisdiction. <b>2016</b> , 107, 47-56	33
749	Implementation of interprofessional education (IPE) in 16 U.S. medical schools: Common practices, barriers and facilitators. <b>2016</b> , 4, 41-49	74
748	Is Health Services Research Important for Surgeons?. <b>2016</b> , 50, 143-55	1
747	Drivers and Barriers to Adoption. <b>2016</b> , 41-57	1
746	A new frontier in healthcare risk management: Working to reduce avoidable patient suffering. <b>2016</b> , 35, 31-7	15
745	The Hospital Safety Crisis. <b>2016</b> , 53, 339-347	3
744	What's the Rush? Tort Laws and Elective Early-term Induction of Labor. <b>2016</b> , 57, 486-501	4
743	Reflections on the Current State of Infusion Therapy. <b>2016</b> , 50, 253-62	7
742	Telemedicine for Trauma and Emergency: the eICU. <b>2016</b> , 2, 132-137	3
741	Crucial Conversations: An interprofessional learning opportunity for senior healthcare students. <b>2016</b> , 30, 777-786	9
740	Advancing interprofessional patient safety education for medical, nursing, and pharmacy learners during clinical rotations. <b>2016</b> , 30, 819-822	14
739	Learning to Work Together Through Talk: Continuing Professional Development in Medicine. <b>2016</b> , 47-73	8
738	Early Examples of Simulation in Training and Healthcare. <b>2016</b> , 9-19	1
737	Outlier-based detection of unusual patient-management actions: An ICU study. <b>2016</b> , 64, 211-221	32
736	Promoting the Health of Families and Communities: A Moral Imperative. <b>2016</b> , 46 Suppl 1, S48-51	8
735	The Nurse as the Patient's Advocate: A Contrarian View. <b>2016</b> , 46 Suppl 1, S43-7	6
734	Optimal medication dosing from suboptimal clinical examples: a deep reinforcement learning approach. <b>2016</b> , 2016, 2978-2981	66

733	A Dual Processing Theory Based Approach to Instruction and Assessment of Diagnostic Competencies. <b>2016</b> , 26, 787-795	3
732	Virtual TeamSTEPPS([]) Simulations Produce Teamwork Attitude Changes Among Health Professions Students. <b>2016</b> , 55, 31-5	36
731	Referral Finder: Saving Time and Improving The Quality of In-hospital Referrals. 2016, 5,	3
730	Disclosure of adverse outcomes in medicine: A questionnaire study on voice intention and behaviour of physicians in Germany, Japan and the USA. <b>2016</b> , 30, 310-337	2
729	To err IS human. <b>2016</b> , 11, 4-4	1
728	Speak up for patient safety. <b>2016</b> , 11, 4-4	2
727	Debriefing as a Supportive Component for Registered Nurses in Transition. <b>2016</b> , 32, 212-8	10
726	Redefining Accountability in Quality and Safety at Academic Medical Centers. <b>2016</b> , 25, 244-247	2
725	How Do Simulated Error Experiences Impact Attitudes Related to Error Prevention?. 2016, 11, 323-333	10
724	Implementing High Reliability for Patient Safety. <b>2016</b> , 7, 46-52	6
723	Leveraging Health Care Simulation Technology for Human Factors Research: Closing the Gap Between Lab and Bedside. <b>2016</b> , 58, 1082-1095	13
722	Stakeholders' Perceptions Regarding the Use of Patient Photographs Integrated with Medical Imaging Studies. <b>2016</b> , 29, 341-6	6
721	Medicolegal Sidebar: Blowback: The Unintended Consequences of Medical Liability Reform. <b>2016</b> , 474, 31-4	
720	On protecting & preserving personal privacy in interoperable global healthcare venues. <b>2016</b> , 6, 53-73	4
719	Handing Off Safety at the Bedside. <b>2016</b> , 25, 473-93	12
718	Patient safety and patient assessment in pre-hospital care: a study protocol. <b>2016</b> , 24, 14	8
717	Medical professional responsibility and clinical safety in the practice of orthopaedic surgery and traumatology. <b>2016</b> , 60, 87-88	
716	Management's Discussion and Analysis: A tool for advancing quality and safety. <b>2016</b> , 4, 129-31	6

## (2016-2016)

715	Editorial Essay: Introduction to a Special Issue on Work and Employment Relations in Health Care. <b>2016</b> , 69, 787-802	2
714	Assessing the relationship between patient safety culture and EHR strategy. <b>2016</b> , 29, 614-27	6
713	Editorial. <b>2016</b> , 35, 123-4	
712	Quality Improvement in Otolaryngology Residency: Survey of Program Directors. <b>2016</b> , 154, 349-54	17
711	Nurses' role in medical error recovery: an integrative review. <b>2016</b> , 25, 906-17	18
710	Nursing physical assessment for patient safety in general wards: reaching consensus on core skills. <b>2016</b> , 25, 1890-900	22
709	Decision-making in healthcare as a complex adaptive system. <b>2016</b> , 29, 4-7	48
708	The challenge of learning from perioperative patient harm. <b>2016</b> , 7-8, 5-10	5
707	The Impact of Combining Conformance and Experiential Quality on HospitalsIReadmissions and Cost Performance. <b>2016</b> , 62, 829-848	69
706	Parent-Reported Errors and Adverse Events in Hospitalized Children. <b>2016</b> , 170, e154608	68
705	An exploration of the role of religion/spirituality in the promotion of physicians' wellbeing in Emergency Medicine. <b>2016</b> , 3, 189-95	27
704	Nursing workload in the acute-care setting: A concept analysis of nursing workload. <b>2016</b> , 64, 244-54	46
703	[Medical professional responsibility and clinical safety in the the practice of Orthopaedic Surgery and Traumatology]. <b>2016</b> , 60, 87-8	О
702	Comparison of barcode scanning by pharmacy technicians and pharmacists' visual checks for final product verification. <b>2016</b> , 73, 69-75	11
701	RFID analytics for hospital ward management. <b>2016</b> , 28, 593-616	13
700	Towards a program of assessment for health professionals: from training into practice. <b>2016</b> , 21, 897-913	87
699	Understanding medical errors and adverse events in ICU patients. <b>2016</b> , 42, 107-9	18
698	How we used a patient visit tracker tool to advance experiential learning in systems-based practice and quality improvement in a medical student clinic. <b>2016</b> , 38, 36-40	8

697	The association between transformational leadership in German hospitals and the frequency of events reported as perceived by medical directors. <b>2017</b> , 20, 499-515	9
696	Improving Insulin Administration Through Redesigning Processes of Care: A Multidisciplinary Team Approach. <i>Journal of Patient Safety</i> , <b>2017</b> , 13, 122-128	3
695	The Surgeon as the Second Victim? Results of the Boston Intraoperative Adverse Events Surgeons' Attitude (BISA) Study. <b>2017</b> , 224, 1048-1056	54
694	Clinical Acuity Shorthand System: a standardized classification tool to facilitate handoffs. <b>2017</b> , 211, 163-171	1
693	An accent modification program. <b>2017</b> , 33, 299-304	2
692	Simulation, Mastery Learning and Healthcare. <b>2017</b> , 353, 158-165	13
691	[Medication errors in anesthesia: unacceptable or unavoidable?]. 2017, 67, 184-192	14
690	Deaths from preventable adverse events originating in hospitals. <b>2017</b> , 26, 692-693	1
689	An Improvement Approach to Integrate Teaching Teams in the Reporting of Safety Events. <b>2017</b> , 139,	12
688	Developing and Evaluating an Automated All-Cause Harm Trigger System. <b>2017</b> , 43, 155-165	22
687	Ordering Interruptions in a Tertiary Care Center: A Prospective Observational Study. <b>2017</b> , 7, 134-139	3
686	Nurse practitioner malpractice data: Informing nursing education. <b>2017</b> , 33, 271-275	12
685	Families as Partners in Hospital Error and Adverse Event Surveillance. <b>2017</b> , 171, 372-381	67
684	Work interruptions resiliency: toward an improved understanding of employee efficiency. <b>2017</b> , 4, 39-58	7
683	Implementation of a structured hospital-wide morbidity and mortality rounds model. 2017, 26, 439-448	27
682	A Model for the Departmental Quality Management Infrastructure Within an Academic Health System. <b>2017</b> , 92, 608-613	9
681	Estimating Hospital-Related Deaths Due to Medical Error: A Perspective From Patient Advocates. <i>Journal of Patient Safety</i> , <b>2017</b> , 13, 1-5	19
680	Exploring the experience of nurse practitioners who have committed medical errors: A phenomenological approach. <b>2017</b> , 29, 403-409	11

### (2017-2017)

679	Error Detection-Based Model to Assess Educational Outcomes in Crisis Resource Management Training: A Pilot Study. <b>2017</b> , 156, 1080-1083	4
678	Non-Health Care Facility Cardiovascular Medication Errors in the United States. <b>2017</b> , 51, 825-833	4
677	Managing Safely the Complexity in Critical Care: Are Protocols for Artificial Ventilation in Pediatric Acute Respiratory Distress Syndrome Beneficial in Searching for Reliable Biomarkers?. <b>2017</b> , 45, 1250-1252	2
676	Integrating Quality and Safety Competencies to Improve Outcomes: Application in Infusion Therapy Practice. <b>2017</b> , 40, 116-122	2
675	Advancing health care quality and safety through action learning. 2017, 30, 148-158	8
674	Applying lessons from social psychology to transform the culture of error disclosure. <b>2017</b> , 51, 996-1001	9
673	Screening for medication errors using an outlier detection system. <b>2017</b> , 24, 281-287	34
672	Capturing Essential Information to Achieve Safe Interoperability. <b>2017</b> , 124, 83-94	11
671	CE: Nursing's Evolving Role in Patient Safety. <b>2017</b> , 117, 34-48	7
670	Systematic approaches to adverse events in obstetrics, Part I: Event identification and classification. <b>2017</b> , 41, 151-155	10
669	Nurses' Experiences With Patients Who Die From Failure to Rescue After Surgery. 2017, 49, 303-311	6
668	Improve IT, Improve Healthcare. <b>2017</b> , 50, 86-91	1
667	La promesa de los Big datalMejorar la seguridad del paciente y la prˆ lītica de la enfermerˆ lī. <b>2017</b> , 34, 20-26	
666	From Board to Bedside: How the Application of Financial Structures to Safety and Quality Can Drive Accountability in a Large Health Care System. <b>2017</b> , 43, 166-175	5
665	Improving Patient Safety through the Use of Nursing Surveillance. <b>2017</b> , 51, 34-43	4
664	Moving Beyond the WHO Definition of Health: A New Perspective for an Aging World and the Emerging Era of Value-Based Care. <b>2017</b> , 9, 127-137	22
663	Presenteeism in nursing: An evolutionary concept analysis. <b>2017</b> , 65, 615-623	28
662	Medication safety in the operating room: literature and expert-based recommendations. <b>2017</b> , 118, 32-43	48

661	Making Patient Safety Event Data Actionable: Understanding Patient Safety Analyst Needs. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e509-e514	3
660	Dependency and AMR Embeddings for Drug-Drug Interaction Extraction from Biomedical Literature. <b>2017</b> ,	10
659	A Communication Training Program to Encourage Speaking-Up Behavior in Surgical Oncology. <b>2017</b> , 106, 295-305	4
658	CE: Original Research: Exploring How Nursing Schools Handle Student Errors and Near Misses. <b>2017</b> , 117, 24-31	13
657	SPOTLIGHTS. <b>2017</b> , 21, 24-31	1
656	Evaluating the Costs of IR in Health Care Delivery: Proceedings from a Society of Interventional Radiology Research Consensus Panel. <b>2017</b> , 28, 1475-1486	6
655	Preventable Surgical Harm in Gynecologic Oncology: Optimizing Quality and Patient Safety. <b>2017</b> , 6, 298-309	1
654	Simulation-Based Training: Malignant Hyperthermia. <b>2017</b> , 106, 158-161	
653	User-Centered Collaborative Design and Development of an Inpatient Safety Dashboard. 2017, 43, 676-685	19
652	How Do We Balance the Long-Term Health of a Patient With the Short-Term Risk to the Physician?. <b>2017</b> , 53, 583-585	O
651	Interaction of Health Care Worker Health and Safety and Patient Health and Safety in the US Health Care System: Recommendations From the 2016 Summit. <b>2017</b> , 59, 803-813	13
650	Establishing face validity of the EPLIT questionnaire. <b>2017</b> , 23, 221-227	1
649	Improving Team Performance Through Simulation-Based Learning. <b>2017</b> , 50, 967-987	5
648	Integration of Quality and Safety Education for Nurses Into Practice: Academic-Practice Partnership's Role. <b>2017</b> , 42, S49-S52	5
647	Moving to a culture of health. <b>2017</b> , 33, 356-362	7
646	. <b>2017</b> , 47, 834-846	18
645	Root Cause Analysis of ICU Adverse Events in the Veterans Health Administration. 2017, 43, 580-590	8
644	Intrahospital transfers and adverse patient outcomes: An analysis of administrative health data. <b>2017</b> , 26, 4927-4935	13

643	What Hospitalists Need to Know About Quality Improvement. 2017, 5, 109-113	1
642	Usability Evaluation and Implementation of a Health Information Technology Dashboard of Evidence-Based Quality Indicators. <b>2017</b> , 35, 281-288	19
641	QSEN Institute RN-BSN Task Force: White Paper on Recommendation for Systems-Based Practice Competency. <b>2017</b> , 32, 354-358	8
640	Technological Complexity: Have We Reached a Tipping Point?. <b>2017</b> , 47, 195-197	2
639	Development of the Barriers to Error Disclosure Assessment Tool. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, 363-374	4
638	Distracted Practice and Patient Safety: The Healthcare Team Experience. <b>2017</b> , 52, 149-164	10
637	Children's Hospitals' Solutions for Patient Safety Collaborative Impact on Hospital-Acquired Harm. <b>2017</b> , 140,	53
636	Patient perspectives on interprofessional collaboration between healthcare professionals during hospitalization: a qualitative systematic review protocol. <b>2017</b> , 15, 2020-2027	3
635	Trainees May Add Value to Patient Care by Decreasing Addendum Utilization in Radiology Reports. <b>2017</b> , 209, 976-981	6
634	Achieving High Reliability with People, Processes, and Technology. <b>2017</b> , 33, 16-25	1
633	Weaving a culture of safety into the fabric of nursing. <b>2017</b> , 48, 18-25	3
632	SEGURIDAD DEL PACIENTE Y CULTURA DE SEGURIDAD. <b>2017</b> , 28, 785-795	5
631	. 2017,	3
630	Mou just canEdo it allEa secondary analysis of nurses' perceptions of teamwork, staffing and workload. <b>2017</b> , 22, 313-325	13
629	Using Facially Expressive Robots to Calibrate Clinical Pain Perception. 2017,	12
628	CE: Original Research: Creating an Evidence-Based Progression for Clinical Advancement Programs. <b>2017</b> , 117, 22-35	11
627	Reducing Surgery Scheduling Errors in Multihospital System. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e469-e4 <b>7.</b>	
626	Association of nurse work environment and safety climate on patient mortality: A cross-sectional study. <b>2017</b> , 74, 155-161	79

625	Interprofessional Clinical Rounding: Effects on Processes and Outcomes of Care. 2017, 39, 85-94	11
624	Time-Out and Checklists: A Survey of Rural and Urban Operating Room Personnel. <b>2017</b> , 32, E3-E10	6
623	Why do surgeons continue to perform unnecessary surgery?. <b>2017</b> , 11, 1	28
622	Intelligent dynamic clinical checklists improved checklist compliance in the intensive care unit. <b>2017</b> , 119, 231-238	20
621	Preventing Harm in the ICU-Building a Culture of Safety and Engaging Patients and Families. <b>2017</b> , 45, 1531-1537	12
620	Exploration of difficult conversations among Australian paramedics. <b>2017</b> , 19, 358-365	3
619	Shaking Up Culture and Communication in PV [V6]. <b>2017</b> , 81-97	1
618	Comparative Effectiveness of Hands-on Versus Computer Simulation-Based Training for Contrast Media Reactions and Teamwork Skills. <b>2017</b> , 14, 103-110.e3	18
617	Burnout in the neonatal intensive care unit and its relation to healthcare-associated infections. <b>2017</b> , 37, 315-320	39
616	Medication errors in anesthesia: unacceptable or unavoidable?. <b>2017</b> , 67, 184-192	10
615	A systematic review of the types and causes of prescribing errors generated from using computerized provider order entry systems in primary and secondary care. <b>2017</b> , 24, 432-440	68
614	Describing clinical faculty experiences with patient safety and quality care in acute care settings: A mixed methods study. <b>2017</b> , 49, 45-50	2
613	Outdoor risky play and healthy child development in the shadow of the lisk society[]A forest and nature school perspective. <b>2017</b> , 38, 318-334	36
612	Evaluation of a Broad-Spectrum Partially Automated Adverse Event Surveillance System: A  Potential Tool for Patient Safety Improvement in Hospitals With Limited Resources. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e653-e664	1
611	Patient Safety. <b>2017</b> , 35, 189-190	
610	Keeping Each Other Safe: An Assessment of The Use of Peer Intervention Programs to Prevent Police Officer Mistakes and Misconduct, Using New Orleans EPIC Program As A Potential National Model. <b>2017</b> , 20, 295-321	11
609	Estimating preventable hospital deaths: the authors reply. <b>2017</b> , 26, 694	7
608	Partnering to Lead a Culture of Safety. <b>2017</b> , 62, 234-237	1

607	Attitudes of Nursing Students Towards Learning Communication Skills. 2017,		2
606	Energy Metabolism in a Revised Medical Model. <b>2017</b> , 305-325		
605	Nurse Educators: Leading Health Care to the Quadruple Aim Sweet Spot. <b>2017</b> , 56, 707-708		
604	The 10 anniversary of patient safety in surgery. <b>2017</b> , 11, 27		1
603	A Proposed Set of Metrics to Reduce Patient Safety Risk From Within the Anatomic Pathology Laboratory. <b>2017</b> , 48, 195-201		6
602	The Effect of Medical Recording Training on Quantity and Quality of Recording in Gynecology Residents of Tabriz University of Medical Sciences. <b>2017</b> , 6, 281-292		1
601	Introducing a new series on innovations in medical education. <b>2017</b> , 206, 13		1
600	Complications: acknowledging, managing, and coping with human error. <b>2017</b> , 6, 773-782		15
599	Theoretical-practical acquisition of topics relevant to patient safety: dilemmas in the training of nurses. <b>2017</b> , 21,		1
598	Impact of Inpatient Harms on Hospital Finances and Patient Clinical Outcomes. <i>Journal of Patient Safety</i> , <b>2018</b> , 14, 67-73	.9	25
597	Validation of time to task performance assessment method in simulation: A comparative design study. <b>2018</b> , 64, 108-114		5
596	Human Cognitive Limitations. Broad, Consistent, Clinical Application of Physiological Principles Will Require Decision Support. <b>2018</b> , 15, S53-S56		11
595	Futility and appropriateness: challenging words, important concepts. <b>2018</b> , 94, 238-243		8
594	Novel Aproach for Localization of Patients in Urgent Admission Department. 2018, 455-464		1
593	Improvement of the Patient Safety Culture in the Primary Health Care Corporation - Qatar. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e1376-e1382	.9	2
592	Fifteen-Year Journey to High Reliability in Pathology and Laboratory Medicine. 2018, 33, 530-539		O
591	A framework for operationalizing risk: A practical approach to patient safety. <b>2018</b> , 38, 38-46		4
590	Incidence of adverse events in Sweden during 2013-2016: a cohort study describing the implementation of a national trigger tool. <b>2018</b> , 8, e020833		16

589	Patient safety vulnerabilities for children with intellectual disability in hospital: a systematic review and narrative synthesis. <b>2018</b> , 2, e000201	14
588	A Transactional "Second-Victim" Model-Experiences of Affected Healthcare Professionals in Acute-Somatic Inpatient Settings: A Qualitative Metasynthesis. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e1001-e10	18
587	Design for patient safety: a systems-based risk identification framework. <b>2018</b> , 61, 1046-1064	23
586	The function of patient-centered care in mitigating the effect of nursing shortage on the outcomes of care. <b>2018</b> , 33, e464-e473	9
585	Transforming Health Care One Team at a Time: Ten Observations and the Trail Ahead. <b>2018</b> , 43, 357-381	27
584	Relationships between Army nursing practice environments and patient outcomes. 2018, 41, 131-144	6
583	Technological Complexity and Emergence of the Entanglement. <b>2018</b> , 48, 65-67	2
582	Diffusing Innovation and Best Practice in Health Care. <b>2018</b> , 36, 127-141	5
581	Use of Simulation in Performance Improvement. <b>2018</b> , 36, 63-74	5
580	"To Err Is Human" but Disclosure Must be Taught: A Simulation-Based Assessment Study. <b>2018</b> , 13, 107-116	6
579	Outcomes From the First Helene Fuld Health Trust National Institute for Evidence-Based Practice in Nursing and Healthcare Invitational Expert Forum. <b>2018</b> , 15, 5-15	10
578	Innovation in the Delivery of Perinatal Health Care. <b>2018</b> , 47, 243-244	
577	Improving Staff Communication and Transitions of Care Between Obstetric Triage and Labor and Delivery. <b>2018</b> , 47, 264-272	9
576	A comparison of teamwork attitude changes with virtual TeamSTEPPS [] simulations in health professional students. <b>2018</b> , 10, 51-55	8
575	Development of a Patient Decision Aid for Syncope in the Emergency Department: the SynDA Tool. <b>2018</b> , 25, 425-433	9
574	Patients not patents: Drug research and development as a public enterprise. 2018, 48, e12875	7
573	Experiences from ten years of incident reporting in health care: a qualitative study among department managers and coordinators. <b>2018</b> , 18, 113	8
57 <sup>2</sup>	Development of the Surgical Patient safety Observation Tool (SPOT). <b>2018</b> , 2, 119-127	2

571	Nurses' rights of medication administration: Including authority with accountability and responsibility. <b>2018</b> , 53, 299	4
57°	Cardiac CT in the Emergency Department: Contrasting Evidence from Registries and Randomized Controlled Trials. <b>2018</b> , 20, 24	2
569	A Standard-Setting Body for US Health Care Quality Measurement. <b>2018</b> , 33, 434-439	
568	Improving guideline compliance and healthcare safety using human factors engineering: The case of Ebola. <b>2018</b> , 23, 93-95	9
567	Developing a Comprehensive Model of Intensive Care Unit Processes: Concept of Operations. <i>Journal of Patient Safety</i> , <b>2018</b> , 14, 187-192	9
566	Sustained Improvement in Neonatal Intensive Care Unit Safety Attitudes After Teamwork Training.  Journal of Patient Safety, <b>2018</b> , 14, 174-180	4
565	When Doing Wrong Feels So Right: Normalization of Deviance. <i>Journal of Patient Safety</i> , <b>2018</b> , 14, 1-2 1.9	21
564	Gamification and Microlearning for Engagement With Quality Improvement (GAMEQI): A Bundled Digital Intervention for the Prevention of Central Line-Associated Bloodstream Infection. <b>2018</b> , 33, 21-29	11
563	Evaluating Situation Awareness: An Integrative Review. <b>2018</b> , 40, 388-424	10
562	The Effectiveness of Simulation on Recognizing and Managing Clinical Deterioration: Meta-Analyses. <b>2018</b> , 40, 582-609	16
561	Severe bark scorpion envenomation in adults. <b>2018</b> , 56, 170-174	1
560	Preparing Tomorrow's Nurses for Collaborative Quality Care Through Simulation. 2018, 13, 46-50	6
559	Evidence-Based Reporting: A Method to Optimize Prostate MRI Communications With Referring Physicians. <b>2018</b> , 210, 108-112	21
558	Consensus achievement of leadership, organisational and individual factors that influence safety climate: Implications for nursing management. <b>2018</b> , 26, 50-58	15
557	Health professional perspectives of patient safety issues in intensive care units in Saudi Arabia. <b>2018</b> , 26, 209-218	6
556	A Department of Medicine Infrastructure for Patient Safety and Clinical Quality Improvement. <b>2018</b> , 33, 413-419	1
555	[Detection of adverse events using IHI Global Trigger Tool during the adoption of a risk management system: A retrospective study over three years at a department for cardiovascular surgery in Vienna]. <b>2018</b> , 131-132, 38-45	5
554	Bridging understanding in nursing and radiography students: An interprofessional experience. <b>2018</b> , 53, 129-136	3

553	The effects of crew resource management on teamwork and safety climate at Veterans Health Administration facilities. <b>2018</b> , 38, 17-37	12
552	Medical and pharmacy students shadowing advanced practice nurses to develop interprofessional competencies. <b>2018</b> , 39, 103-108	25
551	Can assessment be a barrier to successful professional development?. <b>2018</b> , 23, 11-16	4
550	CULTURA DE SEGURAN^ A DO PACIENTE: AVALIA^ D D PELOS PROFISSIONAIS DE ENFERMAGEM. 2018, 27,	11
549	PREVAL <sup>^</sup> DICIA E FATORES ASSOCIADOS PARA A OCORR <sup>^</sup> DICIA DE EVENTOS ADVERSOS NO SERVI <sup>^</sup> DID DE HEMODI <sup>^</sup> LISE. <b>2018</b> , 27,	1
548	Postoperative Brain Function: Toward a Better Understanding and the American Society of Anesthesiologists Perioperative Brain Health Initiative. <b>2018</b> , 129, 861-863	5
547	Safe Passage: Improving the Transition of Care Between Triage and Labor and Delivery. 2018, 27, 223-228	1
546	Multicenter Test of an Emergency Department Trigger Tool for Detecting Adverse Events. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e843-e849	4
545	A prototype of knowledge-based patient safety event reporting and learning system. <b>2018</b> , 18, 110	3
544	Two Decades Since To Err Is Human: An Assessment Of Progress And Emerging Priorities In Patient Safety. <b>2018</b> , 37, 1736-1743	111
543	Therapeutic Landscapes. 2018, 387-413	5
542	An Electronic Health Record-Based Real-Time Analytics Program For Patient Safety Surveillance And Improvement. <b>2018</b> , 37, 1805-1812	19
541	EDITORIAL: Papel de la enfermera en la reducci <sup>^</sup> El de errores en la pr <sup>^</sup> Eltica cl <sup>^</sup> Elica. <b>2018</b> , 35, 6	
540	Evaluation of patient safety culture: comparative study in university hospitals. <b>2018</b> , 52, e03379	9
540 539	Evaluation of patient safety culture: comparative study in university hospitals. <b>2018</b> , 52, e03379  Types and frequency of non-conformances in an IVF laboratory. <b>2018</b> , 33, 2196-2204	9
539	Types and frequency of non-conformances in an IVF laboratory. <b>2018</b> , 33, 2196-2204  Pharmacist-Initiated Medication Error-Reporting and Monitoring Programme in a Developing	8

535	Promoting a safety culture through effective nursing leadership in cancer care. 2018, 36, vi-vii	1
534	Errar es humano. Ocultar los errores es imperdonable. No aprender de ellos, no tiene justificaci <sup>^</sup> 日口 <b>2018</b> , 25, 295-296	
533	. <b>2018</b> , 25, e27-e28	
532	Walk a Mile in the Leadership's Shoes: Why Focus on Quality Improvement?. <b>2018</b> , 49, 411-417	1
531	Prevention of Communication Failures in Radiology or Procedural/Interventional Settings. 2018, 37, 145-146	
530	Introducing Nursing Students to an Environmental Safety Assessment Through Simulation. <b>2018</b> , 13, 190-192	
529	Handoff Tool Enabling Standardized Transitions Between the Emergency Department and the Hospitalist Inpatient Service at a Major Cancer Center. <b>2018</b> , 33, 629-636	6
528	Application of HFACS, fuzzy TOPSIS, and AHP for identifying important human error factors in emergency departments in Taiwan. <b>2018</b> , 67, 171-179	29
527	Priming patient safety: A middle-range theory of safety goal priming via safety culture communication. <b>2018</b> , 25, e12246	2
526	A Checklist Manifesto: Effectiveness of Checklist Use in Hands-On Simulation Examining Competency in Contrast Reaction Management in a Randomized Controlled Study. <b>2018</b> , 211, W1-W12	8
525	Modeling and Comparing Nurse and Physician Trauma Assessment Skills. <b>2018</b> , 183, 47-54	1
524	Identifying, Understanding, and Managing Patient Safety and Clinical Risks in the Clinical Research Environment. <b>2018</b> , 633-644	1
523	The effect of nurse empowerment educational program on patient safety culture: a randomized controlled trial. <b>2018</b> , 18, 158	22
522	The Definition and Scope of Diagnostic Error in the US and How Diagnostic Error is Enabled. <b>2018</b> , 3, 128-134	3
521	Resilience engineering for socio-technical risk analysis: Application in neuro-surgery. <b>2018</b> , 180, 321-335	24
520	Relationships Among Nurse Manager Leadership Skills, Conflict Management, and Unit Teamwork. <b>2018</b> , 48, 383-388	18
519	Prevention of medical errors and malpractice: Is creating resilience in physicians part of the answer?. <b>2018</b> , 60, 35-39	15
518	Introducing Traceability Information Models in Connected Health Projects. 2018,	3

517	POP-PL. <b>2018</b> , 40, 1-37	1
516	A Health System's Journey toward Better Population Health through Empanelment and Panel Management. <b>2018</b> , 6,	3
515	Development of Virtual Simulations for Medical Team Training: An Evaluation of Key Features. <b>2018</b> , 7, 261-266	3
5 <sup>1</sup> 4	Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors. <b>2018</b> , 93, 1571-1580	249
513	A framework for simulation systems and technologies for medical training. 2018,	1
512	The Effects of Nursing Satisfaction and Turnover Cognitions on Patient Attitudes and Outcomes: A Three-Level Multisource Study. <b>2018</b> , 53, 4943-4969	14
511	LC-HRMS Metabolomics for Untargeted Diagnostic Screening in Clinical Laboratories: A Feasibility Study. <b>2018</b> , 8,	8
510	Patient Safety Culture and Barriers to Adverse Event Reporting: A National Survey of Nurse Executives. <b>2018</b> , 9, 9-17	6
509	The effect of workload on nurses' non-observance errors in medication administration processes: A cross-sectional study. <b>2018</b> , 24, e12679	5
508	Fully-automated systems and the need for global approaches should exhort clinical labs to reinvent routine MS analysis?. <b>2018</b> , 10, 1129-1141	3
507	A Conceptual Framework to Reduce Inpatient Preventable Deaths. 2018, 44, 413-420	1
506	Adverse Events in Hospitalized Pediatric Patients. 2018, 142,	27
505	"GAPPS" in Patient Safety. <b>2018</b> , 142,	О
504	Creating a comprehensive, unit-based approach to detecting and preventing harm in the neonatal intensive care unit. <b>2018</b> , 23, 167-175	3
503	Patient Safety Climate: A Study of Southern California Healthcare Organizations. 2018, 63, 175-192	2
502	Using interprofessional medication management simulations to impact student attitudes toward teamwork to prevent medication errors. <b>2018</b> , 10, 982-989	13
501	Using systems thinking to envision quality and safety in healthcare. <b>2018</b> , 49, 32-39	5
500	Implementation of a patient safety program at a tertiary health system: A longitudinal analysis of interventions and serious safety events. <b>2018</b> , 37, 17-24	12

499	Risk factors for death in patients with non-infectious adverse events. <b>2018</b> , 26, e3001	1
498	Potential value of patient record review to assess and improve patient safety in general practice: A systematic review. <b>2018</b> , 24, 192-201	13
497	To err is human: medication patient safety in aged care, a case study. <b>2018</b> , 19, 126-134	О
496	Reflections on the First 50 Years of Human Patient Simulation: Mission Accomplished?. <b>2018</b> , 19, 588-591	
495	Physical Simulators and Replicators in Endovascular Neurosurgery Training. 2018, 29-45	4
494	Effects of Shame and Guilt on Error Reporting Among Obstetric Clinicians. <b>2018</b> , 47, 468-478	9
493	Perspectives on Patient and Family Engagement With Reduction in Harm: The Forgotten Voice. <b>2019</b> , 34, 73-79	3
492	Health care risk managers' consensus on the management of inappropriate behaviors among hospital staff. <b>2019</b> , 38, 32-42	2
491	Reducing drug prescription errors and adverse drug events by application of a probabilistic, machine-learning based clinical decision support system in an inpatient setting. <b>2019</b> , 26, 1560-1565	23
490	Design and Implementation of a Pathology-Specific Handoff Tool for Residents. <b>2019</b> , 6, 2374289519839186	0
489	Psychometric properties of the Korean version of the Occupational Fatigue Exhaustion Recovery Scale in a nurse population. <b>2019</b> , 42, 358-368	8
488	Outcomes of Patient-Engaged Video Surveillance on Falls and Other Adverse Events. <b>2019</b> , 35, 253-263	8
487	Strengthening the Medical Error "Meme Pool". <b>2019</b> , 34, 2264-2267	2
486	Improving Therapeutic Communication in Nursing Through Simulation Exercise. <b>2019</b> , 14, 260-264	11
485	Safety incident reports associated with blood transfusions. <b>2019</b> , 59, 2827-2832	4
484	An analysis of hospital pharmacy practice in six countries of sub-Saharan Africa based on the International Pharmaceutical Federation Basel Statements on the future of hospital pharmacy. <b>2019</b> , 27, 528-535	1
483	Barriers to nurses reporting errors and adverse events. <b>2019</b> , 28, 690-695	7
482	Transfusion Medicine and the Law. <b>2019</b> , 107-116	

481	Factors Influencing the Implementation of a Hospitalwide Intervention to Promote Professionalism and Build a Safety Culture: A Qualitative Study. <b>2019</b> , 45, 694-705	5
480	Smashing into Windows. <b>2019</b> , 17-29	1
479	Online intervention to reduce pediatric anxiety: An evidence-based review. <b>2019</b> , 32, 197-209	1
478	Group and Organizational Safety Norms Set the Stage for Good Post-Fall Huddles. <b>2019</b> , 26, 465-475	1
477	Modeling and Synthesizing Idiopathic Facial Paralysis. 2019,	1
476	Psychometric Testing of a Value-Achievement-Cost Motivation Survey for 12th Grade Health Sciences Students for Use in Simulation-Based-Games. <b>2019</b> , 50, 789-811	3
475	Mitigating risk in Norwegian psychiatric care: Identifying triggers of adverse events through Global Trigger Tool for psychiatric care. <b>2019</b> , 30, 203-216	
474	Avoiding chemotherapy prescribing errors: Analysis and innovative strategies. <b>2019</b> , 125, 1547-1557	11
473	Applying art observation skills to standardized patients. <b>2019</b> , 48, 8-12	4
472	I Hear You, but Do I Understand? The Relationship of a Shared Professional Language With Quality of Care and Job Satisfaction. <b>2019</b> , 10, 1310	8
471	Association between culture of patient safety and burnout in pediatric hospitals. 2019, 14, e0218756	7
470	Implementing Patient Safety Initiatives. <b>2019</b> , 46, 281-292	O
469	Coronary CT Angiography for Evaluation of Acute Coronary Syndrome in the Emergency Department. <b>2019</b> , 331-348	
468	Structured Radiology Reporting: Addressing the Communication Quality Gap. <b>2019</b> , 1, 397-407	3
467	A Decade of Preventing Harm. <b>2019</b> , 45, 480-486	О
466	Patient safety professionals as the third victims of adverse events. <b>2019</b> , 24, 166-175	8
465	Time to Move On: Redefining Chest Pain Outcomes. <b>2019</b> , 8, e012542	2
464	Integration of multiple methods in identifying patient safety risks. <b>2019</b> , 118, 530-537	9

463 Development of a positron emission tomography risks map. **2019**, 38, 38-45

462	The role of patients in the delivery of safe care in hospital: Study protocol. <b>2019</b> , 75, 2015-2023	7
461	The link between healthcare risk identification and patient safety culture. <b>2019</b> , 32, 574-587	11
460	Is there a Theory [Practice [Ethics gap? A Patient Safety Case Study. <b>2019</b> , 10, 38-42	1
459	A statewide initiative integrating Quality and Safety Education for Nurses (QSEN) through academic-clinical partnerships to improve health outcomes. <b>2019</b> , 35, 282-292	1
458	Standardising the Classification of Harm Associated with Medication Errors: The Harm Associated with Medication Error Classification (HAMEC). <b>2019</b> , 42, 931-939	12
457	Regulation and current status of patient safety content in pre-registration nurse education in 27 countries: Findings from the Rationing - Missed nursing care (RANCARE) COST Action project. <b>2019</b> , 37, 132-140	21
456	The unmeasured quality metric: Burn out and the second victim syndrome in healthcare. <b>2019</b> , 28, 189-194	6
455	The Effect of an Undergraduate Perioperative Nursing Course on Safety Knowledge. 2019, 109, 346-354	O
454	Structured reporting of prostate magnetic resonance imaging has the potential to improve interdisciplinary communication. <b>2019</b> , 14, e0212444	12
453	Critical Review, Development, and Testing of a Taxonomy for Adverse Events and Near Misses in the Emergency Department. <b>2019</b> , 26, 670-679	6
452	Users' preferences and perceptions of the comprehensibility and readability of medication labels. <b>2019</b> , 14, e0212173	3
451	Individual and Team-Based Medical Error Disclosure: Dialectical Tensions Among Health Care Providers. <b>2019</b> , 29, 1096-1108	6
450	Attitudes of Doctors and Nurses toward Patient Safety within Emergency Departments of a Saudi Arabian Hospital: A Qualitative Study. <b>2019</b> , 7,	4
449	A multilevel approach on empowering leadership and safety behavior in the medical industry: The mediating effects of knowledge sharing and safety climate. <b>2019</b> , 117, 1-9	16
448	Development of a positron emission tomography risks map. <b>2019</b> , 38, 38-45	O
447	Increased Healthcare-Associated Infections in a Surgical Intensive Care Unit Related to Boarding Non-Surgical Patients. <b>2019</b> , 20, 332-337	0
446	Use of a Checklist for the Postanesthesia Care Unit Patient Handoff. <b>2019</b> , 34, 834-841	5

445	Fast and accurate medication identification. <b>2019</b> , 2, 10	11
444	Performance improvement in surgery. <b>2019</b> , 56, 211-246	1
443	Does work-induced fatigue accumulate across three compressed 12 hour shifts in hospital nurses and aides?. <b>2019</b> , 14, e0211715	23
442	Contribution of adverse events to death of hospitalised patients. <b>2019</b> , 8, e000377	7
441	Developing strategies for patient safety implementation: a national study in Iran. 2019, 32, 1113-1131	3
440	Wearable activity recognition for robust human-robot teaming in safety-critical environments via hybrid neural networks. <b>2019</b> ,	4
439	An environmental scan of quality improvement and patient safety activities in emergency medicine in Canada. <b>2019</b> , 21, 535-541	4
438	If You're HAPI and You Know It, Do No Harm. <b>2019</b> , 20, 1093-1094	
437	Framework for better care: reconciling approaches to patient safety and quality. 2019, 43, 653-655	3
436	Duty and what really matters - profession and self. <b>2019</b> , 87, 1007-1011	
435	Understanding Symptoms of Muscle Tightness, Weakness, and Rigidity From a Nursing Perspective. <b>2019</b> , 44, 271-281	3
434	Patient safety awareness among 309 surgeons in Enugu, Nigeria: a cross-sectional survey. <b>2019</b> , 13, 33	3
433	Using Bayesian Networks for Risk Assessment in Healthcare System. 2019,	3
432	Association Between Physician Depressive Symptoms and Medical Errors: A Systematic Review and Meta-analysis. <b>2019</b> , 2, e1916097	44
431	Systems Thinking Education in RN-BSN Programs: A Regional Study. <b>2019</b> , 44, 112-115	4
430	Should known allergy status be included as a medication administration 'right'?. <b>2019</b> , 28, 1292-1298	3
429	Necrotizing Enterocolitis and Spontaneous Intestinal Perforation: A Spatiotemporal Case Cluster Analysis. <b>2019</b> , 4, e127	1
	Evaluating the Use of High-Reliability Principles to Increase Error Event Reporting: A Retrospective	

427	Systems Perspective for Incivility in Academia: An Integrative Review. <b>2019</b> , 40, 144-150		7
426	Impact of Patient Safety Culture on Missed Nursing Care and Adverse Patient Events. <b>2019</b> , 34, 287-29	4	21
425	Hospital nurse shift length, patient-centered care, and the perceived quality and patient safety. <b>2019</b> , 34, e387-e396		17
424	Patient reaction after health-care service failure: qualitative study. <b>2019</b> , 13, 68-83		1
423	Monitoring Systems. <b>2019</b> , 245-260.e5		
422	Improving Safety. <b>2019</b> , 64-72.e2		1
421	Self-Reported Adherence to High Reliability Practices Among Participants in the Children's Hospitals' Solutions for Patient Safety Collaborative. <b>2019</b> , 45, 164-169		5
420	A Concept Analysis of Organizational Health and Communication. <b>2019</b> , 43, 68-75		2
419	Purposeful interprofessional team intervention improves relational coordination among advanced heart failure care teams. <b>2019</b> , 33, 481-489		21
418	A comparison of two structured taxonomic strategies in capturing adverse events in U.S. hospitals. <b>2019</b> , 54, 613-622		2
417	Medical students' perceptions regarding the use of patient photographs integrated with medical imaging studies. <b>2019</b> , 48, 323-328		
416	Creating a Culture of Continuous Improvement in Outpatient Laboratories: Effects on Wait Times, Employee Engagement, and Efficiency. <b>2019</b> , 34, 389-397		
415	Effects of Six Sigma initiatives in Malaysian private hospitals. <b>2019</b> , 10, 44-57		6
414	Digital health technology enhances resilient behaviour: evidence from the ward. <b>2019</b> , 40, 34-67		15
413	Organisational learning in hospitals: A concept analysis. <b>2019</b> , 27, 633-646		14
412	Epidemiology of Adverse Events and Medical Errors in the Care of Cardiology Patients. <i>Journal of Patient Safety</i> , <b>2019</b> , 15, 251-256	1.9	4
411	Improving Incident Reporting Among Physician Trainees. <i>Journal of Patient Safety</i> , <b>2019</b> , 15, 308-310	1.9	11
410	Impact and Culture Change After the Implementation of a Preprocedural Checklist in an Interventional Radiology Department. <i>Journal of Patient Safety</i> , <b>2019</b> , 15, e24-e27	1.9	7

409	Verification Templates for the Analysis of User Interface Software Design. <b>2019</b> , 45, 802-822		6
408	Pharmacists in humanitarian crisis settings: Assessing the impact of pharmacist-delivered home medication management review service to Syrian refugees in Jordan. <b>2019</b> , 15, 164-172		8
407	The Effect of Performance Transparency on Adherence to Barcode Scanning During Order Preparation in an Adult Inpatient Satellite Pharmacy. <b>2019</b> , 54, 37-44		
406	Developing and implementing a heart failure data mart for research and quality improvement. <b>2019</b> , 44, 164-175		1
405	Forecasting, uncertainty and risk; perspectives on clinical decision-making in preventive and curative medicine. <b>2019</b> , 35, 659-666		10
404	Does Physician's Training Induce Overconfidence That Hampers Disclosing Errors?. <i>Journal of Patient Safety</i> , <b>2019</b> , 15, 296-298	1.9	9
403	Transforming Preprofessional Health Education Through Relationship-Centered Care and Narrative Medicine. <b>2019</b> , 31, 222-233		18
402	Examining the Relationship of an All-Cause Harm Patient Safety Measure and Critical Performance Measures at the Frontline of Care. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, 110-116	1.9	2
401	The Impact of Adverse Events on Clinicians: What's in a Name?. Journal of Patient Safety, 2020, 16, 65-72	1.9	33
400	Description and Yield of Current Quality and Safety Review in Selected US Academic Emergency Departments. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, e245-e249	1.9	4
399	Development of an Emergency Department Trigger Tool Using a Systematic Search and Modified Delphi Process. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, e11-e17	1.9	9
398	Eleven Basic Procedures/Practices for Dental Patient Safety. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, 36-40	1.9	3
397	Two Cultures in Modern Science and Technology: For Safety and Validity Does Medicine Have to Update?. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, e46-e50	1.9	4
396	A Patient Reported Approach to Identify Medical Errors and Improve Patient Safety in the Emergency Department. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, 211-215	1.9	7
395	Root Cause Analyses of Reported Adverse Events Occurring During Gastrointestinal Scope and Tube Placement Procedures in the Veterans Health Association. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, 41-4	<b>£</b> .9	O
394	A Systems Framework for Understanding the Environment® Relation to Clinical Teamwork: A Systematic Literature Review of Empirical Studies. <b>2020</b> , 52, 726-760		7
393	Too much or too little? Investigating the usability of high and low data displays of the same electronic medical record. <b>2020</b> , 26, 88-103		2
392	Mixed-Methods Evaluation of Real-Time Safety Reporting by Hospitalized Patients and Their Care Partners: The MySafeCare Application. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, e75-e81	1.9	11

### (2020-2020)

391	Novices in MRI-targeted prostate biopsy benefit from structured reporting of MRI findings. <b>2020</b> , 38, 1729-1734	2
390	An immersion program for clinical nurse leader students: Comparing health care systems in South Korea and the United States. <b>2020</b> , 36, 83-95	O
389	Improving Communication of the Plan of Care in the Acute Care Setting. 2020, 18, 364-369	О
388	Nursing leadership in policy formation. <b>2020</b> , 55, 4-10	O
387	The second victim phenomenon in health care: A literature review. <b>2020</b> , 48, 629-637	6
386	Adverse events in Malaysia: Associations with nurse's ethnicity and experience, hospital size, accreditation, and teaching status. <b>2020</b> , 35, 104-119	7
385	Nurse Health, Work Environment, Presenteeism and Patient Safety. <b>2020</b> , 42, 332-339	25
384	Experiential Learning Through Local Implementation of a National Chief Resident in Quality and Patient Safety Curriculum. <b>2020</b> , 35, 171-176	O
383	Anonymous reporting of medical errors from The Egyptian Neonatal Safety Training Network. <b>2020</b> , 61, 31-35	7
382	Virtual Everest: Immersive Virtual Reality Can Improve the Simulation Experience. <b>2020</b> , 38, 1-4	6
381	Swedish national survey on MR safety compared with CT: a false sense of security?. 2020, 30, 1918-1926	4
380	Toward systems-centered analysis of patient safety events: Improving root cause analysis by optimized incident classification and information presentation. <b>2020</b> , 135, 104054	3
379	Standardizing Nurse Leader Safety Rounds to Promote Highly Reliable Care. 2020, 35, 252-257	О
378	Evaluation of Methods to Measure Production Pressure: A Literature Review. <b>2020</b> , 35, E14-E19	O
377	The history of crises and crisis management in anesthesia: prevention, detection, and recovery. <b>2020</b> , 58, 2-6	5
376	Key performance gaps of practicing anesthesiologists: how they contribute to hazards in anesthesiology and proposals for addressing them. <b>2020</b> , 58, 13-20	1
375	Performance improvement to address anesthesia hazards. <b>2020</b> , 58, 38-44	
374	Using a Machine Learning System to Identify and Prevent Medication Prescribing Errors: A Clinical and Cost Analysis Evaluation. <b>2020</b> , 46, 3-10	18

373	Technical Issues and Patient Safety in Nonintubated Thoracic Anesthesia. 2020, 30, 1-13	3
372	CAI4CAI: The Rise of Contextual Artificial Intelligence in Computer Assisted Interventions. <b>2020</b> , 108, 198-214	50
371	Patterns in medication incidents: A 10-yr experience of a cross-national anaesthesia incident reporting system. <b>2020</b> , 124, 197-205	9
370	Impact of Patient-Engaged Video Surveillance on Nursing Workforce Safety: Patient Aggression/Violence. <b>2020</b> , 35, 213-219	
369	The impact of patient safety culture and the leader coaching behaviour of nurses on the intention to report errors: a cross-sectional survey. <b>2020</b> , 19, 89	4
368	Retrospective chart review and survey to identify adverse safety events in the emergency medical services care of children with out-of-hospital cardiac arrest in the USA: a study protocol. <b>2020</b> , 10, e039215	1
367	Physician Well-Being in Practice. <b>2020</b> , 131, 1359-1369	4
366	Crisis Resource Management in Medicine: a Clarion Call for Change. <b>2020</b> , 6, 299-316	O
365	[Avoidable adverse events in primary care. Retrospective cohort study to determine their frequency and severity]. <b>2020</b> , 52, 705-711	2
364	Challenges of Electronic Medication Entry-Working Toward Reconciliation: A Case-Based Discussion. <b>2020</b> , 61, 808-813	
363	Does Transparency of Quality Metrics Affect Hospital Care Outcomes? A Systematic Review of the Literature. <b>2020</b> , 129-156	1
362	A Decision Support System for Therapy Prescription in a Hospital Centre. <b>2020</b> ,	O
361	Reforming Health Care: The Single System Solution. <b>2020</b> , 1,	
<b>3</b> 60	Nurse workarounds in the electronic health record: An integrative review. <b>2020</b> , 27, 1149-1165	7
359	A comparative 30-day outcome analysis of inpatient evaluation vs outpatient testing in patients presenting with chest pain in the high-sensitivity troponin era. A propensity score matched case-control retrospective study. <b>2020</b> , 43, 1248-1254	2
358	Transforming Healthcare to Evidence-Based Healthcare: A Failure of Leadership. <b>2020</b> , 50, 248-250	3
357	Coercive Conformity: Does Mandated Reporting of Hospital Errors Improve Patient Safety?. 2020, 145-161	
356	Comparing the Evolution of Risk Culture in Radiation Oncology, Aviation, and Nuclear Power. <i>Journal of Patient Safety</i> , <b>2020</b> , 16, e352-e358	1

355	Analysis of patient safety messages delivered and received during clinical rounds. 2020, 9,	2
354	Dimensions analysis of the Hospital Survey on Patient Safety Culture questionnaire in Iran: Psychometric properties. <b>2020</b> , 35, 1532-1545	1
353	Transferability of Simulation-Based Training in Laparoscopic Surgeries: A Systematic Review. <b>2020</b> , 2020, 5879485	3
352	Educational content and challenges encountered when training service user representatives as peer researchers in a mixed study on patient experience of hospital safety. <b>2020</b> , 6, 50	
351	Impact of a Formal Educational Skill-Building Program Based on the ARCC Model to Enhance Evidence-Based Practice Competency in Nurse Teams. <b>2020</b> , 17, 258-268	8
350	An Intelligent Reminder System Reduces Deficiencies and Errors in Ultrasound Reports. <b>2021</b> , 40, 2087-2094	1
349	How human activity impacted manufacturing non-compliances: A multivariate analysis in a centralized cytotoxic preparation unit. <b>2020</b> , 1078155220973065	0
348	A Neonatal Intensive Care Unit's Experience with Implementing an In-Situ Simulation and Debriefing Patient Safety Program in the Setting of a Quality Improvement Collaborative. <b>2020</b> , 7,	5
347	Comparison of Simulation Assessments: Can They Identify Novice/StudentNurses?. <b>2020</b> , 46, 40-49	2
346	COVID-19: time for paradigm shift in the nexus between local, national and global health. <b>2020</b> , 5, e002622	31
345	Relating Medical Errors to Medical Specialties: A Mixed Analysis Based on Litigation Documents and Qualitative Data. <b>2020</b> , 13, 335-345	1
344	Patient safety climate in a Brazilian general hospital. <b>2020</b> , 31, 97-106	3
343	A Network Analysis of Perioperative Communication Patterns. <b>2020</b> , 111, 627-641	2
342	Identification of adverse events in pediatric severe traumatic brain injury patients to target evidence-based prevention for increased performance improvement and patient safety. <b>2020</b> , 51, 1568-1575	Ο
341	Sleep health and predicted cognitive effectiveness of nurses working 12-hour shifts: an observational study. <b>2020</b> , 112, 103667	9
340	Ten years of the Helsinki Declaration on patient safety in anaesthesiology: An expert opinion on peri-operative safety aspects. <b>2020</b> , 37, 521-610	15
339	What's in That Syringe?. <b>2020</b> , 34, 2524-2531	1
338	Data-driven quality improvement, culture change, and the high reliability journey at a special hospital for people with medically complex developmental disabilities. <b>2020</b> , 1-7	1

337	Improving Safety of Patients With Autism Spectrum Disorder Through Simulation. 2020, 45, 1-5	3
336	Are hospital ratings systems transparent? An examination of Consumer Reports and the Leapfrog Hospital Safety Grade. <b>2020</b> , 37, 41-57	1
335	Sources of Error in Interventional Radiology: How, Why, and When. <b>2020</b> , 71, 518-527	7
334	Predicting Inpatient Medication Orders From Electronic Health Record Data. <b>2020</b> , 108, 145-154	10
333	Nurses perspectives on healthcare errors in oncology care: A cross-sectional study. <b>2020</b> , 45, 101741	1
332	Simulation Training in Urology: State of the Art and Future Directions. <b>2020</b> , 11, 391-396	6
331	Applying safety lessons from aviation to pre-licensure health professions education: A narrative critical review. <b>2020</b> , 12, 1028-1035	1
330	Clinical utility of a targeted smartphone application to aid veterinary students in calculating constant rate infusions and perioperative fluid drip rates. <b>2020</b> , 187, e124	O
329	How Workplace Bullying and Incivility Impacts Patient Safety: A Qualitative Simulation Study Using BSN Students. <b>2020</b> , 45, 16-23	3
328	The Effects of an Intensive Evidence-Based Practice Educational and Skills Building Program on EBP Competency and Attributes. <b>2020</b> , 17, 71-81	10
327	Zero Harm in Health Care. <b>2020</b> , 1,	5
326	Preliminary Efficacy of a Brief Mindfulness Intervention for Procedural Stress in Medical Intern Simulated Performance: A Randomized Controlled Pilot Trial. <b>2020</b> , 26, 282-290	2
325	Failure to rescue and 30-day in-hospital mortality in hospitals with and without crew-resource-management safety training. <b>2020</b> , 43, 155-167	2
324	Clinical pathways on a mobile device. <b>2020</b> , 25, 131-137	
323	Patient-related factors associated with an increased risk of being a reported case of preventable harm in first-line health care: a case-control study. <b>2020</b> , 21, 20	4
322	A Critical Review: Moral Injury in Nurses in the Aftermath of a Patient Safety Incident. <b>2020</b> , 52, 320-328	19
321	Analysis of Patient Safety Incident reporting system as an indicator of quality nursing in critical care units in KwaZulu-Natal, South Africa. <b>2020</b> , 25, 1263	2
320	Measurement as a Performance Driver: The Case for a National Measurement System to Improve Patient Safety. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e128-e134	2

319	Apology laws and malpractice liability: what have we learned?. 2021, 30, 64-67	О
318	Effects of Clinical Reasoning Prompts on Nursing Students' Clinical Judgment for a Patient Experiencing Respiratory Distress. <b>2021</b> , 32, 37-43	2
317	Economic impact of clinical pharmaceutical activities in hospital wards: A systematic review. <b>2021</b> , 17, 497-505	1
316	Metal hypersensitivity screening among frontline healthcare workers-A descriptive study. <b>2021</b> , 30, 541-549	1
315	Harnessing implementation science to optimize harm prevention in critically ill children: A pilot study of bedside nurse CLABSI bundle performance in the pediatric intensive care unit. <b>2021</b> , 49, 345-351	4
314	Just culture in healthcare: An integrative review. <b>2021</b> , 56, 103-111	1
313	Plastic Surgery and the Malpractice Industry. <b>2021</b> , 147, 239-247	2
312	Commentary: Exploratory factor analysis of the Just Culture Assessment Tool for nursing education <b>2021</b> , 26, 60-61	
311	Increased Patient Safety-Related Incidents Following the Transition into Daylight Savings Time. <b>2021</b> , 36, 51-54	3
310	Assessing top management commitment, workforce management, and quality performance of Malaysian hospitals. <b>2021</b> , 14, 236-244	3
309	The Relationship Between Culture of Safety and Rate of Adverse Events in Long-Term Care Facilities. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, 299-304	5
308	Toward the Development of the Perfect Medical Team: Critical Components for Adaptation.  Journal of Patient Safety, <b>2021</b> , 17, e47-e70	10
307	Perceptions of Pediatric Hospital Safety Culture in the United States: An Analysis of the 2016 Hospital Survey on Patient Safety Culture. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e288-e298	3
306	Design of a Heart Perfusion Device for Extending Preservation Time: A Case Study of Risk Management for a High-Risk Medical Device. <b>2021</b> , 679-692	
305	Development of a Simulation Program related to Patient Safety: Focusing on Medication Error. <b>2021</b> , 27, 107	1
304	Telemedicine Quality and Quality Improvement in Pulmonary, Critical Care, Allergy, and Sleep Medicine. <b>2021</b> , 109-126	О
303	Medical Records Documentation of HIV/AIDS Clinical Services at Primary Health Care (PHC) Facilities and Its Implications on Continuum of Care and Operational Research in South Africa. <b>2021</b> , 11, 60-70	
302	Quality and Safety in Healthcare, Part LXXXIV: Using Patient Safety Culture Surveys to Improve High Reliability Organizations. <b>2021</b> ,	O

301	Generating a Future Vision of Patient Safety: A Pilot Program to Test the Integration of Certified Professional in Patient Safety©urriculum into Undergraduate Medical Education. <b>2021</b> , 8, 238212052110258	354 <sup>1</sup>
300	A systematic review of healthcare professionals' core competency instruments. <b>2021</b> , 23, 87-102	4
299	Teasing out Artificial Intelligence in Medicine: An Ethical Critique of Artificial Intelligence and Machine Learning in Medicine. <b>2021</b> , 18, 121-139	17
298	Factors that Determine Comprehensive Categorical Classification of EHR Implementation Levels. <b>2021</b> , 14, 11786329211024788	O
297	Process evaluation of enhancing primary health care for non-communicable disease management in Malaysia: Uncovering the fidelity & feasibility elements. <b>2021</b> , 16, e0245125	
296	Patient Safety in Nurse Education. <b>2021</b> , 157-171	
295	An Exploratory Content Analysis of Human Resources Management in Healthcare Organizations. <b>2021</b> , 80-90	
294	Making a Dent in the Trillion-Dollar Problem: Toward Zero Defects. <b>2021</b> , 2,	3
293	PLAYING A FORTUNE-TELLER AND GETTING READY FOR THE BIG GAME: BEING READY FOR EMA TO BUILD A BRIDGE BETWEEN CODED AND SEMI-STRUCTURED DATA BY VIRTUE OF A DIGITAL FIT STRATEGY. <b>2021</b> , 78-90	
292	Models of generalist and specialist care in smaller hospitals in England: a mixed-methods study. <b>2021</b> , 9, 1-158	Ο
291	Nurses' perception of teamwork and its relationship with the occurrence and reporting of adverse events: A questionnaire survey in teaching hospitals. <b>2021</b> , 29, 1189-1198	9
290	How are nurse educators prepared to teach interprofessional practice?. <b>2021</b> , 98, 104745	Ο
289	Cross-cultural adaptation to the Spanish context and evaluation of the content validity of the Second Victim Experience and Support Tool (SVEST-E) questionnaire. <b>2021</b> ,	4
288	Categorization of Medication Safety Errors in Ambulatory Electronic Health Records. <b>2021</b> , 23-33	
287	Healthcare Professional Experiences of Clinical Incident in Hong Kong: A Qualitative Study. <b>2021</b> , 14, 947-957	1
286	Quality improvement education innovation: evaluation of Coursera MOOC 'Take the Lead on Healthcare Quality Improvement' <b>2021</b> , 26, 62-78	
285	A qualitative study exploring the lived experiences of deconditioning in hospital in Ontario, Canada. <b>2021</b> , 21, 169	3
284	The Effect of Blue-Enriched Lighting on Medical Error Rate in a University Hospital ICU. <b>2021</b> , 47, 165-175	1

## (2021-2021)

283	Fatigue and the Female Nurse: A Narrative Review of the Current State of Research and Future Directions. <b>2021</b> , 2, 53-61		4
282	Patient safety in an endoscopy unit: an observational retrospective analysis of reported incidents. <b>2021</b> , 71, 137-141		2
281	Modeling Character: Servant Leaders, Incivility and Patient Outcomes. 1		О
280	Does problem-based learning education improve knowledge, attitude, and perception toward patient safety among nursing students? A randomized controlled trial. <b>2021</b> , 20, 70		5
279	Medication administration errors: A concept analysis. <b>2021</b> , 56, 980-985		
278	The effect of rosemary essential oil inhalation on sleepiness and alertness of shift-working nurses: A randomized, controlled field trial. <b>2021</b> , 43, 101326		О
277	Implementation of peer learning conferences throughout a multi-site abdominal radiology practice. <b>2021</b> , 46, 5489-5499		0
276	A study protocol to evaluate the implementation and effectiveness of the Clinical Nurse Leader Care Model in improving quality and safety outcomes. <b>2021</b> , 8, 3688-3696		1
275	Neonatal Adverse Events' Trigger Tool Setup With Random Forest <i>Journal of Patient Safety</i> , <b>2022</b> , 18, e585-e590	1.9	1
274	Implementing a Robust Process Improvement Program in the Neonatal Intensive Care Unit to Reduce Harm <b>2022</b> , 44, 23-30		
273	Magnetic Resonance Imaging-Guided Cardiac Catheterization Evacuation Drills. 2021, 41, e19-e26		1
272	Cross-cultural adaptation to the Spanish context and evaluation of the content validity of the Second Victim Experience and Support Tool (SVEST-E) questionnaire. <b>2021</b> , 31, 334-343		1
271	References. <b>2021</b> , 157-178		
270	Perspective: in pursuit of a learning culture. <b>2021</b> , 46, 5017-5020		
269	Vigilance in Cardiac Telemetry Monitoring: Performance Outcomes and Effects on Operators□ Cognitive and Affective States. <b>2021</b> , 10, 223-228		
268	Structure and roles of rapid response teams for adult care in high complexity hospitals: Scoping review. <b>2021</b> , 72, 171-192		
267	The second victim requires more than Medice Cura Te Ipsum. <b>2021</b> , 15, S40-S42		О
266	The influence of nurse leadership style on the culture of patient safety incident reporting: a systematic review. <b>2021</b> , 27, 1-7		2

265	Development of a Novel and Scalable Simulation-Based Teamwork Training Model Using Within-Group Debriefing of Observed Video Simulation. <b>2021</b> , 47, 385-391	
264	A grounded theory of creating space for open safety communication between hospitalized patients and nurses. <b>2021</b> , 69, 632-640	1
263	Clinical Communication Within Hospital Pharmacy Practice: Exploring Pharmaceutical Oncological Consultations. <b>2021</b> , 1-10	1
262	Clinical negligence cases in the English NHS: uncertainty in evidence as a driver of settlement costs and societal outcomes. <b>2021</b> , 1-16	
261	Developing Healthcare Team Observations for Patient Safety (HTOPS): senior medical students capture everyday clinical moments. <b>2021</b> , 7, 164	
260	Editorial: Improving congenital cardiac care through a commitment to quality and safety. <b>2021</b> , 33, 481	
259	The Relationship between High-reliability practice and Hospital-acquired conditions among the Solutions for Patient Safety Collaborative. <b>2021</b> , 6, e470	
258	Identifying nursing documentation patterns associated with patient deterioration and recovery from deterioration in critical and acute care settings. <b>2021</b> , 153, 104525	0
257	Nursing students' self-reported experiences and attitudes regarding patient safety: A cross-sectional study comparing the classroom and clinical settings. <b>2021</b> ,	
256	The "NUTS" statistic: Applying an EBM disease model to defensive medicine. 2021,	O
255	Role of Clinical Pharmacists in Intensive Care Units. <b>2021</b> , 13, e17929	2
254	It is in the box! Improving the usability and benefits of surgical safety checklists <b>(A</b> feasibility study. <b>2021</b> , 86, 103217	1
253	Preparing the Surgical Team for a Quick and Efficient Procedure. 2022, 433-448	1
252	Student outcomes of an international learning collaborative to develop patient safety and quality competencies in nursing <b>2021</b> , 26, 81-94	1
251	Application of big data in healthcare: examination of the military experience. 2021, 11, 251-256	1
250	THE PERCEPTIONS OF NURSES ABOUT PATIENT SAFETY CULTURE: AN EXAMPLE PROVINCE IN	
	NORTH EAST OF TURKEY.	
249	NORTH EAST OF TURKEY.  Failure Mode and Effect Analysis: Engineering Safer Neurocritical Care Transitions. 2021, 35, 232-240	2

Interdisciplinary, Innovative, and International: Nursing and Engineering Technology Students Creating New Patient Technology. **2021**,

246	The Influence of Bullying on Nursing Practice Errors: A Systematic Review. <b>2020</b> , 111, 199-210	8
245	Bridges are waiting to be built: Delivering point-of-care anatomy for everyday practice. <b>2017</b> , 10, 305-306	7
244	Nursing perception of risk in common nursing practice situations. <b>2018</b> , 37, 19-28	5
243	Teamwork: Education and Training in Healthcare. <b>2020</b> , 49-63	3
242	A Quiet Revolution: Communicating and Resolving Patient Harm. <b>2017</b> , 649-664	1
241	Health Care Technology, the Human Machine Interface, and Patient Safety During Intravenous Anesthesia. <b>2017</b> , 667-683	3
240	Introduction: The Problem of Distracted Doctoring. <b>2017</b> , 1-3	1
239	Prevention of Early Readmissions in the Chronically Medically Ill Patient. 2019, 45, 23-27	1
238	Adverse events encountered during clinical placements by undergraduate nursing students in Spain. <b>2020</b> , 91, 104480	7
237	The cost of not addressing the communication barriers faced by hospitalized patients. <b>2018</b> , 3, 99-112	17
236	"Hot Seat" Simulation Model for Conflict Resolution: A Pilot Study. <b>2018</b> , 40, 177-186	4
235	A pilot study to standardize and peer-review shift handoffs in an academic internal medicine residency program: The DOCFISH method. <b>2018</b> , 97, e12798	1
234	An International Perspective on Definitions and Terminology Used to Describe Serious Reportable Patient Safety Incidents: A Systematic Review. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e1247-e1254	4
233	Use of Simulation to Measure the Effects of Just-in-Time Information to Prevent Nursing Medication Errors: A Randomized Controlled Study. <b>2021</b> , 16, e136-e141	1
232	Psychological responses, coping and supporting needs of healthcare professionals as second victims. <b>2017</b> , 64, 242-262	30
231	POP-PL: a patient-oriented prescription programming language. <b>2015</b> ,	3
230	"Not Just a Receiver": Understanding Patient Behavior in the Hospital Environment. <b>2016</b> , 2016, 3103-3114	29

229	POP-PL: a patient-oriented prescription programming language. <b>2016</b> , 51, 131-140	3
228	Coordinating Clinical Teams. <b>2019</b> , 3, 1-30	8
227	Priming Patient Safety Through Nursing Handoff Communication: A Simulation Pilot Study. <b>2017</b> , 39, 1394-1411	7
226	Collective intelligence in fingerprint analysis. <b>2020</b> , 5, 23	4
225	Implementation of patient safety and patient-centeredness strategies in Iranian hospitals. <b>2014</b> , 9, e108831	11
224	Clinical pharmacology technologies for personalization of cardiovascular diseases drug treatment: focus on direct oral anticoagulants. <b>2019</b> , 74, 299-306	1
223	Stop the Blame Game: Restructuring Morbidity and Mortality Conferences to Teach Patient Safety and Quality Improvement to Residents. <b>2016</b> , 12, 10475	14
222	Socio-economic aspects of medical errors and their consequences in medical organizations. <b>2019</b> , 10, 99-113	5
221	The Development and Testing of the Psychometric Properties of the Emotional Response and Disclosure of Errors in Clinical Practice Instrument. <b>2017</b> , 25, 184-200	1
220	Deference to Expertise: Making Care Safer. <b>2017</b> , 23, 7-12	6
219	Deference to Expertise: Making Care Safer. 2017, 23, 7-12  Medical Errors, Medical Malpractice and Death Cases in North Carolina: The Impact of Demographic and System Variables.	0
	Medical Errors, Medical Malpractice and Death Cases in North Carolina: The Impact of Demographic	
219	Medical Errors, Medical Malpractice and Death Cases in North Carolina: The Impact of Demographic and System Variables.  Reinforcement Learning for Clinical Decision Support in Critical Care: Comprehensive Review. 2020,	0
219	Medical Errors, Medical Malpractice and Death Cases in North Carolina: The Impact of Demographic and System Variables.  Reinforcement Learning for Clinical Decision Support in Critical Care: Comprehensive Review. 2020, 22, e18477	0 26
219 218 217	Medical Errors, Medical Malpractice and Death Cases in North Carolina: The Impact of Demographic and System Variables.  Reinforcement Learning for Clinical Decision Support in Critical Care: Comprehensive Review. 2020, 22, e18477  Role of Artificial Intelligence in Patient Safety Outcomes: Systematic Literature Review. 2020, 8, e18599	o 26 38
<ul><li>219</li><li>218</li><li>217</li><li>216</li></ul>	Medical Errors, Medical Malpractice and Death Cases in North Carolina: The Impact of Demographic and System Variables.  Reinforcement Learning for Clinical Decision Support in Critical Care: Comprehensive Review. 2020, 22, e18477  Role of Artificial Intelligence in Patient Safety Outcomes: Systematic Literature Review. 2020, 8, e18599  Evaluation of Home Health Care Devices: Remote Usability Assessment. 2015, 2, e10  Reinforcement Learning for Clinical Decision Support in Critical Care: Comprehensive Review	o 26 38 17
<ul><li>219</li><li>218</li><li>217</li><li>216</li><li>215</li></ul>	Medical Errors, Medical Malpractice and Death Cases in North Carolina: The Impact of Demographic and System Variables.  Reinforcement Learning for Clinical Decision Support in Critical Care: Comprehensive Review. 2020, 22, e18477  Role of Artificial Intelligence in Patient Safety Outcomes: Systematic Literature Review. 2020, 8, e18599  Evaluation of Home Health Care Devices: Remote Usability Assessment. 2015, 2, e10  Reinforcement Learning for Clinical Decision Support in Critical Care: Comprehensive Review (Preprint).	o 26 38 17 3

## (2015-2018)

211	Enhancing Systems Thinking for Undergraduate Nursing Students Using Friday Night at the ER. <b>2018</b> , 57, 687-689	9
210	Interprofessionality. <b>2020</b> , 195-214	1
209	Incident reporting and learning in radiation oncology: Need of the hour. <b>2014</b> , 39, 203-5	5
208	A model for the role of emotional intelligence in patient safety. <b>2015</b> , 2, 112-117	10
207	Medication errors in neonatal intensive care unit of a tertiary care hospital in South India: A prospective observational study. <b>2020</b> , 52, 260-265	1
206	Patient Safety Attitudes, Skills, Knowledge and Barriers Related to Reporting Medical Errors by Nursing Students. <b>2017</b> , 08, 1-11	5
205	Does teaching non-technical skills to medical students improve those skills and simulated patient outcome?. <b>2017</b> , 8, 101-113	28
204	Unanswered clinical questions: a survey of specialists and primary care providers. <b>2017</b> , 105, 4-11	16
203	Incident Reporting System in Pediatric Intensive Care Units of Cairo Tertiary Hospital: An Intervention Study. <b>2019</b> , 7,	1
202	Viable bacterial communities on hospital window components in patient rooms. <b>2020</b> , 8, e9580	1
201	Health information technology in hospitals: current issues and future trends. <b>2015</b> , 2, 50-56	7
200	Generic Crew Resource Management training to improve non-technical skills in acute care - Phase 2: A pre-post multicentric intervention study. <b>2021</b> ,	О
199	SBAR-LA: SBAR Brief Assessment Rubric for Learner Assessment. <b>2021</b> , 17, 11184	
198	Healthcare Knowledge Management: Integrating Knowledge with Evidence-based Practice. <b>2014</b> , 1121-1131	
197	Educational, Recording, and Organizational Interventions Regarding Critical Care Nutritional Support. <b>2014</b> , 1-15	
196	The Role of Simulation in Safety and Training. <b>2015</b> , 675-684	
195	The Role of Communication in Safe and Effective Health Care. <b>2015</b> , 1-23	
194	Clinical Quality. <b>2015</b> , 170-177	

193	Educational, Recording and Organizational Interventions Regarding Critical Care Nutritional Support. <b>2015</b> , 249-261	
192	The Medical Virtual Patient Simulator (MedVPS) Platform. <b>2016</b> , 59-67	5
191	Medication Errors. <b>2016</b> , 111-120	
190	Quality Measures for Oncologic Emergency Medicine. <b>2016</b> , 13-41	
189	Encyclopedia of Global Bioethics. <b>2016</b> , 1923-1930	
188	How accurate and reliable are medical predictions?. <b>2016</b> , 21, 83	
187	Introduction to Patient Safety and Quality in the Pediatric/Hematology Oncology and Hematopoietic Stem Cell Transplant Practice. <b>2017</b> , 1-14	)
186	The VERP Explorer: A Tool for Exploring Eye Movements of Visual-Cognitive Tasks Using Recurrence Plots. <b>2017</b> , 41-55	2
185	Evaluating Effectiveness of Complex System Interventions. 2017, 341-350	
184	Future Directions of Surgical Safety. <b>2017</b> , 869-880	
183	Safety in Surgery. <b>2017</b> , 213-246	
182	Digital Distraction and Legal Risk. <b>2017</b> , 201-218	
181	Introduction to Patient Safety and Quality. <b>2017</b> , 133-144	
180	Robotics Training and Simulation. <b>2017</b> , 9-19	
179	Anonyme Fehlermeldung. <b>2017</b> , 34-37	
178	Anonyme Fehlermeldung. <b>2017</b> , 6, 34-37	
177	Oops! Unintentional Variation. <b>2017</b> , 93-118	
176	Application Root Cause Analysis Technique in Investigating the Causes of a Fatal Sentinel Event:  Case Report. <b>2017</b> , 30, 53-61	ſ

## (2019-2017)

175	Innovative Team Training for Patient Safety: Comparing Classroom Learning to Experiential Training. <b>2017</b> , 48, 563-569	
174	IntroductionWhy Me?. <b>2018</b> , 5-11	
173	The 10 Commandments of Resuscitation.	
172	DRAFT OF THE PILOT VERSION OF THE INCIDENT-MONITORING AND REPORTING SYSTEM FOR THE ANESTHESIOLOGY SERVICE OF UKRAINE. <b>2018</b> , 1, 347	
171	Design of Surgical Nursing Process Based on Patient Safety with Mind Map. 2018, 07, 27-32	
170	Mobile Patient Surveillance. <b>2018</b> , 58-84	
169	South Asian American Health Research and Policy. 2018, 215-233	
168	Things We Do for No Reason: Hospitalization for the Evaluation of Patients with Low-Risk Chest Pain. <b>2018</b> , 13, 277-279	
167	A Two-Phase Mixed Methods Project Illustrating Development of a Virtual Human Intervention to Teach Advanced Communication Skills and a Subsequent Blinded Mixed Methods Trial to Test the Intervention for Effectiveness. <b>2018</b> , 10, 296-316	
166	Pediatri Kliniklerinde ^ 🗄 🖽 Hemlifelerin Hasta G^ 🌡 enliille ligili Sk Kar 🖽 liklar Sorunlar. o	
165	Evolving Autopsy Practice Models. <b>2019</b> , 57-76	
164	In the Shadow of Litigation: Arbitration and Medical Malpractice Reform. <b>2019</b> , 44, 267-301	
163	Respectful Interaction in Complex Situations. <b>2019</b> , 247-261	
162	Nursing Considerations. <b>2019</b> , 337-407	
161	SIMULATION-BASED MEDICAL EDUCATION IPRO AND CONTRA. <b>2019</b> , 17, 713-719	
160	Disclosure of Medical Errors and Complications. <b>2019</b> , 309-316	
159	The Triple Aim and Obesity: Are They at Odds?. <b>2019</b> , 365-373	
158	##### <b>2019</b> , 78-82	

157	References. <b>2019</b> , 447-457	
156	Simulation and Ureteroscopy (URS). <b>2020</b> , 221-237	
155	Next Level Communication. 2020, 157-159	
154	[Medical errors, the third leading cause of death in the United States?]. <b>2019</b> , 34, 339-341	
153	Role of Simulation in Healthcare Quality Assurance. <b>2020</b> , 73-80	
152	Medical error reporting software program development and its impact on pediatric units' reporting medical errors. <b>2020</b> , 36, 10-15	1
151	Clinician Cognition and Artificial Intelligence in Medicine. <b>2020</b> , 193-266	
150	A Novel Patient-oriented Tool for Evaluating Quality Measurements. <b>2020</b> , 12, e7726	
149	The Relationship between Patient Safety Climate and Medical Error Reporting Rate among Iranian Hospitals Using a Structural Equation Modeling. <b>2020</b> , 30, 319-328	0
148	HipHop.js: (A)Synchronous reactive web programming. 2020,	O
147	Sustaining improvements in relational coordination following team training and practice change: A longitudinal analysis. <b>2021</b> , 46, 349-357	1
146	Medical Malpractice Cases in Kerman Province, Iran (2010 - 2014). <b>2020</b> , 24,	O
145	Expert Consensus on Currently Accepted Measures of Harm. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e1726-e <b>1</b> . <b>3</b> 31	2
144	Developing an Analytical Pipeline to Classify Patient Safety Event Reports Using Optimized Predictive Algorithms. <b>2021</b> ,	O
143	The Safety of Patients in Critical Care. <b>2020</b> , 257-271	0
142	Nurse Sensemaking for Responding to Patient and Family Safety Concerns. <b>2021</b> , 70, 106-113	1
141	The difficult talk: Speaking with patients and families after medical error. <b>2020</b> , 59, 101311	
140	Medical Malpractice Crisis: Oversight of the Practice of Medicine. <b>2021</b> , 139-180	1

Pathways and Guidelines: An Approach to Operationalizing Patient Safety and Quality 139 Improvement. 2021, 245-254 138 Quality of Quality Measures. 2020, 215-239 The Impact of Interprofessional Education on Healthcare Team Performance: A Theoretical Model 137 1 and Recommendations. 2020, 21-32 Der verantwortungsvolle Umgang mit Fehlern als Forderung professionellen Handelns im Pflege-136 und Gesundheitswesen. 2020, 1-14 Education and Simulation in Minimally Invasive Surgery. 2020, 419-436 135 Unique Patient-Reported Hospital Safety Concerns With Online Tool: MySafeCare. Journal of 1.9 134 Patient Safety, 2020, 18, Emotional Support and its Medical and Healthcare Implications: A Mind and Body Approach. 2020, 133 20, 60-65 Relationship between Patient Safety Culture and Adverse Events in Hospital: A case study. 2020, 132 23, 13-26 Barriers and enablers in implementing an electronic incident reporting system in a teaching 1 131 hospital: A case study from Saudi Arabia. 2021, Identification and assessment of nursing task errors in emergency department using SHERPA 130 technique and offering remedial strategies. 2021, 59, 101103 The combined effect of psychological and social capital in registered nurses experiencing second 129 1 victimization: A structural equation model. 2021, 128 A Protocol to Examine Surgical Team Communication in a Large Military Medical Center. 2021, 70, 58-66 Medication Errors, 100-109 127 Application of Quality Management in Promoting Patient Safety and Preventing Medical Errors. 91-112 126 Application of Quality Management in Promoting Patient Safety and Preventing Medical Errors. 370-385 125 Simulation Technology in Anesthesia Education. 32-57 124 The effectiveness of scenario-based learning to develop patient safety behavior in first year 123 O nursing students. 2020, 17, Why a Hospital Is the Most Dangerous Place on Earth. 2021, 1-23 122

121	Issues of patient safety in the context of preventing medical errors (analytical review). 2020, 64, 209-213	1
120	Basics of Quality Improvement. <b>2021</b> , 5-32	
119	Peer-Led Surgical Safety Learning Among Medical Students Using a Novel Story-Based Approach. <b>2020</b> , 12, e10242	
118	Promoting critical thinking through an evidence-based skills fair intervention. 2020, ahead-of-print,	1
117	The effects of rudeness, experience, and perspective-taking on challenging premature closure after pediatric ICU physicians receive hand-off with the wrong diagnosis: a randomized controlled simulation trial. <b>2021</b> , 8, 358-367	1
116	The Relationship between Patient Safety Culture and Adverse Events among Nurses in Tehran Teaching Hospitals in 2019. <b>2020</b> , 28, 20-31	2
115	Relationship Between Nursing Communication Characteristics and Patient Safety Culture at Educational Hospitals in Sanandaj City. <b>2020</b> , 28, 74-83	
114	Information Needs and the Use of Documentation to Support Collaborative Decision-Making: Implications for the Reduction of Central Line-Associated Blood Stream Infections. <b>2020</b> , 39, 208-214	1
113	Agent-Based Modeling Simulation of Nurse Medication Administration Errors. 2020, 39, 187-197	
112	Common Barriers to Reporting Medical Errors. <b>2021</b> , 2021, 6494889	2
111	The Medication Error Prioritization System (MEPS): A Novel Tool in Medication Safety. <b>2014</b> , 39, 443-7	3
110	Read all about it. <b>2014</b> , 7, 425-6	1
109	Online deviation detection for medical processes. <b>2014</b> , 2014, 395-404	3
108	Benefits and Barriers of Implementation and Utilization of Radio-Frequency Identification (RFID) Systems in Transfusion Medicine. <b>2015</b> , 12, 1d	4
107	Using the Medication Error Prioritization System To Improve Patient Safety. <b>2016</b> , 41, 54-9	
106	AME survey-003 A2: on the attractiveness of an medicine career in current China with a survey of 7,508 medical professionals and 443 non-medical professionals. <b>2016</b> , 6, 84-102	6
105	Multivariate Conditional Outlier Detection and Its Clinical Application. <b>2016</b> , 2016, 4216-4217	1
104	An Evaluation of CA-1 Residents' Adherence to a Standardized Handoff Checklist. <b>2017</b> , 19, E502	1

103	A Novel Schema to Enhance Data Quality of Patient Safety Event Reports. <b>2016</b> , 2016, 1840-1849	3
102	"Scared to go to the Hospital": Inpatient Experiences with Undesirable Events. <b>2016</b> , 2016, 609-617	6
101	Adoption of a Nationwide Shared Medical Record in France: Lessons Learnt after 5 Years of Deployment. <b>2016</b> , 2016, 1100-1109	4
100	The Impact of Order Source Misattribution on Computerized Provider Order Entry (CPOE) Performance Metrics. <b>2017</b> , 14, 1e	1
99	Towards Analytics of the Patient and Family Perspective: A Case Study and Recommendations for Data Capture of Safety and Quality Concerns. <b>2017</b> , 2017, 615-624	1
98	Initializing and Growing a Database of Health Information Technology (HIT) Events by Using TF-IDF and Biterm Topic Modeling. <b>2017</b> , 2017, 1024-1033	2
97	Medical malpractice in Iran: A systematic review. <b>2019</b> , 33, 110	1
96	Leveraging Clinical Expertise as a Feature - not an Outcome - of Predictive Models: Evaluation of an Early Warning System Use Case. <b>2019</b> , 2019, 323-332	6
95	The Ethics of Error in Medicine. <b>2020</b> , 11,	
94	Review of 20 Years of Continuous Quality Improvement of a Rapid Response System, at Four Institutions, to Identify Key Process Responsible for Its Success. <b>2021</b> , 3, e0448	
93	Gu <sup>^</sup>	O
92	Adverse Event Reporting Priorities. <i>Journal of Patient Safety</i> , <b>2021</b> , Publish Ahead of Print,	1.9
91	ERROR REDUCTION IN TRAUMA CARE: LESSONS FROM AN ANONYMIZED, NATIONAL, MULTICENTER MORTALITY REPORTING SYSTEM. <b>2021</b> ,	
90	Eficacia de un plan de acogida te^ fico-pr^ fitico dirigido a profesionales de enfermer^ fi de nueva incorporaci^ fi en una Unidad de Cuidados Intensivos Pedi^ firica: estudio piloto. <b>2021</b> ,	
89	Introduction. <b>2021</b> , 1-8	
88	An Exploratory Content Analysis of Human Resources Management in Healthcare Organizations. <b>2022</b> , 2092-2102	0
87	Associations between safety outcomes and communication practices among pediatric nurses in the United States <b>2021</b> , 63, 20-27	1

85	Review of 20 Years of Continuous Quality Improvement of a Rapid Response System, at Four Institutions, to Identify Key Process Responsible for Its Success. <b>2021</b> , 3, e0448	1
84	Robotic Surgery and Its Application in Urology: A Journey Through Time. 72-82	О
83	Overstating inpatient deaths due to medical error erodes trust in healthcare and the patient safety movement <b>2022</b> , 17, 399-402	
82	Patient Safety Culture in European Hospitals: A Comparative Mixed Methods Study 2022, 19,	4
81	Accidental 10-fold propofol overdose in a cat undergoing general anaesthesia for diagnostic imaging.	
80	Occurrence of self-perceived medical errors and its related influencing factors among emergency department nurses <b>2022</b> ,	O
79	Medication error awareness among health care providers in Palestine: A questionnaire-based cross-sectional observational study <b>2022</b> , 30, 470-477	О
78	Family Input for Quality and Safety (FIQS): Using mobile technology for in-hospital reporting from families and patients <b>2022</b> ,	
77	Association Between Perceived Medical Errors and Suicidal Ideation Among Chinese Medical Staff: The Mediating Effect of Depressive Symptoms <b>2022</b> , 9, 807006	О
76	Interprofessional Precepting. 2022, Publish Ahead of Print,	
75	Hemodialysis Centers Guide 2020. <b>2021</b> , 41, 1-77	
74	Proving Display Conformance and Action Consistency: The Example of an Integrated Clinical Environment. <b>2022</b> , 316-328	
73	Assessing Patient Safety Culture in United States Hospitals 2022, 19,	О
72	PATIENT SAFETY ATTITUDES OF NURSES WORKING IN SURGICAL CLINICS: A CROSS-SECTIONAL STUDY.	
71	Burnout in and Commission of Medical Errors by Secondary School Athletic Trainers <b>2022</b> , 57, 234-239	
70	Correlation between patients' power distance and their willingness to participate in patients' safety: A cross-sectional study <b>2022</b> ,	
69	Patient Safety Education for Clinical Students: A Systematic Literature Review. <b>2022</b> , 10, 208-214	
68	Effects of tall man lettering on the visual behaviour of critical care nurses while identifying syringe drug labels: a randomised in situ simulation <b>2022</b> ,	O

67	Instruction strategies for drug calculation skills: A systematic review of the literature 2022, 111, 105299	3
66	Underdiagnosis bias of artificial intelligence algorithms applied to chest radiographs in under-served patient populations. <b>2021</b> ,	15
65	Implementation of a Certified Registered Nurse Anesthetist Second Victim Peer Support Program <b>2021</b> ,	0
64	INTRAOPERATIVE PATIENT CARE KNOWLEDGE LEVELS OF OPERATING ROOM NURSES: A CASE OF AFYONKARAHISAR. <b>2022</b> , 23, 152-159	
63	Malpractice Awareness among Surgeons and Surgical Trainees in Ethiopia <b>2022</b> , 32, 117-126	
62	Who killed patient safety?. <b>2022</b> , 27, 56-58	О
61	Choking injuries: Associated factors and error-producing conditions among acute hospital patients in Japan <b>2022</b> , 17, e0267430	О
60	Medication Prescription Errors in Intensive Care Unit: An Avoidable Menace. <b>2022</b> , 26, 539-540	
59	Effective deep Q-networks (EDQN) strategy for resource allocation based on optimized reinforcement learning algorithm.	О
58	Nursing knowledge captured in electronic health record 2022,	О
57	Principles of Surgical Patient Safety. <b>2022</b> , 631-640	
56	Improving Quality in Neonatal Care Through Competency-Based Simulation. <b>2022</b> , 41, 159-167	
55	Application of the HEART method to enhance patient safety in the intensive care unit. 2022, 1-11	
54	Behavioral Assessment in Virtual Reality: An Evaluation of Multi-User Simulations in Healthcare Education. 1-45	
53	Improving Clinical Efficiency and Reducing Medical Errors through NLP-enabled Diagnosis of Health Conditions from Transcription Reports. <b>2022</b> , 435-442	
52	To Err Is Human, but What Happens When Surgeons Err?. <b>2022</b> ,	О
51	The Effect of Spirituality on Burnout Nurses in West Sumatra Hospital During the COVID-19 Pandemic. <b>2022</b> , 10, 1055-1059	
50	Don't forget the oldies: using IoT to connect the legacy medical equipments. <b>2022</b> , 26,	

49	Efficacy of a theoretical and practical programme to newly hired nursing personnel in a Paediatric Intensive Care Unit: A pilot study. <b>2022</b> ,	
48	Leveraging EBP to Establish Best Practices, Achieve Quality Outcomes, and Actualize High Reliability: Building EBP Competency Is Not Enough. <b>2022</b> ,	
47	Development and Usability Testing of a System to Detect Adverse Events and Medical Mistakes. Publish Ahead of Print,	
46	Learning from Mistakes. <b>2022</b> , 83-93	O
45	Real-Time Pill Detection and Recognition Framework Based on a Deep Learning Algorithm. 2022, 117-137	O
44	Understanding how physician perceptions of job demand and process benefits evolve during CPOE implementation. 1-25	O
43	Non-technical skills in Obstetric Aeromedical Transfers (NOAT): development and evaluation of a behavioural marker system.	O
42	Features of incident reports that prompt reviewer feedback and organisational change: A retrospective review. 251604352211249	1
41	Nursing staff as a provider of safe and high-quality medical care. <b>2022</b> , 2, 35-41	O
40	Burnout e a seguran Î do paciente na Aten Î d Prim fia Sa de: aspectos jur dico-sanit fios em tempos de pandemia de COVID-19. <b>2022</b> , 11, 133-147	O
39	Artificial Intelligence in Modern Orthopaedics. <b>2022</b> , 10,	0
38	Application of systems analysis to safety incident investigations in a single centre using anaesthesia as an example.	1
37	Interventions aimed at reducing medication errors in Saudi hospitals: A systematic review. <b>2022</b> , 1, 10	O
36	Influence of Different Protection States on the Mental Fatigue of Nurses During the COVID-19 Pandemic. Volume 15, 1917-1929	O
35	NursesIntentions, Awareness and Barriers in Reporting Adverse Events: A Cross-Sectional Survey in Tertiary Hospitals in China. Volume 15, 1987-1997	O
34	Critical Incident Reports Related to Ventilator Use: Analysis of the Japan Quality Council National Database. Publish Ahead of Print,	O
33	Untenable Expectations: Nurses[Work in the Context of Medication Administration, Error, and the Organization. <b>2022</b> , 9, 233339362211317	0
32	The impact of pharmacists Interventions within the Closed Loop Medication Management process on medication safety: An analysis in a German university hospital. 13,	O

31	The impact of To Err Is Humanlon patient safety in anesthesiology. A bibliometric analysis of 20 years of research. 9,	O
30	Measurement of Information Transfer During Simulated Sequential Complete Shift-to-Shift Intraoperative Handoffs. <b>2023</b> , 7, 9-19	O
29	An introduction to eye tracking in human factors healthcare research and medical device testing. <b>2023</b> , 3, 100031	О
28	Surgical Conscience: A Concept Analysis for Perioperative Nurses. <b>2022</b> , 116, 533-546	O
27	Programa de entrenamiento basado en TeamSTEPPS mediante simulaci de clabica en profesionales de cuidados intensivos: un estudio con metodolog de mixta. <b>2022</b> ,	O
26	Electroencephalography can provide advance warning of technical errors during laparoscopic surgery.	О
25	Prevalence and associated factors of self-reported medical errors and adverse events among operating room nurses in China. 10,	О
24	DrugCentral 2023 extends human clinical data and integrates veterinary drugs.	О
23	Critical Age Theory: Institutional Abuse of Older People in Health Care. <b>2022</b> , 4, 24-37	О
22	Assessment of the Use of Patient Vital Sign Data for Preventing Misidentification and Medical Errors. <b>2022</b> , 10, 2440	О
21	Hospital Work Conditions and the Mediation Role of Burnout: Residents and Practicing Physicians Reporting Adverse Events. Volume 16, 1-13	О
20	Situation, Background, Assessment, Recommendation (SBAR) Education for Health Care Students: Assessment of a Training Program.	О
19	Der verantwortungsvolle Umgang mit Fehlern als Forderung professionellen Handelns im Pflegeund Gesundheitswesen. <b>2022</b> , 145-158	О
18	Policies and incentives for adoption: toward broader use. <b>2023</b> , 57-86	О
17	A Review of the State of the Art of Data Quality in Healthcare. <b>2023</b> , 31, 1-18	О
16	Digital twins for decision support system for clinicians and hospital to reduce error rate. <b>2023</b> , 241-261	О
15	Video-based formative and summative assessment of surgical tasks using deep learning. 2023, 13,	О
14	The accuracy of the Global Trigger Tool is higher for the identification of adverse events of greater harm: a diagnostic test study.	O

13	A Customized Triggers Program: A Children Hospital Experience in Improving Trigger Usability. <b>2023</b> , 151,	О
12	Patient Safety in the Surgery: An Investigation of the Near-miss Cases Encountered by the Surgical Team While Applying the Surgical Safety Checklist. <b>2023</b> , 11, 120-127	o
11	Home oxygen therapy from the emergency department for COVID-19 an observational study. <b>2023</b> , 68, 47-51	0
10	A controlled adaptive computational network model of a virtual coach supporting speaking up by healthcare professionals to optimise patient safety. <b>2023</b> , 81, 37-49	0
9	Capturing New Nurses' Experiences and Supporting Critical Thinking. Publish Ahead of Print,	O
8	Patients Perceptions of Experiences of Postoperative Chest Drain Tube Insertion: A Pilot Survey. <b>2023</b> , 20, 3773	o
7	Nursing Image From the Perspective of Healthcare Professionals During the Post-COVID-19 Pandemic Period: A Cross-Sectional Study. <b>2023</b> ,	0
6	Making the Case. <b>2023</b> ,	O
5	Effects of the Interruption Management Strategy Btay S.A.F.E.During Medication Administration. <b>2023</b> , 48, 65-74	0
4	Ethical Issues on Awake Thoracic Surgery for Seriously Chronically Ill Patients. 12-14	o
3	Malpractice in Psychiatry. <b>2023</b> , 28, 86-90	0
2	Risk Management-Obstetrics and Gynecology Perspective. Publish Ahead of Print,	o
1	Cognitive biases in internal medicine: a scoping review. <b>2023</b> ,	0