## Bryony Dean Franklin

List of Publications by Year in descending order

Source: https://exaly.com/author-pdf/3780416/publications.pdf

Version: 2024-02-01

170 papers 5,305 citations

94433 37 h-index 102487 66 g-index

175 all docs

175 docs citations

175 times ranked

5050 citing authors

#	Article	IF	CITATIONS
1	The impact of a closed-loop electronic prescribing and administration system on prescribing errors, administration errors and staff time: a before-and-after study. Quality and Safety in Health Care, 2007, 16, 279-284.	2.5	240
2	Incidence and Nature of Dosing Errors in Paediatric Medications. Drug Safety, 2004, 27, 661-670.	3.2	216
3	The incidence and nature of prescribing and medication administration errors in paediatric inpatients. Archives of Disease in Childhood, 2010, 95, 113-118.	1.9	216
4	Systematic Review of Medication Errors in Pediatric Patients. Annals of Pharmacotherapy, 2006, 40, 1766-1776.	1.9	210
5	Behavior Change Strategies to Influence Antimicrobial Prescribing in Acute Care: A Systematic Review. Clinical Infectious Diseases, 2011, 53, 651-662.	5.8	209
6	Interventions to optimise prescribing in care homes: systematic review. Age and Ageing, 2011, 40, 150-162.	1.6	150
7	Large scale organisational intervention to improve patient safety in four UK hospitals: mixed method evaluation. BMJ: British Medical Journal, 2011, 342, d195-d195.	2.3	146
8	The Frequency and Potential Causes of Dispensing Errors in a Hospital Pharmacy. International Journal of Clinical Pharmacy, 2005, 27, 182-190.	1.4	144
9	The effects of electronic prescribing on the quality of prescribing. British Journal of Clinical Pharmacology, 2008, 65, 230-237.	2.4	133
10	The attitudes and beliefs of healthcare professionals on the causes and reporting of medication errors in a UK Intensive care unit. Anaesthesia, 2007, 62, 53-61.	3.8	126
11	The causes of prescribing errors in English general practices: a qualitative study. British Journal of General Practice, 2013, 63, e713-e720.	1.4	121
12	eHealth in the future of medications management: personalisation, monitoring and adherence. BMC Medicine, 2017, 15, 73.	5.5	113
13	The Incidence of Prescribing Errors in Hospital Inpatients. Drug Safety, 2005, 28, 891-900.	3.2	109
14	Health information technology and digital innovation for national learning health and care systems. The Lancet Digital Health, 2021, 3, e383-e396.	12.3	107
15	Multiple component patient safety intervention in English hospitals: controlled evaluation of second phase. BMJ: British Medical Journal, 2011, 342, d199-d199.	2.3	104
16	Methodological variations and their effects on reported medication administration error rates. BMJ Quality and Safety, 2013, 22, 278-289.	3.7	99
17	Prescribing errors in hospital inpatients: a three-centre study of their prevalence, types and causes. Postgraduate Medical Journal, 2011, 87, 739-745.	1.8	96
18	Failure mode and effects analysis: too little for too much?. BMJ Quality and Safety, 2012, 21, 607-611.	3.7	96

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19	The prevalence and nature of prescribing and monitoring errors in English general practice: a retrospective case note review. British Journal of General Practice, 2013, 63, e543-e553.	1.4	92
20	Failure mode and effects analysis outputs: are they valid?. BMC Health Services Research, 2012, 12, 150.	2.2	89
21	Is Failure Mode and Effect Analysis Reliable?. Journal of Patient Safety, 2009, 5, 86-94.	1.7	87
22	Appropriateness of use of medicines in elderly inpatients: qualitative study. BMJ: British Medical Journal, 2005, 331, 935.	2.3	81
23	Expanding healthcare failure mode and effect analysis: A composite proactive risk analysis approach. Reliability Engineering and System Safety, 2018, 169, 117-126.	8.9	66
24	A clinical information system reduces medication errors in paediatric intensive care. Intensive Care Medicine, 2011, 37, 691-694.	8.2	60
25	Errors and discrepancies in the administration of intravenous infusions: a mixed methods multihospital observational study. BMJ Quality and Safety, 2018, 27, 892-901.	3.7	59
26	Using discrete event simulation to design a more efficient hospital pharmacy for outpatients. Health Care Management Science, 2011, 14, 223-236.	2.6	50
27	Patient involvement in medication safety in hospital: an exploratory study. International Journal of Clinical Pharmacy, 2014, 36, 657-666.	2.1	50
28	LSE–Lancet Commission on the future of the NHS: re-laying the foundations for an equitable and efficient health and care service after COVID-19. Lancet, The, 2021, 397, 1915-1978.	13.7	49
29	Measuring the Severity of Prescribing Errors: A Systematic Review. Drug Safety, 2013, 36, 1151-1157.	<b>3.</b> 2	48
30	Optimising antimicrobial use in humans – review of current evidence and an interdisciplinary consensus on key priorities for research. Lancet Regional Health - Europe, The, 2021, 7, 100161.	5.6	46
31	Methodological variability in detecting prescribing errors and consequences for the evaluation of interventions. Pharmacoepidemiology and Drug Safety, 2009, 18, 992-999.	1.9	44
32	Providing feedback to hospital doctors about prescribing errors; a pilot study. International Journal of Clinical Pharmacy, 2007, 29, 213-220.	1.4	43
33	Reconceptualising the digital maturity of health systems. The Lancet Digital Health, 2019, 1, e200-e201.	12.3	43
34	Facilitators and Barriers to Safe Medication Administration to Hospital Inpatients: A Mixed Methods Study of Nurses' Medication Administration Processes and Systems (the MAPS Study). PLoS ONE, 2015, 10, e0128958.	2.5	43
35	An outpatient parenteral antibiotic therapy (OPAT) map to identify risks associated with an OPAT service. Journal of Antimicrobial Chemotherapy, 2008, 62, 177-183.	3.0	42
36	Clinical decision support systems and antibiotic use. International Journal of Clinical Pharmacy, 2007, 29, 342-349.	1.4	40

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37	Medication errors in older people with mental health problems: a review. International Journal of Geriatric Psychiatry, 2008, 23, 564-573.	2.7	39
38	An evaluation of two automated dispensing machines in UK hospital pharmacy. International Journal of Pharmacy Practice, 2010, 16, 47-53.	0.6	39
39	Testing a trigger tool as a method of detecting harm from medication errors in a UK hospital: a pilot study. International Journal of Pharmacy Practice, 2010, 18, 305-311.	0.6	39
40	Missing Clinical Information in NHS hospital outpatient clinics: prevalence, causes and effects on patient care. BMC Health Services Research, 2011, 11, 114.	2.2	38
41	Obtaining antibiotics online from within the UK: a cross-sectional study. Journal of Antimicrobial Chemotherapy, 2017, 72, 1521-1528.	3.0	38
42	Dispensing errors in community pharmacy: frequency, clinical significance and potential impact of authentication at the point of dispensing. International Journal of Pharmacy Practice, 2010, 15, 273-281.	0.6	35
43	Medication administration errors and mortality: Incidents reported in England and Wales between 2007 i¶ 2016. Research in Social and Administrative Pharmacy, 2019, 15, 858-863.	3.0	34
44	The Use and Functionality of Electronic Prescribing Systems in English Acute NHS Trusts: A Cross-Sectional Survey. PLoS ONE, 2013, 8, e80378.	2.5	33
45	A national survey of inpatient medication systems in English NHS hospitals. BMC Health Services Research, 2014, 14, 93.	2.2	33
46	Carers' Medication Administration Errors in the Domiciliary Setting: A Systematic Review. PLoS ONE, 2016, 11, e0167204.	2.5	33
47	A new approach to treatment of resistant gram-positive infections: potential impact of targeted IV to oral switch on length of stay. BMC Infectious Diseases, 2006, 6, 94.	2.9	32
48	Including pharmacists on consultant-led ward rounds: a prospective non-randomised controlled trial. Clinical Medicine, 2011, 11, 312-316.	1.9	31
49	Improving feedback on junior doctors' prescribing errors: mixed-methods evaluation of a quality improvement project. BMJ Quality and Safety, 2017, 26, 240-247.	3.7	30
50	Technological Capabilities to Assess Digital Excellence in Hospitals in High Performing Health Care Systems: International eDelphi Exercise. Journal of Medical Internet Research, 2020, 22, e17022.	4.3	30
51	Medication errors with electronic prescribing (eP): Two views of the same picture. BMC Health Services Research, 2010, 10, 135.	2.2	28
52	A quality improvement programme to increase compliance with an anti-infective prescribing policy. Journal of Antimicrobial Chemotherapy, 2011, 66, 1916-1920.	3.0	28
53	How reliable are clinical systems in the UK NHS? A study of seven NHS organisations. BMJ Quality and Safety, 2012, 21, 466-472.	3.7	28
54	Feedback on prescribing errors to junior doctors: exploring views, problems and preferred methods. International Journal of Clinical Pharmacy, 2013, 35, 332-338.	2.1	28

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55	The Role of Hospital Inpatients in Supporting Medication Safety: A Qualitative Study. PLoS ONE, 2016, 11, e0153721.	2.5	28
56	Evaluation of My Medication Passport: a patient-completed aide-memoire designed by patients, for patients, to help towards medicines optimisation. BMJ Open, 2014, 4, e005608-e005608.	1.9	27
57	The effect of the electronic transmission of prescriptions on dispensing errors and prescription enhancements made in English community pharmacies: a naturalistic stepped wedge study. BMJ Quality and Safety, 2014, 23, 629-638.	3.7	27
58	Exploring the Current Landscape of Intravenous Infusion Practices and Errors (ECLIPSE): protocol for a mixed-methods observational study. BMJ Open, 2016, 6, e009777.	1.9	27
59	The use of a consultant-led ward round checklist to improve paediatric prescribing: An interrupted time series study. European Journal of Pediatrics, 2012, 171, 1239-1245.	2.7	24
60	Identifying systems failures in the pathway to a catastrophic event: an analysis of national incident report data relating to vinca alkaloids. BMJ Quality and Safety, 2014, 23, 765-772.	3.7	23
61	The impact of a hospital electronic prescribing and medication administration system on medication administration safety: an observational study. BMC Health Services Research, 2017, 17, 547.	2.2	23
62	Systematic review of the safety of medication use in inpatient, outpatient and primary care settings in the Gulf Cooperation Council countries. Saudi Pharmaceutical Journal, 2018, 26, 977-1011.	2.7	21
63	Development and performance evaluation of the Medicines Optimisation Assessment Tool (MOAT): a prognostic model to target hospital pharmacists' input to prevent medication-related problems. BMJ Quality and Safety, 2019, 28, 645-656.	3.7	21
64	Infusion device standardisation and dose error reduction software. British Journal of Nursing, 2014, 23, S16-S24.	0.7	20
65	Identification of priorities for improvement of medication safety in primary care: a PRIORITIZE study. BMC Family Practice, 2016, 17, 160.	2.9	20
66	Intravenous Infusion Administration: A Comparative Study of Practices and Errors Between the United States and England and Their Implications for Patient Safety. Drug Safety, 2019, 42, 1157-1165.	3.2	20
67	The impact of electronic prescribing systems on healthcare professionals' working practices in the hospital setting: a systematic review and narrative synthesis. BMC Health Services Research, 2019, 19, 742.	2.2	20
68	How can patient-held lists of medication enhance patient safety? A mixed-methods study with a focus on user experience. BMJ Quality and Safety, 2020, 29, 764-773.	3.7	20
69	Failure Mode and Effects Analysis: Views of Hospital Staff in the UK. Journal of Health Services Research and Policy, 2012, 17, 37-43.	1.7	19
70	Procedural and documentation variations in intravenous infusion administration: a mixed methods study of policy and practice across 16 hospital trusts in England. BMC Health Services Research, 2018, 18, 270.	2.2	19
71	Differences in pharmacy terminology and practice between the United Kingdom and the United States. American Journal of Health-System Pharmacy, 2007, 64, 1541-1546.	1.0	18
72	Is the Principle of a Stable Heinrich Ratio a Myth?. Drug Safety, 2008, 31, 637-642.	3.2	18

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73	Exploring the theory, barriers and enablers for patient and public involvement across health, social care and patient safety: a protocol for a systematic review of reviews. BMJ Open, 2017, 7, e018426.	1.9	18
74	A prospective risk assessment of informal carers' medication administration errors within the domiciliary setting. Ergonomics, 2018, 61, 104-121.	2.1	18
75	Theoretical and methodological considerations in evaluating large-scale health information technology change programmes. BMC Health Services Research, 2020, 20, 477.	2.2	18
76	Economic impact of electronic prescribing in the hospital setting: A systematic review. International Journal of Medical Informatics, 2016, 88, 1-7.	3.3	17
77	Impact of an inpatient electronic prescribing system on prescribing error causation: a qualitative evaluation in an English hospital. BMJ Quality and Safety, 2018, 27, 529-538.	3.7	17
78	Mixed methods study of medication-related decision support alerts experienced during electronic prescribing for inpatients at an English hospital. European Journal of Hospital Pharmacy, 2019, 26, 318-322.	1.1	17
79	Identifying risks areas related to medication administrations - text mining analysis using free-text descriptions of incident reports. BMC Health Services Research, 2019, 19, 791.	2.2	17
80	The Contribution of Staffing to Medication Administration Errors: A Text Mining Analysis of Incident Report Data. Journal of Nursing Scholarship, 2020, 52, 113-123.	2.4	17
81	The impact of implementing a hospital electronic prescribing and administration system on clinical pharmacists' activities - a mixed methods study. BMC Health Services Research, 2019, 19, 156.	2.2	16
82	The impact of an electronic prescribing and administration system on the safety and quality of medication administration. International Journal of Pharmacy Practice, 2010, 16, 375-379.	0.6	15
83	Medicines Optimisation Assessment Tool (MOAT): a prognostic model to target hospital pharmacists' input to improve patient outcomes. Protocol for an observational study. BMJ Open, 2017, 7, e017509.	1.9	14
84	Reported error rates are likely to be underestimation. BMJ: British Medical Journal, 2009, 338, b1814-b1814.	2.3	13
85	Redesigning the â€~choice architecture' of hospital prescription charts: a mixed methods study incorporating in situ simulation testing. BMJ Open, 2014, 4, e005473.	1.9	12
86	Exploring structure, agency and performance variability in everyday safety: An ethnographic study of practices around infusion devices using distributed cognition. Safety Science, 2019, 118, 687-701.	4.9	12
87	Interorganizational Knowledge Sharing to Establish Digital Health Learning Ecosystems: Qualitative Evaluation of a National Digital Health Transformation Program in England. Journal of Medical Internet Research, 2021, 23, e23372.	4.3	12
88	Comment on †Prevalence, Incidence and Nature of Prescribing Errors in Hospital Inpatients: A Systematic Review'. Drug Safety, 2010, 33, 163-165.	3.2	11
89	Community pharmacists' interventions with electronic prescriptions in England: an exploratory study. International Journal of Clinical Pharmacy, 2013, 35, 1030-1035.	2.1	11
90	Using Blueprints to promote interorganizational knowledge transfer in digital health initiatives—a qualitative exploration of a national change program in English hospitals. Journal of the American Medical Informatics Association: JAMIA, 2021, 28, 1431-1439.	4.4	11

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91	Multidisciplinary hospital antibiotic stewardship: a West London model. Clinical Governance, 2004, 9, 237-243.	0.3	10
92	Using Imipenem and Cilastatin During Continuous Renal Replacement Therapy. International Journal of Clinical Pharmacy, 2005, 27, 371-375.	1.4	10
93	The contribution of a pharmacy admissions service to patient care. Clinical Medicine, 2008, 8, 53-57.	1.9	10
94	The impact of a closed-loop electronic prescribing and automated dispensing system on the ward pharmacist's time and activities. International Journal of Pharmacy Practice, 2010, 15, 133-139.	0.6	10
95	Development and validation of criteria to identify medication-monitoring errors in care home residents. International Journal of Pharmacy Practice, 2010, 16, 317-323.	0.6	10
96	Secondary use of data from hospital electronic prescribing and pharmacy systems to support the quality and safety of antimicrobial use: a systematic review. Journal of Antimicrobial Chemotherapy, 2017, 72, 1880-1885.	3.0	10
97	What is the impact of introducing inpatient electronic prescribing on prescribing errors? A naturalistic stepped wedge study in an English teaching hospital. Health Informatics Journal, 2020, 26, 3152-3162.	2.1	10
98	Factors contributing to reported medication administration incidents in patients' homes – A text mining analysis. Journal of Advanced Nursing, 2020, 76, 3573-3583.	3.3	10
99	User-testing guidelines to improve the safety of intravenous medicines administration: a randomised in situ simulation study. BMJ Quality and Safety, 2021, 30, 17-26.	3.7	10
100	Concomitant prescribing and dispensing errors at a Brazilian hospital: a descriptive study. Clinics, 2011, 66, 1691-7.	1.5	10
101	Driving digital health transformation in hospitals: a formative qualitative evaluation of the English Global Digital Exemplar programme. BMJ Health and Care Informatics, 2021, 28, e100429.	3.0	10
102	Pharmacists' documentation in patients' hospital health records: issues and educational implications. International Journal of Pharmacy Practice, 2010, 18, 108-15.	0.6	10
103	Comparing the upper limb disorder risks associated with manual and automated cytotoxic compounding: a pilot study. European Journal of Hospital Pharmacy, 2012, 19, 293-298.	1.1	9
104	Quality of stepped-wedge trial reporting can be reliably assessed using anÂupdated CONSORT: crowd-sourcing systematic review. Journal of Clinical Epidemiology, 2019, 107, 77-88.	5.0	9
105	The devil is in the detail: How a closed-loop documentation system for IV infusion administration contributes to and compromises patient safety. Health Informatics Journal, 2020, 26, 576-591.	2.1	9
106	Developing Strategic Recommendations for Implementing Smart Pumps in Advanced Healthcare Systems to Improve Intravenous Medication Safety. Drug Safety, 2022, 45, 881-889.	3.2	9
107	â€~Smart' intravenous pumps: how smart are they?. BMJ Quality and Safety, 2017, 26, 93-94.	3.7	8
108	Interruptions in medication administration: are we asking the right questions?. BMJ Quality and Safety, 2017, 26, 701-703.	3.7	8

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109	A comparison between independent nurse prescribing and patient group directions in the safety and appropriateness of medication provision in United Kingdom sexual health services: A mixed methods study. International Journal of Nursing Studies, 2020, 107, 103590.	5 <b>.</b> 6	8
110	Medicines management at home during the COVID-19 pandemic: a qualitative study exploring the UK patient/carer perspective. International Journal of Pharmacy Practice, 2021, 29, 458-464.	0.6	8
111	An evaluation of the contribution of the medical admissions pharmacist at a London teaching hospital. International Journal of Pharmacy Practice, 2010, 12, 1-6.	0.6	7
112	Medication errors: do they occur in isolation?. BMJ Quality and Safety, 2014, 23, e1-e1.	3.7	7
113	Medication errors during simulated paediatric resuscitations: a prospective, observational human reliability analysis. BMJ Open, 2019, 9, e032686.	1.9	7
114	Formative independent evaluation of a digital change programme in the English National Health Service: study protocol for a longitudinal qualitative study. BMJ Open, 2020, 10, e041275.	1.9	7
115	An Evaluation of the Impact of Barcode Patient and Medication Scanning on Nursing Workflow at a UK Teaching Hospital. Pharmacy (Basel, Switzerland), 2020, 8, 148.	1.6	7
116	Of snarks, boojums and national drug charts. Journal of the Royal Society of Medicine, 2013, 106, 6-8.	2.0	6
117	A descriptive exploratory study of how admissions caused by medication-related harm are documented within inpatients' medical records. BMC Health Services Research, 2014, 14, 257.	2.2	6
118	Omitted doses as an unintended consequence of a hospital restricted antibacterial system: a retrospective observational study. Journal of Antimicrobial Chemotherapy, 2015, 70, dkv264.	3.0	6
119	Highâ€risk medicines associated with clinically relevant medicationâ€related problems in UK hospitals: A prospective observational study. British Journal of Clinical Pharmacology, 2020, 86, 165-169.	2.4	6
120	Medication non-adherence: an overlooked target for quality improvement interventions. BMJ Quality and Safety, 2020, 29, 271-273.	3.7	6
121	Promoting inter-organisational knowledge sharing: A qualitative evaluation of England's Global Digital Exemplar and Fast Follower Programme. PLoS ONE, 2021, 16, e0255220.	2.5	6
122	User Testing to Improve Retrieval and Comprehension of Information in Guidelines to Improve Medicines Safety. Journal of Patient Safety, 2022, 18, e172-e179.	1.7	6
123	Independent nurse medication provision: A mixed method study assessing impact on patients' experience, processes, and costs in sexual health clinics. Journal of Advanced Nursing, 2022, 78, 239-251.	3.3	6
124	The evaluation of a novel model of providing ward pharmacy services. International Journal of Clinical Pharmacy, 2012, 34, 518-523.	2.1	5
125	Patient and public involvement in patient safety research: a workshop to review patient information, minimise psychological risk and inform research. Research Involvement and Engagement, 2016, 2, 19.	2.9	5
126	A comparison of two methods of assessing the potential clinical importance of medication errors. Safety in Health, 2018, 4, .	0.7	5

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127	Adherence to antibiotic guidelines and reported penicillin allergy: pooled cohort data on prescribing and allergy documentation from two English National Health Service (NHS) trusts. BMJ Open, 2019, 9, e026624.	1.9	5
128	Use of Pediatric Injectable Medicines Guidelines and Associated Medication Administration Errors: A Human Reliability Analysis. Annals of Pharmacotherapy, 2021, 55, 1333-1340.	1.9	5
129	Intravenous infusion practices across England and their impact on patient safety: a mixed-methods observational study. Health Services and Delivery Research, 2020, 8, 1-116.	1.4	5
130	A technical note concerning non-adherence to drug therapy: exact expressions for the mean and variance of drug concentration. Health Care Management Science, 2008, 11, 296-301.	2.6	4
131	The effect of electronic prescribing and medication administration on nurses' workflow and activities: an uncontrolled before and after study. Safety in Health, 2016, 2, .	0.7	4
132	Pharmacy staff views on the implementation of patient handheld medication tools to improve information transfer: a qualitative study. Safety in Health, 2018, 4, .	0.7	4
133	Qualitative study exploring the phenomenon of multiple electronic prescribing systems within single hospital organisations. BMC Health Services Research, 2018, 18, 969.	2.2	4
134	Patients' Perspectives on the Quality and Safety of Intravenous Infusions: A Qualitative Study. Journal of Patient Experience, 2020, 7, 380-385.	0.9	4
135	Factors Related to Medication Administration Incidents in England and Wales Between 2007 and 2016. Journal of Patient Safety, 2020, Publish Ahead of Print, e850-e857.	1.7	4
136	Validation of a Method to Assess the Severity of Medication Administration Errors in Brazil: A Study Protocol. Journal of Public Health Research, 2022, 11, jphr.2022.2623.	1.2	4
137	Research into practice: safe prescribing. British Journal of General Practice, 2014, 64, 259-261.	1.4	3
138	Use of patient-held information about medication (PHIMed) to support medicines optimisation: protocol for a mixed-methods descriptive study. BMJ Open, 2018, 8, e021764.	1.9	3
139	Analysis of pharmacist-identified medication-related problems at two United Kingdom hospitals: a prospective observational study. International Journal of Pharmacy Practice, 2020, 28, 643-651.	0.6	3
140	Costs and Cost-Effectiveness of User-Testing of Health Professionals' Guidelines to Reduce the Frequency of Intravenous Medicines Administration Errors by Nurses in the United Kingdom: A Probabilistic Model Based on Voriconazole Administration. Applied Health Economics and Health Policy, 2022, 20, 91-104.	2.1	3
141	The Potential Role of Smart Infusion Devices in Preventing or Contributing to Medication Administration Errors: A Descriptive Study of 2 Data Sets. Journal of Patient Safety, 2021, 17, e1894-e1900.	1.7	3
142	Household medication safety practices during the COVID-19 pandemic: a descriptive qualitative study protocol. BMJ Open, 2020, 10, e044441.	1.9	3
143	Distributed Cognition: Understanding Complex Sociotechnical Informatics. Studies in Health Technology and Informatics, 2019, 263, 75-86.	0.3	3
144	Analysis of the third WHO Global Safety Challenge †Medication Without Harm†patient-facing materials: exploratory descriptive study. European Journal of Hospital Pharmacy, 2021, 28, e109-e114.	1.1	3

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145	Improving medication safety in UK care homes: challenges and current perspective. JRSM Open, 2014, 5, 204253331351547.	0.5	2
146	Development and evaluation of a pocket card to support prescribing by junior doctors in an English hospital. International Journal of Clinical Pharmacy, 2015, 37, 762-766.	2.1	2
147	Perceived causes of prescribing errors by physicians: A qualitative study. Tropical Journal of Pharmaceutical Research, 2018, 17, 1415.	0.3	2
148	Electronic ordering and the management of treatment interdependencies: a qualitative study of paediatric chemotherapy. BMC Medical Informatics and Decision Making, 2020, 20, 193.	3.0	2
149	Automatic dispensing cabinets and governance of controlled drugs: an exploratory study in an intensive care unit. European Journal of Hospital Pharmacy, 2021, , ejhpharm-2020-002552.	1.1	2
150	Interruptive alerts: only one part of the solution for clinical decision support. BMJ Quality and Safety, 2021, 30, 933-936.	3.7	2
151	Resilience of Medication Adherence Practices in Response to Life Changes: Learning from Qualitative Data Obtained during the COVID-19 Pandemic. Healthcare (Switzerland), 2021, 9, 1048.	2.0	2
152	Benefits realization management in the context of a national digital transformation initiative in English provider organizations. Journal of the American Medical Informatics Association: JAMIA, 2022, 29, 536-545.	4.4	2
153	Replicating and publishing research in different countries and different settings: advice for authors. BMJ Quality and Safety, 2022, 31, 627-630.	3.7	2
154	Retrospective descriptive assessment of clinical decision support medication-related alerts in two Saudi Arabian hospitals. BMC Medical Informatics and Decision Making, 2022, 22, 101.	3.0	2
155	Potentially inappropriate medication in elderly patients with chronic renal disease—is it a problem?. Postgraduate Medical Journal, 2013, 89, 245-246.	1.8	1
156	Infusion device standardisation and dose error reduction software. British Journal of Health Care Management, 2015, 21, 68-76.	0.2	1
157	Dispensing errors. International Journal of Pharmacy Practice, 2009, 17, 7-8.	0.6	1
158	Researching Collective Mindfulness and Health IT: A Framework and Translation to Context-Specific Questions. Studies in Health Technology and Informatics, 2019, 265, 31-36.	0.3	1
159	Getting palliative medications right across the contexts of homes, hospitals and hospices: protocol to synthesise scoping review and ethnographic methods in an activity theory analysis. BMJ Open, 2022, 12, e061754.	1.9	1
160	Medication errors: developing methodologies and evaluating solutions. International Journal of Pharmacy Practice, 2010, 13, R4-R5.	0.6	0
161	Dispensing errors. International Journal of Pharmacy Practice, 2010, 17, 7-8.	0.6	0
162	Introduction from the new editors-in-chief. BMJ Quality and Safety, 2020, 29, 873-874.	3.7	0

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163	Do patients and family carers have different concerns about the use of medicines compared with healthcare professionals? A quantitative secondary analysis of healthcare concerns relating to adults with complex needs. Patient Education and Counseling, 2022, 105, 447-451.	2.2	0
164	Combining research and design: A mixed methods approach aimed at understanding and optimising inpatient medication storage systems. PLoS ONE, 2021, 16, e0260197.	2.5	0
165	Challenges of Digital Commons: A Qualitative Study of an Automated Dispensing Cabinet in a Paediatric Intensive Care Unit. Studies in Health Technology and Informatics, 2021, 284, 244-248.	0.3	0
166	Evaluation of an Automated Dispensing Cabinet in Paediatric Intensive Care – Focus on Controlled Medications. Studies in Health Technology and Informatics, 2021, 284, 323-325.	0.3	0
167	Delivering Digital Drugs: An Exploratory Study of the Digitalisation of Supply and Use of Medicines. Studies in Health Technology and Informatics, 2017, 245, 1259.	0.3	0
168	Pharmacy Interweaving Safety Within Hospital Health Information Technology. Studies in Health Technology and Informatics, 2018, 252, 105-111.	0.3	0
169	The Secondary Use of Data to Support Medication Safety in the Hospital Setting: A Systematic Review and Narrative Synthesis. Pharmacy (Basel, Switzerland), 2021, 9, 198.	1.6	0
170	The 'Back Office' of a Dispensing Cabinet: Technology and Work Contributing to Medication Safety. Studies in Health Technology and Informatics, 2020, 270, 1405-1406.	0.3	0