

Tanja Manser

List of Publications by Year in descending order

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Version: 2024-02-01

90
papers

3,212
citations

147801

31
h-index

161849

54
g-index

96
all docs

96
docs citations

96
times ranked

3083
citing authors

#	ARTICLE	IF	CITATIONS
1	Teamwork and Adherence to Guideline on Newborn Resuscitationâ€™ Video Review of Neonatal Interdisciplinary Teams. <i>Frontiers in Pediatrics</i> , 2022, 10, 828297.	1.9	9
2	Separate Medication Preparation Rooms Reduce Interruptions and Medication Errors in the Hospital Setting: A Prospective Observational Study. <i>Journal of Patient Safety</i> , 2021, 17, e161-e168.	1.7	11
3	Influence of Gender, Profession, and Managerial Function on Cliniciansâ€™ Perceptions of Patient Safety Culture: A Cross-National Cross-Sectional Study. <i>Journal of Patient Safety</i> , 2021, 17, e280-e287.	1.7	17
4	Does interprofessional team-training affect nursesâ€™ and physiciansâ€™ perceptions of safety culture and communication practices? Results of a pre-post survey study. <i>BMC Health Services Research</i> , 2021, 21, 341.	2.2	13
5	Simulation-based training improves patient safety climate in acute stroke care (STREAM). <i>Neurological Research and Practice</i> , 2021, 3, 37.	2.0	2
6	Measuring Patient Safety Climate in Acute Stroke Therapy. <i>Frontiers in Neurology</i> , 2021, 12, 686649.	2.4	1
7	Assessing Patients' Perceptions of Safety Culture in the Hospital Setting: Development and Initial Evaluation of the Patients' Perceptions of Safety Culture Scale. <i>Journal of Patient Safety</i> , 2020, 16, 90-97.	1.7	10
8	Psychometric properties of the Georgian version of the Safety Attitudes Questionnaire: a cross-sectional study. <i>BMJ Open</i> , 2020, 10, e034863.	1.9	8
9	A Strategic Core Role Perspective on Team Coordination: Benefits of Centralized Leadership for Managing Task Complexity in the Operating Room. <i>Human Factors</i> , 2020, 63, 001872082090604.	3.5	6
10	Coordination and Communication in Healthcare Action Teams. <i>Swiss Journal of Psychology</i> , 2020, 79, 123-135.	0.9	3
11	Piloting and evaluating feasibility of a training program to improve patient safety for inter-professional inpatient care teams â€™ study protocol of a cluster randomized controlled trial. <i>Trials</i> , 2019, 20, 386.	1.6	3
12	Exploring healthcare providersâ€™ mental models of the infection prevention â€™patient zoneâ€™ a concept mapping study. <i>Antimicrobial Resistance and Infection Control</i> , 2019, 8, 138.	4.1	4
13	Healthcare professionalsâ€™ perspectives on working conditions, leadership, and safety climate: a cross-sectional study. <i>BMC Health Services Research</i> , 2019, 19, 53.	2.2	63
14	Psychometric properties of the Georgian version of Hospital Survey on Patient Safety Culture: a cross-sectional study. <i>BMJ Open</i> , 2019, 9, e030972.	1.9	7
15	Assessing the quality of medication documentation: development and feasibility of the MediDocQ instrument for retrospective chart review in the hospital setting. <i>BMJ Open</i> , 2019, 9, e034609.	1.9	10
16	Hospital Survey on Patient Safety Culture (HSPSC): a systematic review of the psychometric properties of 62 international studies. <i>BMJ Open</i> , 2019, 9, e026896.	1.9	50
17	How effective is teamwork really? The relationship between teamwork and performance in healthcare teams: a systematic review and meta-analysis. <i>BMJ Open</i> , 2019, 9, e028280.	1.9	203
18	Quality in Postoperative Patient Handover. <i>Journal of Nursing Care Quality</i> , 2019, 34, E1-E7.	0.9	12

#	ARTICLE	IF	CITATIONS
19	Effektive Kommunikation in METs. , 2019, , 179-188.		0
20	Frequency and Nature of Infectious Risk Moments During Acute Care Based on the INFORM Structured Classification Taxonomy. Infection Control and Hospital Epidemiology, 2018, 39, 272-279.	1.8	10
21	Likelihood of Infectious Outcomes Following Infectious Risk Moments During Patient Care—An International Expert Consensus Study and Quantitative Risk Index. Infection Control and Hospital Epidemiology, 2018, 39, 280-289.	1.8	9
22	Development of the Team<scp>OBS</scp>â€œ<scp>PPH</scp> â€œ targeting clinical performance in postpartum hemorrhage. Acta Obstetrica Et Gynecologica Scandinavica, 2018, 97, 677-687.	2.8	11
23	Training Needs for Adaptive Coordination: Utilizing Task Analysis to Identify Coordination Requirements in Three Different Clinical Settings. Group and Organization Management, 2018, 43, 504-527.	4.4	22
24	Prospective systemic risk analysis of the dispensing process in German community pharmacies. International Journal of Health Planning and Management, 2018, 33, e320-e332.	1.7	5
25	Do Occupational and Patient Safety Culture in Hospitals Share Predictors in the Field of Psychosocial Working Conditions? Findings from a Cross-Sectional Study in German University Hospitals. International Journal of Environmental Research and Public Health, 2018, 15, 2131.	2.6	26
26	Reflection in the heat of the moment: The role of inâ€œaction team reflexivity in health care emergency teams. Journal of Organizational Behavior, 2018, 39, 749-765.	4.7	46
27	Using Failure mode and Effects Analysis to reduce patient safety risks related to the dispensing process in the community pharmacy setting. Research in Social and Administrative Pharmacy, 2017, 13, 1159-1166.	3.0	11
28	A cross-national comparison of incident reporting systems implemented in German and Swiss hospitals. International Journal for Quality in Health Care, 2017, 29, 349-359.	1.8	6
29	A combined intervention to reduce interruptions during medication preparation and double-checking: a pilot-study evaluating the impact of staff training and safety vests. Journal of Nursing Management, 2017, 25, 539-548.	3.4	15
30	Using Prospective Risk Analysis Tools to Improve Safety in Pharmacy Settings. Journal of Patient Safety, 2017, Publish Ahead of Print, e515-e523.	1.7	5
31	Evaluation of psychometric properties of the German Hospital Survey on Patient Safety Culture and its potential for cross-cultural comparisons: a cross-sectional study. BMJ Open, 2017, 7, e018366.	1.9	28
32	3. Von der Risikoschwangerschaft zur Sicherheitskultur in der Geburtshilfe. , 2016, , 27-30.		0
33	You canâ€™t improve what you donâ€™t measure: Safety climate measures available in the German-speaking countries to support safety culture development in healthcare. Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen, 2016, 114, 58-71.	0.9	26
34	The German clinical risk management survey for hospitals: Implementation levels and areas for improvement in 2015. Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen, 2016, 114, 28-38.	0.9	22
35	Integrating teamwork, clinician occupational well-being and patient safety â€œ development of a conceptual framework based on a systematic review. BMC Health Services Research, 2016, 16, 281.	2.2	83
36	The interplay between teamwork, cliniciansâ€™ emotional exhaustion, and clinician-rated patient safety: a longitudinal study. Critical Care, 2016, 20, 110.	5.8	115

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37	Studying Patient Safety and Quality from Different Methodological Angles and Perspectives. , 2016, , 43-56.		0
38	Perceived barriers to computerised quality documentation during anaesthesia: a survey of anaesthesia staff. BMC Anesthesiology, 2015, 15, 13.	1.8	6
39	Adaptive coordination in surgical teams: an interview study. BMC Health Services Research, 2015, 15, 128.	2.2	47
40	Structured Performance Assessment in Three Pediatric Emergency Scenarios: A Validation Study. Journal of Pediatrics, 2015, 166, 1498-1504.e1.	1.8	9
41	Effective coordination in medical emergency teams: The moderating role of task type. European Journal of Work and Organizational Psychology, 2015, 24, 761-776.	3.7	45
42	Beobachtung von Kommunikations- und Interaktionsprozessen in Konstruktiven Kontroversen: ein Perspektivenwechsel. , 2015, , 227-256.		0
43	Infectious Risk Moments: A Novel, Human Factorsâ€“Informed Approach to Infection Prevention. Infection Control and Hospital Epidemiology, 2014, 35, 1051-1055.	1.8	14
44	Job satisfaction among chairs of surgery from Europe and North America. Surgery, 2014, 156, 1069-1077.	1.9	15
45	Identifying medication error chains from critical incident reports: A new analytic approach. Journal of Clinical Pharmacology, 2014, 54, 1188-1197.	2.0	24
46	Five Steps to Develop Checklists for Evaluating Clinical Performance. Academic Medicine, 2014, 89, 996-1005.	1.6	57
47	Emotional exhaustion and workload predict clinician-rated and objective patient safety. Frontiers in Psychology, 2014, 5, 1573.	2.1	210
48	Clinical risk management in hospitals: strategy, central coordination and dialogue as key enablers. Journal of Evaluation in Clinical Practice, 2013, 19, 363-369.	1.8	22
49	Clinical risk management in mental health: a qualitative study of main risks and related organizational management practices. BMC Health Services Research, 2013, 13, 44.	2.2	26
50	Human factors in clinical handover: development and testing of a 'handover performance tool' for doctors' shift handovers. International Journal for Quality in Health Care, 2013, 25, 58-65.	1.8	35
51	Team Communication During Patient Handover From the Operating Room. Human Factors, 2013, 55, 138-156.	3.5	80
52	Co-ACTâ€“a framework for observing coordination behaviour in acute care teams. BMJ Quality and Safety, 2013, 22, 596-605.	3.7	60
53	Fragmentation of Patient Safety Research: A Critical Reflection of Current Human Factors Approaches to Patient Handover. Journal of Public Health Research, 2013, 2, jphr.2013.e33.	1.2	18
54	Teamwork and Collaboration. Reviews of Human Factors and Ergonomics, 2013, 8, 55-102.	0.5	32

#	ARTICLE	IF	CITATIONS
55	In Response. Anesthesia and Analgesia, 2013, 116, 1184-1186.	2.2	0
56	Verhalten ist messbar: Behavioural Marker Systeme und Kompetenzentwicklung. , 2013, , 169-180.		1
57	Motivational antecedents of incident reporting: evidence from a survey of nurses and physicians. Swiss Medical Weekly, 2013, 143, w13881.	1.6	13
58	A wealth of information creates a poverty of attention?: Understanding information requirements at handovers. Proceedings of the Human Factors and Ergonomics Society, 2012, 56, 860-862.	0.3	0
59	Speaking Up Is Related to Better Team Performance in Simulated Anesthesia Inductions. Anesthesia and Analgesia, 2012, 115, 1099-1108.	2.2	125
60	Taking care of patients, relatives and staff after critical incidents and accidents. European Journal of Anaesthesiology, 2012, 29, 303-306.	1.7	2
61	The Effects of Patient Handoff Characteristics on Subsequent Care. Academic Medicine, 2012, 87, 1105-1124.	1.6	92
62	Receiving care providers' role during patient handover. Trends in Anaesthesia and Critical Care, 2012, 2, 156-160.	0.9	9
63	An observational study of teamwork skills in shift handover. International Journal of Surgery, 2012, 10, 355-359.	2.7	16
64	Team mental models and their potential to improve teamwork and safety: A review and implications for future research in healthcare. Safety Science, 2012, 50, 1344-1354.	4.9	107
65	Komplexität handhaben – Handeln vereinheitlichen – Organisationen sicher gestalten. , 2012, , 295-311.		2
66	The Study of Factors Affecting Human and Systems Performance in Healthcare Using Simulation. Simulation in Healthcare, 2011, 6, S24-S29.	1.2	78
67	Managing the aftermath of critical incidents: Meeting the needs of health-care providers and patients. Bailliere's Best Practice and Research in Clinical Anaesthesiology, 2011, 25, 169-179.	4.0	36
68	Effective handover communication: An overview of research and improvement efforts. Bailliere's Best Practice and Research in Clinical Anaesthesiology, 2011, 25, 181-191.	4.0	142
69	Psychometric properties of the Hospital Survey on Patient Safety Culture for hospital management (HSOPS_M). BMC Health Services Research, 2011, 11, 165.	2.2	47
70	Interactions of team mental models and monitoring behaviors predict team performance in simulated anesthesia inductions.. Journal of Experimental Psychology: Applied, 2011, 17, 257-269.	1.2	95
71	Minding the gaps. European Journal of Anaesthesiology, 2011, 28, 613-615.	1.7	16
72	The Role of Coordination in Preventing Harm in Healthcare Groups: Research Examples from Anaesthesia and an Integrated Model of Coordination for Action Teams in Health Care. , 2011, , 75-92.		9

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73	Managing Nonroutine Events in Anesthesia: The Role of Adaptive Coordination. <i>Human Factors</i> , 2010, 52, 282-294.	3.5	93
74	Assessing hospitals' clinical risk management: Development of a monitoring instrument. <i>BMC Health Services Research</i> , 2010, 10, 337.	2.2	34
75	Development of the German version of the Hospital Survey on Patient Safety Culture: Dimensionality and psychometric properties. <i>Safety Science</i> , 2010, 48, 1452-1462.	4.9	90
76	Assessing the quality of patient handoffs at care transitions. <i>BMJ Quality and Safety</i> , 2010, 19, e44-e44.	3.7	63
77	Patient Safety in the Operating Theatre. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2010, 54, 855-856.	0.3	2
78	Healthcare Handover and Patient Safety. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2010, 54, 947-948.	0.3	1
79	Interprofessional collaboration among nurses and physicians: Making a difference in patient outcome. <i>Swiss Medical Weekly</i> , 2010, 140, w13062.	1.6	122
80	Coordination Patterns Related to High Clinical Performance in a Simulated Anesthetic Crisis. <i>Anesthesia and Analgesia</i> , 2009, 108, 1606-1615.	2.2	100
81	Team Performance Assessment in Healthcare. <i>Simulation in Healthcare</i> , 2008, 3, 1-3.	1.2	15
82	Komplexität handhaben – Handeln vereinheitlichen – Organisationen sicher gestalten. , 2008, , 273-288.		1
83	Reality and Fiction Cues in Medical Patient Simulation: An Interview Study with Anesthesiologists. <i>Journal of Cognitive Engineering and Decision Making</i> , 2007, 1, 148-168.	2.3	75
84	Cognitive Aids in a Simulated Anesthetic Crisis. <i>Anesthesia and Analgesia</i> , 2007, 104, 1293.	2.2	0
85	A Comparative Study Of Coordination Processes Related To Different Levels Of Performance During A Simulated Anesthetic Crisis. <i>Simulation in Healthcare</i> , 2006, 1, 103.	1.2	1
86	A research strategy integrating simulator and field data on teamwork: Implications for the development of theory, methods and curricula.. <i>Simulation in Healthcare</i> , 2006, 1, 186.	1.2	0
87	Use of Cognitive Aids in a Simulated Anesthetic Crisis. <i>Anesthesia and Analgesia</i> , 2006, 103, 551-556.	2.2	189
88	Self-regulation as a central mechanism to collaboratively manage unexpected events in complex work environments. , 2006, , .		1
89	A PDA-based system for online recording and analysis of concurrent events in complex behavioral processes. <i>Behavior Research Methods</i> , 2005, 37, 155-164.	4.0	34
90	Teambuilding. , 0, , 152-159.		0