

# Kaveh G Shojania

## List of Publications by Year in descending order

Source: <https://exaly.com/author-pdf/7153364/publications.pdf>

Version: 2024-02-01

48  
papers

2,839  
citations

394421

19  
h-index

223800

46  
g-index

49  
all docs

49  
docs citations

49  
times ranked

3998  
citing authors

#	ARTICLE	IF	CITATIONS
1	Looking back on the history of patient safety: an opportunity to reflect and ponder future challenges. <i>BMJ Quality and Safety</i> , 2022, 31, 148-152.	3.7	12
2	A Novel Collaborative Care Program to Augment Nursing Home Care During and After the COVID-19 Pandemic. <i>Journal of the American Medical Directors Association</i> , 2022, 23, 304-307.e3.	2.5	8
3	What problems in health care quality should we target as the world burns around us?. <i>Cmaj</i> , 2022, 194, E311-E312.	2.0	8
4	Striving for high reliability in healthcare: a qualitative study of the implementation of a hospital safety programme. <i>BMJ Quality and Safety</i> , 2022, 31, 867-877.	3.7	13
5	The effects of on-screen, point of care computer reminders on processes and outcomes of care. <i>The Cochrane Library</i> , 2021, 2021, CD001096.	2.8	323
6	Cost of contact: redesigning healthcare in the age of COVID. <i>BMJ Quality and Safety</i> , 2021, 30, 236-239.	3.7	29
7	Vulnerability of the medical product supply chain: the wake-up call of COVID-19. <i>BMJ Quality and Safety</i> , 2021, 30, 331-335.	3.7	50
8	An Association Between Cardiologist Billing Patterns, Health Care Use, and Outcomes in Cardiac Patients. <i>CJC Open</i> , 2021, 3, 758-768.	1.5	1
9	Implementation of a central-line bundle: a qualitative study of three clinical units. <i>Implementation Science Communications</i> , 2021, 2, 105.	2.2	4
10	Incident Reporting Systems: What Will It Take to Make Them Less Frustrating and Achieve Anything Useful?. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2021, 47, 755-758.	0.7	1
11	Education as a low-value improvement intervention: often necessary but rarely sufficient. <i>BMJ Quality and Safety</i> , 2020, 29, 353-357.	3.7	79
12	Computerised clinical decision support systems and absolute improvements in care: meta-analysis of controlled clinical trials. <i>BMJ</i> , 2020, 370, m3216.	6.0	188
13	Modelling resource requirements and physician staffing to provide virtual urgent medical care for residents of long-term care homes: a cross-sectional study. <i>CMAJ Open</i> , 2020, 8, E514-E521.	2.4	5
14	Experiential Learning in Project-Based Quality Improvement Education: Questioning Assumptions and Identifying Future Directions. <i>Academic Medicine</i> , 2020, 95, 1745-1754.	1.6	17
15	Medication non-adherence: an overlooked target for quality improvement interventions. <i>BMJ Quality and Safety</i> , 2020, 29, 271-273.	3.7	6
16	Identifying adverse events: reflections on an imperfect gold standard after 20 years of patient safety research. <i>BMJ Quality and Safety</i> , 2020, 29, 265-270.	3.7	30
17	Choosing quality problems wisely: identifying improvements worth developing and sustaining. <i>BMJ Quality and Safety</i> , 2020, 29, 1.12-2.	3.7	9
18	Beyond CLABSI and CAUTI: broadening our vision of patient safety. <i>BMJ Quality and Safety</i> , 2020, 29, 361-364.	3.7	6

#	ARTICLE	IF	CITATIONS
19	Putting out fires: a qualitative study exploring the use of patient complaints to drive improvement at three academic hospitals. <i>BMJ Quality and Safety</i> , 2019, 28, 894-900.	3.7	20
20	Addressing the identity crisis in healthcare: positive patient identification technology reduces wrong patient events. <i>Transfusion</i> , 2019, 59, 899-902.	1.6	11
21	Evidence-based medicine: A cornerstone for clinical care but not for quality improvement. <i>Journal of Evaluation in Clinical Practice</i> , 2019, 25, 363-368.	1.8	16
22	Are increases in emergency use and hospitalisation always a bad thing? Reflections on unintended consequences and apparent backfires. <i>BMJ Quality and Safety</i> , 2019, 28, 687-692.	3.7	11
23	Follow-up of Incidental High-Risk Pulmonary Nodules on Computed Tomography Pulmonary Angiography at Care Transitions. <i>Journal of Hospital Medicine</i> , 2019, 14, 349-352.	1.4	17
24	The data of diagnostic error: big, large and small. <i>BMJ Quality and Safety</i> , 2018, 27, 499-501.	3.7	10
25	Inpatient bedspacing: could a common response to hospital crowding cause increased patient mortality?. <i>BMJ Quality and Safety</i> , 2018, 27, 1-3.	3.7	5
26	Physician Characteristics Associated With Ordering 4 Low-Value Screening Tests in Primary Care. <i>JAMA Network Open</i> , 2018, 1, e183506.	5.9	18
27	Media Dissemination of the Montreal Cognitive Assessment After President Donald Trump's Medical Evaluation. <i>JAMA Neurology</i> , 2018, 75, 1286.	9.0	2
28	Rigor in Quality Improvement Studies and the Role of Time-Series Methodologies. <i>JAMA Internal Medicine</i> , 2018, 178, 724.	5.1	1
29	Identifying vendors in studies of electronic health records: the editor replies. <i>BMJ Quality and Safety</i> , 2018, 27, e1-e1.	3.7	0
30	Estimating deaths due to medical error: the ongoing controversy and why it matters: Table 1. <i>BMJ Quality and Safety</i> , 2017, 26, bmjqs-2016-006144.	3.7	61
31	Use of Rheum to Improve Quality Improvement in Outpatient Rheumatology. <i>Journal of Rheumatology</i> , 2017, 44, 1304-1310.	2.0	9
32	Estimating preventable hospital deaths: the authors reply. <i>BMJ Quality and Safety</i> , 2017, 26, 694-694.	3.7	10
33	Point-of-care decision support for reducing inappropriate test use: easier said than done. <i>BMJ Quality and Safety</i> , 2016, 25, 6-8.	3.7	2
34	Ethnography as a methodological descriptor: the editors' reply. <i>BMJ Quality and Safety</i> , 2016, 25, 555-556.	3.7	6
35	Expanding the scope of Critical Care Rapid Response Teams: a feasible approach to identify adverse events. A prospective observational cohort. <i>BMJ Quality and Safety</i> , 2015, 24, 764-768.	3.7	13
36	Temporal trends in patient safety in the Netherlands: reductions in preventable adverse events or the end of adverse events as a useful metric?. <i>BMJ Quality and Safety</i> , 2015, 24, 541-544.	3.7	21

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37	Application of a trigger tool in near real time to inform quality improvement activities: a prospective study in a general medicine ward. <i>BMJ Quality and Safety</i> , 2015, 24, 272-281.	3.7	34
38	Simpson's paradox: how performance measurement can fail even with perfect risk adjustment. <i>BMJ Quality and Safety</i> , 2014, 23, 701-705.	3.7	23
39	Impact of stated barriers on proposed warfarin prescription for atrial fibrillation: a survey of Canadian physicians. <i>Thrombosis Journal</i> , 2014, 12, 13.	2.1	10
40	Multiple Interacting Factors Influence Adherence, and Outcomes Associated with Surgical Safety Checklists: A Qualitative Study. <i>PLoS ONE</i> , 2014, 9, e108585.	2.5	41
41	“Bad apples”: time to redefine as a type of systems problem?. <i>BMJ Quality and Safety</i> , 2013, 22, 528-531.	3.7	37
42	Trends in adverse events over time: why are we not improving?. <i>BMJ Quality and Safety</i> , 2013, 22, 273-277.	3.7	109
43	Continuing Medical Education and Quality Improvement: A Match Made in Heaven?. <i>Annals of Internal Medicine</i> , 2012, 156, 305.	3.9	57
44	Effect of point-of-care computer reminders on physician behaviour: a systematic review. <i>Cmaj</i> , 2010, 182, E216-E225.	2.0	276
45	Interventions to Reduce Unnecessary Antibiotic Prescribing. <i>Medical Care</i> , 2008, 46, 847-862.	2.4	200
46	Quality Improvement Strategies for Hypertension Management. <i>Medical Care</i> , 2006, 44, 646-657.	2.4	279
47	Changes in Rates of Autopsy-Detected Diagnostic Errors Over Time. <i>JAMA - Journal of the American Medical Association</i> , 2003, 289, 2849.	7.4	564
48	Safe but Sound. <i>JAMA - Journal of the American Medical Association</i> , 2002, 288, 508.	7.4	187