

DAFTAR PUSTAKA

- AHRQ. 2018. *Transitions of Care*. Content last reviewed June 2018. Agency for Healthcare Research and Quality, Rockville, MD.
<https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html>
- AHRQ. 2019. *Agency for Healthcare Research and Quality. TeamSTEPPS™: national implementation [online]*. Available from Internet: <http://teamstepps.ahrq.gov/index.html>
- Andersson, A. *et al.* (2017) Factors contributing to serious adverse events in nursing homes. doi: 10.1111/jocn.13914
- Asif, M. *et al.* (2019) 'Linking transformational leadership with nurse-assessed adverse patient outcomes and the quality of care: Assessing the role of job satisfaction and structural empowerment', *International Journal of Environmental Research and Public Health*, 16(13), pp. 1–15. doi: 10.3390/ijerph16132381.
- Aspden, P. *et al.* (2004) *Patient Safety: Achieving a New Standard for Care*. Available at: <http://www.nap.edu/catalog/10863.html>.
- Babiker, A. *et al.* (2014) 'Health care professional development: Working as a team to improve patient care.', *Sudanese journal of paediatrics*, 14(2), pp. 9–16.
 Available at: <http://www.ncbi.nlm.nih.gov/pubmed/27493399> <http://www.ncbi.nlm.nih.gov/pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC4949805>.
- Baines, R. (2018) *Monitoring adverse events in hospitals*.
- Baraki, Z. *et al.* (2018) 'Medication administration error and contributing factors among pediatric inpatient in public hospitals of Tigray, northern Ethiopia', *BMC Pediatrics*. *BMC Pediatrics*, 18(1), pp. 1–8. doi: 10.1186/s12887-018-1294-5.
- Boamah, S. (2017) 'Linking Nurses' Clinical Leadership to Patient Care Quality: The Role of Transformational Leadership and Workplace Empowerment', *The Canadian journal of nursing research = Revue canadienne de recherche en sciences infirmieres*, 50(1), pp. 9–19. doi: 10.1177/0844562117732490.
- Boamah, S. A. *et al.* (2017) 'Effect of transformational leadership on job satisfaction and patient safety outcomes', *Nursing Outlook*. Elsevier Inc., 66(2), pp. 180–189. doi: 10.1016/j.outlook.2017.10.004.
- Boet, S. *et al.* (2019) 'Measuring the teamwork performance of teams in crisis situations: A systematic review of assessment tools and their measurement properties', *BMJ Quality and Safety*, 28(4), pp. 327–337. doi: 10.1136/bmjqs-2018-008260.
- Bolton-Maggs, P. H. B. and Cohen, H. (2013) 'Serious Hazards of Transfusion (SHOT) haemovigilance and progress is improving transfusion safety', *British Journal of Haematology*, 163(3), pp. 303–314. doi: 10.1111/bjh.12547.

- Budihardjo, V. S. (2017) 'FAKTOR PERAWAT TERHADAP KEJADIAN MEDICATION ADMINISTRATION ERROR DI INSTALASI RAWAT INAP No Title', 5, pp. 52–61.
- Bukhari, B. (2019) 'BUDAYA KESELAMATAN PASIEN RUMAH SAKIT PEMERINTAH DAN RUMAH SAKIT SWASTA DI KOTA JAMBI', *Jurnal 'Aisyiyah Medika*, 3(1), pp. 1–18.
- Burn, Shwan. M. 2004. *Groups Theory and Practice*, Canada: Thomson & Wadsworth
- Castner, J. *et al.* (2012) 'A leadership challenge: Staff nurse perceptions after an organizational teamSTEPPS initiative', *Journal of Nursing Administration*, 42(10), pp. 467–472. doi: 10.1097/NNA.0b013e31826a1fc1.
- Cooke, M. 2016. *TeamSTEPPS for health care risk managers: Improving teamwork and communication*
- Delgado, M. C. M. *et al.* (2015) 'Analysis of contributing factors associated to related patients safety incidents in Intensive Care Medicine &', *Medicina Intensiva (English Edition)*. SEGO, 39(5), pp. 263–271. doi: 10.1016/j.medine.2015.05.001.
- DepKes RI (2008) *Panduan Nasional Keselamatan Pasien Rumah Sakit*. Departemen Kesehatan Republik Indonesia, Jakarta.
- Didem, K. (2016) *The Role of Teamwork in Patient Safety at Healthcare Institutions*. Available at: https://www.researchgate.net/publication/314448658_The_Role_of_Teamwork_in_Patient_Safety_at_Healthcare_Institutions.
- Emanuel, L. *et al.* (2008) 'What Exactly Is Patient Safety?', *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 1: Assessment)*, pp. 1–18. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21249863>.
- Gillespie, B. M., Chaboyer, W. and Fairweather, N. (2012) 'Interruptions and Miscommunications in Surgery: An Observational Study', *AORN Journal*. AORN, Inc., 95(5), pp. 576–590. doi: 10.1016/j.aorn.2012.02.012.
- Grover, E., Porter, J. E. and Morphet, J. (2017) 'An exploration of emergency nurses' perceptions, attitudes and experience of teamwork in the emergency department', *Australasian Emergency Nursing Journal*. College of Emergency Nursing Australasia, 20(2), pp. 92–97. doi: 10.1016/j.aenj.2017.01.003.
- Grubaugh, M. L. and Flynn, L. (2018) 'Relationships among Nurse Manager Leadership Skills, Conflict Management, and Unit Teamwork', *Journal of Nursing Administration*, 48(7–8), pp. 383–388. doi: 10.1097/NNA.0000000000000633.
- Handayani, T. W. (2017) 'FAKTOR PENYEBAB MEDICATION ERROR DI RSU ANUTAPURA', 02, pp. 224–229.

- Haque, M. *et al.* (2018) 'Health care-associated infections – An overview', *Infection and Drug Resistance*, 11, pp. 2321–2333. doi: 10.2147/IDR.S177247.
- Hara, J. K. O. *et al.* (2018) 'What can patients tell us about the quality and safety of hospital care? Findings from a UK multicentre survey study', pp. 673–682. doi: 10.1136/bmjqs-2017-006974.
- Heilman, J. *et al.* (2016). Adapting the I-PASS Handoff Program for Emergency Department Inter-Shift Handoffs. DOI: 10.5811/westjem.2016.9.30574
- Herzberg, S. *et al.* (2019) 'Association between measured teamwork and medical errors: an observational study of prehospital care in the USA', *BMJ Open*, 9(10), pp. 4–10. doi: 10.1136/bmjopen-2018-025314.
- Hillen, H., Pfaff, H. and Hammer, A. (2015) 'The association between transformational leadership in German hospitals and the frequency of events reported as perceived by medical directors', *Journal of Risk Research*, 20(4), pp. 499–515. doi: 10.1080/13669877.2015.1074935.
- Holmes, B. *et al.* (2010) 'Nutrition-related patient safety incidents', *Proceedings of the Nutrition Society*, 69(OCE7), p. 2010. doi: 10.1017/s0029665110004635.
- Hunt, C. M. (2010) 'Patient Safety is Enhanced by Teamwork', *Pennsylvania Patient Safety Advisory*, 7(2), pp. 14–17.
- Irwin, A. and Weidmann, A. E. (2015) 'A mixed methods investigation into the use of non-technical skills by community and hospital pharmacists', *Research in Social and Administrative Pharmacy*. Elsevier Inc, 11(5), pp. 675–685. doi: 10.1016/j.sapharm.2014.11.006.
- Ismainar, H., Dahesihdewi, A. and Dwiprahasto, I. (2012) 'Efektivitas Kepemimpinan dan Komunikasi Tim Keselamatan Pasien di RSI Ibnu Sina Pekanbaru Riau', *Jurnal Kesehatan Komunitas*, 2(1), pp. 2–8. doi: 10.25311/jkk.vol2.iss1.34.
- Jylhä, V., Bates, D. W. and Saranto, K. (2016) 'Adverse events and near misses relating to information management in a hospital', *Health Information Management Journal*, 45(2), pp. 55–63. doi: 10.1177/1833358316641551.
- Kalisch, B. J., Curley, M. and Stefanov, S. (2007) 'An intervention to enhance nursing staff teamwork and engagement', *Journal of Nursing Administration*, 37(2), pp. 77–84. doi: 10.1097/00005110-200702000-00010.
- Kapaki, V. and Souliotis, K. (2016) *Defining Adverse Events and Determinants of Medical Errors in Healthcare*, *Intech*. doi: <http://dx.doi.org/10.5772/57353>.
- Keers, R. N. *et al.* (2015) 'Understanding the causes of intravenous medication administration errors in hospitals: A qualitative critical incident study', *BMJ Open*, 5(3), pp. 1–10. doi: 10.1136/bmjopen-2014-005948.
- Kerrin, M. and Oliver, N. (2002) 'Collective and Individual Improvement Activities: the Role of Reward Systems', *Personal Review*, vol. XXXI, no. 3,

Mar, pp. 320-337.

KKPRS (2015) *Panduan Nasional Keselamatan Pasien Rumah Sakit*.

Kouchak, F. and Askarian, M. (2012) 'Nosocomial Infections: The Definition Criteria', *Iran Journal Med Sci*, 37(2), pp. 72–73. doi: 10.1053/jhin.1998.0550.

Liukka, M., Hupli, M. and Turunen, H. (2017) 'How transformational leadership appears in action with adverse events? A study for Finnish nurse manager', *Journal of Nursing Management*, 26(6), pp. 639–646. doi: 10.1111/jonm.12592.

Mansah, M. *et al.* (2014) 'Older Folks in Hospitals : The Contributing Factors and Recommendations for Incident Prevention', 10(3), pp. 146–153.

Manser, T. (2009) 'Teamwork and patient safety in dynamic domains of healthcare: A review of the literature', *Acta Anaesthesiologica Scandinavica*, 53(2), pp. 143–151. doi: 10.1111/j.1399-6576.2008.01717.x.

Marshall, D. C. and Finlayson, M. P. (2018) 'Identifying the nontechnical skills required of nurses in general surgical wards', *Journal of Clinical Nursing*, 27(7–8), pp. 1475–1487. doi: 10.1111/jocn.14290.

Martin, H. A. and Ciurzynski, S. M. (2015) 'Situation, Background, Assessment, and Recommendation-Guided Huddles Improve Communication and Teamwork in the Emergency Department', *Journal of Emergency Nursing*. Elsevier B.V., 41(6), pp. 484–488. doi: 10.1016/j.jen.2015.05.017.

Mayer, C. M. *et al.* (2011) 'Evaluating efforts to optimize team STEPPS implementation in surgical and pediatric intensive care units', *Joint Commission Journal on Quality and Patient Safety*. The Joint Commission, 37(8), pp. 365–374. doi: 10.1016/s1553-7250(11)37047-x.

McElroy, L. M. *et al.* (2015) 'Clinician perceptions of operating room to intensive care unit handoffs and implications for patient safety: A qualitative study', *American Journal of Surgery*. Elsevier Inc, 210(4), pp. 629–635. doi: 10.1016/j.amjsurg.2015.05.008.

McShane, Steven L. & Von Glinow, Mary Ann.(2008). " Organizational Behavior ". Fourth Edition. McGRAW-Hill International, United States of America.

Merrill, K. C. (2015) 'Leadership Style and Patient Safety: Implications for Nurse Managers', *Journal of Nursing Administration*, 45(6), pp. 319–324. doi: 10.1097/NNA.000000000000207.

Michel, P. *et al.* (2017) 'Patient safety incidents are common in primary care: A national prospective active incident reporting survey', *PLoS ONE*, 12(2), pp. 1–14. doi: 10.1371/journal.pone.0165455.

Mitchell, R. J., Williamson, A. and Molesworth, B. (2015) 'Use of a human factors classification framework to identify causal factors for medication and medical device-related adverse clinical incidents', *Safety Science*. Elsevier Ltd, 79, pp. 163–174. doi: 10.1016/j.ssci.2015.06.002.

- Mulyati, Lia., D. (2016) 'Faktor Determinan yang Memengaruhi Budaya Keselamatan Pasien di RS Pemerintah Kabupaten Kuningan Determinant factors that are Influencing Patient Safety Culture in a Government-owned Hospitals in Kuningan Regency', *Jurnal STIKes*, 4, pp. 179–190.
- Parker. 2018. TeamSTEPPS: An evidence-based approach to reduce clinical errors threatening safety in outpatient settings: An integrative review
- PERMENKES RI No. 1691. 2011. *Keselamatan Pasien Rumah Sakit*. Menteri Kesehatan Republik Indonesia
- Reason, J. (2008) *The Human Contribution: Unsafe Acts, Accidents and Heroic Recoveries*, CRC Press Taylor & Francis Group.
- Roig, C. et al. (2020). Implementation of a structured patient handoff between health care providers at a private facility in the Autonomous City of Buenos Aires. *Arch Argent Pediatr* 2020;118(3):e234-e240
- Russ, S. et al. (2013) 'Do safety checklists improve teamwork and communication in the operating room? A systematic review', *Annals of Surgery*, 258(6), pp. 856–871. doi: 10.1097/SLA.0000000000000206.
- Rutherford, J. S., Flin, R. and Irwin, A. (2015) 'The non-technical skills used by anaesthetic technicians in critical incidents reported to the Australian Incident Monitoring System between 2002 and 2008', *Anaesthesia and Intensive Care*, 43(4), pp. 512–517. doi: 10.1177/0310057x1504300416.
- Schulz, C. M. et al. (2016) 'Situation awareness errors in anesthesia and critical care in 200 cases of a critical incident reporting system', *BMC Anesthesiology*. *BMC Anesthesiology*, 16(1), pp. 1–10. doi: 10.1186/s12871-016-0172-7.
- Shubeck, S. P., Kanters, A. E. and Dimick, J. B. (2019) 'Surgeon leadership style and risk-adjusted patient outcomes', *Surgical Endoscopy*. Springer US, 33(2), pp. 471–474. doi: 10.1007/s00464-018-6320-z.
- Staggs, V. S., Mion, L. C. and Shorr, R. I. (2014) 'Assisted and unassisted falls: Different events, different outcomes, different implications for quality of hospital care', *Joint Commission Journal on Quality and Patient Safety*, 40(8), pp. 358–364. doi: 10.1016/S1553-7250(14)40047-3.
- Steelman, V. M. et al. (2019) 'Unintentionally Retained Foreign Objects: A Descriptive Study of 308 Sentinel Events and Contributing Factors', *Joint Commission Journal on Quality and Patient Safety*. The Joint Commission, 45(4), pp. 249–258. doi: 10.1016/j.jcjq.2018.09.001.
- Sugiyono. 2018. *Metode Penelitian Kuantitatif, Kualitatif, dan R&D*. Bandung: Alfabeta.
- Sutayana, D. N. (2018) *Analisis Hubungan Sikap Keselamatan Pasien dan Tipe Kepemimpinan dengan Insiden Keselamatan Pasien*, *Perpustakaan Universitas Airlangga*. doi: 10.1017/CBO9781107415324.004.
- Thomas, A. N. (2016) 'Patient safety incidents associated with failures in

- communication reported from critical care units in the North West of England between 2009 and 2014', *Journal of the Intensive Care Society*, 17(2), pp. 129–135. doi: 10.1177/1751143715626938.
- Thomas, L. *et al.* (2017) 'Impact of Interruptions , Distractions , and Cognitive Load on Procedure Failures and Medication Administration Errors', 00(00), pp. 1–9. doi: 10.1097/NCQ.0000000000000256.
- Uramatsu, M. *et al.* (2017) 'Do failures in non-technical skills contribute to fatal medical accidents in Japan? A review of the 2010-2013 national accident reports', *BMJ Open*, 7(2), pp. 1–7. doi: 10.1136/bmjopen-2016-013678.
- De Vries, E. N. *et al.* (2008) 'The incidence and nature of in-hospital adverse events: A systematic review', *Quality and Safety in Health Care*, 17(3), pp. 216–223. doi: 10.1136/qshc.2007.023622.
- Wallin, A. *et al.* (2018) 'Radiographers' experience of risks for patient safety incidents in the radiology department', *Journal of Clinical Nursing*, 28(7–8), pp. 1125–1134. doi: 10.1111/jocn.14681.
- Weller, J., Boyd, M. and Cumin, D. (2014) 'Teams, tribes and patient safety: Overcoming barriers to effective teamwork in healthcare', *Postgraduate Medical Journal*, 90(1061), pp. 149–154. doi: 10.1136/postgradmedj-2012-131168.
- Wigiyantoro, S. and Surya Darmawan, E. (2018) 'Medication Errors (MEs) in Several Countries: A Systematic Review', in *The 2nd International Conference on Hospital Administration, KnE Life Sciences*, pp. 329–339. doi: 10.18502/cls.v4i9.3583.
- World Health Organisation (WHO) (2016) *Transitions of Care: technical series on safer primary care*. Available at: <https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=F02F4867BC0581E4B21DE72B23FC0994?sequence=1>.
- Wundavalli, L. *et al.* (2018) 'Patient safety at a public hospital in southern India: A hospital administration perspective using a mixed methods approach', *National Medical Journal of India*, 31(1), pp. 39–43. doi: 10.4103/0970-258X.243415.
- Wung, C. H. Y. *et al.* (2011) 'Is it enough to set national patient safety goals? An empirical evaluation in Taiwan', *International Journal for Quality in Health Care*, 23(4), pp. 420–428. doi: 10.1093/intqhc/mzq093.