

DAFTAR PUSTAKA

- Antoninda, Dara Benedicta. Indasah. (2023). Team Work, Openness of Communication and Working Period for Reporting Patient Safety Events at the Regional General Hospital dr. ISKAK Tulungagung. Kediri. Indonesia.
- Abuosi, Aaron Asibi. (2022). *Safety culture and adverse event reporting in Ghanaian healthcare facilities: Implications for patient safety*. Brazil.
- Baker, G.R.; Norton, P.G.; Flintoft, V.; Blais, R.; Brown, A.; Cox, J.; Etchells, E.; Ghali, W.A.; Hébert, P.; Majumdar, S.R.; et al. (2004). *The Canadian Adverse Events Study: The incidence of adverse events among hospital patients in Canada*. CMAJ 2004, 170,1678–1686.
- Cady, R.F. (2008). “*Becoming a high reliability organization-operational advice for hospital leaders*” report. JONA’S Healthc. Law Ethics Regul. 10, 33.
- Hessels A, Paliwal M, Weaver SH, Siddiqui D, Wurmser TA. (2019). *Impact of patient safety culture on missed nursing care and adverse patient events*. J Nurs Care Qual. 34(4):287
- Buchholz, Steve. (2000). *Creating the High Performance Team*. Canada: John Wiley & Sons, Inc.
- Kohn, L.T.; Corrigan, J.M.; et al. (2000). *Building a Safer Health System*. National Academies Press: Washington, DC, USA.

- Gallego, B., Westbrook, M. T., Dunn, A. G., & Braithwaite, J. (2012). *Investigating patient safety culture across a health system: Multilevel modelling of differences associated with service types and staff demographics*. International Journal for Quality in Health Care, 24(4), 311–320. <https://doi.org/10.1093/intqhc/mzs028>.
- H. Koike, William B. Gudykunst, Lea P. Stewart, Stella Ting-Toomey, Tsukasa Nishida. (1988). *Communication openness, satisfaction, and length of employment in Japanese organization*.
- Pronovost PJ, Morlock LL, Sexton JB, Miller MR, Holzmueller CG, Thompson DA, et al. (2008). *Improving the value of patient safety reporting systems*. In: Henriksen K, Battles JB, Keyes MA, Grady ML, eds. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 1: Assessment)*. Rockville: Agency for Healthcare Research and Quality.
- Muhith, Abdul., & Siyoto, A. (2018). *Aplikasi Komunikasi Terapeutik Nursing & Healty*. Yogyakarta: CV. Andi Offset.
- Kirwan M, Matthews A, Scott PA. The impact of the work environment of nurses on patient safety outcomes: A multi-level modelling approach. Int J Nurs Stud 2013; 50:253–63. <https://doi.org/10.1016/j.ijnurstu.2012.08.020>.
- Kim HW, Kim MR. (2013). *Correlations between Perception Stress,*

Exhaustion, and Job

Satisfaction in Hospital Nurses. Advanced Science and Technology

Letters; 36:

73-7.

Available

from:

http://www.onlinepresent.org/proceedings/vol36_2013/17.pdf.

Mountford, J.; Marshall, M. (2014). *More Dialogue, More Learning, More Action.*

BMJ Qual.

Saf, 23, 89–91.

Kemendes RI. (2015). *Pedoman Nasional Keselamatan Pasien Rumah Sakit (Patient Safety).*

Edisi III.

Kemendes RI. (2017). *Peraturan Menteri Kesehatan Republik Indonesia Nomor 11 Tahun*

2017 tentang Keselamatan Pasien. Jakarta: Kementerian Kesehatan

Republik

Indonesia.

Kemendes RI. (2020). *Nomor 80 Tentang Komite Mutu Rumah Sakit.* Jakarta.

World Health Organization. (2020). *10 facts on patient safety.*

Qasim Al Ma'mari, et al. (2020). *Exploring Frequency of Event Reporting as*

Perceived by Intensive Care Unit Nurses in the Sultanate of Oman A quality improvement project. Oman.

Güneş ÜY, Gürlek Ö, Sönmez M. *A survey of the patient safety culture of hospital*

nurses in Turkey. Collegian. (2016) ;23(2):225–32. [https://doi.](https://doi.org/10.1016/j.colegn.2015.02.005)

[Org/10.1016/j.colegn.2015.02.005.](https://doi.org/10.1016/j.colegn.2015.02.005)

El-Jardali F, Dimassi H, Jamal D, Jaafar M, Hemadeh N. *Predictors and outcomes of patient safety culture in hospitals.* *BMC Health Serv Res.* (2011); 11(1):1–12.

Leavitt. Claremont and Stanford Universities. *Leavitt's Diamond Models.* Change

Management Models: Actionable Ways to Lead Organisational Change
(daniellock.com).

Simsekler ME, Gurses AP, Smith BE, Ozonoff A. (2019). Integration of multiple methods in identifying patient safety risks. *Saf Sci.*

Varallo Rossi Fabiana. (2018). *Incidents reporting: barriers and strategies to promote safety culture.* *Incidents reporting: barriers and strategies to promote safety culture - PubMed (nih.gov).*