

DAFTAR PUSTAKA

- Adam, E. (2013). Redesain Pelayanan DM tipe 2 Dengan Pendekatan Failure Mode and Effect Analysis di RSUD Prof. Dr. Kandou Manado. *Tesis: Minat Utama Manajemen Rumah Sakit Ilmu Kesehatan Masyarakat Pascasarjana Universitas Gadjah Mada*. Yogyakarta.
- Agency for Healthcare Research and Quality (2001). Making Healthcare Saver: a Critical Analysis of Patient Safety Practice. Available at: <http://archive.ahrq.gov/clinic/ptsafety/pdf/ptsafety.pdf>. Diakses pada tanggal 10 November 2015.
- Alamry, A., Al Owais, S., Marini, A.M., Al-Dorzi, H., Alsolamy, S., Arabi, Y. (2014). Application of Failure Mode Effect Analysis to Improve the Care of Septic Patients Admitted Through the Emergency Department. *Journal of Patient Safety*, 00.
- Australian Commission on Safety and Quality in Health Care (2011). *National Safety and Quality Health Service Standards*. Sidney: ACSQHC.
- Avidan, M., Barnett, K.M., Hill, L.L., Hopley, L., Jones, N.M., Schalkwyk, J. (2008). *Intensive Care*. Churchill Livingstone: Elsevier.
- Baruch, M. & Messer, B. (2012). Criteria For Intensive Care Unit Admission and Severity of Illness. *Critical Illness and Intensive Care*, 1.
- Carrol, R.L. (2009). *Risk Management Handbook for Health Care Organization*. San Fransisco: American Society for Health Care Risk Management.
- Chang, Y.N., Lin, L.H., Chen, W.H., Liao, H.I., Hu, P.H., Chen, S.F. *et al.* (2010). Quality Control Work Group Focusing on Practical Guidelines For Improving Safety of Critically Ill Patient Transportation in The Emergency Department. *Journal of Emergency Nursing*, 36 .
- Choi, H.K., Shin, S.D., Ro, Y.S., Kim, D.K., Shin, S.H., Kwak, Y.H. A. (2012). Before and After Intervention Trial for Reducing Unexpected Events During the Intrahospital Transport of Emergency Patients. *The American Journal of Emergency Medicine*, 30.
- Currie, V.L., Watterson, L. (2008). *Improving The Safe Transfer of Care: A Quality Improvement Initiative Final Report*. Oxford: RCN Learning & Development Institute.
- Darling Downs Hospital and Health Service (2014). *Clinical Governance Framework*. Available at <http://www.health.qld.gov.au/darlingdowns> Diakses pada tanggal 9 November 2016.
- Dehnavieh, R., Ebrahimipour, H., Molavi-Taleghani, Y., Vafae-Najar, A., Hekmat, S.N, Esmailzdeh, H. (2015). Proactive Risk Assessment of Blood Transfusion Process, in Pediatric Emergency, Using Health care Failure Mode and Effect Analysis (HFMEA). *Global Journal of Health Science*, 7 (1).
- Durak, V.A., Armagan., E., Ozdemir, F., Kahrman, N. (2015). Discharge of Emergency Patients to the Clinical Ward or Intensive Care Units: an Assessment of Complication and Possible Shortcomings. *Injury, Int. J. Care Injured*, 46

- Fanara, B., Manzon, C., Barbot, O., Desmettre, T., Capellier, G. (2010). Recommendation for the Intra-Hospital Transport of Critical Ill patients. *Critical care*, 14: R87.
- Farokhzadian, J., Nayeri, N.D., Borhani, F. (2015). Assessment of Clinical Risk Management System in Hospitals: An Approach for Quality Improvement. *Global Journal of Health Science*, 1 (5).
- Foronda, C., VanGraafeiland, B., Davidson, P. (2016). Handover and Transport of Critically Ill Children: An Integrative Review. *International Journal of Nursing Studies*, 62.
- Gray, A., Airey, M., Williams, R. (2003). Descriptive Epidemiology of Adult Critical Care Transfers from the Emergency Department. *Emerg Med*, 20.
- Griffin, F.A. & Resar, R.K. 2009. *IHI Global Trigger Tool for Measuring Adverse Events (Second Edition)*. Institute for Health Improvement: Cambridge, Massachusetts
- Halvorson, S., Wheeler, B., Willis, M., Watters, J., Eastman, J., O'Donnell, R. *et al.* (2016). A Multidisciplinary Initiative to Standardize Intensive Care to Acute Care Transition. *International Journal for Quality in Health Care*, 1.
- Harish, D., Kumar, A., Singh, A. (2015). Patient Autonomy and Informed Consent: The Core of Modern Day Ethical Medical. *J Indian Acad Forensic Med*, 37 (4).
- Institute of Medicine. 1999. *To Err is Human: Building a Safer Health System*. Available at <http://www.nap.edu/books/0309068371/html/> Diakses pada tanggal 9 November 2016.
- Jarden, R.J. & Quirke, S. (2010). Improving Safety and Documentation in Intrahospital Transport: Development of an Intrahospital Transport Tool for Critical patient. *Intensive and Critical Care Nursing*, 26.
- Joint Australian New Zealand International Standard (2004). Risk Management Guidelines Companion to AS/NZS 4360:2004. Standard Australia Ltd: Sydney.
- Joint Commission on Accreditation of Healthcare Organization (2005). *Failure Mode and Effect Analysis in Health care: Proactive Risk Reduction*. USA: Joint Commission Resources.
- Komisi Akreditasi Rumah Sakit (2012). *Instrumen Akreditasi Rumah Sakit Standar Akreditasi Versi 2012*. Jakarta: KARS.
- Knight, P.H., Maheshwari, N., Hussain, J., Scholl, M., Hughes, M., Papadimos, T.J., *et al.* (2015). Complication During Intrahospital Transport of Critically Ill Patients: Focus on Risk Identification and Prevention. *International Journal of Critical Illness and Injury Science*, 5.
- Kue, R., Brown, P., Ness, C., Scheulen, J. (2011). Adverse Events During Intrahospital Transport By a Specialized Team: A Preliminary Report. *Am J Crit Care*, 20 (2).
- Lago, P., Bizzarri, G., Scalzoto, F., Parpaiola, A., Amigoni, A., Putoto, G., *et al.* (2012). Use of FMEA Analysis to Reduce Risk of Error in Prescribing and Administering Drugs in Pediatric wards: a Quality Improvement Report. *BMJ Open*, 2.

- McElroy, L.M., Collins, K.M., Koller, F.L., Khorzad, R., Abecassis, M.M., Holl, *et al.* (2015). Operating Room to Intensive Care Unit Handoffs and The Risk of Patient harm. *Surgery*, 158.
- McSherry, R. & Pearce, P. (2011). *Clinical Governance: A Guide to Implementation for Healthcare Professionals Third Edition*. Wiley-Blackwell: UK.
- Nakayama, D.K., Lester., S.S., Rich, D.R., Weidner, B.C., Glenn, J.B., Shaker, I.J. (2012). Quality Improvement and Patient Care Checklists in Intrahospital Transfers Involving Pediatric Surgery Patients. *Journal of Pediatric Surgery*, 10 (30).
- National Risk Management Programme Departemen of Health (2007). *Best Practice in Managing Risk*. London: London Development Centre.
- Ookalkar, A.D., Joshi, A.G., Ookalkar, D.S. (2009). Quality Improvement in Haemodialysis Process Using FMEA. *International Journal of Quality & Reliability Management*, 26 (8).
- Ott, L., Hoffman, L.A., Hravak, M. (2011). Intrahospital Transpor to the Radiology Departement: Risk for Adverse Events, Nursing Surveillance, Utilization of a MET, and Practice Implications. *J Radiol Nurs*, 30.
- Pallares, M.V.D., Silveira, E.D., Accame, M.E.C., Vicedo, T.B. (2012). Using Healthcare Failure Mode and Effect Analysis to Reduce Medication Error in the Process of Drug Prescription, Validation and Dispensing in Hospitalised patient. *BMJ Qual Saf*, 0.
- Paparella, S. & Valley, H. (2007). Failure Mode and Effects Analysis: A Useful Tool for Risk Identification and Injury Prevention. *Journal of Emergency Nursing*, 3 (9).
- Parmentier-Decrucq, E., Poissy, J., Favory, R., Nseir, S., Onimus, T., Guerry, M., *et al.* (2013). Adverse Events During Intrahospital Transpor of Critical Ill Patients: Incidence and Risk Factor. *Annals of Intensive care*, 3 (10).
- Reinders, A.H.B., Arbous, M.S., Kulper, S.G., Jonge, E.D. (2015). A Comprehensive Method to Develop a Checklist to Increase Safety of Intrahospital Transpor of Critical Ill Patient. *Critical Care*, 19 (214).
- Sandlin, D. (2007). Improving Patient Safety by Implementing a Standardize and Consistent Approach to Hand-Off Communication. *Journal of Perianesthesia Nursing*, 22 (4).
- Shahrami, A., Rahmati, F., Kariman, H., Hashemi, B., Rahmati, M., Baratloo, A., *et al.* (2013). Utilization of Failure Mode and Effect Analysis (FMEA) Method in Increasing the Revenue of Emergency Department; a Prospective Cohort Study. *Emergency*, 1 (1).
- Shield, J., Overstreet, M., Krau, S.D. (2015). Nurse Knowledge of Intrahospital Transpor. *Nurs Clin N Am*, 50.
- Stalkhandske, E., DeRosier, J., Wilson, R., Murphy, J. (2009). Healthcare FMEA in the Veteran Health Administration. *Patient Safety & Quality Healthcare*.
- Stevenson, A., Fiddler, C., Craig, M., Gray, A. (2005). Emergency Department Organisation of Critical Care Transfer in the UK. *Emerg Med*, 22.

- Vazquez, A., Santiago-saez, A., Perea-Perez, B., Labajo-Gonzalez, E., Albarran-Juan, M.E. (2016). Utility of Failure Mode and Effect Analysis to Improve Safety in Suctioning by Orotracheal Tube. *Journal of PeriAnesthesia Nursing*, 10 (1-10)
- Warren, J., Fromm, R.E., Orr, R.A., Rotello, L.C., Horst, H.M. (2004). Guidelines for the Inter- and Intra-hospital Transport of Critical Ill Patients. *Crit Care Med*, 32 (1).
- Wasliyah, S. (2013). Analisis Faktor-faktor Yang Berkontribusi Terhadap Kejadian Tak Diharapkan Pada Pasien Kritis Selama Menjalani Transportasi Intra Rumah Sakit di RSUP dr. Hasan Sadikin Bandung. *Tesis: Ilmu Keperawatan Pascasarjana Universitas Padjajaran*. Bandung.
- WHO Collaborating Centre for Patient Safety Solution. (2007). Communication During Patient Hand-Overs. *Patient Safety Solution*, 1 (3).
- Winter, M.W. (2010). Intra-hospital Transfer of Critical Ill Patient; a Prospective Audit Within Flinders Medical Centre. *Anaesth Intensive Care*, 38.
- Yarmohammadian, M.H., Abadi, T.N.H., Tofighi, S., Esfahani, S.S. (2014). Performance Improvement Through Proactive Risk Assessment: Using Failure Modes and Effects Analysis. *Journal of Education and Health Promotion*, 3 (28).
- Yousefinezhadi, T., Nobari, F.A.J., Goodari, F.B., Arab, M. (2016). A Case Study on Improving Intensive Care Unit (ICU) Services Reliability: By Using Process Failure Mode and Effect Analysis (PFMEA). *Global Journal of Health Science*, 8(9).