Improving OVA incident investigations

Preventing and responding to occupational violence and aggression in Victorian health services

30 June 2017
Why focus on OVA incident investigations?

Incident investigation has been identified as an area that needs immediate attention to reduce OVA in our hospitals.
We can change things

There are always things that can be done to reduce the likelihood or severity of an OVA incident.

There is opportunity for prevention through improved investigation.
Pilot project: OVA Incident Investigation Tool

Process:

Step 1: Tool development

Step 2: Pilot the tool in hospital wards

Step 3: Develop the tool into WorkSafe guidance
Why a tool?

To help Unit Managers (UMs) and Assistant Unit Managers conduct effective OVA incident investigations and improve:

- identification of contributing factors
- formulation and implementation of appropriate controls/actions to prevent recurrences of OVA
- communication
Pilot version of OVA incident investigation tool

- Quick and simple to use
- Lots of checkboxes
- Prompt questions
How we developed the tool

Spoke with nurses, UMs, and OHS managers in metro and regional hospitals

Considered leading incident investigation theories, systems and processes

Consulted with the ANMF

Consulted with WorkSafe inspectors and experts in OVA and in incident investigation

Tested draft versions with nurses and UMs
Process for incident investigation

1. Wellbeing is confirmed
2. Details of event are sought and **contributing factors** are identified
3. **Existing measures** that should have prevented the incident are reviewed
4. **Improved or additional measures** to prevent a similar incident are identified
5. Staff with **responsibility for implementing** these measures are informed/sign-off
6. Information about the incident and control measures are **communicated** to all relevant staff (e.g., reporting/other nurse, management, OHS)
Benefits of using this tool

- Increased effectiveness of OVA incident investigations leading to **prevention** of recurrences
- Increased **awareness** of OVA
- Increased belief that OVA is not acceptable and can be **prevented and managed**
The tool is to guide Unit Managers to conduct their investigation.

It does not change the way that the results of an investigation are recorded.
Step 2: Pilot the tool

The **tool has been trialled** for four months in nine acute wards across:

- Frankston Hospital
- Knox Private
- the Royal Women’s

Our research partners at BehaviourWorks (Monash University) have **collected feedback** from participating Unit Managers & OHS teams as well as nurses

BehaviourWorks are **evaluating the feedback and preparing recommendations** on how we further develop and release the tool

Thank you!
What happened during the pilot?

Nurses in pilot wards completed surveys before and after introduction of the tool, focused on:

- type and frequency of OVA they experienced
- their reporting of OVA incidents
- attitudes towards OVA
- perceptions of management response to OVA incidents

Unfortunately, we had a low response rate to surveys

- it will be difficult to draw firm conclusions about the impact that use of the tool by Unit Managers had on nurses
What happened during the pilot?

Unit Managers in pilot wards:

• attended a **briefing session** to learn about the project and how to use the tool.

• were encouraged to **use the tool** as a prompt to guide them when they investigated OVA incidents that took place on their ward.

• participated in an **interview** at the end of the pilot period, to share their experience with us and provide feedback on the tool.
What happened during the pilot?

Some positive quotes about the tool from Unit Manager and OHS interviews included:

“culture has changed in [the ward]… they are reporting more and are more aware of the process”

“…takes away looking at the behaviour only and makes you look at the reasons behind it”.

“regardless what level of management you are it gives you things to consider”

“good prompts in this section”
What happened during the pilot?

Barriers to using the tool included:

- “…purely a time factor”
- “…it’s just the staff don’t report the incidents”
- “…need some training on actually how to do this sort of thing”

Suggestions to improve the tool included:

- “really it is a space issue”
- “…the more streamlined you can make it the better”
- “like to see any investigation tool incorporated into the reporting system”
Step 3: We are now working with our research partners to:

- Measure the tool’s impact
- Make some improvements
- Release the tool as WorkSafe guidance
As the tool is adopted within Victorian hospitals, we expect to see a reduction in the:

- reporting of OVA incidents
- number of OVA incidents
- severity of OVA incidents
Working together for ... 

Better investigation using tool 

Better incident prevention and management 

Reduction in staff stress 

Safer ward environment 

Reduction in patient/visitor stress
Other WorkSafe activity focused on OVA incident investigation

• **Inspectorate visits:** focusing on review of risk control undertaken by managers following an OVA incident or report of an MSD
  
  > What has the employer done post-incident to prevent a similar incident recurring?

• **Guidance:** refresh of WorkSafe’s key guidance for OVA in health services has included an update of the section on incident investigation
  
  > Future updates to this guidebook will incorporate or refer to this tool