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RESEARCH ARTICLE

Exploring the Utility of a Novel Approach of Evaluating Application of a Validated Violence Risk Assessment Instrument

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ABSTRACT

Mental health nurses are often responsible for assessment/management of inpatient aggression. Validated instruments such as the Dynamic Appraisal of Situational Aggression (DASA), can aid risk assessment. However, limited attention has been paid to evaluating nurses' ability to administer risk assessment instruments. An entrustable professional activity may offer way of evaluating risk assessment clinical activities. DASA trainers' perceptions of the value and utility of an EPA were explored via collection of data through focus groups, with 17 participants from six countries. Thematic analysis was conducted to analyze the data. Three themes were interpreted: (1) DASA trainers-a way of knowing and being (2) An EPA-something you did not know you need until you see it; (3) The DASA-EPA supports the need for training and importance of integrity in assessment. Trainers engaged in innovative ways to ensure training is suitable and responsive to needs of nurses and their setting. Participants understood how an EPA could be used to evaluate DASA administration, monitor DASA use, provide feedback, and highlight the importance of training to ensure best practice.

1 | Introduction

Inpatient aggression is a persistent challenge for staff and health services, often resulting in a range of negative outcomes at the individual (consumer and staff), unit and service level (Lamanna et al. 2016). The presence of inpatient aggression has highlighted the importance of risk assessment, and mental health nurses are often charged with the critical tasks of assessment, prevention, and management of inpatient aggression (Ezeobele et al. 2019; Maguire et al. 2018; Nyman et al. 2019; Trenoweth 2003). Instruments and frameworks to assist can vary, ranging from locally derived processes to the use of evidence-based instruments and frameworks. Risk assessment instruments designed at the local service level may not be reliable or valid (Haque 2016), and for this reason validated risk assessment instruments have been developed to support the day-to-day assessment of violence risk (Ramesh et al. 2018). Instruments such as the Dynamic Appraisal of Situational Aggression (DASA, Ogloff and Daffern 2006) have been designed to appraise risk of imminent aggression (within the next 24 h) in mental health units. The DASA is a seven-item (irritability, impulsivity, unwillingness to follow instructions, sensitive to perceived provocation, easily angered when requests are denied, negative attitudes, and verbal threats) actuarial risk assessment instrument that has consistently demonstrated good predictive validity (see Dumais et al. 2012;

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Summary

- There are competencies for many clinical activities mental health nurses undertake; however, to date there have been no formalized method of evaluating administration of short-term risk assessment.
- Assessing a nurses' ability to administer validated short-term risk assessment is important; as with any risk assessment instrument, it is important that the assessment is carried out properly to ensure best practice; however, some aspects of the assessment are relatively complex.
- Entrustable professional activities may offer an alternative method for describing and evaluating clinical practice activities and can incorporate the dynamic nature of professional activities such as administration of violence risk assessment and support the need for training and integrity in assessment.

Maguire et al. 2017; Vojt, Marshall, and Thomson 2010), has been recommended for use in assessing and managing the risk of violence and aggression in the National Institute of Health and Care Excellence (NICE) guidelines (2015), and received an Australian award for Clinical Excellence and Patient Safety (Australian Council on Healthcare Standards, 2020).

Each DASA item is rated as either 0-absent, or 1-present. The summed score of 0 reflects a low risk of aggression, a score of 1, 2, or 3, indicates the risk of aggression is moderate, and scores of 4, 5, 6, or 7 signify a high risk of imminent aggression. In practice the DASA assessment is usually conducted by nurses (Daffern and Ogloff 2020), and on acute units often completed daily often around midday to inform the next shift and to assist in making decisions about intervention. Assessment relies upon raters having sufficient opportunity to interact with the consumer to understand their current risk state. Ratings are made following a review of background information that includes clinical records (for the previous 24 h), consultation with other staff, handover from the previous shift, as well as interacting with the consumer. Comprehensive assessment incorporating information from different sources produces a more valid assessment. Where there is confusion or disagreement about the level of risk, consultation with other members of nursing may also be helpful (Daffern and Ogloff 2020).

Risk assessment by itself, however, is not enough to prevent an act of aggression, for this reason, the aggression prevention protocol (APP; Maguire et al. 2019) was designed to be used in conjunction with the DASA, to provide nurses with guidance about how to intervene to prevent violence for patients presenting with different levels of risk. Different interventions (there are seven in total in the APP which are: one-to-one nursing, reassurance, distraction, de-escalation, limit setting, close observation, and use of as needed medication) are suggested according to whether the person is assessed as being in the low, moderate or high risk DASA band. Testing of the DASA+APP has produced reductions in aggression, use of PRN medication and use of restrictive practices (see Griffith et al. 2021; Maguire et al. 2019).

To enhance the implementation of the DASA+APP assessment of a nurse's ability to appraise administration of the DASA, and application of the interventions as suggested in the APP is also critical to ensure appropriate application. Some components of DASA assessment and APP intervention can be considered as relatively straight forward activities (e.g., reading the last 24 h of clinical documentation for the DASA assessment, and engaging consumers in distraction techniques; however, some can be considered more complex clinical activities such as limit setting and de-escalation) (Maguire, McKenna, and Daffern 2022; Maguire et al. 2023), which may make assessment using traditional competency-based standards difficult. Competency-based assessment has been prominent in healthcare teaching curricula, but this type of framework may lack practical value in the clinical setting and provide challenges for assessors when marking learners against traditional competency measures (Hawkins et al. 2015; ten Cate 2016).

1.1 | Entrustable Professional Activities

Entrustable professional activities (EPAs) offer an alternative method for describing and evaluating clinical practice activities carried out by competent health care professionals (Bramley and McKenna 2021; Croft et al. 2020; Lau et al. 2020). An EPA translates practice proficiencies (or competencies) into observable and measurable clinical practice activities by integrating multiple competencies (Hennus et al. 2022; Shorey et al. 2019). An EPA is well-suited for evaluating practice due to the ability to encompass the complexity and unpredictability of the clinical context. Mental Health environments are often dynamic and unpredictable, requiring nurses to adapt to changing circumstances and diverse consumer needs. An EPA can incorporate the dynamic requirement of professional activities and offer a practical and flexible framework for assessment. This approach allows for a more accurate evaluation of a nurse's capability to handle the multifaceted and evolving challenges inherent in mental health settings. The authorization to provide healthcare indicates entrustment, and decisions of entrustment are the link between a nurse's readiness for the task and the task execution (ten Cate and Schumacher 2022). Assessing a nurses' ability to administer DASA is important; as with any risk assessment instrument, it is important that the assessment is carried out properly, as the assessment information is used to inform intervention. This manuscript describes a study conducted to explore the potential utility of the DASA-EPA and to determine if the EPA framework is a suitable method to evaluate nurses' ability to administer the DASA.

The EPA was drafted (see Table 1) according to the Association for Medical Education Europe (AMEE) Guide No. 99. This guide provides a recommended description of an EPA (ten Cate 2016). A scale of entrustment was then developed (see Table 2), which serves to operationalize the progressive autonomy of the nurse (ten Cate, Schwartz, and Chen 2020). The DASA-EPA was then mapped against Standards of Practice for Australian Mental Health Nurses Australian College of Mental Health Nurses (ACMHN 2010) and Forensic Mental Health Nursing Standards of Practice (Martin et al. 2013) (see Table 3 to describe the competence level of nursing care required to administer the DASA). A manual titled: "Entrustable Professional Activities for the

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TABLE 1 | Entrustable professional activity for administering the DASA in clinical practice.

Required knowledge, skills, attitudes, and experiences to allow for entrustment in DASA administration

Knowledge

The mental health nurse demonstrates an understanding of:

1 The purpose of undertaking a DASA assessment and why assessment needs to be followed by intervention.
2 Effective observation and communication skills that can be used to observe and engage the consumer.

Skills

The mental health nurse:

1 Establishes and maintains a therapeutic relationship with consumers while incorporating person-centered, gender sensitive and culturally sensitive practice principles.
2 Reviews the consumer's notes (for the last 24 h) to determine if there has been any evidence of the presence of the seven DASA items (irritability, impulsivity, unwillingness to follow directions, sensitivity to perceived provocation, easily angered when requests denied, negative attitudes and verbal threats).
3 Engages with the consumer and interacts with them to understand their current state.
4 Consults with other staff to determine the consumer's current state (including any information gathered about the consumer during handover).
5 Uses assessment skills including observation of the consumer on the unit and with others.
6 Documents the DASA assessment including the rationale and any recommendations for intervention.

Attitudes

The mental health nurse:

1 Values validated risk assessment instruments in guiding nursing practice.
2 Values and works with consumers to identify their needs.
3 Recognizes that an escalation in risk is a signal that the person is unsettled, strives to work collaboratively to understand their personal concerns and works collaboratively to help resolve these concerns.

Information sources for assessors to establish progress and support entrustment

Approaches	**Methods**	**Tools**
Observing	Focused observation of the consumer including their behavior and interactions with others	Direct observation of the consumer using nursing observation skills
Engaging	Engaging with the consumer to determine their current state Engaging with other relevant staff and/or families and carers to determine a consumer's current state	Using nursing therapeutic engagement skills
Reviewing	Reviewing the past 24 h of clinical documentation searching for any presence of DASA items	Entries in the consumer's clinical file using the DASA rating sheet

TABLE 2 | Scale of entrustment for DASA administration.

Level of entrustment	**Level descriptor: The learner has demonstrated a readiness to work in the practice setting with the following level of trust**
Level 1	I trust the nurse, under direct supervision and with assistance, to carry out the DASA assessment within the inpatient setting. The nurse accepts feedback for performance improvement.
Level 2	I trust the nurse to carry out the DASA assessment with guidance but without direct supervision or assistance.
Level 3	I trust the nurse to carry out the DASA assessment independently.
Level 4	I trust the nurse to carry out the DASA assessment and that they have mastered the skill such that they would be considered a good role model for other nurses in DASA assessment.

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TABLE 3 | Nursing practice standards mapped against DASA-EPA.

The EPA is based on assessment using the DASA	Explanation	Map to Standards of Practice for Australian Mental Health Nurses (2010) and the FMHN standards (2012)
Essential as part of assessment to prevent and manage aggression	Nurses have a key role in the prevention and management of aggression. By using a valid risk assessment instrument nurses can assess the level of risk and consider appropriate strategies that may be used to prevent aggression and reduce the use of restrictive interventions.	MHN standard 2, 3, 4, 7, 8, 9 FMHN standard 3, 5, 7, 8, 12, 15
Require adequate knowledge, skills and attitudes	Nursing assessment to prevent and manage aggression requires a combination of knowledge, skills and attitudes to assess risk, intervene appropriately and document the outcomes.	Standards 1, 2, 3, 4, 7, 8, 9 FMHN standards 3, 5, 6, 7, 8, 9 12, 15
Observable and have a measured output	The level of risk needs to be assessed by receiving a handover from the previous shift, reading clinical documentation from the past 24h, and observing and engaging the consumer. Documentation of the assessment needs to be accurate.	Standards 2, 3, 4, 7, 8, 9 FMHN standards 5, 8, 15

Dynamic Appraisal of Situational Aggression" was also developed to provide information about the DASA, an introduction to Entrustable Professional Activities, the DASA-EPA scale of entrustment and the details of the DASA-EPA.

2 | Materials And Methods

2.1 | Study Design

This study used a descriptive qualitative design via the collection of data through focus groups with expert DASA trainers. This approach was employed as there is no research on the use of an EPA with risk assessment instruments. The Enhancing the QUAlity and Transparency of Health Research (EQUATOR) network recommendations for qualitative research have been used for reporting by using the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury, and Craig 2007). The ethics approval was from Swinburne University of technology's human research ethics committee. Data were collected from November to December 2023.

2.2 | Participants

Purposeful sampling was used to identify people ($n=30$) with expertise and recent experience (past 2 years) in training nurses how to use DASA. Seventeen DASA trainers from 11 different services participated in one of two focus groups. One focus group featured $n=8$ Australian DASA trainers (from the states of Victoria, $n=5$; and Tasmania, $n=3$; $n=2$ males, and $n=6$ females). The other focus group included nine international DASA trainers (from Canada $n=3$; the USA, $n=2$; the UK $n=1$; Finland $n=1$; and the Netherlands $n=1$; $n=5$ males and $n=4$ females), from 11 different services. The trainers' involvement in teaching the DASA ranged from 18 months to 10 years. There were various clinical settings in which the participants had taught the DASA, including generalist mental health settings, forensic mental health settings, emergency departments, intensive care units, and medical units.

Participants were identified by searching an email folder kept by MD with people who had been in contact regarding the DASA in the 2 years prior to commencement of the study. An email describing the study was sent to eligible participants. Informed consent was gained using electronic consent forms, where DASA trainers returned the signed consent form via email, prior to attending the focus group. Five working days before the focus groups, participants were sent a copy of the DASA-EPA manual and the focus group questions. They were asked to read the manual prior to attending the focus group. The participants were selected because of their knowledge and expertise using and teaching the DASA in practice. The researchers all have qualitative research experience and researchers TM, MD and BM have expertise in DASA training and research, and GW has experience in nursing education and assessment.

2.3 | Data Collection

Data were collected via the two focus groups using the online conferencing application Microsoft Teams. A focus group guide was developed and followed during the focus groups. The guide sought to elicit if, and how DASA administration is assessed, and thoughts on the proposed DASA-EPA and EPA assessment scale. The focus groups commenced with an introduction to the DASA-EPA and the researchers investigated whether participants were familiar with EPAs, before inquiring about the DASA-EPA and the manual. The focus group comprising Australian participants lasted 55 min and the focus group with international participants lasted 70 min. Both focus groups were audio-recorded with permission from the participants and then transcribed verbatim for analysis. TM Moderated and BM monitored both focus groups.

2.4 | Data Analysis

Data were thematically analyzed utilizing the six-stage steps recommended by Braun and Clarke (2019). Firstly, the audio file was professionally transcribed. After this, TM (nursing

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academic with experience conducting research related to the DASA and EPA) checked the transcripts against the audio files to ensure accuracy. The transcripts were then analyzed separately by BM. Following familiarization with the data, codes were developed, where similar accounts were labeled by assigning codes using Microsoft Word. Computer aided data analytic software was not used. The codes were then discussed together by TM, MD, GW and BM. The codes were then categorized into potential themes, and then further reviewed in relation to the coded extracts, followed by the full dataset. The full research team then discussed and identified the final themes. Changes were made to the codes and themes following this discussion. Writing this paper was the final step. Authors TM, MD and BM have mental health experience, GW has educational expertise, and all authors have qualitative research experience.

3 | Results

Before presenting the results, it is worth noting that none of the participants in this study reported using any formal means of evaluating the ability of nurses at their service to administer the DASA. The participants noted that there were, however, a range of competencies for other clinical activities such as mental state examinations and medication administration that were relevant to this task. Most participants reported that the DASA training provided was often substituted with the online DASA training video developed by MD and TM, or with service specific online training modules or face-to-face training and/or consultation.

Three themes were interpreted from the data: (1) DASA trainers-a way of knowing and being (2) EPAs, something you do not know you need until you see it and (3) The DASA-EPA supports the need for training and importance of integrity in assessment.

3.1 | Theme One: DASA Trainers-a Way of Knowing and Being

Participants reflected on how they worked to engage nurses to train them in the administration of the DASA. Participants from both focus groups outlined a wide array of innovative techniques and skills which they used to ensure training met the needs of their intended audience. From their perspective, DASA trainers need to have a sound knowledge of risk assessment and management and be up to date with the latest research regarding the DASA, as can be seen from the following quotes.

> "You do need to know what aggression is, what is violence risk, what is structured professional judgment, what is the theory behind aggression, what do you assess and what's the consequence of assessing" (P12).

> "We as trainers need to have a theoretical understanding, and an expectation as trainers to be up to date with the research and what's coming out, for example, when the DASA risk bands changed, we made sure we disseminated that knowledge" (P6).

> "We are the holders of the most up to date evidence-based practice, and any kind of changes" (P5).

Participants suggested being a DASA trainer is not something that everybody can do. For example, one participant stated, "obviously our skillset varies quite considerably (within the service) so, I'd be hesitant to be open slather on everyone being able to be a DASA trainer" (P4). This is an indication of a need for certain knowledge and skills required as a DASA trainer. Participants in this study demonstrated leadership and innovation in their ability to work with clinicians to engage them in training, workforce development, and daily use of the DASA.

> "One of the important things was ensuring we did face-to-face training … there is so much learning taken from each environment that's actually increased our understanding of how DASA can work. So, I'll go visit a ward, and we'll look at some of the issues surrounding the DASA." (P11)

> "We can be contacted by the Unit Managers to do what we call a DASA Q&A. The idea is it's specific for the unit. You might have a particular person who is struggling to rate. We'll have conversations about rating it correctly, how we are doing the interventions, why that person's staying low and not being rated. It's very specific to the unit and the person" (P5).

The participants often used DASA data to inform their training and education.

> "I'll look at the data on that ward … what we do is try and make the training live and incorporate the patients that are on the ward at the time" (P11).

> "The auditing (of the DASA) is usually six to 12 months, and then we will train staff using the audit recommendations" (P6).

> "I put a logbook on the unit also in training as another strategy, and I said this is a logbook, it's free to fill in any comments or any questions you have. I will take any comment serious. This logbook, it gave me some new insights on my blind spots as an expert" (P12).

Participants also spoke of working together as a group of trainers to hold debrief sessions to discuss the DASA and any associated practice issues, such as scoring the DASA.

> "We do have a core group, those five people who come weekly to meet together to talk about what's

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> going on, and the ratings and how to handle certain scenarios so that we can then look across the system and say these ratings are reliable between raters" (P15).

Finally, participants spoke of how they worked to ensure collaboration with consumers and, in some instances, ensuring current consumers were provided with DASA training.

> "We've trained patients in the past ... so they can help in a collaborative approach to do a support chart for the care team. So, these things really come about when you really understand your ward and your ward populations and the dynamics around that" (P11).

The participants in the focus groups conveyed their dedication to ensuring that DASA in their service was administered correctly, staff (and consumers) were kept up to date, that trainers were actively involved across the service, and at a unit and individual level to engage and lead practice. There was a sense that their role as a DASA trainer was much more to them than just a commitment to the provision of formal training. Participants were enthusiastic about their role, they also suggested DASA can assist practice, and they were committed to ensuring best practice in their services.

3.2 | Theme Two: DASA-EPA-Something You Did Not Know You Needed Until You See It

Most of the participants were unfamiliar with the EPA framework. Despite being unfamiliar, there was a perception that the DASA-EPA was something they could incorporate into their training in a variety of ways. One of the participants stated, "I didn't realize that it (DASA-EPA) was something that we needed, and then, after reading the DASA-EPA, I was thinking, why don't we have something like this? It was so straightforward to use" (P2). Participants agreed there was a need for a way of evaluating nurses use of DASA to ensure quality and integrity of the assessments. There was also interest in the shift from traditional competencies.

> "I got really excited because traditionally, competencies were heavily used, especially for entry to practice for nursing and traditionally mental health, and it was really hard to quantify or explain the behaviour, and how you demonstrate that you observed a certain approach" (P14).

Participants also recognized several ways the EPA could be used in practice, which included supporting and monitoring other trainers, observation and feedback to novice nurses, and identification of the required knowledge, skills, and attitudes.

> "I like how it (the DASA-EPA) does identify the knowledge, skills and attitudes, and really like the rating scale. It gives me some kind of a tool or path forward to help qualify where our raters are on a continuum and then selectively intervene ... I could use it to monitor or give them additional training" (P15).

> "The curriculum (DASA EPA manual) is very feasible in terms of anyone who actually knows how to score or do the DASA properly. Then they're able to actually observe how the novice people are doing and then they can give the feedback. So, it is a very straightforward kind of thing" (P3).

3.3 | Theme Three: DASA-EPA Supports the Need for Training and Importance of Integrity in Assessment

The final theme relates to how the DASA-EPA may support the integrity of DASA assessments. Participants commented that there is a level of complexity involved in risk assessment and the EPA made "it clear that risk assessment is not a quick trick" (P12). At times, it was reported that short-term risk assessment can be viewed by some as a "tick box exercise" (P11). Participants highlighted complexities such as being unaware of "unconscious bias" (P6) while undertaking the assessment, or not understanding the items in the DASA, leading to incorrect ratings. The EPA was seen as a method that may help maintain the integrity of DASA assessments by allowing for assessment of the rater, while also highlighting the importance of training.

> "Many units are using (another risk assessment framework) and there is no training for that. And I know in some papers it says that minimal, or no training is needed. "It's so easy to use", but it is not. I know many units that have started to use (another risk assessment framework), In most cases they have discontinued because they don't have a clue what they are doing or if they continue the use, they are just ticking that box. They are not thinking what they are doing. The DASA-EPA gives the value that really this requires knowledge and skills and experience" (P9).

To further support the implementation of the DASA-EPA, the trainers also suggested some changes to the DASA-EPA manual. These included mapping the EPA against the standards of practice common to all nurses, because the DASA is also being used in generalist health settings, and not just mental health and forensic mental health settings. They also suggested there is a section for self-reflection.

4 | Discussion

This study explored international expert DASA trainers' perceptions of the value and utility of the DASA-EPA, to determine if the EPA framework may be a suitable method to evaluate nurses' ability to administer the DASA. The participants in this study described a range of skills and techniques they used to train nurses in the administration of the DASA to ensure best practice. The participants took the responsibilities of their role as a DASA trainer seriously in their everyday work and were committed to ensuring others had the necessary skills to undertake DASA assessments.

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The different teaching and learning strategies the participants used, aligns with the six core strategies (Huckshorn 2005) used to reduce restraint and seclusion leadership toward organizational change, using data to inform practice, workforce development, use of restraint reduction tools, consumer roles in inpatient settings, and debriefing techniques (Crisis Prevention Institute 2024). For example, the participants demonstrated leadership by attending the unit and engaging people in their workplace to work through current practice examples, and by analyzing and using DASA data to understand real time practice. They also responded to questions about administering DASA. The trainers also worked with staff (and consumers in some instances) to develop the skills of the workforce in a range of ways; for example, running Q&A sessions, one-to-one bespoke training, using logbooks to capture issues as they arise, using the DASA and its associated practice to debrief one another, ensuring consumer involvement in the DASA training where services engaged consumers in their DASA assessments, and finally, using the DASA (and often linked to the APP) as a restraint reduction tool. Using a variety of active methods to engage staff may assist in ensuring success by highlighting how administration of the DASA is clinically relevant and useful for nursing practice. Increasing workforce capability in evidence-based practice (such as administering the DASA and then structuring interventions) is necessary. Evaluation of training approaches for evidence-based practice suggests that didactic approaches alone are insufficient for skill acquisition and competent delivery of evidence-based practice. Rather, active, experiential training in conjunction with expert consultation while applying the evidence-based care with consumers is needed for optimum outcomes (Orfaly et al. 2005; Triplett et al. 2020; Yarber et al. 2015). The EPA was seen as enabling the assessment of the necessary knowledge, skills and attitudes required by nurses.

The trainers in this study recognized the initial introductory training of the DASA was insufficient, and there was a need for local practice setting issues to be addressed at the individual and unit level. Previous studies have also suggested that a considerable benefit of training is that local trainers have a greater understanding of contextual issues relevant to violence and violence risk assessment, and they can use their relationships with nurses to train effectively. They can also share application of evidence-based practice (such as real-world examples of using the DASA) and provide solutions for practice challenges in the same setting as the learner (Triplett et al. 2020).

Current nursing education predominantly uses a time-based method of assessment, where clinical skills are assessed based on exposure to the task over a defined period of time, rather than through actual observation of the person's knowledge, skills, and attitudes in the clinical settings (Wagner, Dolansky, and Englander 2018; Zhou et al. 2022). The EPA offers an evaluation approach to assessing practice that allows for the observation of complex practice activities to determine capability. The EPA is not limited to one skill, rather encompasses the dynamic nature of professional activities such as the DASA. In this regard, even though trainers were unfamiliar with an EPA, their expertise in the clinical setting enabled them to see the benefit of such a framework in their teaching practices to assess a nurse's ability to administer the DASA, and to provide feedback following the initial training, while in the clinical setting.

4.1 | Limitations and Strengths

This study involved participants from various countries and various settings, including medical units and emergency departments, where there is currently limited exploration of the use of the DASA. The generalizability of these findings to other countries and settings not represented in this paper will need to be determined by experts in these settings. A key strength of this study was involvement of expert trainers who hold extensive knowledge and expertise in DASA training. Importantly, this study did not include the opinions of the consumer/career workforce. Refinement of the DASA-EPAs has been planned. A key task is to work with consumer, family and career consultants to ensure inclusion of their perspectives, this is part of our ongoing work.

5 | Conclusion

Preventing aggression and limiting the use of restrictive practices is essential work for mental health nurses. Validated risk assessment instruments can assist nurses with this task. To date, there has been no formalized method of assessing nurse's ability to administer the DASA. An EPA for the DASA may provide a suitable framework to outline the necessary skills, knowledge and attitudes required, while also providing opportunity for DASA trainers to monitor and provide feedback to nurses at an individual and unit level. An EPA may also support nurses need to be provided with unit-based introductory/initial and follow-up training, which takes into account the context in which they work. Expert trainers in this study reported use of a range of leadership, debriefing, data analysis, training development and consumer inclusion techniques while training nurses in the use of DASA to assist in the reduction of restrictive practices. Trainers were of the opinion the DASA-EPAs offered a framework to address a practice-gap and facilitate evaluation to ensure evidence-based practice is implemented and embedded.

5.1 | Relevance for Clinical Practice

Competencies can appear detached from clinical activities, and as such EPA were developed to create a connection between competencies and the clinical activities to be entrusted clinicians (ten Cate and Scheele 2007; ten Cate and Taylor 2021). Participants in this study were excited to see a shift away from traditional competency-based assessment and could see benefit in the EPA outlining the necessary knowledge, skills and attitudes needed to conduct a DASA assessment. Participants identified that they could use the EPA framework to enhance the work they were already undertaking. The way in which the DASA EPA has been documented and structured may also provide a clear template for other clinicians/educators/researchers wanting to develop EPAs in other areas.

Another identified advantage of an EPA was how it highlights the importance of training and the need to maintain integrity

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of assessment. Often the cost of providing training, as well as resourcing to take staff away from the clinical setting to attend training, has been an impediment to embedding clinical activities into practice (Alatawi et al. 2020). It can be argued that some level of training and oversight is needed for the administration of instruments such as the DASA. Risk assessment instruments have a more valuable impact when services use careful implementation approaches and provide nurses with training and guidance for risk management. This highlights the importance of training and ongoing support (Viljoen, Cochrane, and Jonnson 2018), which may be complemented by the use of the DASA-EPA.

Author Contributions

Tessa Maguire: conceptualization, investigation, writing – original draft, methodology, validation, visualization, writing – review and editing, project administration, data curation. **Michael Daffern:** conceptualization, investigation, methodology, visualization, validation, writing – review and editing. **Georgina Willetts:** conceptualization, investigation, methodology, validation, visualization, writing – review and editing. **Brian McKenna:** conceptualization, investigation, methodology, validation, visualization, writing – review and editing.

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Conflicts of Interest

Michael Daffern is a co-author of the Dynamic Appraisal of Situational Aggression (DASA). The DASA manual is sold by the Centre for Forensic Behavioural Science (CFBS). Profit from these sales are held in a CFBS account and used to support DASA research. The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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