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Assessing nurses performance on a violence risk assessment instrument paired with structured intervention guidelines to prevent aggression

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Abstract

Background Forensic mental health nurses are responsible for maintaining safety and ensuring a positive therapeutic climate, in complex secure settings, where aggression occurs frequently. A validated risk assessment instrument, the Dynamic Appraisal of Situational Aggression (DASA), paired with a structured Aggression Prevention Protocol (APP) have been associated with reduction in aggression and restrictive practices. However, limited attention has been paid to evaluating the assessment methodologies used to support forensic mental health nurses learning to apply DASA + APP. The aim of this paper is to explore Entrustable Professional Activities (EPAs) as a teaching and assessment framework for supporting learning and appraisal of performance of DASA + APP.

Methods An EPA framework was developed for DASA + APP and trialled using simulation in two separate but linked studies. Participants had the opportunity to complete the DASA assessment (study one) and apply interventions (study two) derived from the APP in a simulation. The EPA framework was used to examine how effectively the EPA captured the processes involved in risk assessment and associated intervention decision making. Data were collected in focus groups and analysed using thematic analysis.

Results Participants recognised how an EPA framework could be used to structure assessment conversations, support reflective learning, and clarify expectations for practice. Participants appreciated the strengths-based feedback and chance to self-reflect via the EPAs.

Conclusions The opportunity to receive supportive feedback via EPA frameworks could enhance nursing risk assessment and aggression prevention practices. EPA's offer potential to enhance preparation for safe, independent practice in aggression prevention.

Clinical trial number Not applicable.

Keywords Risk assessment, Intervention, Restrictive practices, Entrustment, Mental health nursing, Psychiatric nursing, Competencies

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Introduction

Aggression in health settings, particularly mental health inpatient units, remains a persistent challenge, often resulting in negative outcomes for patients and staff, units and health services [1]. Assessment and management of patients' potential for aggression is a critical task and is most often the responsibility of nurses. Contemporary practice also requires that prevention and management of aggression are achieved where possible, by avoiding the use of coercive practices such as restraint and seclusion [2]. Yet nurses who carry the greatest responsibility for assessment and management of aggression are frequently given limited guidance about how to achieve this in practice [3]. Additionally, some of the knowledge and skills required for accurate assessment and skilled intervention are complex clinical tasks (e.g., limit setting and de-escalation; [4, 5].

Despite the importance of these tasks and the inherent complexities, there is no methods for evaluating the educational processes that support nurses to conduct risk assessment and apply interventions designed to prevent and manage aggression. This paper is focused on exploring the suitability of Entrustable Professional Activities (EPAs) as an assessment methodology for supporting teaching, feedback, and entrustment decision-making related to risk assessment and aggression prevention.

Background

Risk assessment instruments such as the Dynamic Appraisal of Situational Aggression (DASA [6]), were designed to appraise the risk of imminent aggression (within the next 24-hours) in forensic mental health units and is also used across civil mental health. DASA has been subject to many validation studies and implemented in many services around the world, including in North America, Europe, Singapore and New Zealand see [7, 8]. Forensic Mental Health Nursing (FMHN) is a specialised area of nursing, where nurses work with patients who have a mental illness and experience with the criminal justice system. Patients will often have complex trauma experiences, histories of engaging in offending behaviour, and may engage in aggression during their admission, which can be lengthy (from months to years). The environment is complex with a range of restrictions, the presence of risk and security requirements [9–11], therefore accurate use of a validated risk assessment instrument is important.

The DASA is comprised of seven items rated as either 0-absent, or 1-present (i.e., a total score is summed with a range of 0 to 7). The summed score of 0 reflects a low risk of aggression, a score of 1–3 indicates the risk of aggression is moderate, and scores of 4–7 signify a high risk of imminent aggression. In practice the DASA assessment is usually conducted by nurses [12]. Risk assessment by itself, however, is not enough to prevent aggression; for this reason, the Aggression Prevention Protocol (APP; [3]) was designed to be used in conjunction with the DASA, to provide nurses with guidance about how to intervene to prevent aggression, for patients presenting with different levels of risk according to the DASA assessment. Different interventions (seven in total: one-to-one nursing, reassurance, distraction, de-escalation, limit setting, close observation and use of Pro Re Nata medication [PRN)]) are suggested according to risk level (low, moderate or high). Implementation of the DASA + APP has been associated with reduced aggression, use of PRN medication and restrictive practices [3, 13]. Although the DASA and APP guide risk assessment and risk mitigation practices, methods for appraising how nurses learn and apply these tools remain underdeveloped.

To enhance use of the DASA + APP, robust educational approaches are needed to support learners in developing the knowledge, skills, and clinical reasoning involved in accurate DASA administration and APP-aligned intervention selection. Some components of DASA assessment and APP intervention can be considered as relatively straight forward activities (for example reading the last 24 h of clinical documentation for the DASA assessment, and engaging patients in distraction techniques). However, some components can be considered more complex clinical activities [14, 15], which may make assessment difficult using competency-based standards. Traditional competency-based assessment is common in nursing education, but it tends to fragment complex work into discrete checklists and does not easily capture the integration of knowledge, skills, attitudes, and context-sensitive judgement that characterises real-world aggression assessment and prevention [16–18].

Entrustable Professional Activities (EPAs) offer an alternative to traditional competency-based assessment in nursing practice. EPAs translate practice proficiencies (or competencies) into authentic, observable units of practice through the integration of multiple competencies and provide entrustment scales to articulate progressive autonomy [19–21]. EPAs have been successfully used to structure feedback-rich assessment conversations, support learner reflection, and build assessor confidence in making defensible judgements about readiness for practice [22–25]. An EPA framework is well-suited for evaluating clinical practice due to the ability to encompass the complexity and occasional instability of the clinical context. An EPA can incorporate the dynamic requirements of professional activities and offer a practical and flexible framework for assessment. This approach allows for a more accurate evaluation of a nurse's ability to handle the multifaceted and evolving challenges inherent in health care settings, such as the task of assessing and managing inpatient aggression.

The authorisation to provide healthcare indicates (entrustment refers to the process where an experienced nurse gives a novice nurse or less-experienced nurse the authority to perform clinical tasks or deliver patient care with limited or no supervision), and decisions of entrustment are the link between a nurse's readiness for the task and the task execution [18]. Assessing a nurse's ability to administer the DASA and apply the APP interventions is important, as the risk assessment must be conducted accurately, because the results directly inform intervention. It is also important that nurses are able to skilfully apply the interventions to prevent aggression, while also trying to reduce the use of restrictive practices.

Against this background, the aim of this study was to explore EPAs as a teaching and assessment framework to support learning, feedback and entrustment decisions in forensic mental health nursing risk assessment and aggression prevention practices.

To meet the study aims, this paper positions EPAs as a teaching and assessment method for the complex nursing practice involved in aggression prevention. We developed EPA frameworks for (1) DASA administration and (2) APP intervention, mapped to relevant professional standards [9, 15, 26], and then trialled each in simulation supported workshops. We present two pedagogically linked studies, since safe and effective practice requires both accurate risk assessment and appropriate interventions. Using a single approach across these interlinked aspects of nursing practice, demonstrates how educators can coherently appraise clinical decision-making from recognising imminent risk, to acting upon it.

Study 1 examined the DASA EPA focusing on focusing on entrustment in assessment practice. Study 2 examined the APP EPA learning and appraisal of intervention skills. Across both studies we explored utility of the EPA frameworks for learning, provision of feedback, reflection, and entrustment decisions in forensic mental health nursing.

Methods

Design

A qualitative design was used to explore the utility of the EPA framework for the DASA + APP. To examine each of the two EPA frameworks independently, two separate studies (see Figs. 1 and 2) were used to explore each EPA framework. A train the trainer model was used for both studies, where participants were provided with education on how to teach others DASA administration or how to apply the APP interventions and use the corresponding EPA frameworks. The second half of each workshop was dedicated to the trainers using the EPA framework to appraise the assigned learners in the workshop.

Development of the EPA frameworks

EPA frameworks for the DASA and APP were drafted according to the Association for Medical Education Europe (AMEE) Guide No. 99. This guide outlines recommended components of EPA development, including defining the unit of practice, mapping required competencies, and constructing entrustment scales [27]. A scale of entrustment was then developed for each, serving to operationalise the progressive autonomy of the nurse as they gain greater authority, accountability, and independence in clinical decision-making and nursing practice with increasing skills, experience, knowledge, and competence [27]. The EPAs were then mapped against the Standards of Practice for Australian Mental Health Nurses [28] and Forensic Mental Health Nursing Standards of Practice [29]. Two manuals were developed, one for the DASA EPA and one for the APP EPA to provide

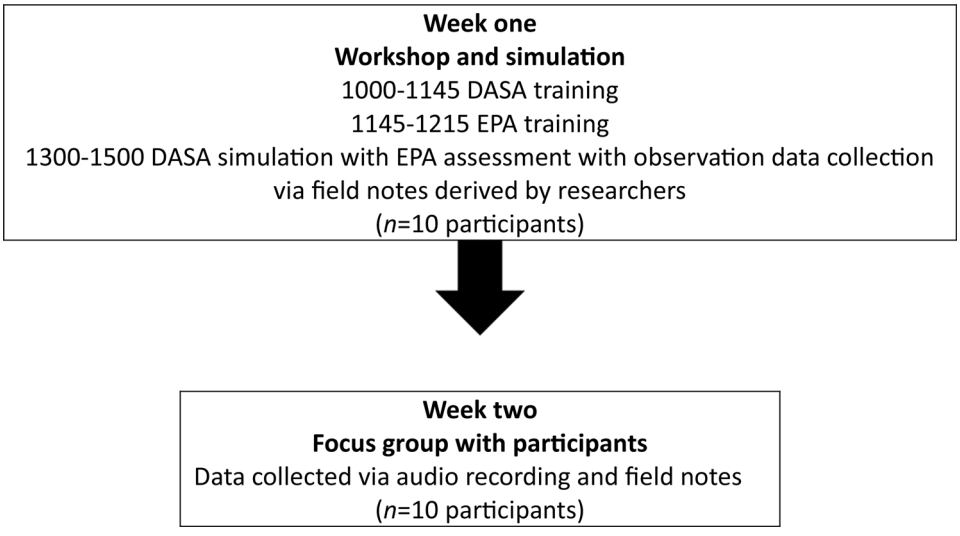

Fig. 1 Study one trialling the DASA EPA framework

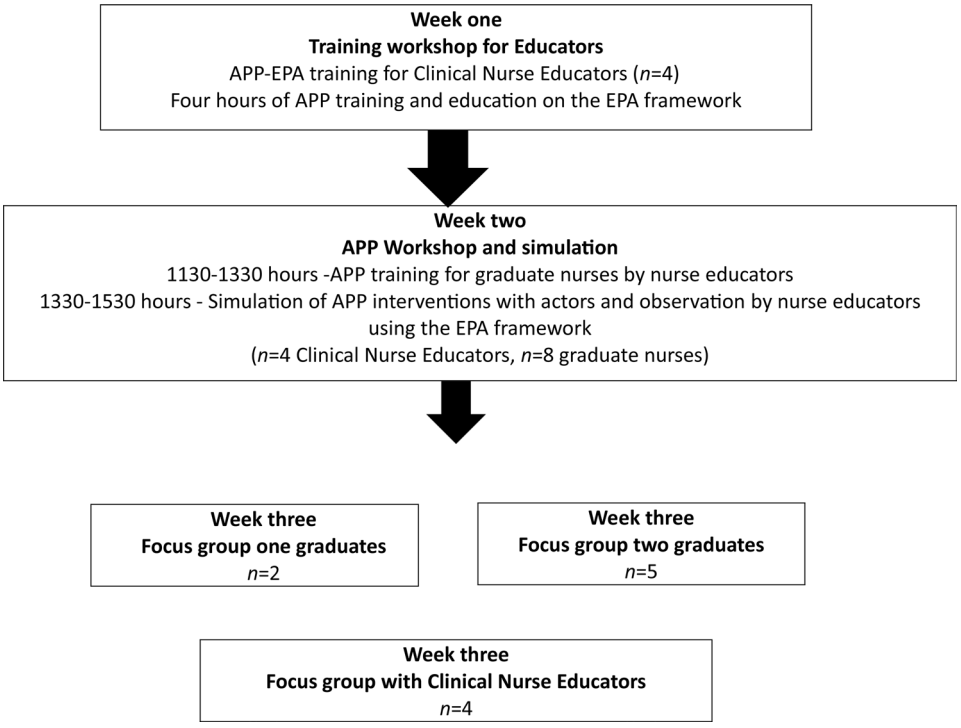

Fig. 2 Study two trialling the APP-EPA framework

information about the DASA/APP, an introduction to EPAs and the scale of entrustment. See Table 1 for the DASA EPA, Table 2 for the DASA scale of entrustment, and Table 3 for an example of one of the APP interventions (see supplementary material for all remaining APP interventions) and Table 4 for the associated scale of entrustment.

Setting

The workshop for both studies was conducted in person face-to-face at (name blinded for review). The workshops were held in non-clinical locations that are typically used for training and holding meetings. Online focus groups were held using Microsoft Teams the following week to seek feedback about the use of the EPA framework in practice. An interview guide was used for both studies (please see supplementary files 1–4).

Participants

Purposeful sampling [29] was used in both studies to identify participants who would be able to appropriately provide insights into the suitability of the EPA framework for the DASA + APP.

Study one

For this study we sought participants with experience in management of aggression training and assessment. All participants had a role in the management of aggression prevention in their services and/or experience in DASA training. Participants were recruited from two cohorts to capture the necessary experience, (1) 'blinded name of' forum and (2) nurses from 'blinded name of service', who had experience administering DASA in practice. The *forum is comprised of clinicians from public health services across (blinded) who have responsibility in the prevention and management of aggression. From the (blinded) service DASA has been used in practice since 2006 and has a group of dedicated DASA-trainers across the service. Ten participated in the DASA + EPA training and simulation and focus group to seek feedback about the use of the EPA in the simulation. Participants were from five health services across (blinded). All had a role in their service teaching and/or responsibilities in prevention/management of aggression, and two participants were DASA trainers in their service (see Fig. 1).

Study one trialled the DASA EPA framework in which aggression management trainers were provided training on how to administer the DASA assessment, and then had the opportunity to either carry out the DASA assessment in a simulation, or use the EPA framework to provide the trainer feedback, while they administered the DASA assessment in the simulation.

Study two

At the (blinded, name of mental health service), Clinical Nurse Educators (CNEs) employed in the Nursing Practice Development Unit who provide leadership and support in professional development, education, and practice

Table 1 Entrustable professional activity for administering the DASA in clinical practice

Approaches	Methods	Tools
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 patient.	-	-
Skills The mental health nurse: 1. establishes and maintains a therapeutic relationship with patients while incorporating person-centred, gender sensitive and culturally sensitive practice principles. 2. reviews the patient'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 patient and interacts with them to understand their current state. 4. consults with other staff to determine the patient's current state (including any information gathered about the patient during handover). 5. uses assessment skills including observation of the patient 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 patients to identify their needs. 3. recognises 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		
Observing	Focused observation of the patient including their behaviour and interactions with others	Direct observation of the patient using nursing observation skills
Engaging	Engaging with the patient to determine their current state Engaging with other relevant staff and/or families and carers to determine a patient'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 patient'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.

development were recruited. Nurses in these roles across the service were invited to participate, as they are familiar with training and evaluating clinical performance. We also sought nurses in first or second year of the organisation's graduate nursing program. To ensure the learning session was authentic, graduate nurses with availability in their training program were invited to attend the workshop and simulation. They were identified as a group likely to benefit from feedback on the use of the EPA framework in supporting their learning needs. The (blinded) service runs a program where graduates complete a Graduate Diploma in Mental Health Nursing and are supported in placements for two years.

Four Clinical Nurse Educators and eight graduate nurses participated in the study. All attended the training workshop and the simulated activity (see Fig. 2). In the workshop learners were involved in scenarios with simulation actors. Simulation was used to explore the utility of the APP EPA framework in a realistic and safe environment. Graduate nurses were provided education on applying the APP interventions, following education, they had the opportunity to apply the interventions in a simulation, while the CNEs used the EPA framework to provide feedback on their application of the interventions.

Recruitment

For both studies a description of the study was emailed to eligible participants introducing the study and asking to indicate their interest to participate by responding to the email. Consent was obtained using electronic consent forms, where participants returned the signed consent form via email or handing in a copy to (researcher initials).

Data collection

Following the workshops in study one and study two, focus groups were conducted to elicit perceptions on the use of the EPA framework and effectiveness in learning to use the DASA (study one) or APP (study two). A separate focus group guide was used for both studies exploring participants experience with the utility of the EPA. Microsoft Teams was used for the online focus groups. Researchers commenced the simulation and focus groups for both studies with an explanation of the study objectives. Audio-recording of the focus groups were used to investigate the utility of the EPA framework. This design allowed a detailed exploration of educators' and learners' experience with the EPA methodology. This approach was employed as there is currently no research on the use of an EPA with risk assessment instruments or structured nursing intervention.

Data analysis

Focus group data were analysed using Braun and Clarks [30] six-stage thematic approach. For both studies TM listened to the audio recordings while checking the transcripts making any necessary changes to ensure accuracy of the transcription. Two researchers (AB &CD *note initials are blinded) then read and re-read the transcript several times while also developing notes. Coding then occurred which involved identifying similar statements in the text and assigning codes. Searching for themes was carried out by AB and CD developing thematic maps on a word document. The themes were then discussed by the research team, which resulted in further analysis and refinement. Themes were then finalised and written up in the form of this paper. Data for each study were analysed separately and then synthesised in this manuscript. Researchers in both studies have extensive qualitative research experience, CD and EF have extensive education experience, AB, GH and IJ have extensive FMH and aggression prevention experience.

Ethical considerations

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 [31]. Study one and two were approved by Swinburne University of Technology Human Research Ethics Committee (SHREC), (study one project SHREC ID:7220; study two: project SHREC ID: 7184), and approval for access to Forensicare and to include Forensicare in this study was granted by the Forensicare Operational Research Committee. Data were collected from November to December 2023 for study one, and in August 2023 for study two. Ethical requirements were adhered to, and the studies were conducted in accordance with the Declaration of Helsinki. Confidentiality of participants was retained by de-identifying data and assigning participant numbers.

Table 3 Aggression prevention protocol one-to-one nursing EPA

According to the APP, one-to-one nursing is:
Time spent one-to-one with the purpose of engaging the person to explore their thoughts and feelings, and actively listening to what the person is saying. During the one-to-one, the nurse may use a variety of communication skills such as active listening, demonstrating empathy, open ended questions, clarification, summarising, suggesting collaboration, encouraging goal setting, and assisting with formulating a plan etc. One-to-one nursing might also involve reading and discussing with the person documents such as Personal Safety Plans, or sensory modulation plans. It is important to differentiate one-to-one nursing from other interventions such as reassurance, limit setting, observations, and de-escalation, as each of these interventions have different purposes (you might start off with one-to-one nursing and assess that the person may be presenting as anxious and/or stressed, which would then prompt you to use an intervention such as reassurance). When one-to-one nursing is documented, the communication skills that were used and the outcomes of this intervention need to be described (Maguire et al., 2021).

Knowledge

The mental health nurse demonstrates an understanding of:
1. the purpose of one-to-one nursing and how it differs from other interventions in the APP, such as reassurance and distraction techniques
2. effective communication skills that can be used during one-to-one
3. the importance of early intervention

Skills

The mental health nurse:
1. establishes and maintains a therapeutic relationship with patients
2. engages patients during one-to-one to explore their thoughts and feelings
3. incorporates active listening skills during one-to-one
4. demonstrates empathy when engaging in one-to-one
5. uses assessment skills during one-to-one to constantly monitor the suitability of one-to-one as an intervention, and acts to change the intervention when necessary
6. incorporates person-centred, gender sensitive and culturally sensitive practice principles
7. documents how and why one-to-one was used, including the communication skills used, outcomes and any recommendations for future use of one-to-one

Attitudes

The mental health nurse:
1. values and works with patients to identify their needs
2. recognises that patients want to have their concerns heard
3. recognises the expression of empathy by the nurse is important during one-to-one
4. reflects on their one-to-one nursing skills to identify aspects that need improvement
5. recognises that an escalation in risk is a signal that the person is unsettled, strives to work collaboratively to understand their concerns, and works collaboratively to help resolve these personal concerns.

Table 4 Scale of entrustment for one-to-one nursing intervention in the APP

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 one-to-one nursing within the inpatient setting. The nurse accepts feedback for performance improvement.
Level 2	I trust the nurse to carry out one-to-one nursing with guidance but without direct supervision or assistance.
Level 3	I trust the nurse to carry out one-to-one nursing independently.
Level 4	I trust the nurse to carry out one-to-one nursing independently and that they have mastered the skill such that they would be considered a good role model for other nurses.

Results

Study one: trial of the DASA EPA framework

The inductive analysis of the views and comments made by participants during the focus group resulted in the interpretation of three themes: (1) It's just not a tick box: The importance of the process of risk assessment: (2) Conditioned to competencies and (3) What remains challenging with professional practice.

Theme one: it's just not a tick box: the importance of the process of risk assessment

Participants identified the importance of nurses undertaking an accurate DASA assessment, as opposed to just doing the DASA assessment to "tick a box". Participants discussed how simply completing assessments is not enough; accurate DASA assessments are needed for quality care. Participants also stated none of their services currently had any formal mechanism of appraising the quality of risk assessment undertaken by staff and/or trainers. One participant mentioned that an external audit on risk assessment processes had "*recommended there should be a competency for trainers and trainees for DASA*" (P1). There was also mention of what can happen when there is no appraisal, highlighting need for quality checks to ensure best practice.

> *Speaking from use of another tool the 4AT, you can complete it, but whether it's accurate is a very different thing and that changes the potential escalation process…with the DASA its exactly the same… If it's not being done properly, it's not reflecting the actual risk (P7)*

Complex activities are difficult to assess for proficiency, and focusing only on completion numbers is limiting. EPAs were seen to offer a more comprehensive approach for assessing DASA accuracy, than traditional competencies.

> *The EPA looks at attitude and collaboration, it's not just can you do that thing (P5)*

Participants valued the potential for EPAs to capture the quality of the assessment process, including engagement with the patient.

> *It's the quality of your assessment and engagement with the person, that's what the DASA score or quality score is related to (P1)*
> *An EPA might be more beneficial when there's more complex activities that have parts around engagement, reflection and using yourself as a therapeutic tool, rather than a piece of equipment (P6)*

Theme two: Conditioned to competencies

The second theme highlights the limitations of competencies; a person deemed "competent" may still struggle with independent clinical activities, as highlighted in the following quote:

> *I had a situation with a grad recently who met all components of a medication competency. Yet I knew in practice they were petrified. It was very clear they might've been competent according to the competency, but they were absolutely petrified doing a medication round on their own. I think the EPAs definitely have a space supporting grads (P2)*

Despite recognising the challenges with competencies, participants were very accustomed to use of competencies as a method of appraising clinical activities. One participant stated, *"we are so conditioned to competencies"* (P1). The familiarity with competencies perhaps made the concept of an EPA seem a little abstract initially.

> *We're so used to following tick box processes. Once you have an understanding of the content (EPA), it would be best not to have the EPA out on the table and just have the ratings there to discuss with the person (P7)*
> *We struggled in the first scenario, getting your head out of a competency is hard (P6)*

There was also reflection of the advantages of using a different type of framework.

> *Definitely more dialogue and conversation around using that (EPAs) as opposed to a competency-based tool (P7)*

Some participants preferred structuring EPAs like competencies, with potential sanctions for underperformance, rather than seeing an EPA as a strength-based reflective tool.

> *Competency is a bit clearer. You can either do the thing or you don't (P5)*
> *I know we are trying to change our thinking and make it more reflective, but there still has to be some kind of grading system…and attached consequences for people (P1)*

Despite these concerns, participants could see clear advantages where an EPA was "*patient centered*" (P5) and growth focused, encouraging "*self-reflection*" (P6). An EPA was viewed as helpful in promoting practice conversations during appraisals and could be used from novice to expert.

> *The EPA, I can see how you could pull it out at any level because we know with any sort of assessments, tick box initially may have the kind of translation to practice and after a while if people become complacent it could just become a tick box exercise. You can always pull out an EPA with a very experienced person and say, let's see where you're at. It (the EPA) has cross experience level application, better than competencies (P6)*

Theme three: what remains challenging with professional practice

The final theme addresses participants apprehension about difficult conversations with colleagues, fearing that those evaluated, might think they were more capable than the assessor.

> *I've seen people hold a grudge because they perceived they were judged unfairly and still required to perform that task (P8)*

In contrast on two occasions during the simulation feedback, the person administering the DASA placed themselves at a lower level than the person using the EPA to provide feedback, suggesting EPAs may facilitate accurate self-reflection. Some participants felt that feedback, regardless of whether it's based on competencies or EPAs, may not be well-received.

> *You'll always find, no matter whether you're using competencies or an EPA, people who don't like being assessed, who don't like having hard conversations (P5)*

In this regard however, an EPA seemed to offer the chance to build skills and provide structured, strengths-based feedback and support to build the necessary skills.

> *For engaged nurses, it's a great conversation and great tool, it's more than the alternative (competencies)… This (EPAs) is a real skills builder, and for me personally, I would find that really supportive. I would prefer that type of assessment (EPA) (P5)*

Participants highlighted that trainers need more than knowledge and skills for administering the DASA, they also required the ability to facilitate self-reflection and provide feedback to assist skill development.

> *If someone's a very experienced person and they're sitting at level-four or feel they are, and you think they're at a level three, being able to have that conversation of, well actually I think there's still some capacity that we can build. You need to be confident in that feedback and be able to challenge people's thoughts around what they need to apply (P6)*

Participants reflected on how to educate and prompt self-reflection, indicating they are already addressing difficult conversations. It is possible these conversations may be necessary, regardless of the assessment method, however an EPA unlike pass/fail processes can identify areas for practice improvement and uses strengths-based language which may make receiving feedback more palatable.

Study two: trial of the APP EPA framework

Two themes were interpreted from the analysis: (1) An EPA framework for the APP has utility but takes time to learn; and (2) the EPA framework is strengths-based and allows for self-reflection.

Theme one: an EPA framework for the APP has utility but takes time to learn

The first theme reflects the CNEs and graduate nurses' overall perception that EPAs provide promise as a framework for appraising practice of the interventions contained in the APP. This was despite the CNEs stating they initially struggled slightly with application of an EPA due to the novel nature of these for nursing at present.

> *…trying to use the EPA was a bit messy at first (Nurse 1)*

However, on reflection after the simulation, the educators considered the usefulness of the EPA framework in allowing timely identification of the level of entrustment for each graduate and learner readiness.

You can work out that they are confident in the skill, so then I know what that looks like, and then the scenario is the application of the skill (N2)

Some early confusion arose about how an EPA framework differs from traditional competencies and how they are to be used in practice. For example, there was some discussion about identifying "*deficits*" (N2) leading to further discussion about intent of an EPA framework. Educators considered how the term "entrustable" implies you can be trusted, and the EPA framework was designed to be about identifying growth and seeking to understand what "*support the person needed to then grow*" (N4), as opposed to a perfunctory exercise, or an activity to highlight practice insufficiencies in a negative way.

The graduates were in support of the EPA framework as for them it signalled a shift away from competencies which they were familiar with in their undergraduate training, and the EPA framework was also seen as providing the necessary elements to reflect the complexity of applying APP interventions in practice.

I'm looking at this document (the APP Entrustable professional activity framework), it's concise and obvious outline of skill. I feel like I could read it, brush up on my knowledge and take that with me into practice (G1)
In uni… you can be assessed doing a blood pressure. You walk in, you do this and then that's it.…Whereas this (APP) is very complex. There's a blanket way to do blood pressure, you put the cuff on. limit-setting is very complex and it's hard to have a guideline and say, these are the points you have to hit to, to pass the competency (G4)

The educators suggested that once more people were provided education, an EPA framework would become familiar, integrate into clinical practice and *"become the normal day-to-day way…of intervention observing…and self-reflection*" (N3), however, acknowledged that an EPA framework does potentially take time, communication and consistent use to embedded across the service.

Theme two: the EPA framework is strengths based and allows for self-reflection

The language used in EPAs is quite a shift from traditional competencies which often refer to pass or fail, competent/not yet competent, satisfactory/unsatisfactory. The graduate nurses appreciated the strengths-based language in the EPA framework as demonstrated in the following quote.

The language used is positive and nice, I trust a nurse, it's very strength-focused, which adds something to a profession, it changes the language and culture around competence (G2)

The educators and graduates also considered the EPA framework could be used to self-reflect on one's own practice, as well as a way for the educators to provide strengths-based structured feedback.

I like that reflection and that conversation, it's really important…we are looking for this as educator, and then maybe have a reflection sheet for each person to complete (N1)

Graduates identified that before attending the workshop and using the EPA framework, they had previously had little-to-no feedback provided from their mentors on the units as to how they carried out interventions like the APP interventions in practice. This was seen as a gap the EPA framework could fill.

I liked getting feedback afterwards, there's never been a situation when I've had feedback…having that conversation with the educators was helpful (G7)

Discussion

This paper reports findings from two linked studies, demonstrating how EPAs can function as both a teaching mechanism and assessment methodology to support learning, reflection and entrustment decision-making for nurses in aggression risk assessment and prevention strategies. Across subsequent focus groups in both studies there was evidence of support for the use of the EPA framework to evaluate application of the DASA + APP, establish level of entrustment, and in assisting to providing strengths-based feedback to nurses. However, it must be acknowledged that the EPA framework was experienced as a shift from traditional competency assessment, and as with anything unfamiliar and novel, requires educators to adapt their thinking and practice over time [32, 33].

Despite initial challenges, participants recognised the value of incorporating an EPA framework to evaluate practice and assist with practice development. The EPA framework for risk assessment and intervention may offer a practical, structured approach for making entrustment decisions and supporting readiness for independent practice, addressing a current gap in practice. Participants consistently described EPAs as changing the quality of assessment conversations from pass/fail judgements towards developmental feedback linked to observable practice. By focusing on specific, observable tasks, learners in both studies were engaged in self-reflection of complex clinical activities and potentially fostered a deeper understanding of their clinical strengths and areas

for improvement via feedback using an EPA framework [34, 35]. This aligns with the intent of EPAs to integrate multiple competencies (knowledge, technical skills, communication, ethics and clinical reasoning) into authentic professional activities, with entrustment decisions making explicit a learner's readiness for independent practice [20, 17, 18]. The EPA framework also offers a practical and tangible way to measure professional practice in the clinical setting, as opposed to a rigid approach presented by competencies, which may also be somewhat deficits-based [36].

The concept of EPA is to anchor the person in real-world contexts and professional activities. The opportunity to test the utility of the EPA in the simulated learning experience significantly enhanced the opportunity to gather feedback on the use of an EPA framework for the DASA + APP. EPAs provide portable, shared rubrics that teachers/managers can use to observe real work, offer timely, strengths-based feedback, and make defensible entrustment decisions about independent practice in aggression assessment and intervention. Moreover, EPAs provide assessors with a clear framework for delivering targeted, constructive feedback that can help learners refine their professional practice but also build their confidence in performing professional responsibilities. Through this process, EPAs encourage a culture of continuous improvement and professional growth, ensuring that learners are prepared to effectively meet professional practice requirements safely and independently [22, 25]. As identified by the participants, rather than reducing practice activities to pass or fail, an EPA assists in identifying areas where improvements can be made and encourages reflection on one's own practice [34]. The change requires a shift in mindset from traditional to innovative thinking to reshape how we identify practice proficiency.

Change in nursing practice has not always been embraced quickly and change itself may be resisted, especially when there is a drive to maintain the status-quo [37]. Participants expressed some concern about having difficult conversations about practice issues and providing feedback [38]. In practice pass or fail grades may be less palatable than an EPA, which is not dichotomous in nature and designed to support growth and reflection. EPAs offer a scaffold to sequence learning, from guided participation to independent practice, linking simulation with clinical placements. Embedding DASA and APP focused EPAs enables curricula to target readiness for practice rather than isolated skill proficiency. It is also important to be aware that all clinicians have a personal responsibility to adhere to relevant codes of conduct of their profession, legal requirements and maintain their own professional development. This requires nurses to be committed to excellence in care delivery, personal development, and ongoing learning and self-reflection [39].

Strengths and limitations

Both studies include a relatively small purposively selected sample. As such, findings may not be representative of nurses in other settings or jurisdictions or with greater/less clinical experience. The small size was due to a range of factors including ongoing limits at the time on the number of nurses who can be in a room and released from clinical areas due to COVID-19, and limitations with the size of the room needed to conduct the simulations, which limited participant numbers we could accommodate in the workshops. Despite the small number of participants this was appropriate for exploratory qualitative research and generated rich data in both studies.

A key strength was the involvement of educators and aggression management trainers who have expertise and knowledge appraising clinical practice. A further strength relates to the interdisciplinary expertise of the research team, which included experienced educators, qualitative researchers, and forensic mental health clinicians. This diversity supported nuanced interpretation of how the EPA frameworks functioned as teaching and assessment tools. Using simulation allowed safe, standardised observation of complex practice and rich feedback on EPA use. Running the simulations also highlighted practical considerations for future implementation, informing refinements to the EPA manuals and offering insight into the support educators may require when adopting EPA-based assessment.

Conclusions

The development of nursing practice, particularly within the inherent complexity of forensic mental health care settings, exposes the inadequacy of single-dimensional competency tools, which fail to capture the nuanced and context-dependent nature of practice. There is a clear need for contextually grounded, practice-based observational assessment approaches that can account for this complexity and more robustly inform judgements of trustworthiness in practice. Nurses themselves as identified in these studies are certainly aware of this gap in assessment tools. The opportunity to practice DASA administration, apply APP interventions and receive feedback using an EPA framework, provided valuable insight into how EPAs can function as an educational and assessment methodology in aggression-prevention practice. While any change to practice can be challenging, the EPA framework may offer a strengths-based approach that assists feedback, skills development and self-reflection to aid practice development and enhance nursing practice. The framework also offers promise in

evaluating complex clinical activities in practice. Furthermore, accurate use of a validated risk assessment instrument and appropriate aggression prevention intervention, evaluated through a dedicated EPA framework, may help improve readiness for independent practice in mental health settings and, ultimately, for safer, less coercive care.

Abbreviations

APP	Aggression Prevention Protocol
DASA	Dynamic Appraisal of Situational Aggression
EPA	Entrustable Professional Activity
FMHN	Forensic Mental Health Nurse
PRN	Pro re nata, "as needed'

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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Author contributions
TM: Conceptualization, Funding acquisition, methodology, ethics application, data curation, Investigation, data analysis, writing – review & editing, writing – original draft, Project administration, Final approval. LG: Conceptualization, methodology, investigation, data analysis, writing – review & editing, final approval. GW: Conceptualization, investigation, data analysis review and editing final draft, final approval. BM: Conceptualization, methodology, writing – review & editing, Final approval. TF: Conceptualization, methodology, investigation, review & editing final draft, final approval. MD Conceptualization, funding acquisition, methodology, ethics application, data curation, investigation, data analysis, review & editing original and final draft, final approval.

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Data availability
The supporting the conclusions of this article are included within the article by way of supporting quotes.

Declarations

Ethics approval and consent to participate
Study one and two were approved by Swinburne Human Research Ethics Committee (study one project ID:7220; study two: project ID: 7184), and approval for access to Forensicare and to include Forensicare staff in this study was granted by the Forensicare Operational Committee. Data were collected from November to December 2023 for study one, and in August 2023 for study two. Ethical requirements were adhered to, and the studies were conducted in accordance with the Declaration of Helsinki. Confidentiality of participants was retained by de-identifying data and assigning participant numbers. All participants provided written informed consent to participate in the study.

Consent for publication
N/A.

Competing interests
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). Dr Michael Daffern, Dr Tessa Maguire and Dr Brian McKenna are co-authors of the APP. The APP manual is also sold by the CFBS. Profit from the sales of the DASA and APP manuals are held in a CFBS account and used to support DASA research. There are no other disclosures or conflicts of interest to declare.

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