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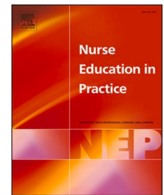

Developing entrustable professional activities to enhance application of an aggression prevention protocol

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ABSTRACT

Aim: The research aim of this study was to seek feedback from prevention of aggression training experts about the suitability of Entrustable Professional Activities (EPAs) as an assessment tool for an Aggression Prevention Protocol. The protocol was designed to structure intervention to prevent aggression and reduce the use of restrictive practices following risk assessment using a validated instrument (the Dynamic Appraisal of Situational Aggression).

Background: Preventing aggression and limiting the use of restrictive practices are key priorities for inpatient mental health services. Assessing clinical activities using a competence framework has limitations, particularly when determining complex interventions. EPAs could provide a suitable method for assessing complex clinical activities like de-escalation and limit setting, which comprise some of the interventions in the Aggression Prevention Protocol. EPAs are new to forensic mental health nursing; therefore, feedback was sought regarding the utility of EPAs to assess aggression prevention interventions.

Methods: Data were collected via focus groups including 11 aggression prevention experts from Australia and New Zealand. A thematic analysis, comparative analysis and a Strength, Weakness, Opportunity and Threats analysis was conducted.

Results: Three themes were interpreted from the data: 1) Frameworks such as the APP are needed to work towards elimination of restrictive practices; 2) APP-EPAs afford an opportunity to set the standard for practice; and 3) 'who watches the watchers', were identified by the experts as well as areas to enhance EPAs prior to introduction into practice.

Conclusions: EPAs address a practice-gap and offer a framework to assist movement towards elimination of restrictive practices, while prompting best-practice, self-reflection and practice improvement guidance.

1. Introduction

Despite workplace reform, enhanced focus on occupational health and safety and introduction of policies and procedures to protect staff aggression remains a significant and seemingly intractable problem in mental health units around the world (Australian College of Nursing, 2021; Dafney et al., 2022). Mental health nurses have a critical role in the assessment and prevention of aggressive behaviour and as a staff group are most exposed to aggression and most likely to be assaulted (Roets et al., 2018; Maguire et al., 2021). Effective skills for preventing aggression include a range of coping strategies and communication skills, including de-escalation (Yang et al., 2018). To-date there has been

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limited guidance as to when and how to apply interventions designed to prevent aggression, while also reducing the use of restrictive practices (e.g., restraint) (Maguire et al., 2019; Muir-Cochrane et al., 2018).

Preventing aggression whilst also limiting the use of restrictive practices is crucial since aggression has deleterious mental, physical and emotional impacts on staff and consumers, as well as having an adverse impact on the unit climate (Lantta et al., 2016a). Restrictive practices may harm therapeutic relationships, escalate conflict and lead to serious physical harm (Goodman et al., 2020). This paper is focused on the development of an assessment methodology to complement a training program designed to prevent aggression and limit use of restrictive practices.

2. Background

Concern about inpatient aggression has led to the development of a range of risk assessment instruments, interventions and training programs (Bowers et al., 2006), viewed as vital in assessment, prevention and management of aggression (Baby et al., 2018; Livingston et al., 2010). Several risk assessment instruments have been designed for use in inpatient mental health units to facilitate assessment of risk for imminent (within the next 24-hours) aggression (e.g., the Dynamic Appraisal of Situational Aggression (DASA; Ogloff and Daffern, 2006). DASA is a seven-item risk assessment instrument with good predictive validity (Lantta et al., 2016b; Maguire et al., 2017; Ramesh et al., 2018) that is quick and considered easy to use (Daffern and Ogloff, 2020). In practice, DASA is most often used by nurses, who tend to lead aggression-prevention efforts. Like much risk assessment research, the focus of DASA research has been on predictive accuracy. Although the assessment of risk is important, assessment alone will not prevent aggression; for aggression to be prevented the risk assessment must stimulate a process whereby nursing efforts are concentrated toward intervening to prevent the person from acting aggressively. Interventions that are collaborative (with the consumer) and led by non-intrusive and non-restrictive methods are preferred.

To-date, there has been little focus on this risk mitigation process. To address this practice gap, a decision-making protocol to guide intervention following risk assessment using the DASA was developed. The protocol, known as the Aggression Prevention Protocol (APP; Maguire et al., 2019) was designed to structure nursing interventions according to the level of assessed risk, thereby avoiding excessively restrictive interventions when risk is low, or not intervening adequately, in a timely manner, when risk is high. Two recent studies testing the DASA+APP produced reductions in aggression and use of restrictive practices (Griffith et al., 2021; Maguire et al., 2022).

The APP consists of seven nursing interventions (one-to-one nursing, distraction, reassurance, de-escalation, PRN medication, close observations and limit-setting), indicated by different levels of risk. While some of these interventions are uncomplicated for skilled nurses to undertake, they still require multifaceted capabilities including understanding of local policy, how, why and when these interventions should be applied or when contra-indicated. The APP also contains complex nursing interventions (e.g., de-escalation) that require verbal and non-verbal communication skills, along with the ability of the de-escalator to assess the situation, intervene accordingly, while self-regulating and maintaining the safety of other consumers and staff (Hallet and Dickens, 2017). It is assumed that staff can apply complex skills such as de-escalation (Hallet and Dickens, 2015; Price and Baker, 2012), when this may not always be necessarily true in practice.

Despite the DASA+APP's promise, a barrier to broader implementation is availability of training (Maguire et al., 2022). Currently DASA+APP training is face-to-face and takes approximately six-hours, rendering widespread implementation difficult. A recent study by Maguire et al. (2022) investigated approaches used in prevention of aggression training to determine the best way to educate nurses in use of the DASA+APP. One recommendation was the need to include competencies to ensure learners could be assessed against competencies to determine proficiency to deliver APP interventions.

Effectively assessing complex interventions such as the APP once training is complete requires a tool that can determine the capability of the nurse in situ. The usual approach to clinical assessment in nursing practice is through competency assessment. Competency standard frameworks are commonly used in healthcare education programs as an outcome-based assessment approach (Batt et al., 2021; Coombe et al., 2022). Such frameworks break down tasks and roles into detailed subcategories (Bramley and McKenna, 2021; Hawkins et al., 2015). However, the reality of clinical practice is complex and difficult to parse into subcategories of competence. Assessing clinical practice using a competence framework has significant limitations, particularly in determination of complex multifaceted interventions like de-escalation. A more meaningful approach is to determine a person's ability to integrate multiple professional activities to ensure capability and holistic approach to care. Encapsulating an aspect of professional work into a unit of entrustable activities connects theory, competence-based education and clinical practice (Mulder et al., 2010).

Entrustable Professional Activities (EPAs) offer a way of defining and assessing daily practice (Croft et al., 2020; Lau et al., 2020; Moore and Hawkins-Walsh, 2020). EPAs connect competencies to practice through assessment that focuses on the complexities of clinical activities without the limitations of competencies (ten Cate, 2014; 2016). EPAs are not designed to replace competencies, they provide a way of translating competencies into clinical practice (Shorey et al., 2019) and are a synthesis of competency in knowledge, skills and attitude that collect together to form activities a professional is able to do or are entrusted to do. As such, competencies are required within EPAs, but an EPA characterises these collectively (ten Cate and Taylor, 2021). According to ten Cate et al. (2015, p. 983) "while competencies are descriptors of the qualities of individual persons, EPAs describe the work that is being done or must be done in the workplace". Most work in healthcare can be described as tasks and responsibilities entrusted to clinicians to perform.

The advantage of using EPAs for assessment is they lend themselves to more integrated, holistic evaluation of learners, which include both specific skills and more tacit but important impressions of trustworthiness of a trainee concerning a clinical activity (ten Cate et al., 2015). The medical profession uses EPAs as part of the curricula and in a variety of clinical rotations including surgical, anaesthesiology and emergency medicine, as a way of enhancing supervision of trainees (Bramley and McKenna, 2021; Moore et al., 2017). While there has been some uptake of EPAs in nursing, this has tended to be in undergraduate education and to-date there has not been any development of EPAs in mental health nursing (Lau et al., 2020; Moore and Hawkins-Walsh, 2020; Wagner et al., 2018). The EPA framework is beneficial in two-ways, identification of the critical parts of practice that must be mastered, whilst also enabling a foundation for assessment (Mulder et al., 2010). The prevention of aggression and the capacity of the nurse to intervene whilst limiting use of restrictive practices is a complex multi-faceted professional activity. To assess the nurse's ability to undertake the APP activities, the EPA framework may offer an appropriate assessment methodology. EPAs provide guidance to learners and supervisors/educators by outlining the expectations for earning trust to complete a specific EPA and assist supervisors in knowing what needs to be evaluated before making entrustment decisions (ten Cate et al., 2015).

To enhance the DASA+APP training and the proficiency to assess learner's ability to apply the interventions in practice, EPAs for each seven interventions within the APP were developed using the Association for Medical Education Europe (AMEE) Guide No. 99, which details the recommended description of an EPA (ten Cate et al., 2015). Each APP-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., 2012). A manual titled: Entrustable Professional

Activities for the Aggression Prevention Protocol Nursing Interventions, referred to as 'the manual', was developed to provide context for the EPAs, which included the background of the eDASA+APP, an introduction to Entrustbale Professional Activities, the EPA scale of entrustment (see Table 1) and the details of each APP-EPA (see Table 2 for the EPA description for reassurance).

This paper describes a study that explores expert's perceptions on the utility of the APP-EPAs, to determine if the EPA framework is a relevant and suitable approach to the assessment of APP interventions and if it assesses learner's readiness to transition between learning and professional practice.

3. Methods

3.1. Research design

This study employed a descriptive qualitative design involving the collection of data through focus groups with experts in prevention of aggression training in the *. This exploratory approach is warranted as there in no research on the use of EPAs in mental health nursing. It is reported here using Enhancing the QUAlity and Transparency Of health Research (EQUATOR) network recommendations for qualitative research, using the COnsolidated criteria for REporting Qualitative research (COREQ) checklist (Tong et al., 2007). This study was approved by a X. Data were collected from August to September 2022.

3.2. Participants

Purposeful sampling was used to identify mental health nurses with expertise in prevention of aggression. These participants were selected because they have experience in the teaching and assessment of the prevention and management of aggression from theoretical and conceptual perspectives. Criteria for inclusion was skill and expertise in teaching aggression prevention and exclusion of participants who only teach restrictive techniques (e.g., restraint). Experts were recruited from two cohorts to capture Trans-Tasmin expertise, 1) Xforum and 2) members of the Xtraining group. The Xforum includes designated clinicians from public health services across the state of X in leadership or training roles in the prevention and management of aggression. Xtraining group is a national training program in X managed, trainers are situated across mental health services in X. The X and X members are experts in their field and services. Eleven trainers from ten different health services participated in the focus groups (three males, eight females). Five participants attended both groups, eleven attended the first focus group and four attended the second focus group.

An email outlining the study was sent to all eligible participants introducing the nature and purpose of the research. Informed consent was obtained using electronic consent forms, where participants returned the signed consent form via email, prior to attending their first focus group. Two-working weeks before the focus groups, participants were emailed a copy of the manual and asked to read the manual prior to the focus group.

Table 1
Scale of entrustment for EPA for APP interventions.

Level of entrustment	Level descriptor: The leaner 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 frequent and/or assistance, to carry out the APP nursing intervention within the inpatient setting. The nurse accepts feedback for performance improvement.
Level 2	I trust the nurse to carry out the APP intervention with indirect supervision. The nurse demonstrates self-direction and seeks guidance as required.
Level 3	I trust the nurse to completely and accurately carry out the APP intervention independently.
Level 4	I trust the nurse has mastered the ability to completely and accurately carry out the APP intervention independently and provide a level of supervision and feedback to other nurses.

3.3. Data collection

Data were collected in five focus groups, via online conferencing to enable Trans-Tasmin recruitment. Zoom and Microsoft Teams were used to connect participants to allow for service preference of online platforms. A focus group protocol was developed for the research. The initial focus groups began with brief orientation to the DASA+APP and EPAs and facilitators inquired if participants were familiar with EPAs, before seeking feedback on the APP-EPAs and the manual. In the Xcohort there was one focus groups, with four participants. In the Xcohort, there were two focus groups, the first had five participants and the second group had two participants.

A follow-up second round of focus groups was held approximately four-weeks later. There was one group held for the X cohort where two participants attended. The X participants joined together for the second focus group where two participants attended. The second focus group commenced with a member-check, where a summary of the previous focus group was provided, discussed and points clarified.

The first focus groups lasted between 54 and 60 minutes and the second focus groups lasted between 45 and 50 minutes. The focus groups were audio-recorded and transcribed verbatim for analysis. Field notes were also taken. X moderated and X monitored and took notes with the X trainers, X moderated and X monitored and took notes with the X participants. Data saturation was reached at the point of the second round of focus groups where no new information/ideas were emerging from the focus groups.

3.4. Data analysis

The data were then subject to 1) thematic analysis, 2) comparative analysis 3) Strength, Weakness, Opportunity and Threats (SWOT) analysis (see Fig. 1).

3.4.1. Thematic analysis

Data were thematically analysed using the six-stage thematic steps suggested by Braun and Clarke (2021). Following professional transcription, X listened to and ensured transcripts were accurate, transcripts were then subject to analysis by X and X. After familiarisation with the data, initial codes were generated, where similar accounts were identified and assigned codes using Microsoft word (noting that that computer aided data analytic software was not used). The codes were then discussed together by X, X and X. The codes were then collated into potential themes, which were then reviewed in relation to the coded extracts, followed by the full dataset, X, X and X then discussed and identified the final themes. Changes were made to the codes and/or themes following discussion. The writing up the results was the final step in writing this paper. All authors have either extensive mental health experience (X) or extensive nursing and education experience (X) and all have qualitative research experience.

3.4.2. Comparative analysis

The APP-EPAs were also subject to a comparative analysis against the universally accepted EPA standard for healthcare professionals as outlined in the AMEE guide. This was undertaken to ensure the APP-EPA tools met the expected standard and format. The most recent AMEE guide, updated in 2021, was used for this comparison, which included all recommended sections in a full EPA, with the addition of a rationale for each inclusion (ten Cate and Taylor, 2021). The analysis was informed by comparing the recommended description of an EPA according to the AMEE Guide and critically analysing of quality of the APP-EPAs based on the data received from the focus groups. The process allowed for identification of areas that require further refinement to

Table 2
APP EPA description and EPA for reassurance.

Aggression Prevention Protocol Reassurance Intervention

According to the APP, reassurance is the pragmatic use of communication skills to calm anxiety, promote comfort, shape beliefs and prompt motivation. When using reassurance nurses are encouraged to consider the tone, rate and volume of their voice. Non-verbal interactions are also important, such as the distance between the nurse and the consumer, posture, level of eye contact and facial expressions. Some of the communication skills used during reassurance may include active listening skills and demonstrating empathy. Following any event on the unit that might contribute to anxiety for consumers (e.g. aggression and self-harm), there should also be some increased efforts to be more visible and present on the unit, engaging in a warm and caring manner. The goal of nurse presence, explanation and support is to ensure that everyone feel safe and supported.

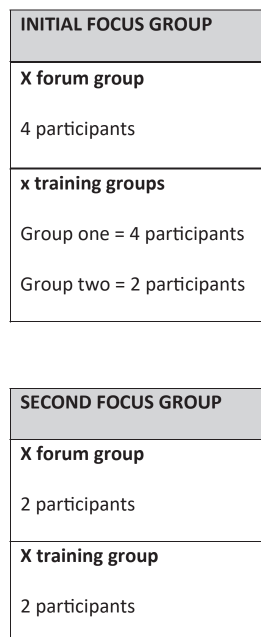
Knowledge competencies
The mental health nurse demonstrates an understanding of:
recommended principles when providing reassurance and how to provide reassurance
why reassurance is not recommended in the moderate DASA risk band in the APP

Skills competencies
The mental health nurse:
recognises situations that may require reassurance
uses the APP as a guide to determine when reassurance is appropriate
incorporates active listening skills during reassurance
demonstrates empathy when applying reassurance
establishes effective verbal and non-verbal communication skills while providing reassurance
incorporates person-centred, gender sensitive and culturally sensitive practice principles
documents how and why reassurance was applied, including outcomes and any recommendations for future use of reassurance specific to the consumer
evaluates the effectiveness of reassurance with consumers

Attitude competencies
The mental health nurse:
recognises how inpatient mental health care and mental health concerns can be anxiety provoking for consumers
is genuinely interested in what is happening for the consumer and tries to understand and meet their personal and mental health needs
reflects on their reassurance skills to identify aspects that need improvement

Scale of entrustment for reassurance

Level of entrustment	Level descriptor: The leaner 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 frequent and/or assistance, to carry APP reassurance within the inpatient setting. The nurse accepts feedback for performance improvement.
Level 2	I trust the nurse to carry out APP reassurance with indirect supervision. The nurse demonstrates self-direction and seeks guidance as required.
Level 3	I trust the nurse to completely and accurately carry out APP reassurance independently.
Level 4	I trust the nurse has mastered the ability to completely and accurately carry out APP reassurance independently and provide a level of supervision and feedback to other nurses.



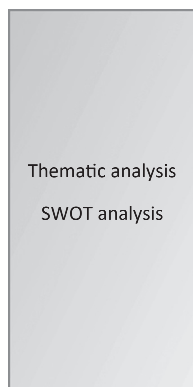


Fig. 1. APP-EPA data collection and analysis.

ensure the EPAs are appropriate for future implementation. Analysis was undertaken by X and checked by X.

3.4.3. *SWOT analysis*

A SWOT analysis was conducted on the APP-EPA's using data collected from the focus groups. A SWOT analysis is a technique used to appraise the 'strengths', 'weaknesses', 'opportunities' and 'threats' in a project (Gürel and Tat, 2017), or in this study, the proposed APP-EPAs. The focus group data on the EPAs were grouped into four categories: strengths, weaknesses, opportunities and threats to implementation and use of the EPAs. A SWOT analysis framework was selected because it is capable of exploring internal and external facilitators and barriers and has been used as a tool to assist mental health care services enhance care delivery (Swysen et al., 2012). X initially conducted the SWOT analysis and this was reviewed by X and X.

3.5. *Rigour*

Rigour was ensured by employing a methodical and reflexive approach in study design and during data collection and analysis phases (Baillie, 2015). Participants were recruited because they are experts in the field. Experienced researchers conducted and moderated the focus groups. Member-checking was also included, where initial findings from the first focus groups were returned to the participants and responses collected. All transcripts were reviewed by X for accuracy against the audio-recordings. Coding and understanding of data was achieved in a shared collaborative manner and themes were established by grounding these on reflections of the research team. Quotes that exemplify themes were selected based on the most suitable representation of the theme.

4. Results

For the thematic analysis three themes were identified: 1) frameworks such as the APP are needed to work towards elimination of restrictive practices; 2) the APP-EPAs afford an opportunity to set the standard for practice and; and 3) who watches the watchers?

4.1. Thematic analysis

4.1.1. Theme one: frameworks such as the APP are needed to work towards elimination of restrictive practices

Participants reported nursing staff concerns about elimination of restrictive practices, as noted by one participant who stated, “there is lots of stress and anxiety around moving from more restrictive to less restrictive practice” (P8). Participants considered the teaching and assessment of skills included in the APP-EPAs as important, particularly to assist the move towards elimination of restrictive practices, however the reality was that services still tended to prioritise teaching and assessment of skills associated with restrictive practices, including physical restraint:

> *“If we are going to move towards elimination and significant reduction, that comes from skilled de-escalation and assessment and early warning signs…however…we haven’t got the capacity to take them off for training that’s where the biggest gains can come from is teaching this prevention stuff and making sure people are learning and capable of prevention and de-escalation” (P1).*

> *“We need to challenge restrictive practice otherwise we’re never going to move forward. This is how we nurse (DASA+APP); this is mental health nursing in 2022. This is the level of expectation on our staff to level up their practice” (P9).*

Furthermore, service review, practice and documentation tends to also focus on restraint and seclusion rather than review of the use of interventions such as de-escalation:

> *“We review restraints and seclusions and do an incident review to find out where we went wrong. We don’t review the everyday work, which is de-escalation, limit setting. We can pull up data of how many PRN meds are given on a shift…. But assessing what’s happening on the ground is difficult to see or to find if it works as staff don’t tend to write this in their notes. They just said, de-escalation techniques utilized, but don’t say exactly what it is” (P2)*

There was concern expressed about the lack of training related to prevention skills as demonstrated by the following quotes:

> *“I’ve always been really disappointed there’s hardly anything about de-escalation. You talk about how we need to do it, but it’s glossed over” (P10)*

> *“If we are expecting registered professionals to gain these skills and utilize them in practice, then as services we have obligations to ensure that they are well-supported and able to do that effectively and then monitor the outcomes for our people” (P11).*

There was recognition of the need for prevention skills training, such as those included in the APP, due to the potential for these interventions to be carried out in a manner that is not recognised as best-practice:

> *“Some of our biggest issues or blow ups have been caused by people who have potentially become complacent with their approach…and potentially jaded. Without realizing it, they’ve lost empathy and compassion when engaging with somebody” (P4)*

4.1.2. Theme two: APP-EPAs afford an opportunity to set the standard for practice

Participants considered the APP-EPAs to reflect evidence-based practice and helpful in terms of describing practice expectations, as this is not always apparent in training and practice:

> *“This is adding a framework to what would be counted as good-practice and good de-escalation. It’s good to see it written down and to go I can see that happening and you have that framework” (P1)*

> *“It’s clear that its evidence-based. It’s all well researched, its gold standard practice” (P9)*

> *“It’s all very vague (the current training package). We say, "Use de-escalation skills."when I’m working as a trainer, I always try and emphasize that, but there’s no official training for it…A lot of people don’t really know what it is and it’s really essential” (P10)*

The APP-EPAs were viewed by participants as a good way to guide practice and assess how people carry out aggression prevention interventions in practice:

> *“It’s (APP-EPA’s) really good to not only guide practice, but hold people accountable for their skills as well” (P11)*

> *“Any fresh nurse coming onto an inpatient unit, it can be really intimidating and it takes time to develop skills to feel safe on a unit. Having something like this (APP-EPAs) would really help. Have the goal to work towards and have specific things that they can do to strengthen their skills” (P10)*

> *“My understanding going through the manual is each competency is broken down into different and understandable, less complicated clinical activities and that will be easy for the assessor to assess” (P8)*

Participants expressed difficulty of addressing practice issues related application of some nursing skills where currently no framework such as the APP-EPAs exist in particular when addressing poor practice of more experienced staff. *“As difficult as it is to tell somebody who’s worked for 40 years to suck eggs, eventually you need to have that conversation”* (P4). However, the APP-EPAs were perceived to offer a way to tackle some of these difficult conversations *“(the EPAs) are a really great way to do it, especially with more senior people”* (P2).

4.2. Theme three: who watches the watchers?

The final theme relates to participants’ expression of the need to ensure people who are doing the assessment and evaluation of others using APP-EPAs maintain their current awareness of relevant policies, research and practice to ensure teaching and assessment using the APP-EPAs is undertaken with integrity:

> *“Who watches the watchman? We’re going to have people buddying up and teaching our young nurses, but we need to make sure that the people who are teaching are teaching the right thing and doing the right thing” (P4)*

> *“I could see your mental health Clinical Nurse Consultants (CNCs) being the mentors especially, your grad educator for the grads and you’re CNC for the others. And if they’ve then got support from whoever is implementing their APP-EPAs, it would help if then they’ve got someone to go to. You’ve always got someone who’s watching the watchers” (P2)*

Support was also considered important to ensure that the training and practice does not depart from the original intent:

> *“It would be important to have that higher end peer supervision or Community of Practice, to make sure that you’re checking in and that we’re all still working to the same thing. The language stays the same and so the expectations stay the same, so it doesn’t just get wishy-washy and murky” (P1)*

Participants discussed past experiences where without oversight and support *“things fall over quickly” (P1),* where other initiatives were discussed as examples that resulted in *“losing what it was originally implemented for” (P2).*

Participants also discussed the need for resourcing to support implementation as it was acknowledged that using the APP-EPAs would require someone to take a leadership role and this could add to an already stretched workforce:

> *"This would be a lot of work for a nurse educator or a clinical coach. to actually find someone at the right time with the competing demands" (P7).*

4.3. Comparative analysis

Table 3 presents the comparative analysis.

4.4. SWOT analysis

A SWOT analysis was conducted on the APP-EPAs using data collected from the focus groups. Table 3 provides a summary of themes from the SWOT analysis.

4.5. Strengths

The strengths include the APP-EPAs addressing a practice-gap, as illustrated by one participant who stated, "*I've always been quite concerned that we don't focus a lot on assessment of skills like de-escalation and do any real skills teaching*" (P6). It was suggested there is currently no form of assessment for interventions like the ones in the APP and as identified by one participant *"it's (the APP-EPAs) got value for sure"* (P7). Furthermore, despite participants not being familiar with EPAs, they found them easy to understand and relevant to practice:

> *"The EPAs clarifies what they are (APP interventions) and it gives you a framework to work with" (P4)*

> *"I like the way it is set out to have a brief description and then break it down, its short and brief and easy to consume, you very quickly get a picture" (P1)*

> *"It's very applicable, very relevant, it makes sense" (P6)*

4.6. Weaknesses

To date, the APP-EPAs have not had any input from people with lived-experience, this is a requirement for most services prior to adopting any new framework, as suggested by one participant, "*rolling out (APP-EPAs) would be much quicker and easier if they have been reviewed through consumer input*" (P1). During the focus groups there was some discussion that although the APP-EPAs were designed for registered nurses, some interventions are carried out by nursing assistants. With current workforce shortages, participants suggested "*the workforce of others is probably only going to grow with the shortage of registered nurses…. it's only matter of time before services look at auxiliary staff*" (P1) and these staff will eventually deliver some interventions. The potential addition to already stretched workloads was also identified as a possible weakness.

Table 3
SWOT analysis of APP-EPAs.

EPAs for APP SWOT Analysis			
S Strengths	**W Weaknesses**	**O Opportunities**	**T Threats**
There is nothing currently like this EPA's for such interventions is needed The EPAs are easy to understand The EPAs are relevant to MHN practice The EPAs provide a framework and set the standard The APP EPAs are suitable for the novice to expert	Some APP EPAs are subjective The APP EPAs could add to workload The APP EPAs need to be taken to a consumer group for feedback The APP EPAs were designed for registered staff but in reality other areas of the workforce are doing these interventions	Provide opportunity for self-reflection Provides the opportunity work on culture of reducing restrictive interventions Provides learning opportunities and supervision Could be used for performance improvement Could be used to enhance documentation	The APP EPA's could be time consuming to administer Who would be responsible for the APP EPA's The APP EPA's need to lead by those who are committed and passionate or risk not been taken seriously

4.7. Opportunities

Participants viewed the APP-EPAs as providing opportunity to reflect on one's own practice, for example *"you do a self-assessment and a peer does an assessment of your skills as well"* (P7), as well as providing a foundation for clinical supervision and performance improvement. Further opportunities for the APP-EPAs were identified in assisting documentation by highlighting details of the intervention to provide more description about how it was carried out in practice, as demonstrated in the following quotes:

> *"The details for each of the skill, for example how and why reassurance is applied is provided…. Something that just drives me around the bend, in clinical practice is how little time people spend describing therapeutic interventions and effectiveness…I like the fact that the EPAs prompt this and if you're assessing its needs to be documented it too. I really like that about your manual" (P7)*

4.8. Threats

Participants suggested ownership of APP-EPAs was an important consideration and needed to be championed by "*a team of people who are identified as being passionate, who are committed to reducing restrictive practice and preventing violence, who could be a team that are specifically for monitoring EPAs, even if they're not senior, but really committed to it*" (P10), or through "*provision of support through a Community of Practice*" (P11). Without oversight from committed people participants felt there was risk EPAs would not be taken seriously and potentially signed off without adequate reflection.

5. Discussion

This study explored the utility of EPAs as an in-situ assessment tool to determine nurses' trustworthiness and capability to carry-out APP interventions. In this study, while expert nurses articulated the importance of training and assessing interventions such as those contained in the APP, it was acknowledged that contemporary prevention of aggression training tended to still prioritise teaching of restrictive practices. These practices are more easily assessed, as they can be broken down into concrete subcategories and fit better into a competence framework (Sklar, 2015). The complexity of other psychosocial interventions such as de-escalation cannot be parsed in the same way. The EPA is a tool that enables assessment of capability encompassing the activity. Participants identified that there is currently nothing available such as APP-EPAs to guide practice and training and to evaluate trainees. The development of the APP-EPAs addresses this practice-gap.

The EPAs were identified as having utility to set the appropriate standard for practice, while providing a framework to undertake and assess some of the more complex skills such as de-escalation and limit setting. The complexity of de-escalation and ability to confidently assess this activity within allocated time service priorities and timeframes were considered reasons for less emphasis in training. Providing feedback on performance when these complex tasks are undertaken at a lesser standard was also seen as a practice challenge. The detail in the EPAs

was also seen as a precise tool to assist with providing feedback when practice may not be ideal. Participants also identified the need for appropriate oversight and resourcing of initiatives that would assist standards of practice and this would be required to appropriately implement the APP-EPAs, if practice standards were to be enhanced. As participants previous experience suggests, without appropriate oversight and resources it is likely there will be issues with implementation, sustainability and deviation from intent.

Although not the primary focus of this research, concern was expressed about the move towards elimination of restrictive practices. While there has been concerted effort over many years to reduce use of restrictive practices, the challenge of keeping everyone safe while addressing challenging behaviour and not resorting to restrictive practices remains (Blair et al., 2017; Hallett and McLaughlin, 2022). This task often falls to nurses, resulting in fear, anxiety and moral distress regarding how to safely manage challenging behaviour (Kinner et al., 2017; Muir-Cochrane et al., 2018). The focus of training needs to shift towards prevention interventions such as de-escalation. The current legislative and policy changes are increasingly restricting use of restrictive practices (McKenna et al., 2017) and have compounded the need for effective assessment tools for complex preventative interventions.

To limit use of restrictive practices, there is a need to provide nurses with the skills to assess and manage people at risk of behaving aggressively. Participants identified the DASA+APP-EPAs as novel and unique, which offer a viable way to prevent aggression, reduce use of restrictive practices and assess application of the specified APP interventions. The APP, like Six-Core Strategies (Huckshorn, 2005) and models of care such as Safewards (Bowers, 2014), can be used to upskill staff in delivery of person-centered interventions. However, there is commitment required from services to successfully implement, train, assess and sustain practice (Michie et al., 2007).

While the focus on teaching restraint and seclusion techniques is understandable from an occupational violence perspective, teaching of prevention and de-escalation skills is also vital, particularly regarding the move to eliminate restrictive practices. Additionally, as suggested by participants, some of the skills such as de-escalation receive little attention during training and if not carried out correctly may lead to an escalation of conflict. Some services have successfully implemented seclusion reduction projects with financial savings, as well as obvious benefits for consumers and staff (Curie, 2005; Duxbury et al., 2019). The EPAs could assist in upskilling and assessing the workforce by ensuring high standards of practice in application of early and least restrictive interventions.

In mental health nursing, a lack of communication and interaction with consumers and lack of willingness to employ alternative interventions to restrictive practices exemplify poor practice and can contribute to aggression (Brophy et al., 2016; Janner and Delaney, 2012). Addressing poor practice with colleagues can be difficult, particularly for junior staff, who may be required to have these conversations with senior staff, or nurses who have more experience (Sahay and Willis, 2022). Supportive education programs are suggested as part of the strategy to work on reduction of restrictive practices and to ensure optimal working environments (Power et al., 2020). The APP-EPAs can enhance nursing practice by promoting best-practice via a structured framework, whereby the practice standards and assessment of APP interventions are clear. Additionally, EPAs provide a means for feedback delivery and assist in navigating difficult conversations when practice may be a departure from expected standard.

5.1. Relevance for practice

Participants suggested the APP-EPAs would be helpful for all nurses, from graduates to more experienced. However, conversations about practice with a cohort of experienced nurses may prove challenging, especially if the assessing nurse may be at a lower grade/level of nursing to the learner. To avoid such complications, it was considered important for APP trainers and EPA evaluators to hold authority and be recognised as experts in the application of APP interventions. These nurses would be expected to be performing at level-four of the entrustment scale. In this regard, clinical champions for EPAs are seen as necessary for practice improvement and ensuring staff are skilled, keep up-to-date with practice and do not drift from intent of the APP-EPAs. Clinical champions can be effective in promoting practice change (Morena et al., 2022). To assist champions who co-ordinate the APP-EPAs, participants considered the creation of a Community of Practice as a way of supporting the champions and maintaining consistency in teaching and ensuring no deviation from best practice. Communities of Practice can assist people to work together and share/transfer knowledge, support practice, develop strategies and solutions and create a culture of collaboration (Piat et al., 2016) and may also assist in having oversight of people doing the assessing (watching the watcher).

The comparative and SWOT analysis identified where the APP-EPAs achieved the AMEE criteria and areas for refinement. Importantly participants suggested the APP-EPAs addressed a current practice-gap and could assist in movement towards the elimination of restrictive practices, while also reducing aggression and offering opportunity for self-reflection and practice-improvement. Assessing the strengths, weaknesses, opportunities and threats at a local service level, could assist in addressing areas of potential concern prior to implementation. Future directions include pilot implementation and evaluation of EPAs in practice.

5.2. Limitations

This study included participants across X and X. As such, the generalizability of these findings to other countries will need to be determined by experts in these other settings. Not all participants were able to attend the second focus group; however, a key strength of this study was involvement of expert trainers who hold extensive knowledge and expertise in prevention of aggression training. Importantly, this study did not include the opinions of the consumer/carer workforce. Refinement of the APP-EPAs has been planned to canvas and take consumer views into consideration.

6. Conclusions

Defining, applying and assessing practice activities that aim to prevent aggression and limit the use of restrictive practices is essential, although methods to assist nurses with this task are lacking. Results from this study suggest that EPAs may provide a suitable method to define and assess practice. To enable practice improvement, health professionals need to be equipped appropriately with training and to be assessed regarding their competency to implement complex least-restrictive interventions. APP-EPAs offer a framework to address this practice-gap. This is the first structured framework developed to define aggression prevention interventions and assess the learner's ability to apply them in practice. The EPAs afford opportunity for self-reflection and guidance for practice improvement. It is crucial to recognize the intricacies and complexities involved in these essential professional activities in mental health nursing and imperative there is development and implementation of techniques and strategies that facilitate evaluation to ensure best standards of practice

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Declaration of Competing Interest

We do not have any actual or potential competing interests that could have appeared to influence the work reported in this paper

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